8

WOMEN AND PSYCHIATRIC MODERNISM

The therapies of Rivers and Yealland represented the two modes of English psychiatric modernism which would affect women both inside and outside the asylum from the 1920s to the 1960s: psychoanalysis, which offered the twentieth century's most influential theory of femininity and female sexuality; and traditional medical psychiatry, which made rapid advances in scientific knowledge and technological skill.

In many respects, it seemed as if women had benefitted from the social upheaval of the war. The image of idle middle-class women as the chief clientele for nervous disorders had been substantially modified. In the decade after the war, the incidence of female hysteria dramatically declined. Many believed that women had become stronger and less vulnerable to mental breakdown when they were faced with real crises and when they were given meaningful work. "If the First World War was a clear-cut victory for anything," the historian David Mitchell proclaims, "it was a clear-cut victory for women's emancipation."[1]

Furthermore, the field of psychiatry seemed more open to women's participation, to women's ideas, and to new thinking about female psy-

chology. In 1927, "after much heart-searching" and in view of the large number of female patients, the employment of women doctors in London County mental hospitals was sanctioned by the London County Council, and two women were immediately appointed as assistant medical officers.[2] Over all, forty women members of the Medico-Psychological Association were working in English hospitals by this date.[3]

Within the field of psychoanalysis, the situation was even more promising. Many feminists had been attracted to psychoanalysis from its earliest years, seeing it as a theory that accepted female sexuality and freed women from the shackles of a puritanical Darwinian science. Freudian ideas became immediately popular with the literary avant-garde after the war. "All literary London discovered Freud," the novelist Bryher (Winifred Ellerman) recalled; "the theories were the great subject of conversation wherever one went at that date."[4] As the heiress to an enormous fortune, Bryher herself provided financial support for the psychoanalytic movement in Vienna, helped to found the *Psychoanalytic Review,* and gave money directly to Freud in the 1930s. She and the poet H.D. were among the first to be analyzed themselves. Furthermore, because psychoanalysis was a new field, women found fewer barriers against them within it than in the traditional work of the asylum or consulting room. Among the thirty original members of the British Psychoanalytic Society, six were women: Alix Strachey (1892–1973), Joan Rivière (1883–1962), Sylvia Payne (1880–1976), Barbara Low, Susan Isaacs (1885–1948), and Ella Freeman Sharpe (1875–1947).

Yet the real effect of these changes was disappointing; in cold reality the political or psychic victories women gained during the war were few. By the 1920s, women found themselves with little progress besides the vote (which had, in any case, been won by 1914) to show for their brief period of wartime emancipation. Although women's employment had skyrocketed during the war, returning soldiers took their industrial jobs back from the women who had replaced them. In 1921, the female percentage of the work force was exactly what it had been in 1911—29 percent—and it did not increase significantly during the next thirty years.[5] Sexual behavior and standards also quickly reverted to prewar levels. Illegitimacy rates dropped and divorce rates stabilized in the late 1920s, as women were encouraged by advertising and urged by the government to return to domesticity and chastity. Feminist feeling, which had reached a peak in the suffrage movement, subsided.

Denied their work and coping with emotional loss, many women felt

despair at the prospect of returning to shopworn roles and old routines. For them, too, the war continued to be fought in the psyche, and the period of readjustment precipitated psychological problems. By the 1930s, the Tavistock Clinic, founded for the psychoanalytic treatment of functional nervous disorders, reported that 61 percent of its patients were women.[6] And psychoanalysis, for its part, hardened into a discourse that devalued women—despite the presence of women in its ranks.

The failure of women analysts to develop a feminist view of female sexuality and psychology is a fascinating instance of the general collapse of the feminist movement after the war. The turn of the century had been a period in which definitions of both masculinity and femininity were being revised. The postwar period, however, was one of renewed conservatism about sex roles and gender issues. One of the main signs of this conservatism was the erosion of late Victorian institutions formed by and for middle-class women (settlement houses, schools, colleges, and sisterhoods). Another was the shift of feminist interests away from questions of women's independence to questions of women's relationship to men. Both changes affected woman's role in the early years of psychoanalysis.

The story of the Medico-Psychological Clinic in London offers a striking illustration of the way that male professionalism could crush the early experimentation of women in psychoanalysis. Founded in 1913 by two women, Dr. Jessie Margaret Murray and Julia Turner, and funded by the novelist May Sinclair, this was the first public clinic in England to offer psychoanalytic treatment. While not explicitly feminist in theory, the clinic was clearly a practical feminist initiative in the field that might well have become a center for new ideas on the psychology of women. Murray had a medical degree from Durham and had studied with the neurologist Pierre Janet in Paris; she and Turner were well read in a variety of psychotherapeutic fields, including the work of Freud, Jung, Brill, and Breuer. They took an eclectic approach to the treatment of nervous disorders, combining psychoanalysis with diet, exercise, and medical treatment. They also sponsored a training center in which students took a three-year course in applied psychology.

Originally, the clinic served mainly women patients, as was undoubtedly the intention of its founders. During the war, however, Murray and Turner found themselves besieged by male patients discharged from the armed services because of shell shock and nervous disorders.

In order to handle the deluge of cases, they expanded the clinic in Brunswick Square to include a residence for shell-shocked soldiers, and took on a partner, Dr. James Glover, a young doctor interested in psychoanalysis who had been rejected for military service because of the early symptoms of diabetes.

Tragically, Jessie Murray developed cancer in 1919 and died the following year at the age of fifty-three, leaving Glover and Turner in charge of the clinic. Once the war was over, Glover was eager to learn more about psychoanalysis at first hand. In 1920, he had the opportunity to attend the Sixth International Psychoanalytical Congress at The Hague, where he met Karl Abraham; and a few months later, he went to Berlin to undergo a Freudian analysis with Abraham. When Glover returned to London, he had become "a total convert to psychoanalysis. He firmly believed that only psychoanalytic treatment, on proper Freudian lines, should be applied to all patients accepted by the Clinic, and that the eclectic practice which Dr. Jessie Murray had established should be abandoned."[7]

Glover further proposed that the clinic and its program should become affiliated with the new British Psycho-Analytical Society founded by Ernest Jones. When Julia Turner refused to join, Glover left the clinic, taking most of the women students and staff with him. By 1922, Julia Turner was forced to close the clinic and to liquidate its assets to pay her debts. Several of her medical consultants joined the staff of the Tavistock Clinic, opened in 1919 by Dr. Hugh Crichton-Miller; others joined the British Psycho-Analytical Society. Within a few years, the work of Murray and Turner had passed into oblivion.

