The appearance of the New Woman, with her demands for education, work, and personal freedom, presented Darwinian psychiatry with a direct challenge to its social gospel. At the same time that new opportunities for self-cultivation and self-fulfillment in education and work were offered to women, doctors warned them that pursuit of such opportunities would lead to sickness, sterility, and race suicide. They explicitly linked the epidemic of nervous disorders—anorexia nervosa, hysteria, and neurasthenia—which marked the fin de siècle to women’s ambition. As T. Clifford Allbutt noted, “the stir in neurotic problems first began with the womankind”; by the 1890s, he continued, “daily we see neurotics, neurasthenics, hysteric[s], and the like...every large city [is] filled with nerve-specialists and their chambers with patients.”

From a feminist perspective, Darwinian psychiatry posed especially serious problems for women, and not only because it was carried out by such a moralistic, domineering, and masculinist generation of doctors. Theories of biological sexual difference generated by Darwin and his disciples gave the full weight of scientific confirmation to narrow
Victorian ideals of femininity. Female intellectual inferiority could be understood as the result of reproductive specialization, and the “womanly” traits of self-sacrifice and service so convenient for the comfort of a patriarchal society could be defended in evolutionary terms as essential for the survival and improvement of the race. In 1871 Darwin himself had confidently defined the “natural” differences in the mental powers of the sexes in *The Descent of Man*. Through natural selection, he explained, man had become superior to woman in courage, energy, intellect, and inventive genius, and thus would inevitably excel in art, science, and philosophy. Even those faculties in which women had the edge—intuition, perception, and imitation—were actually signs of inferiority, “characteristic of the lower races, and therefore of a past and lower state of civilisation.”

Darwin’s ideas were further developed in Herbert Spencer’s widely read treatises on social evolution, and in work by the Scottish biologists Patrick Geddes and J. Arthur Thompson on the biology of sex differences. In *Principles of Sociology* (1876), Spencer argued that human development depended on the expenditure of a fixed fund of energy. Since women depleted, or sacrificed, their energy in the reproductive process, they were heavily handicapped, even developmentally arrested, in intellectual competition. *The Evolution of Sex* (1889) by Geddes and Thompson put forward a theory of sexual differentiation based on cell metabolism. Male cells, they explained, were *katabolic,* or active and energetic; female cells were *anabolic,* or energy-conserving, passive, and life-supporting. Moving from simple to complex forms of life, Geddes and Thompson argued that men, like the flagellate sperm, were aggressive, competitive, and inventive, while women, like the ovum, were placid, altruistic, and nurturant.

The theories of sexual difference adumbrated by Darwinian science were incorporated into a highly prescriptive late Victorian psychology of women. From the 1870s onward, this generation of doctors, and especially Henry Maudsley and T. S. Clouston, presented a constellation of rigid views on gender roles. While the fundamental differences between the sexes were, of course, physical, Darwinian psychiatrists insisted that (in Maudsley’s words), “there is sex in mind as distinctly as there is sex in body.” Clearly, they agreed, female physiology marked women “for very different offices in life from those of men.” But because the brain responded to the operation of the reproductive organs (as it did to the other organs of the body), the mentalities of the
sexes differed as well. It was the totality of the physical and the mental differences that made up the essence doctors confidently called woman’s “nature.”

By nature, then, woman was constituted to be “the helpmate and companion of man”; her innate qualities of mind were formed to make her man’s complement rather than his equal. Among these qualities, Clouston believed, were the cheerfulness, vivacity, and powers of endurance that made woman capable “not only of bearing her own share of ills, but helping to bear those of others.”

Furthermore, women were mentally constituted to take care of children, as well as physically constituted to give birth. While women, Maudsley explained, “are manifestly endowed with qualities of mind which specially fit them to stimulate and foster the first growths of intelligence in children,” men had much less mental capacity for patience, attachment, and sympathy. Thus, “if the nursing of babies were given over to men for a generation or two, they would abandon the task in despair or in disgust, and conclude it to be not worth while that mankind continue on earth.”

The sexual division of labor advocated by psychiatrists followed on these beliefs. Woman’s work was clearly motherhood, which fulfilled and exercised her nature as it also served the needs of society and the race. “Man’s chief work,” as Clouston put it, was “more related to the present”; woman’s chief work, however, was related “to the future of the world.” And women’s “foreordained work as mothers and nurses of children,” even if it might be seen as less noble than man’s work as father of ideas, had to be done in a serious and dedicated way.

Mental breakdown, then, would come when women defied their “nature,” attempted to compete with men instead of serving them, or sought alternatives or even additions to their maternal functions. And once it appeared, mental disorder might be passed on to the next female generation, endangering future mothers. All Darwinian psychiatrists agreed that “the greater tendency of mothers to transmit insanity to their female children” was among the chief causes for the predominance of women among asylum patients.

It is clear to a twentieth-century reader that these theories were convenient ramifications of existing social relations between the sexes. Despite his pious words about the importance of the maternal function in essays written for a general audience, Maudsley revealed in his
professional texts how disgusting he found childbirth and how degrading he found childcare:

Looking at the matter objectively in the dry light of reason, could anything be more ridiculous than all this affectionate fuss about what is essentially an excretory product and comes into the world by excretory ways? Moreover, there is nothing nice in the process of parturition nor in the base services which the child exacts.¹⁰

If half the population was to be consigned to these lowly activities, it was reassuring to know that their nature made pleasant to them what would have been boring, repellant, and maddening to men. The counterarguments of feminists fell upon deaf Darwinian ears. Maudsley dismissed John Stuart Mill’s *The Subjection of Women* (1869) as an absurdity, especially Mill’s claim that “what is now called the nature of women is an eminently artificial thing.” That a women’s movement seemed actually to be under way in the 1870s, Maudsley explained, owed less to widespread female discontent than to the “awakened moral sense and... more enlightened views of men,” who magnanimously assisted a handful of feminists instead of suppressing their efforts.¹¹

In the decades from 1870 to World War I, psychiatrists and feminists battled over the question of what women should be. These battles were waged on many fronts: in journals, where a few women doctors at last had access; in courts of law, where there were protests over wrongful confinement of wives and daughters; and in fiction, where the nerve specialist and his hysterics became a familiar couple. There were also contests fought on more private terrain—in the sickroom and the consulting room, where nervous women communicated their malaise in a variety of baffling symptoms, and where doctors strove for mastery and domination.¹²

Feminist reformers and Darwinian doctors clashed first and most dramatically over the issue of higher education for women. In a famous essay, “Sex in Mind and Education,” published in the *Fortnightly Review* in 1874, Maudsley argued that the intellectual training of adolescent girls could produce permanent injury to their reproductive systems and their brains. The occasion of Maudsley’s essay was the publication of a book by an American doctor, Edward Clarke, called *Sex in Education*, which purported to describe the disastrous effect of coeducation upon the health of American women. Were the English reformers who were most eager to improve the education and social status of woman giving
“proper consideration to the nature of her organization, and to the
demands which its special functions make upon its strength.” Maudsley
felt that the “extraordinary expenditure of vital energy” made through
the establishment of menstruation during the critical years of puberty
(and after) left “little vitality to spare” for other functions.

Drawing on the new theories of conservation of energy, Maudsley
maintained that the demands of intellectual work and physiological
change were antagonistic: “The energy of a human body being a deﬁ-
nite and not inexhaustible quantity, can it bear, without injury, an
excessive mental drain as well as the natural physical drain which is so
great at that time? . . . Nor does it matter greatly by what channel the
energy be expended; if it be used in one it is not available for use in
another. What Nature spends in one direction, she must economise in
another direction.”

He painted a dire picture of the results of this overexpenditure of
vital energy. The stimulus of competition, healthy and even necessary
to bring out the best in boys, would act powerfully and disastrously to
upset the more unstable nerve centers of girls, who could then become
seriously deranged. Menstrual functions could be made irregular or
even arrested by sustained mental effort; headache, lassitude, and in-
omnia might ensue. In the long run, the girl would become a “delicate
and ailing woman, whose future life is one of more or less suffering.”
The injuries to the menstrual cycle might never be corrected, and in
some cases might even lead to epilepsy, chorea, or mental breakdown.

The most horrible outcome of such a calamitous chain of events was
the degeneration of the reproductive capacity, beginning with the atro-
phy of the breasts and ending with a total loss of “pelvic power,” or
sexless sterility. Feminine vanity, Maudsley warned, would conceal the
early physical defects from the physician’s watchful eye. “Those in
whom the organs are wasted invoke the dressmaker’s aid in order to
gain the appearance of them; they are not satisfied unless they wear the
show of perfect womanhood.” If these imperfect women were not quite
lunatics, they were nonetheless freaks and monstrosities, “something
which having ceased to be woman is yet not man.” If women continued
to unsex themselves in study, race suicide must follow. Maudsley could
foresee the day when “a race of sexless beings . . . undistracted and
unharassed by the ignoble troubles of reproduction, shall carry on the
intellectual work of the world, not otherwise than as the sexless ants do
the work and fighting of the community.”

Similarly, Hack Tuke reported cases of “complete prostration of
brain” in girls cramming for examinations, and George Savage, concerned about “the danger of solitary work” for girls “of nervous family” studying at home, forbade the fifteen-year-old Virginia Woolf to continue with her lessons, and ordered her to spend four hours a day gardening. T. S. Clouston foresaw an even darker prospect: that soon “all the [female] brain energy would be used up in cramming a knowledge of the sciences, and there would be none left at all for . . . reproductive purposes.” When this catastrophe left England exhausted and barren, it would be necessary for men to look to other nations for more docile and fecund wives, to make “an incursion into lands where educational theories were unknown, and where another rape of the Sabines was possible.”

Women fought back in a variety of ways. Maudsley’s and Clarke’s attacks on the dangers of female higher education were vigorously refuted by women doctors—Mary Putnam Jacobi and Elizabeth Garrett Anderson. The 1870s also initiated a period of legal and journalistic agitation over the wrongful confinement of women in lunatic asylums. Georgiana Weldon’s *How I Escaped the Mad-Doctors* (1878) and Rosina Bulwer-Lytton’s *A Blighted Life* (1880) were essentially protests against the power that could be exerted by vengeful husbands over rebellious or difficult wives. At least one of these narratives, Louisa Lowe’s *The Bastilles of England; or, The Lunacy Laws at Work* (1883), went further in developing a feminist critique of the whole structure of Victorian psychiatry. An energetic campaigner against the lunacy laws, Lowe also attacked the male monopoly over the asylum system and the absence of highly trained and well-paid female professionals within its ranks. Lowe was the first to suggest that women’s feelings would be better understood by women doctors, attendants, and inspectors.

Too much stress can scarcely be laid on the appointment of inspectresses for female patients. The rapid growth of medical studies among women affords hope that at no distant period there will be sufficient female doctors to obviate entirely the cruel necessity of placing female lunatics in the charge of men at all; meanwhile, few things would tend more to be their comfort, and, in some cases, hasten their cure, than inspection by persons of their own sex, who, *ceteris paribus*, would, in the nature of things, be better able to enter into their feelings, and detect the border-line between sanity and insanity than those of an opposite sex, and consequently, different habit of mind.
And, moreover, it surely needs but little reflection to convince all thoughtful persons that there is most unseemly moral cruelty in subjecting woman in her hour of weakness and humiliation to the inspection of man, in forcing her to lay bare to him perhaps the most secret sorrows of her life, possibly the vagaries of a diseased mind, or of morbid and polluted affections. From personal observation, I am convinced that many a sane and pure-minded woman has passed with the commissioners as the reverse, simply through the confusion and pain occasioned by interrogatories, which, coming from an inspecress, would have been calmly and satisfactorily answered. Except as occasional consultants, the less men-doctors have to do with female lunatics the better.\textsuperscript{15}

Not until 1894, and after much debate, however, did the Medico-Psychological Association admit women to membership; by 1898 there were still only eight women working as medical officers in British state, private, and charitable hospitals.\textsuperscript{16}