James Glover's conversion in Berlin and his subsequent "normalization" of the Medico-Psychological Clinic can be seen as a reaction against the feminist leadership of an older generation. Murray and Turner were representatives of the first generation of college-educated women in England. Their relationship was typical of the intimate friendships that for so many pioneering women relieved the pressure of professional careers; and their clinic was modeled on other women's institutions founded at the end of the century. But by the time of the war, both women's friendships and women's institutions were under direct attack, not only in the writings of male sexologists and psychologists such as Havelock Ellis and Freud, but also in sensational novels about lesbian villainy, such as Clemence Dane's *Regiment of Women* (1917). As Martha Vicinus has shown, at a time when "single women

were powerful and highly visible leaders in the public sphere," loving friendships between single women were attacked as deviant and perverse.[8]

Glover's takeover of the clinic occurred in the context of this cultural change. Indeed, it was Glover's analyst, Karl Abraham, who had first interpreted the feminist movement of the period as the expression of a "masculinity complex" in neurotic women. In the famous paper he gave at the postwar psychoanalytical congress attended by Glover, "Manifestations of the Female Castration Complex," Abraham described feminists as women who sublimated their wish to be men by "following masculine pursuits of an intellectual and professional nature."[9]

Freud accepted Karl Abraham's view on feminists, praising Abraham's description of the female castration complex as "unsurpassed." In addition to his work on hysteria, Freud formulated his own views about female psychology and sexuality in three brief essays of the late 1920s and early 1930s: "Some Psychological Consequences of the Anatomical Differences Between the Sexes" (1925); "Female Sexuality" (1931); and "Femininity" (1933). In these essays, Freud developed his theory of the girl's anatomical deficiency, or what he called "the fact of her castration," leading to the female version of the Oedipus complex, which comprised penis envy, feelings of inferiority or self-hatred, and contempt for the mother. In coming to terms with her "castration" in early childhood, the girl had three possible paths of psychic development: sexual fear and withdrawal; defiant competition with men, and possibly homosexuality; or the happy resolution in which she switched affection from her mother to her father, changed her libidinal object from female to male, repressed her "masculine, active, clitoral sexuality," and finally accepted an infant, particularly a male infant, as a substitute for the phallus. Freud thus modeled his theory of female sexual identity on the woman's difference from the male. But he did not consider the importance for female identity of the daughter's similarity to the mother. Although in his later work Freud recognized that mother-infant bonding in the pre-Oedipal phase (the term for the period of exclusive attachment to the mother) might have a significant and possibly a determining influence on the construction of femininity, he also believed that this phase was almost impossible to uncover in analytic practice, that it was "grey with age and shadowy," like the buried civilization of the Minoans behind the civilization of Greece.[10]

For a brief period, from about 1925 to 1935, there was an intense

debate within the psychoanalytic movement on the question of femininity, female sexuality, and the psychology of women. This came about in part because Freud encouraged female rather than male disciples after 1924. Yet one historian has argued that Freud sought out surrogate daughters because they were "less difficult and competitive" than men.[11] Paradoxically, it was often female analysts, such as Helene Deutsch, Ruth Mack Brunswick, Jeanne Lampl-de Groot, and Marie Bonaparte, who (despite their differences) sided with Freud, while some male analysts, such as Ernest Jones and Carl Muller-Braunschweig, disagreed with Freud's fundamental assumptions about feminine psychology as a defective version of masculine psychic development.

The leading figure in this debate was the German analyst Karen Horney (1885–1952). In a series of powerful papers written between 1926 and 1935, Horney challenged the basic tenets of Freudian psychoanalysis with regard to women. She described psychoanalysis as a male-dominated and androcentric discipline, "the creation of a male genius," in which the psychology of women had necessarily "been considered only from the point of view of men." Horney stressed the sociocultural influence on female psychology, "the actual disadvantages under which women labor in social life"; the role of male fantasy in the construction of feminine "nature" and of "male narcissism" in such psychoanalytic concepts as penis envy.[12] Speaking not only from her psychoanalytic training but also from her experience as the mother of three children, she argued that Freud had overlooked the importance of motherhood in female psychology, and the significance of men's envy of pregnancy, childbirth, suckling, and mothering.

Yet in the 1930s, after she moved from Berlin to the United States, Horney ended her quarrel with Freud; she dropped the subject of feminine psychology and turned to investigating the problems of marriage. The feminist historian Dee Garrison has speculated that the shift was partly Horney's response to problems in her own marriage, and partly her prudence in abandoning a dangerously controversial position. Women analysts, moreover, were handicapped by the absence of a feminist movement that could help them articulate a collective position.[13] As female dissidents were marginalized or converted by the Freudian community, which pressed for internal cohesion and solidarity, the feminist discourse within psychoanalysis collapsed, and was not revived until the 1970s, when important studies of the pre-Oedipal phase and its implications for female development by Nancy Chodo-

row, Margaret Mahler, and Carol Gilligan, among others, reopened the field to feminist analysis.

The English women analysts, meanwhile, tended to avoid the debate over female psychology altogether. Low, Payne, and Isaacs concentrated on work with children and on the training and teaching of other analysts. Rivière and Strachey took responsibility for translating Freud's work into English, both through the *International Journal of Psychoanalysis* and through the Hogarth Press edition of Freud's collected works. Sharpe, who had been an English teacher before she trained with Jessie Murray's clinic, devoted herself to psychoanalytic readings of literature, especially Shakespeare. The most influential woman in the British Psycho-Analytical Society, Melanie Klein, did break with Freud; but she, too, chose to specialize in an alternative psychoanalysis of children and infants, which ignored the woman question. As Juliet Mitchell has noted, although Klein drew attention to the importance of the mother-child relation and the pre-Oedipal phase, the Kleinian school "avoided contributing anything really new or specific to the understanding of feminine psychology."[14]

Over all, the fields that became the special purview of women psychoanalysts in England during the 1920s and 1930s—child psychiatry, mother-child relations, literary criticism, translation, and pedagogy—can be seen as defenses against orthodox Freudian charges of the "masculinity complex." In a sense, the women analysts in the British Psycho-Analytical Society assumed roles within the discipline and the profession that were extensions of their prewar feminine roles, and that were not a threat to the Society itself—run "in a patriarchal manner," as one woman recalled, by Ernest Jones and Edward Glover.[15]

Just as there were few changes in the theoretical view of female insanity within the profession, so too with regard to the treatment of female insanity in asylums and mental institutions, neither psychoanalysis nor the lessons of the war had much effect. Moreover, the employment of forty women doctors in British mental hospitals was ultimately insignificant. They had little impact on the traditional structure of these institutions.