But the most dramatic battle took place within the doctor-patient relationship, as nervous women and nerve specialists clashed over the relationship of sex roles to sick roles. The first of the female nervous disorders to be labeled during this period was anorexia nervosa, which was identified in 1873 as a new clinical syndrome among adolescent girls in both England and France. In a report to the Clinical Society of London read in October 1873, Dr. William Witney Gull, a prominent physician who treated members of the royal family, discussed cases of the disorder among young girls between the ages of fifteen and twenty. He described its major symptoms as extreme emaciation, loss of appetite, amenorrhea, and restless activity. Gull attributed “the want of appetite . . . to a morbid mental state. I have not observed in these cases any gastric disorder to which the want of appetite could be referred. I believe, therefore, that its origin is central and not peripheral. That mental states may destroy appetite is notorious, and it will be admitted that young women at the ages named are specially obnoxious to mental perversity.”\textsuperscript{17} E. C. Lasègue, a Parisian doctor who reported on eight cases of the disorder in the same year, viewed anorexia as characterized by the patient’s “truly pathological” contentment: “Not only does she not sigh for recovery, but she is not ill-pleased with her condition, notwithstanding all the unpleasantness it is attended with.”\textsuperscript{18}

During the years when Gull and Lasègue were seeing their first
anorexic patients, celebrated cases of “fasting girls,” who seemingly lived without nourishment of any kind, attracted popular attention on both sides of the Atlantic. Such cases, taken up by the press and treated as miraculous, had also occurred previously; Ann Moore, the fasting woman of Tutbury, was a notorious early-nineteenth-century case. While many of these women were exposed as impostors, their fasting behavior could be seen as a form of female cultural protest. This is how Florence Nightingale interpreted it in a vehement passage in Cassandra:

To have no food for our heads, no food for our hearts, no food for our activity, is that nothing? If we have no food for the body, how do we cry out, how all the world hears of it, how all the newspapers talk of it, with a paragraph headed in great capital letters, DEATH FROM STARVATION! But suppose one were to put a paragraph in the “Times,” Death of Thought from Starvation, or Death of Moral Activity from Starvation, how people would stare, how they would laugh and wonder! One would think we had no heads or hearts, by the indifference of the public towards them. Our bodies are the only things of any consequence.

What Nightingale had said about fasting girls could also be applied to anorexia. When only the body was regarded as important, anorexic girls paraded physical starvation as a way of drawing attention to the starvation of their mental and moral faculties. The portrait of the anorexic painted by Darwinian psychiatry is paradoxically that of the self-sacrificing Victorian heroine. Refusing to eat, she acted out the most extreme manifestation of the feminine role, flaunting her martyrdom, literally turning herself into a “little” woman. In his essay on anorexia as a “neurosis of the stomach,” T. Clifford Allbutt described the typical anorexic as a young woman of “ardent and self-forgetful nature,” and he noted that “happily there are many such.” Despite the fact that at the limits of self-starvation her clothes were hanging on her body, her pulse was slow, her menstrual periods had stopped, her hair was “like that of a corpse dry and lusterless, her face and limbs ashy and cold, [and] her hollow eyes the only vivid thing about her,” the ardent anorexic continued her hectic round of feminine duties, attending “mother’s meetings,” sewing dresses for her little sisters, and persisting in various activities that Allbutt praised as “unselfish effort.”
In her attempt to become the incorporeal Victorian angel, unaffected by earthly appetite, the anorexic particularly renounced meat; "meat, even the smell of it, makes them sick," Allbutt reported. Meat, the "roast beef of old England," was not only the traditional food of warriors and aggressors but also believed to be the fuel of anger and lust. Disgust with meat was a common phenomenon among Victorian girls; a carnivorous diet was associated with sexual precocity, especially with an abundant menstrual flow, and even with nymphomania.22 Earlier in the century, Victorian physicians such as Edward J. Tilt had recommended low-protein diets as a way to retard menarche. In late Victorian women's literature, feminism, chastity, and vegetarianism often appear together as connected values; in feminist utopias such as Charlotte Perkins Gilman's *Herland* (1915), the virginal heroines abstain from the "heating diet" of red meat. Thus, in the rigid control of her eating, the anorexic both expressed her fear of adult sexual desire and enacted an exaggerated form of the deadening life of the dutiful daughter.

Some physicians regarded anorexia as one of the manifold forms of hysteria, a disorder whose symptoms and cultural meaning changed from era to era. For centuries, hysteria had been the quintessential female malady, the very name of which derived from the Greek *hysteron*, or womb; but between 1870 and World War I—the "golden age" of hysteria—it assumed a peculiarly central role in psychiatric discourse, and in definitions of femininity and female sexuality.23 By the end of the century, "hysterical" had become almost interchangeable with "feminine" in literature, where it stood for all extremes of emotionality.24 Not only did the analysis and management of hysterical women occupy a major place in the work of leading English, American, French, and German physicians of the period, and become the starting point for psychoanalysis, but also cases of classic hysteria peaked in frequency; by the twentieth century, the clinical incidence of the dramatic episodes had greatly declined. "Hysteria" was linked with the essence of the "feminine" in a number of ways. Its vast, unstable repertoire of emotional and physical symptoms—fits, fainting, vomiting, choking, sobbing, laughing, paralysis—and the rapid passage from one to another suggested the lability and capriciousness traditionally associated with the feminine nature. As Dr. Edward J. Tilt noted in his textbook on female diseases, "mutability is characteristic of hysteria, because it is characteristic of women—'La donna è mobile.'"25 Like other aspects of
the feminine, it seemed elusive and enigmatic, resistant to the powers of masculine rationality. Thus Weir Mitchell calls hysteria "the nosological limbo of all unnamed female maladies" and protests that it might just as well be called "mystery."