Octavia Wilberforce (1888–1963), who later became Virginia Woolf's physician, was one of the pioneering English women doctors who worked in mental institutions. With the support of the feminist writer Elizabeth Robins, she had defied her family and qualified as a physician in 1920, and at the beginning of her career she worked for a

few weeks at Graylingwell Mental Hospital in Chichester. Wilberforce divided the responsibility for three hundred women patients with one other doctor, and she wrote up reports on six of them each day. As the first woman doctor to work in the hospital, she faced the suspicion of both nurses and patients: "Before I came they were all very agitated and *hated* the thought of a woman Dr." But her enthusiasm, her interest in the patients, and her forthrightness with the nursing staff won them all over.

Despite good intentions, the overworked staff had few resources—intellectual, medical, or psychological—for dealing with withdrawn, or even worse, violent women patients. Because her stay at Graylingwell was brief, Wilberforce did not have time to become discouraged by her work. She found it a challenge to persuade patients to exercise and eat by addressing them politely and treating them like adults. Despite the demands on her time, she listened to the women's worries and talked to them often, urging one to play the piano, another to remember her happy memories. "This place is going to make *me* a very good conversationalist," she noted. Wilberforce also thought about the reasons for the women's behavior. She observed that many were former governesses. "Why should teaching send you dotty? Continual hard work, no future, no ambitions, *bad pay,* eh?" The worst cases seemed to be "the inelastic conservative governesses in *military families*"; and Wilberforce quickly perceived the connection between women's economic dependence and oppression, and mental breakdown: "As you see, I hold the view that it's quite a presentable complaint in *many* instances. Were slaves ever mad? What about its being *mentally unhealthy* to be the underdog? Socialism is needed." Wilberforce interpreted the patients' symptoms too in terms of the restrictions and anxieties of the female role. Among the women were "a good number of folk whose husbands have been unfaithful." Many patients were angry and abusive: "It's interesting, isn't it, that women use worse language and are more obscene than men? Why? 'Cos they've been taught to repress it always." When she left Graylingwell, Wilberforce felt that she had "done *quite good spade work* here for any future women who might like to come," and that being there "was the best thing that could have happened to me."[16] She had bolstered her own self-confidence, won the nurses' respect, and shown them how to handle the women patients with dignity and good humor.

But Wilberforce's optimism was contradicted by the resistance of

old-fashioned asylums to applying new ideas to the treatment of female mental patients. In 1922, the novelist Antonia White had a serious mental breakdown and spent ten harrowing months in Bethlem, where she was forcibly fed, heavily drugged, straitjacketed, put in a padded cell, and tied down to her bed. In her novel *Beyond the Glass* (1954), White described her memories of the asylum, which retained its Victorian ambience—"wax flowers under cases, and engravings of Queen Victoria and Balmoral"—as well as its pre-Victorian harshness: "She woke up in a small bare cell. The walls were whitewashed and dirty, and she was lying on a mattress on the floor, without sheets, with only rough, red-striped blankets over her. She was wearing a linen gown, like an old-fashioned nightshirt, and she was bitterly cold."[17] The enlightened thinking that had made Sassoon's stay at Craiglockhart so comfortable did not extend beyond a few privileged institutions.

Many women's inmate narratives contrast the male psychiatrists—uncomprehending, patronizing, hurried, even cruel—with the comforting and maternal woman doctor. But despite official acceptance of women doctors in English mental hospitals, they remained a powerless minority. Thus, Mary Cecil met "a lady doctor, very kind and interested, not so detached as the men," whom everyone on the ward liked and respected. But she was quickly replaced by another man.[18] Moreover, Colney Hatch did not hire even one woman doctor until World War II. As late as 1964, Morag Coate laments in *Beyond All Reason,* "women psychiatrists in mental hospitals are such a rare species that I have scarcely ever met them."[19]

During the postwar period, the female malady, no longer linked to hysteria, assumed a new clinical form: schizophrenia. And whereas psychoanalysis rarely treated schizophrenia, confining itself to the neuroses, traditional medical psychiatry here came into its own.

The psychotic syndrome of schizophrenia was defined around the turn of the century in the work of Emil Kraepelin and Eugen Bleuler. In 1896, Kraepelin's model of "dementia praecox" emphasized the qualities of listlessness, vacancy, and withdrawal in the patient, a "peculiar and fundamental want of any *strong feeling of the impressions of life.*" Typically stricken in late adolescence, the patient rapidly deteriorated through hallucinations and delusions to dementia. In 1911, Kraepelin's theory was modified by Bleuler, who proposed the term "schizophrenia" ("split mind"). He saw the chief issue as the split between thoughts

and emotions, and described four symptoms that characterized the schizophrenic disorder: lack of affect, disturbed associations, autism, and ambivalence. Schizophrenics who were untreated eventually lost all emotional responsiveness:

> They sit about the institutions to which they are confined with expressionless faces, hunched-up, the image of indifference. They permit themselves to be dressed and undressed like automatons, to be led from their customary place of inactivity to the messhall, and back again, without expressing any sign of satisfaction or dissatisfaction.[20]

Still the most baffling, controversial, and malignant of the psychoses, schizophrenia has, since Bleuler's time, been extended to cover a vast assortment of odd behaviors, cultural maladjustments, and political deviations, from shabbily dressed bag ladies to Soviet dissident writers. In England, diagnostic criteria have been relatively conservative, following the outline endorsed by the World Health Organization in 1973, which includes auditory hallucinations, delusions, and episodes of passivity in which the individual feels his thoughts or impulses to be under external control. There are disputes over whether schizophrenia is an organic disease, caused by biochemical and genetic disfunctions, or a social disease caused by the breakdown of relationships between an individual and his milieu; but there is a growing consensus that schizophrenia encompasses several different disorders rather than a single phenomenon with a single cause.

Schizophrenia offers a remarkable example of the cultural conflation of femininity and insanity. First of all, unlike hysteria, anorexia nervosa, or depression, schizophrenia is clinically and statistically *not* a predominantly female mental disorder. Most studies seem to show that the incidence is about equal in women and men.[21] Nevertheless, schizophrenia does carry gender-specific meanings. The best-known studies of the inner life of the schizophrenic—Marguerite Sechaye's *Autobiography of a Schizophrenic Girl,* Barbara O'Brien's *Operators and Things,* and Hannah Green's *I Never Promised You a Rose Garden*—have female protagonists.[22] Moreover, the schizophrenic woman has become as central a cultural figure for the twentieth century as the hysteric was for the nineteenth. Modernist literary movements have appropriated the schizophrenic woman as the symbol of linguistic, religious, and sexual breakdown and rebellion. In surrealist texts, such as André Breton's *Nadja* (1928), in

Yeats's "Crazy Jane" poems of the 1930s, and in Jean Giraudoux's *The Madwoman of Chaillot* (1945), psychotic women become the artist's muse, and speak for a revolutionary potential repressed in the society at large. Films such as Ingmar Bergman's *Persona* and *Through a Glass Darkly,* Robert Altman's *Images,* Richard Benner's *Outrageous,* and John Cassavetes' *A Woman Under the Influence* also use the female schizophrenic as symbol.

Most significantly, the treatments for schizophrenia have strong symbolic associations with feminization and with the female role. From the 1930s to the 1950s, the main English treatments for schizophrenia were insulin shock, electroshock, and lobotomy. Although serious questions have been raised about the effectiveness and the ethics of all three, none has been completely discredited, and all are still in active, if diminished, use today. In the case of each, women are both statistically and representationally predominant as patients.

The medical rationale for the shock treatments which were invented in the 1930s originated in the belief that the grand-mal convulsions of epilepsy were biologically antagonistic to schizophrenia, and that one disorder could be prevented or cured by inducing the symptoms of the other. In insulin therapy, developed by the Viennese psychiatrist Manfred Sakel (1900–1957), schizophrenic patients were given injections of insulin to reduce their blood-sugar level and to induce hypoglycemic shock, which produced convulsions or a coma. After twenty minutes to an hour they were revived by the intravenous injection of glucose. A course of treatment involved anywhere from thirty to ninety shocks. Under insulin therapy, patients also gained twenty to sixty pounds, and in this respect for women this prolonged and very controlling treatment seemed to parallel the pseudopregnancy of the rest cure. It also had effects on the patient's memory. Among Sakel's early cases was a schoolteacher who had developed an "obsessive" love for her superintendent. After insulin shock, she briefly forgot her imaginary love affair, but permanently lost her ability to teach.[23]

Insulin-shock treatment was brought to England by a Viennese doctor who worked in a private mental hospital, Moorcraft House. In November 1938, two English psychiatrists, William Sargent and Russell Fraser, began to use insulin shock at the Maudsley Hospital to induce deep comas in schizophrenic patients.[24] Insulin was administered by female nurses on the wards, and had emotional connotations of infantilization. After receiving her injection, the patient was put to bed to wait for the coma. For some, the worst part was waiting for the

several days it initially took for the insulin level to produce a reaction, listening to the hoarse animal cries of the other comatose women, knowing they too would slobber or grunt, wet the bed, and become ugly and grotesque; and seeing afterwards in the ward each "flushed or chalky face stamped with a sort of nullity." Being revived from an insulin coma, as Mary Cecil recalls, was a peculiarly slow and humiliating rebirth: "I tried to address a nurse who looked in, and to my horror heard only unintelligible sounds. The bedtable was pushed across and my nightgown handed to me. I changed into it with clumsy movements. It took a long time. I handled the spoon like a baby; it kept going the opposite way on the plate and then missing my mouth. I wept with shame."[25]

There were other aspects of insulin therapy, however, such as the daily hot baths, the personal attention, the diet of sugar and starch, that suggested surrogate mothering; and the infantile regression that Mary Cecil found so degrading was seen by some doctors as part of the cure. William Sargent reports that one hospital unit recommended that nurses with big breasts should have charge of the treatment so that when the patient came out of the coma, "he or she was greeted on rebirth with this invitingly maternal sight."[26]

Electroconvulsive therapy, or ECT, was developed by an Italian researcher, Ugo Cerletti, who did his first experiments on pigs in the Rome slaughterhouse. It was first administered to human subjects in 1938, and over the next two decades became established as the major physical treatment for schizophrenia and depression. Early in 1940, electric shock was introduced to England by two neurologists in Bristol. Shortly after, Drs. E. A. Straus and W. Macphail were treating patients at St. Bartholomew's Hospital in London with their own shock machine. Although the London County Council at first refused to buy electric-shock machines for its hospitals, ECT was soon widely used throughout England. In the early days of ECT, before the advent of muscle-relaxant drugs, the spasms produced by the current were so powerful that nurses had to hold the patient down, and fractures of the spine, arm, pelvis, or leg were not uncommon. At Colney Hatch, the occurrence of fractures among patients doubled in the late 1940s with the introduction of electroconvulsive treatment.[27]

In current practice, a patient receiving ECT does not eat for several hours before the treatment. He "lies on a bed or couch with the pillow removed and the usual precautions (e.g., removal of false teeth, spec-

tacles, etc.) observed. He is then given an intravenous injection of a short-acting anaesthetic . . . and through the same needle, a dose of muscle relaxant. . . ." Respiration is controlled by an anaesthetist with a face mask and a pressure bag. When the patient is unconscious, "two electrodes, dampened with a bicarbonate solution to prevent skin burns at their points of contact, are applied to the anterior temporal areas of the scalp. . . . A gag is inserted in the patient's mouth to prevent him biting his tongue. An electric current, usually eighty volts . . . is given which results in a 'modified' convulsion. . . . After the convulsion, the gag is removed, the patient is turned on his side. . . . Within five to twenty minutes the patient gradually returns to full consciousness although he may feel sleepy. . . ."[28] Among the most frequently noted side effects are short-term and partial amnesias.

Although this clinical description of ECT, taken from a recent text by the psychiatrist Anthony Clare, uses the male pronoun, the available statistical evidence shows that in England and the United States women to this day outnumber men as ECT patients by a ratio of two or even three to one. Peter Breggin, an American doctor who has been a forceful opponent of ECT, argues that women more often receive this treatment because they "are judged to have less need of their brains." Much psychiatric literature on ECT, he maintains, recommends it for the less-skilled persons whose livelihoods are not dependent on the use of memory and intellect; housewives can be seen as excellent candidates on these terms. The "improvement" seen in their behavior after the treatment may simply reflect their greater tractability, or reflect the male bias in the profession that finds "mental incapacity and helpless dependence . . . far more acceptable in women than in men."[29]