Classic hysteria, as it had been described by doctors in the early nineteenth century, had many symptoms, but two defining characteristics: the seizure, and the globus hystericus, or sensation of choking. The hysterical attack generally began with pain in the uterine region, and with a sense of obstruction in the chest and throat. At its height, the victim alternately sobbed and laughed; she might have convulsive movements of the body, heart palpitations, impaired hearing and vision, or unconsciousness. The fits were followed by exhaustion, and usually by rapid recovery, although occasionally the effects lasted for days. A striking aspect of the seizure was the globus hystericus, the sensation that a ball was rising in the esophagus, producing a feeling of choking or suffocation. Indeed, the ancients had believed that this feeling was caused by the rising of the womb itself within the body.

The basic explanatory model of hysteria generated by Darwinian psychiatry, however, related it to faulty heredity exacerbated by the biological and social crisis of puberty. While these explanations emphasized the physical element, they were not blind to the significance of the particular constraints—restricted activity and sexual repression—placed on women. In 1879 Maudsley summed up the problem of female adolescence thus:

Girls are more liable to suffer at this period, I think, than youths; and it is not difficult to understand why. In the first place, the affective life is more developed in proportion to the intellect in the female than in the male sex, and the influence of the reproductive organs upon the mind more powerful; secondly, the range of activity of women is so limited, and their available paths of work in life so few, compared with those which men have in the present social arrangements, that they have not, like men, vicarious outlets for feelings in a variety of healthy aims and pursuits; in the third place, social feelings sanction tacitly for the one sex an illicit indulgence which is utterly forbidden to the other; and lastly, the function of menstruation, which begins at puberty in women, brings with it periodical disturbances of the mental tone which border closely on disease in some cases, while the irregularities and suppressing to which it is liable from a variety of mental and bodily causes may affect the mind seriously at any time.
These views were echoed by Charles Mercier in his treatise *Sanity and Insanity*. Mercier noted that women did not share the masculine “safety-valve” of physical exercise to work off nervous and sexual energy. Partly as a result, he believed, adolescent hysteria was the norm rather than the exception: “few women pass through this period of their development without manifesting signs of disorder... at this period, more or less decided manifestations of hysteria are the rule.”

The neurologist Horatio Bryan Donkin, who wrote the essay on hysteria for the *Dictionary of Psychological Medicine* (1892), went further in pointing to the sexual inhibition and enforced passivity of girls as factors of nervous disorders. Unlike Maudsley and Mercier, Donkin was a progressive thinker, accepted not only in the medical and club worlds (he was on the Committee of the Savile Club) but also in radical and socialist circles. He had been an active participant in the Men and Women’s Club, a London-based group of intellectuals and feminists who met in the late 1880s to discuss the relations between the sexes. He was the friend and admirer of several New Women whose prolonged struggles to integrate their radical beliefs about marriage and independence with traditional injunctions about femininity had led to a variety of nervous affictions. In 1881 he had treated Eleanor Marx, who was suffering from physical symptoms of anorexia, trembling, and convulsive spasms, as well as depression and exhaustion. He had also been the physician and even the suitor of Olive Schreiner. Thus he was unusually familiar with, and sympathetic to, the stresses experienced by intellectual and ambitious women.

In his essay for the *Dictionary*, Donkin described the “typical subject of hysteria” as “the young woman” and related the disease not only to “her organism” but also to “her social conditions.” Like his contemporaries, he saw puberty as a risky period in female development, the stress of which was “more sudden and intense in the female” than in the male, but he also condemned the education and social repression that impeded female development: “All kinds of... barriers to the free play of her power are set up by ordinary social and ethical customs. ‘Thou shalt not’ meets a girl at every turn.”

Yet even Donkin preferred the biological argument that female hysteria comes from unsatisfied sexual and maternal drives to the cultural argument that women were unsatisfied and thwarted in other aspects of their lives. In discussing the case of Olive Schreiner, he concluded that her “nerve-storms,” asthma attacks and recurring breakdowns were caused by her efforts to stifle and deny her sexual desires; he did not go
further to question the pressures of her public role as a writer, feminist, or political activist. It was much simpler to blame sexual frustration, to continue to see hysterical women as lovelorn Ophelias, than to investigate women’s intellectual frustration, lack of mobility, or needs for autonomy and control.

The idea that sexual frustration was a significant cause of hysteria was a traditional one, which had been strongly revived in the mid-nineteenth century by Dr. Robert Brudenell Carter. In an influential study of hysteria written in 1852 when he was only twenty-five, Carter had observed:

It is reasonable to expect that an emotion, which is strongly felt by great numbers of people but whose natural manifestations are constantly repressed in compliance with the usages of society, will be the one whose morbid effects are most frequently witnessed. This anticipation is abundantly borne out by facts; the sexual passion in women being that which most accurately fulfills the prescribed conditions, and whose injurious influence upon the organism is most common and familiar.

Women were more liable to hysteria than men because “the woman is more often under the necessity of endeavouring to conceal her feelings.”

What Carter does not go on to suggest is that sexual feelings were not the only ones women endeavored to conceal; and indeed, as some historians argue, there may have been much more leeway within nineteenth-century bourgeois marriage for female sexual expression than we have realized. But longings for independence and for mastery were socially unacceptable at every phase of the female life-cycle. Even when doctors observed these longings in their female patients, and noted the women’s powerless position in their families, they did not make the obvious connections.

F. C. Skey, for example, who delivered an important series of lectures on hysteria to the students of St. Bartholomew’s Hospital in 1866, noticed that hysterical girls were typically energetic and passionate, “exhibiting more than usual force and decision of character, of strong resolution, fearless of danger, bold riders, having plenty of what is termed nerve.” He noticed, too, that the parents of these girls were unusually interfering and controlling. In one case a patient had been
treated unsuccessfully for pain under the ribs by her own father, a physician who had applied leeches by the hundred and “blisters, the sum of which might be calculated by the square yard.” In another case, an eighteen-year-old girl complained of acute pain in eating. At the interview her mother insisted on answering all the questions, and Skey had to ask her to leave. Yet he does not wonder whether the mother’s interference might have been a source of the girl’s pain.\textsuperscript{12}