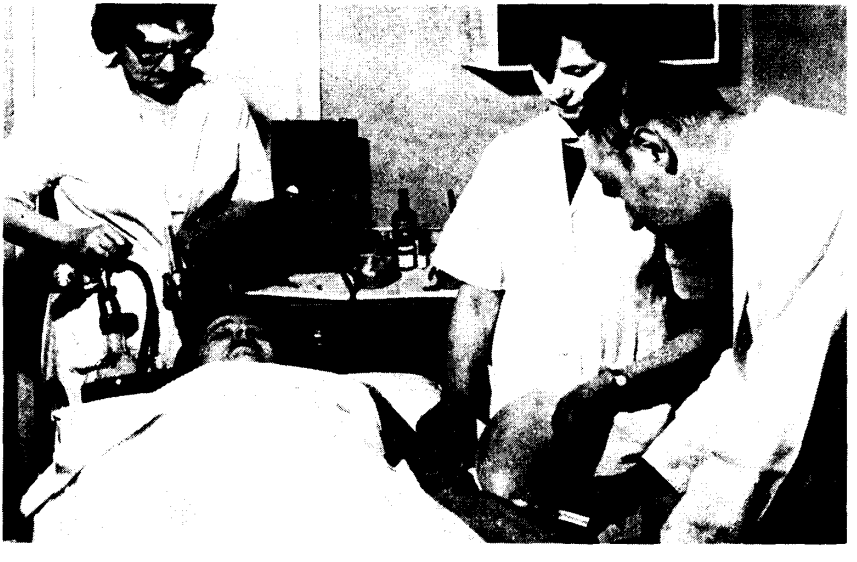
The photographic and cinematic representation of ECT, moreover, almost always depicts a female patient. Following the iconographic conventions of the mesmerist and his subject, the vampire and his victim, Charcot and his hysteric, and the prison doctor and his suffragette, the representation of shock treatment too makes use of archetypal patterns of masculine dominance and feminine submission. In the photograph of ECT reproduced, for example, in a history of Cheadle Royal Hospital in Manchester (fig. 27), the anaesthetized woman is covered with a white sheet so that only her calm and beautiful face is seen. Leaning over her with a needle is the male doctor; the two women nurses, both older than the patient, are holding her down and manipulating the ugly arrangement of boxes and tubes. Insofar as gender de-

fines the positions in the scene, the electroshock patient is always "feminine"—that is, even a male patient plays a feminine role.

Lobotomy is the most extreme and irreversible form of medical intervention in schizophrenia. In 1935, the Portuguese neurosurgeon Egas Moniz first developed a method of surgically severing portions of the brain to produce modifications in behavior. Experimenting on social misfits provided by the Portuguese government, Moniz developed a procedure he called "prefrontal lobotomy," which worked especially well on people with "anxiety-tension states" and "obsession syndromes." He believed he had discovered a treatment of revolutionary potential for the management of schizophrenics, alcoholics, homosexuals, and even political dissidents. Moniz, who has become one of Portugal's national heroes, received the Nobel Prize in 1949.[30]

The chief advocate and pioneer of lobotomy in the United States was Dr. Walter Freeman, the head of neurology at George Washington University. "The father of American lobotomy," Freeman developed a simplified surgical technique he called "transorbital lobotomy." The surgeon or psychiatrist entered the patient's brain under the eyelid with an icepicklike instrument, severing the nerves connecting the cortex with the thalamus. The operation could be performed in a few minutes,

Figure 27. ECT treatment in the 1940s.



often with local anaesthetics.[31] In the 1940s Freeman traveled extensively in the United States, teaching his surgical method to doctors in state mental institutions and performing mass lobotomies himself. In West Virginia, on one memorable occasion, he lobotomized thirty-five women in one afternoon; in 1948, at Washington State Hospital, he lobotomized thirteen women, probably including the actress Frances Farmer. Although Freeman never confronted the issue of gender, most of the photographs in his textbook *Psychosurgery* show women before and after the operation.[32]

In 1939, William Sargent and Russell Fraser went to see Freeman and his colleague, the neurosurgeon James Watts, and examined three of his postoperative patients: a chronic alcoholic, a chronic depressive, and a chronic schizophrenic. The alcoholic was enthusiastic about the operation; now, he claimed, he could get twice as drunk on half as much whiskey. The depressive was much less inhibited about telling people when she was angry or resentful, and felt remarkably better. The schizophrenic (predictably female) could still hear threatening voices but refused to let them bother her. Sargent and Fraser realized that lobotomy did not cure her schizophrenia, only her anxiety; but they were eager to take it back to England in a modified form, called leucotomy.

For Sargent, a zealous advocate of physical treatment for mental disorder, any medical or governmental effort to prevent his experimentation on patients was a pointless frustration or "irksome restraint" to be circumvented or outwitted. As he triumphantly notes in his memoir, he and Fraser "generally got our own way in the end." In order to perform lobotomies, or leucotomies, which were banned by the London County Council (LCC), he and Eliot Slater collaborated on a ruse to get their patients transferred from Belmont Hospital to St. George's, a teaching hospital where the LCC prohibitions did not apply. Through this trick they were able to perform several leucotomies and to experiment with different forms of the operation.[33] During a sabbatical year in the United States, however, Sargent was outraged when he was prevented by the Veterans' Hospital Administration in Washington from lobotomizing fifty black schizophrenic patients at the Tuskegee Hospital in Alabama as part of another experiment.

Like electroshock, lobotomy is a treatment more frequently recommended for and performed on women. Since 1941 the majority of the 15,000 lobotomies performed in England have been on women: "Psy-

chosurgeons consider that the operation is potentially more effective with women because it is easier for them to assume or resume the role of a housewife."[34] Two-thirds of all patients lobotomized were schizophrenics. At the Glasgow Royal Hospital, when R. D. Laing was psychiatric resident there in the 1950s, chronic female schizophrenics were given baths and electroshock once a week. Every once in a while, Laing has recalled, "a neurosurgeon would turn up . . . patients would line up," and he would perform lobotomies on all of them.[35] Sargent and Slater's widely used English psychiatric textbook published in 1972 recommends psychosurgery for a depressed woman "who may owe her illness to a psychopathic husband who cannot change and will not accept treatment." When separation is ruled out by the patient's religious convictions or by her "financial or emotional dependence" and when antidepressant drugs do not work, the authors suggest that a lobotomy will enable the woman to cope with her marriage.[36]

These cultural and medical associations of schizophrenia and femininity were given a particular interpretation in the very extensive English women's literature dealing with madness, institutionalization, and shock. In scores of literary and journalistic works produced between 1920 and the early 1960s, from inmate narratives protesting against the asylum to autobiographical novels and poems, schizophrenia became the bitter metaphor through which English women defined their cultural situation. Individually and collectively, these narratives provide the woman's witness so marginal or absent in the nineteenth-century discourse on madness; they give us a different perspective on the asylum, on the psychiatrist, and on madness itself; and they transform the experiences of shock, psychosurgery, and chemotherapy into symbolic episodes of punishment for intellectual ambition, domestic defiance, and sexual autonomy.