But it is precisely in a reaction against this kind of supervision that hysterical women were led to violate the expectations of the female domestic role. When the hysterical woman became sick, she no longer played the role of the self-sacrificing daughter or wife, as did the anorexic. Instead, she demanded service and attention from others. The families of hysteric found themselves reorganized around the patient, who had to be constantly nursed, indulged with special delicacies, and excused from ordinary duties. Carroll Smith-Rosenberg has speculated that such behavior threatened the male physician by placing him in a position of conflict. As a doctor, he certified and confirmed the hysteric in her sick role, one that legitimated her withdrawal from the accepted sex role in the belief that she was ill and trying to get well. But as a result, he was made to side with the woman against male family members, fathers and husbands. Physicians were concerned that hysterical women were indeed enjoying their freedom from domestic and conjugal duties, as well as their power over the family and the doctor himself. They did not wish to become “accomplices in her deviant role.”\textsuperscript{13}

Thus physicians perceived hysterical women as their powerful antagonists. Despite a certain sympathy for women’s restricted lives, English doctors found their hysterical patients personally and morally repulsive, idle, intractable, and manipulative. Like pauper lunatics, hysterical women were the products of bad heredity and bad habits. “Exceeding selfishness,” wrote Donkin, “delight in annoying others, groundless suspicion, and unprovoked quarrelsomeness are of very common occurrence; and the instances of self-mutilation and wondrous filthy habits are numerous.”\textsuperscript{14} Maudsley roundly denounced the “moral perversion” of hysterical young women who, “believing or pretending that they cannot stand or walk, lie in bed . . . all day . . . objects of attentive sympathy on the part of their anxious relatives, when all the while their only paralysis is a paralysis of will.” The “immoral vagaries” and the “moral degeneration” of some of these women, he thought, would make them perfect case studies of systematic moral insanity: “nowhere
more perfect examples of the subtest deceit, the most ingenious lying, the most diabolic cunning, in the service of vicious impulses.”

Hysterics also expressed “unnatural” desires for privacy and independence. “The cardinal fact in the psychopathy of hysteria,” wrote Donkin, “is an exaggerated self-consciousness . . . the hysteric is pre-eminentiy an individualist, an unsocial unit.” Darwinian psychiatry generally held that “asociality,” the avoidance of company and withdrawal from society into morbid introspection and solitary habits, was “perhaps the most distinguishing feature of the insane.” G. Fielding Blandford maintained that the ideal treatment should redirect the patient’s feelings from “morbid self-contemplation” to a more normal “care and concern for others.” Not surprisingly, since altruistic care and concern for others was regarded as especially natural in women, its absence struck doctors as unhealthy or insane egoism.

Neurasthenia, the third disorder of the 1870s, was a more prestigious and attractive form of female nervousness than hysteria, although it shared so many of hysteria’s symptoms that even specialists could not always distinguish between the two. Like hysteria, neurasthenia encompassed a wide range of symptoms from blushing, vertigo, headaches, and neuralgia to insomnia, depression, and uterine irritability. Dr. George Savage’s description of the neurasthenic, for example, incorporated some of the sexual stereotypes of the hysterical:

A woman, generally single, or in some way not in a condition for performing her reproductive function, having suffered from some real or imagined trouble, or having passed through a phase of hypochondriasis of sexual character, and often being of a highly nervous stock, becomes the interesting invalid. She is surrounded by good and generally religious and sympathetic friends. She is pampered in every way. She may have lost her voice or the power of a limb. These temporary paralyses often pass off suddenly with a new doctor or a new drug; but, as a rule, they are replaced by some new neurosis. In the end, the patient becomes bedridden, often refuses her food, or is capricious about it, taking strange things at odd times, or pretending to starve. Masturbation is not uncommon. The body wastes, and the face has a thin anxious look, not unlike that represented by Rossetti in many of his pictures of women. There is a hungry look about them which is striking.

Unlike the disagreeable and disliked hysterics, however, neurasthenics were thought to be cooperative, ladylike, and well-bred, “just the kind
of women one likes to meet with,” one doctor declared, “sensible, not over sensitive or emotional, exhibiting a proper amount of illness . . . and a willingness to perform their share of work quietly and to the best of their ability.” Physicians often contrasted the hysteric’s *belle indifférence* and moral turpitude with the neurasthenic’s “refined and unselfish nature.”

Originally, neurasthenia was an American disorder, described as “American nervousness” by the neurologist George Miller Beard in the late 1860s. Beard saw a significant correlation between modern social organization and nervous illness. A deficiency in nervous energy was the price exacted by industrialized urban societies, competitive business and social environments, and the luxuries, vices, and excesses of modern life. Five characteristic features of nineteenth-century progress—the periodical press, steam power, the telegraph, the sciences, and especially the increased mental activity of women—could be held to blame for the sapping of American nervous strength.

American nervousness was alarmingly frequent “among the well-to-do and the intellectual, and especially among those in the professions and in the higher walks of business life, who are in deadly earnest in the race for place and power.” The labors of domestic servants, the harshness of rural existence, the brutalities of savage tribes, were nowhere near as mentally wearing and exhausting as the refinements of civilization. Masturbation, for example, could rapidly deplete the nervous force of the refined, but “strong, phlegmatic Irish servant-girls may begin early the habit of abusing themselves and keep it up for years, with but little apparent harm.” And the Indian squaw enjoyed her “slow and easy drudgery . . . in the open air,” spared the “exhausting sentiment of love,” while the sensitive white woman had the more demanding anxieties of romance to handle. It was absurd to expect that a Southern black should suffer from nervous diseases, or that insanity, epilepsy, and neurasthenia should flourish on the banks of the Amazon or the Nile.

In the United States, neurasthenia was seen as an acceptable and even an impressive illness for men, ideally suited to a capitalistic society and to the identification of masculinity with money and property. Many American nerve specialists, including Beard himself, had experienced crises of nervous exhaustion in their own careers, and they were highly sympathetic to other middle-class male intellectuals and professionals tormented by vocational indecision, sexual frustration, internalized cultural pressure to succeed, and severely repressed emotional needs.
When Herbert Spencer visited the United States in 1882, he was struck by the widespread ill-health of male intellectuals and businessmen: "In every circle I have met men who had themselves suffered from nervous collapses, due to stress of business, or named friends who had crippled themselves by overwork." An elaborate system of cures, including nerve tonics, galvanic belts, electric faradization, health spas, and retreats catered to the prosperous neurasthenic seeking help for his sexual problems or nervous exhaustion.