Beginning with Rachel Grant-Smith's *Experiences of an Asylum Patient* in 1922, most of this literature is set in the female wards of ironically named asylums: Gardenwell, Scott-Haven, Nazareth, Heartbreak House. As Ellen Moers has observed, the insane asylum is the contemporary locale of the female Gothic novel. In these stories, "the asylum itself becomes . . . an elaborated, enclosed, and peculiarly feminine testing ground for survival. There are the large, spreading, mysteriously complicated buildings; the harsh guards and strange rules; the terrifying inmates; the privations, restraints, and interrogations; the well-meant but indubitable torture of electric shock treatment."[37]

Few of the twentieth-century narratives before the 1960s, however, attempt anything like Mary Wollstonecraft's feminist protest against the wrongs of women, except perhaps in the discussion of shock. They are guilt-ridden accounts of institutionalization as a punishment for transgressing the codes of feminine behavior, docility, and affection. Unlike the representation of madwomen in male texts of the same period, they do not romanticize madness. "It is seldom," writes Janet Frame in *Faces in the Water,* "the easy Opheliana recited like the pages of a seed catalog, or the outpouring of Crazy Janes who provide, in fiction, an outlet for poetic abandon. Few of the people who roamed the dayroom would have qualified as acceptable heroines in popular taste."[38]

For women writers, Alice's journey through the looking glass is a more apt analogy than Ophelia's decline for the transition from sanity to schizophrenia, an allusion from the nursery world which the infantilization of the institution brings readily to mind. Mary Cecil called her memoir *Through the Looking Glass.* In Antonia White's *Beyond the Glass,* Clara Batchelor, coming to her senses in a mental hospital she calls the "House of Mirrors," watches several women patients playing a topsy-turvy game of croquet: "Her first thought was 'Alice in Wonderland again. They might as well play with hedgehogs and flamingoes.' But the next moment it came to her. These women were mad. . . . She was imprisoned in a place full of mad people."[39]

The asylums are indeed confusing places, secretive prisons operated on Wonderland logic. Their female inmates are instructed to regard themselves as "naughty girls" who have broken a set of mysterious rules that have to do with feminine conduct. "What *kind* of hospital am I in?" asks Helen in Antonia White's "The House of Clouds." "A hospital for girls who ask too many questions and need to give their brains a rest," the nurse replies; "Now go to sleep." "What shall I do?" cries another woman on a ward called Sixes and Sevens. "I'm wicked . . . I've broken my word . . . I *promised* my husband I'd get better."[40]

In the asylums, the symptoms of schizophrenia reflect specifically female anxieties. In Maude Harrison's novel *Spinner's Lake* (1941), a schizophrenic's voices torment her with her status: "Of course women go mad in far greater numbers than men, especially the unmarried ones, my dear."[41] Within the looking-glass house of the asylum, moreover, the female body, in all of its phases from puberty to senility, is always on display. In the communal bath, women gaze "curiously at one an-

other's bodies, at the pendulous bellies and tired breasts, the faded wisps of body hair, the unwieldy and the supple shapes that form to women the nagging and perpetual 'withness' of their flesh."[42] The "withness" of the flesh, and its proper management, adornment, and disposition, are a crucial and repeated motif in the schizophrenic women's sense of themselves as unoccupied bodies. Feeling that they have no secure identities, the women look to external appearances for confirmation that they exist. Thus they continually look at their faces in the mirror, but out of desperation rather than narcissism.

The abyss that opens between the schizophrenic's body and mind, however, can be seen as an exaggeration of women's "normal" state. The art historian John Berger has suggested that woman's psyche is split in two by her constructed awareness of herself as a visual object and her resulting double role as actor and spectator. "A woman must continually watch herself," Berger says in *Ways of Seeing.*

> She is almost continually accompanied by her own image of herself. Whilst she is walking across a room or whilst she is weeping at the death of her father, she can scarcely avoid watching herself walking or weeping. From earliest childhood she has been taught and persuaded to survey herself continually.
>
> And so she comes to consider the *surveyor* and the *surveyed* within her as the two constituent yet always distinct elements of her identity as a woman.[43]

In the asylums, too, women are encouraged, persuaded, and taught to become surveyors, to "watch themselves being looked at," and to make themselves attractive objects being surveyed. In their make-up from the ward box with its "stump of lipstick," and "box of blossom-pink powder," the patients at one asylum dance, Janet Frame sardonically observes, "looked like stage whores."[44] As in the nineteenth century, female sanity is measured against a detailed standard of grooming and dress. In fact, as one American psychiatrist in the 1930s jovially remarked, "the 'female of the species' never becomes too psychotic to enjoy her visits to the Beauty Shop."[45] Evaluating chronic female schizophrenics in English mental hospitals in the 1960s, J. W. Wing and G. W. Brown noted that although Mapperley Patient No. 5 had "attractively styled hair," she wore too much make-up, had it "slightly smeared on her nose—and her powder was not uniformly applied." As

in Victorian asylums, women were also censured for too *much* concern for physical appearance. Veronica A., for example, had appropriate make-up and had learned to style her hair to conceal her lobotomy scars, but her home visits were a failure because it took her three hours to get dressed.[46]

It is not surprising that in the female narrative the hectoring spirit of the auditory hallucination, the loquacious demon who jeers, judges, commands, and controls schizophrenics, is almost invariably male. He delivers the running critique of appearance and performance that the woman has grown up with as a part of her stream of consciousness; but in psychosis, the assessing voice of the surveyor becomes the voice of the Other, an actual voice that she no longer recognizes as part of herself. Frequently, too, the dictatorial voice of the "surveyor" is echoed by that of the male therapist. Having wrestled with the nagging, wheedling, abusing spirit she calls her "resident," for example, Mary Cecil meets an equally hostile psychiatrist: " 'Been behaving very oddly indeed, haven't you?' he thundered contemptuously in exactly the jargon of my resident who was now joining in."[47] The doctors, the demons, and the fathers begin to sound alike; their voices merge in a chorus of condemnation.