The majority of American neurasthenic patients, however, were female, often educated, urban, and middle-class. In such essays as "Neurasthenia and Its Relation to Diseases of Women" (1886), Dr. Margaret Cleaves, herself a sufferer who would describe her experience in the anonymously published *Autobiography of a Neurasthene*, attributed female neurasthenia not simply to overwork but to women's ambitions for intellectual, social, and financial success, ambitions that could not be accommodated within the structures of late-nineteenth-century society. She herself was the daughter of a doctor who had encouraged her to pursue a medical career. Nonetheless, she felt, "women, more than men, are handicapped at the outset, not necessarily because they are women, but because, suddenly and without the previous preparations that men for generations have had, they attempt to fulfill certain conditions and are expected to qualify themselves for certain work and distinctions." It may be true, she conceded, "that girls and women are unfit to bear the continued labor of mind because of the disqualifications existing in their physiological life." Beard, too, had felt that women were more at risk than men in trying to follow careers, since they were accustomed to using their brains "but little and in trivial matters." At several points in her life, Cleaves suffered what she called a "sprained brain," and had to take a leave of absence from her work to recuperate.

English psychiatrists quickly picked up the neurasthenia diagnosis as an apt description of English nervousness. They maintained that neurasthenia was "neither a modern nor an American disease only" but simply a new name for what they had long called spinal irritation, neuralgic disease, or nervous weakness. Neurasthenics were viewed as borderers, denizens of Driftland and Mazeland whose mental organization was weakened by hereditary predisposition. Furthermore, in its passage from America to England, neurasthenia was mainly associated with young women. "Inasmuch as neurasthenia is mainly congenital," wrote a late Victorian expert, "and always associated with
chlorosis...it is natural that the female sex, being more sensitive, should be more subject to it.”\textsuperscript{46} For many late Victorian female intellectuals, especially those in the first generation to attend college, nervous illness marked the transition from domestic to professional roles. Similar to the fears and depressions described by Nightingale, Brontë, and Craik in the 1850s, these protracted and vaguely understood illnesses were now subsumed under the label of “neurasthenia.” From the pioneering doctor Sophia Jex-Blake to the social worker Beatrice Webb, New Women and nervous illness seemed to go together.\textsuperscript{47}

Whether the disorder was anorexia, hysteria, or neurasthenia, English psychiatric treatment of nervous women was ruthless, a microcosm of the sex war intended to establish the male doctor’s total authority. It could be compared to “a game of chess...a complex sequence of offensive and defensive maneuvers requiring elaborate strategic planning.... And the medical ideal of a full and radical cure took the form of a kind of moral checkmate—the complete submission of the patient to the physician’s authority, with a full confession of moral wretchedness and the various tricks and artifices involved in the presentation of the ‘symptoms.’”\textsuperscript{48} The goal was to isolate the patient from her family support systems, unmask her deceitful stratagems, coerce her into surrendering her symptoms, and finally overcome her self-centeredness.

In the case of anorexia, doctors had noted that fasting girls exercised an unusual degree of control over their families. At mealtimes, Allbutt observed, “her mother may cry, her father may storm”; Lasegue’s patients became the center of family concern, “the sole object of preoccupation and conversation.”\textsuperscript{49} Approved medical attitudes towards the anorexic girl are described in Sarah Grand’s best-selling novel The Heavenly Twins (1893), where the London nerve specialist Sir Shadwell Rock treats an anorexic patient as if he were taming a shrew; he sends her away from her family with “a perfect stranger, a hard, cold, unsympathetic person who would irritate her, if possible; and she was not to be allowed luxuries of any kind.... When she fainted she was left just where she fell to recover as best she could, and when any particular food disagreed with her, it was served to her incessantly.” The girl at last confesses to Dr. Rock that she had been “shamming from beginning to end.”\textsuperscript{50}

The assumption that the patient was shamming also dictated the psychiatric treatment of hysteria. With hardened actresses, Allbut sug-
gested, the only remedy was to stop paying attention—to empty the theater and take away the audience. Physicians agreed on the benefits of “observant neglect” in which indifference to the patient’s expectations of sympathy established the physician’s lofty authority. Some went beyond mere indifference to intimidation, blackmail, and threats. The treatments suggested for hysterical fits included “the sudden production of some painful impression”: pouring water on the head, compressing the supraorbital nerve, stopping the patient’s breathing, slapping the face and neck with wet towels, and exercising pressure “on some tender area.” In his lectures on hysteria, Skey advised his audience that “ridicule to a woman of sensitive mind, is a powerful weapon . . . but there is no emotion equal to fear and the threat of personal chastisement.”

In late Victorian literature, too, representations of the hysterical woman as a malingering support punitive treatment. Charles Reade, for example, gives a full account of a faked hysterical seizure in *A Terrible Temptation* (1870). Rhoda Somerset falls to the floor, grinding her teeth, banging her head, and waving her arms, and revives only when the page is about to fling water on her. This traditional remedy for female hysteria was also employed at the Cheltenham Ladies College in 1889. When the school first opened, the addiction of some of the pupils to fainting fits in chapel or study hall had a bad effect on academic discipline. The matron solved the problem, however, by calling for cold water to pour over the victim; those who recovered before the water arrived were dosed with laxative powders.