As this example suggests, schizophrenic symptoms of passivity, depersonalization, disembodiment, and fragmentation have parallels in the social situation of women. Some feminist critics have maintained that schizophrenia is the perfect literary metaphor for the female condition, expressive of women's lack of confidence, dependency on external, often masculine, definitions of the self, split between the body as sexual object and the mind as subject, and vulnerability to conflicting social messages about femininity and maturity.[48]

These parallels between schizophrenia and female identity were developed most fully in three important women's autobiographical novels of the 1960s: Jennifer Dawson's *The Ha-Ha* (1961), Janet Frame's *Faces in the Water* (1961), and Sylvia Plath's *The Bell Jar* (1963). While the earlier novels did not question the idea that madness was the woman's own fault, these novels place the blame for women's schizophrenic breakdowns on the limited and oppressive roles offered to women in modern society, and deal very specifically with institutionalization and shock treatment as metaphors for the social control of women.

Jennifer Dawson's *The Ha-Ha* is a moving and neglected novel that criticizes the marginal social roles of educated women in England in the

mid-1950s. The narrator, Josephine Traughton, is an intelligent and imaginative Oxford scholarship student with an eccentric, overprotective mother. Stifled by the fusty decorum her widowed mother imposes on their household, Josephine has always been a lonely outsider. At Oxford, she is painfully aware that she is wearing the wrong clothes, that she does not know the social rules, that she cannot play the required conversational games. And while she is absorbed in books, her women classmates seem to be marking time until they can marry and vegetate. "Tony says I'm almost a cabbage already," says one with a pleased and happy look. "So much for the higher education of women."[49] As Dawson commented in 1985, "*The Ha-Ha* was written during another lull . . . in the feminist movement." For many young women, Oxford "was still a superior kind of finishing school. Others were there on sufferance, guiltily in a house that had been the man's for nearly eight hundred years."[50] Unable to adapt to the social codes of femininity in this patriarchal world, Josephine invents a world of her own to which she can retreat, populated by exotic and comic animals. When her mother dies suddenly, Josephine has a breakdown and is committed to a mental hospital, "Gardenwell Park," where the insane are kindly herded like the zoo animals of her fantasies.

Diagnosed as a schizophrenic, Josephine is treated with insulin and befriended by the motherly ward nurse. But dependence on controlling maternal figures is one of her problems. She is finally shocked into maturity and a kind of sanity when she is seduced and then abandoned by another patient, an ex-medical student with a history of impotence and bad relationships with women. Alisdair demands that she recognize repressed hatred for her mother, and relief at her mother's death, as the source of her illness. His prescription for her schizophrenia is sex, which conveniently cures his "performance anxiety" and does him "lots of good." Josephine, however, feels "slightly sick": "It did not surprise me that I did not enjoy it. I had not expected pleasure, only some contact with the real world, and that I had found. Only my head felt odd, as though it were not mine, and the world seemed farther, not nearer."[51]

When Alisdair deserts her with only a thank-you note, Josephine runs away from the hospital and lets herself be picked up by a variety of men. But she is brought back by the police under certificate and given ECT, which she regards as a punishment for her sexual experimentation. Her sexuality is as much of a problem as her intelligence; both must be managed according to the rules of the hospital, which are

like the rules of middle-class society. In order to get out of the hospital, Josephine realizes, she must learn all "the rules of what to do and what to say," to have "the corners rubbed off." This means joining in the sing-song around the ward piano, knitting sweaters in occupational therapy, playing cards with the other women, keeping a bright smile for the superintendent, and growing fat and dull. Looking into the mirror, Josephine sees that she has become a grotesque image of female passivity: "There was the grey skirt and pink jumper strapped about me, and the shoes bolted on. And above them was the face, heavy, puffy, quilted; the eyes too small and almost sealed down in the eyelids; the expression blank and shut-down. . . . I could only giggle and eat too much and knit cardigans and follow the routine of little things that kept the momentous things out." Rather than remain a rule-follower all her life and become "a rubberized old woman, immune to all hope and fear and illusion," Josephine decides to escape and to take her chances with madness. The novel ends with her climbing over the hospital wall and running "until I knew for certain that I had not been extinguished, and that my existence had been saved."[52]

While *The Ha-Ha* anticipated the feminist movement in seeing mental institutions as environments in which deviants from conventional feminine roles were forced to conform, Dawson does not romanticize madness as prophetic insight. "I was lucky to have written *The Ha-Ha* before being influenced by the ideas of the mid-sixties," she wrote. Indeed, in 1961, Dawson recalled, "very few people thought that mental disturbance had any social meaning, or political, as opposed to cultural, interest. It was [not] associated with . . . women with bad feet on the assembly line or in the home. Here it was something to be kept hidden; to keep quiet about. A few pained and painful letters which I later received from women made me surprised at the damp cellar of guilt."[53]

In her autobiography *An Angel at My Table* (1984), the novelist Janet Frame has explained how in her early twenties, as a lonely, imaginative university student, she was diagnosed as schizophrenic; how she read up on the disease and consciously played the role of schizophrenic, inventing hallucinations and fantasies in order to win the attention of a young male professor who was fascinated by psychology and art; and how she was finally committed to a series of mental institutions in which she spent eight years of her life, underwent over two hundred electroshock treatments, and nearly had a lobotomy. Unable to escape from the asylum, she was released only when she published a book of poems that won a literary award.[54]

These events are recounted in Frame's novel *Faces in the Water,* structured around the experience of shock treatment, which she, like Dawson, connects with the enforcement of feminine conformity. Her heroine, Istina Mavet, sees ECT as "the new and fashionable means of quieting people and of making them realize that orders are to be obeyed and floors are to be polished without anyone protesting and faces are made to be fixed into smiles and weeping is a crime."[55]

An anomaly in her family, stubbornly intellectual and unfeminine, resistant even to shock treatment in the asylum, Istina is finally told that her "personality [has] been condemned, like a slum dwelling." The lobotomy, she is assured, will make her a happier and more successful woman. "With your personality changed," she is told, "no one will dream you were what you were." She will be able to leave the hospital and get a job selling hats or working in an office; she can wear a lobotomy scarf on her head, with a butterfly bow at the top, and she "will never regret having had a lobotomy." Frame's asylums are only too clearly places where thinking women are executed and replaced by clockwork dolls, their minds "cut and tailored to the ways of the world."[56]