The standard treatment for neurasthenia was Silas Weir Mitchell’s rest cure, a technique that this distinguished American neurologist had developed after the Civil War. Mitchell’s rest cure, which he first described in 1873, depended upon seclusion, massage, electricity, immobility, and diet. When his neurasthenic subjects, among them such prominent American women intellectuals as Jane Addams, Winifred Howells (daughter of William Dean Howells), and Edith Wharton, became thin, tense, fretful, and depressed, Mitchell ordered them to enter a clinic for “a combination of entire rest and of excessive feeding, made possible by passive exercise obtained through steady use of massage and electricity.” For six weeks the patient was isolated from her family and friends, confined to bed, forbidden to sit up, sew, read, write, or to do any intellectual work, visited daily by the physician, and fed and massaged by the nurse. She was expected to gain as much as fifty
pounds on a diet that began with milk and gradually built up to several substantial meals a day. Mitchell was well aware that the sheer boredom and sensory deprivation of the rest cure made it a kindly punishment for neurasthenia, the psychological equivalent of the hysterical's bucket of water: "When they are hidden to stay in bed a month, and neither to read, write, nor sew, and 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 which has become pleasantly welcome and eagerly looked for."55

Although it had the medical rationale of building up the patient's depleted supply of fat and blood, the rest cure had striking psychological effects. Mitchell insisted on isolation both as a way of removing the patient from the sympathetic collusion of her family and as a way of maximizing his own semimagical influence over her, an influence he believed essential to a cure. The misogynistic implications of the rest cure have been the subject of controversy among contemporary feminist historians. Barbara Seichman points out the similarities between the enforced dependency of the rest cure and infancy, and suggests that such a temporary yielding up of the will in childlike obedience to a charismatic physician may actually have been restorative for some women who were unable to accept their own emotions and dependencies.56 But other feminist historians see Mitchell in a harsher light, not as the benignly paternal guardian, but as a man unaware of his own hostility to women who "cured" them by "restoring them to their femininity or... by subordinating them to an enlightened but dictatorial male will." Forced back into "womblike dependence," the patient was reborn, re-educated by the parental team of subservient female nurse and godlike male doctor, and "returned to her menfolk's management, recycled and taught to make the will of the male her own."57

Yet another aspect of the rest cure emerges in the practice of W. S. Playfair, professor of obstetric medicine at King's College, who introduced Mitchell's rest cure to England in the 1880s. Playfair suggested the adoption of Mitchell's method for women suffering from neurasthenia associated with pregnancy problems, and for "the worn and wasted, often bedridden woman, who had broken down, either from some sudden shock, such as grief, or money losses, or excessive mental or bodily strain."58

Whereas Playfair resented the "fat, well-feeding hysterics who thor-
oughly enjoy their life of inert self-indulgence,” he felt an intuitive sympathy for the neurasthenic invalids, who were often emaciated and enfeebled, who were “of high culture and refinement,” and “who heartily long for good health if they only knew how to obtain it.” The neurasthenic woman was already a model of ladylike deportment and hyperfemininity, a paradigm of that wasting beauty that the late Victorians found so compelling. Like the consumptive, the neurasthenic woman was spiritualized, incorporeal, and pure. Playfair treated a woman so “fine and cultivated” that she had spent most of her married life lying in a dark room at the back of the house, unable to bear the slightest noise, light, or physical contact. This exquisite invalid, who also had no appetite and fainted frequently, had to be totally anaesthetized before she could be conveyed from her house in the country to Playfair’s London clinic. In encouraging her to eat, acclimatizing her to vigorous massage, and moving her to a bright room, Playfair ended her bondage to a debilitating ideal of angelic womanhood. The rest cure made women who were denying their bodies, their appetites, and their sensations confront nothing but the body, the appetite, and the senses for a prolonged period. This cannot have been entirely a bad thing.

In fact, Playfair used the rest cure successfully in many cases where women had been total invalids of many years’ duration, and he was able to restore his patients to lives that were much more active and satisfying than the ones they had been leading. Most of his clients were women reacting to traumatic miscarriages, stillbirths, or painful deliveries that had left them physically and emotionally scarred. In case after case, their immobility, sensitivity, loss of appetite, and depression seem to be forms of sexual withdrawal, the body protecting itself against further invasion. Playfair was able to get these women physically fit, and less fearful of the future.

It would seem that the practice of the rest cure had different implications in the United States and England, and two fictional studies by American and English feminist writers suggest how differently this controversial therapy could be experienced and perceived. The more famous of the two accounts is the short story “The Yellow Wallpaper” (1892) by the American socialist and feminist Charlotte Perkins Gilman. Gilman explained the genesis of the story in her journal The Forerunner. In 1887, suffering from chronic acute depression, she had consulted Weir Mitchell, who applied the rest cure for a month and then sent her home with advice to lead a thoroughly domestic life, to
limit her reading to two hours a day, and to give up writing altogether. “I went home,” Gilman told her readers,

and obeyed these directions for some three months, and came so near the borderline of utter mental ruin that I could see over.

Then, using the remnants of intelligence that remained... I cast the noted specialist’s advice to the winds and went to work again—work, the normal life of every human being... ultimately recovering some measure of power.

Being naturally moved to rejoicing by this narrow escape, I wrote “The Yellow Wallpaper”... and sent a copy to the physician who so nearly drove me mad. He never acknowledged it.... [But] many years later I was told that the great specialist had admitted to friends of his that he had altered his treatment of neurasthenia since reading “The Yellow Wallpaper.”

Her story is a powerful polemic against Mitchell’s methods. The woman narrator of “The Yellow Wallpaper” is a writer being treated for postpartum depression by her doctor-husband in an isolated country house. Although she thinks that “congenial work,” variety, stimulation, excitement, the company of friends, and the advice and support of other writers would restore her spirits, her husband thinks otherwise. He insists on total passivity, isolation, mental blankness, and provides her with an hourly schedule of phosphates, tonics, food, naps, and exercise. Most of the time he is away on business, leaving her in the watchful care of his sister.

The room in which she spends most of her time is also her husband’s choice. They call it “the nursery at the top of the house,” and it is certainly related to her enforced infantilism and regression. But it also has all marks of a cell for the solitary confinement of a raving lunatic: the windows are barred, there are rings in the wall, the wallpaper is torn, the floor is scratched, the plaster is dug out, the bed is nailed down, and the bedposts have been gnawed. The sinuous lines and oscillating abstractions of the sulphurous yellow wallpaper torment her, and she pleads with her husband to let her leave the house or at least move to another room. But he blandly assures her that he knows what is best, and threatens that if she does not improve he will send her to Weir Mitchell.