Of all these novels, Sylvia Plath's *The Bell Jar* offers the most complex account of schizophrenia as a protest against the feminine mystique of the 1950s. In the first part of the novel, Plath's autobiographical heroine, Esther Greenwood, is spending the summer of 1953 in New York as a college guest editor for a fashionable women's magazine. A brilliant student and an aspiring poet, Esther feels lost and displaced among the sexual sophisticates, prom queens, and future homemakers who are her fellow editors. She enters a depressive spiral in which none of the alternatives available to educated women seems satisfactory. Career women, like her editor-in-chief or the professors at her college, seem sexless and even freakish. Housewives, like her boyfriend's mother, seem defeated and servile. Esther feels most keenly that she is trapped by her sexuality, that if she experiments she will be trapped by marriage and children. Motherhood and writing, she believes, are incompatible. Esther's sense of an absolute division between her creativity and her femininity is the basis of her schizophrenia. And her frustration precisely reflects the values endorsed even by liberals for intellectual women in the mid-1950s. At Sylvia Plath's Smith graduation in 1955, for example, Adlai Stevenson exhorted her class to write "laundry lists" rather than poems.[57]

While Esther Greenwood is a less accomplished and forceful person than Plath herself was at twenty, the novel goes on to follow the events of the summer in which Plath attempted suicide and then spent several months in a private mental hospital where she was treated with insulin and ECT. For several years after, Plath had tried to bury her memories of breakdown, institutionalization, and shock treatment. From the perspective of her family, especially her widowed mother, these experiences were shameful and should be forgotten. But in terms of her identity as a poet, Plath came more and more to view her recovery from madness through shock treatment as a poetic rebirth in which the split between the feminine and the creative selves was resolved. In her journals in the late 1950s, she wrote detailed descriptions of her shock treatment, describing "the deadly sleep of her madness, and . . . waking to a new world, with no name, being born again, and not of woman."[58] In her poetry, Plath mythologized ECT as a possession by a male god who is also the Muse. "By the roots of my hair some god got hold of me," she wrote in "The Hanging Man"; "I sizzled in his blue volts like a desert prophet." To be seized by this electric god was to be born again only of *man,* fathered rather than mothered, and thus, in Plath's imagination, purged of the inheritance of feminine vulnerability. The woman artist achieves her freedom and sanity, Plath seems to argue, by transcending ordinary womanhood not just through madness but also through the terrifying and redemptive ordeal of ECT.

Why should Plath have identified this act of purgation and rebirth with electroshock treatment? First of all, ECT has the trappings of a powerful religious ritual, conducted by a priestly masculine figure. The procedure itself, as Joseph Berke has pointed out, is "invested with magic and fantasy. The apparatus of anaesthesia, the small black box covered with dials and buttons, the electrodes attached to the head, everything is charged with significance for both patients and professional staff." Furthermore, the magic of ECT, according to Berke, comes from its imitation of a death and rebirth ceremony. For the patient it represents a rite of passage in which the doctor kills off the "bad" crazy self, and resurrects the "good" self. For this reason, suicidal patients are often comforted by ECT; upon awakening, they feel that in a sense they have died and been born again, with the hated parts of the self annihilated—literally, electrocuted.[59]

The Bell Jar makes a number of metaphorical connections between electricity and death, but Plath also connects this theme to female sex-

uality and creativity. The novel begins in "the summer they electrocuted the Rosenbergs"; political dissidence and sexual dissidence both will be punished electrically. And while shock treatment may lead to renewal, it is also painful and controlled by men. In this respect, it is like sex. When a man first touches Esther's hair, "a little electric shock" flares through her; her first experience of intercourse produces "a sharp, startlingly bad pain." Childbirth too is like electrotherapy; Esther watches a drugged woman give birth "on a bed like some awful torture table, with . . . all sorts of instruments and wires and tubes." Women have become passive objects in these rituals; as a medical student remarks in the delivery room, "They oughtn't to let women watch."

In order to become creative, active, and free in a social milieu that denies these options to women, Esther must symbolically destroy the female side of her psyche, the side controlled by sexual need, maternal pieties, and social conventions. The paradox of the novel, then, is that a woman can free herself from the constraints of schizophrenic womanhood only by denying her solidarity and emotional bonds with other women. We see this process dramatized in *The Bell Jar.* After her first insulin shock treatment, Esther tells her psychiatrist that she hates her mother. After her first electroshock treatment in the hospital, she looks coldly upon her women friends in the ward, noting that they are too ugly and sour to hold a man's interest. Although she often feels closer to women than to men, when she accidentally walks in on two women in bed together, Esther is disgusted and harshly condemning. On the eve of her discharge from the hospital, Joan, the lesbian who is Esther's alter ego in the novel, kills herself. Esther's graduation from the asylum thus comes at the price of her feminist double's death. Although she is reborn at the end of the book, "born twice—patched, retreaded, and approved for the road," she is certainly not reborn of woman.[60]

It is only fair to note that in the early 1960s, shock treatment was also a metaphor in men's writing. Yet the male literature of shock, such as Harold Pinter's *The Caretaker* (1960), Anthony Burgess's *A Clockwork Orange* (1962), and Ken Kesey's *One Flew over the Cuckoo's Nest* (1962), makes an instructive contrast to these female condemnations of psychiatric power. All of them represent shock treatment as a feminizing therapy. In Pinter's play, it turns the violent Aston into a slow-thinking, passive man who describes his accumulation of disjointed memories as "interior decoration."

Anthony Burgess's version of shock treatment is an Orwellian brain-

washing called the Ludovico technique, a sadistic aversion therapy designed to restrain psychopathic aggression in young men. But the reconditioning of Burgess's teen-age hoodlum Alex becomes a political issue, and the government is forced by the public uproar against tampering with man's existential freedom to reverse the procedure and to re-educate Alex in robbery, rape, and the old ultra-violence. And in Ken Kesey's *One Flew over the Cuckoo's Nest* the social forces that are out to shock and tame the amoral, violent, sexually aggressive male are represented as feminine, embodied in the figure of Big Nurse. Kesey's novel, and the movie version in which Jack Nicholson gave another brilliant performance of the woman-hating man he has played in many films, might seem to be just a reversal of the women's narratives. But whereas women's accounts of institutionalization and treatment reflect their powerlessness in patriarchal institutions, Kesey's novel (and to some degree, Burgess's) is a disquieting fantasy of sexual violence against women, a fantasy rationalized by the fiction that women push the buttons and call the shots.

By the early 1960s, then, a very powerful female literature had grown up outside the medical journals and the psychiatric institutes, which presented schizophrenia and institutionalization as extremes of typical female experiences of passivity and confinement. The literature of schizophrenia would have a double impact. The feminist aspects were important in the early years of the women's liberation movement, which, in its reclamation of female "victims," made Plath, among others, a heroine. And the fascination with psychotic experience would influence the valorization of schizophrenia by R. D. Laing and the antipsychiatry movement.