As the days go by, depression, repressed anger towards her husband,
and inactivity make the woman less able to assert her own needs without breaking down in tears, which would only confirm her “sickness”; and even when she escapes the dual surveillance of husband and sister-in-law to try to write, she finds herself too tired to make the effort. All her blocked imaginative power gradually fixes on the wallpaper, which in the story becomes the correlate of her mental disintegration. She first sees “bulbous eyes” in the pattern staring at her, and then “a strange, provoking, formless sort of figure that seems to skulk about behind that silly and conspicuous front design.” Soon the faint figure has become a woman, trapped in the encircling arabesque, who makes the pattern quiver and shake in her desperate efforts to escape its strangling curves. Finally the narrator, completely mad, rips all the paper off the wall to release her double. She has lost the sense of ego boundaries; the wallpaper woman is at once the other, herself, and many women, creeping away into “the open country, creeping as fast as a cloud shadow in the wind.” Frantic to escape, yet bound in one direction by the dim memories of wifely propriety, and in the other by injunctions against suicide, she escapes into madness, making the room her refuge, creeping around its margins, and locking the door against her husband. When he breaks it down, he finds her on her hands and knees. Her triumph over the rest cure and its complacent guardians comes at the price of her mind.

Gilman’s haunting and passionate protest against the rest cure has become a modern feminist classic, a paradigmatic text for critics and historians looking at the relation between sex roles, madness, and creativity. Like Nightingale’s Cassandra, it shows how solitary confinement within the bourgeois family could be maddening for intelligent women. Because Gilman’s story deals specifically with a woman writer who is denied any legitimate outlet for her imagination and craft, it has also been interpreted as a parable of female literary confinement, “the story that all literary women would tell if they could speak their ‘speechless woe.’” And the loving destruction of the woman in the rest cure which Gilman so chillingly portrays has been taken as symbolic of the effects of marriage on women, a bold attack on “the sexual politics of the male-female, husband-wife relationship.” When the husband forces his way into the room, Ann Douglas suggests, he enacts the sexual violence that some nineteenth-century American feminists saw reproduced in the relations of male doctors and female patients.

The English version of the rest cure, however, turns Gilman’s story
inside out. In Elizabeth Robins’s novel *A Dark Lantern* (1905), the rest cure is a rescue from an impoverished life, and the doctor-lover is a savior. Robins too was a feminist, an American-born actress who moved to England in 1889 and became an activist in the suffrage movement. Her heroine, Katharine Dereham, is a young poet who becomes neurasthenic from overwork, anxiety about her family, and sexual pressure. After a variety of doctors have been unable to help her, she turns to Garth Vincent, a glamorous nerve specialist who has become celebrated for his successful rest cures. Dr. Vincent’s demands are as rigid, his manner as brusque, as Mitchell’s. He orders her to bed, cuts off her visitors and her mail, regulates her diet, hires her nurses, restricts her reading, and prescribes vigorous massage. Katharine resists the massage most of all, “to be touched by strange hands was an offence to the spirit, a positive hurt to the nerves.”

However, the English doctor allows his patient to write; Katharine grows stronger, and during the few hours Vincent allows her to work each day she composes the most powerful poems of her career. The final step in her cure comes when in a startling turnabout she herself goes to his country estate to ask the doctor to become her lover. Robins stresses love rather than mere lust, but obviously the physical element is the great transformer: “Spring! What would it bring to her? What was to be her awakening? For she too, in a fashion, had slept, had been quiescent as the bare brown fields, not looking before or after; lulled; yes, yes, she had slept, and must awake.”

Spring brings her sexual fulfillment, physical strength, and glowing reviews for her book of sonnets. And summer brings marriage to the high-handed but adoring physician. At the end of *A Dark Lantern*, when the doctor-husband breaks down Katharine’s door after she locks him out in a quarrel, he is clearly meant to represent life-giving passion breaking in upon her neurotic withdrawal, and not rape or violation of her spirit. Although Robins’s novel is lurid and sentimental, it shows that even for feminists, the rest cure might have had creative and sexual advantages.

Not long after her first rest cure in 1904, Virginia Woolf read and reviewed *A Dark Lantern*: “I have been reading Miss Robin’s [sic] book all the evening, till the last pages. It explains how you fall in love with your doctor, if you have a rest cure. She is a clever woman, if she weren’t so brutal.” Although Woolf’s doctor was George Savage, by then a stout clubman in his sixties, she did not make fun of Robins’s
plot as we might expect. Even Gilman, linking the husband with the physician in “The Yellow Wallpaper,” acknowledged a kind of eroticism in the rest cure. For Woolf as for Gilman, however, the romantic implications of this quasi-courtship were overshadowed by its intrusions. She resisted even the mild rest cure that Savage imposed upon her after her father’s death. Under his orders she was sent to stay with an aunt in the country. “I have never spent such a wretched 8 months in my life,” she wrote to Violet Dickinson, “and yet that tyrannical and as I think, shortsighted Savage wants yet another two... Really a doctor is worse than a husband.”65 Alice James, too, found the condescension of her doctors to be one of the worst burdens of her neurasthenia: “I suppose one has a greater sense of intellectual degradation after an interview with a doctor than from any human experience,” she confided to her diary in 1890.66

Surely the “hungry look” that Savage saw in the faces of his neurasthenic female patients was a craving for more than food. The nervous women of the fin de siècle were ravenous for a fuller life than their society offered them, famished for the freedom to act and to make real choices. Their nervous disorders expressed the insoluble conflict between their desires to act as individuals and the internalized obligations to submit to the needs of the family, and to conform to the model of self-sacrificing “womanly” behavior. As the feminist novelist “George Egerton” wrote in 1894, “When we shall have larger and freer lives, we shall be better balanced than we are now.”67 There were important differences between the phenomena of hysteria, anorexia, and neurasthenia, even if diagnostic categories were far from precise. But in England, these terms became three labels for the same unhappy woman, three faces of Eve.