The Female Malady

Tensive note of the uncanny, of a parodied ceremony, is struck in many anecdotes.

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...ing the patriarchal character of the Victorian age, the asylum became increasingly like the family, ruled by the father, and subject to his values and his law.
THE RISE OF THE VICTORIAN MADWOMAN

Within the ideology and practice of Victorian psychiatry, women occupied a special place. Like most visitors to the Victorian asylum, Charles Dickens was particularly struck by the female lunatics. When he went to St. Luke’s Hospital in 1851 for the Christmas Ball, Dickens looked with special interest at the madwomen who attended the ball: “There was the brisk, vain, pippin-faced little old lady, in a fantastic cap—proud of her foot and ankle; there was the old-young woman, with the dishevelled long light hair, spare figure, and weird gentility; there was the vacantly-laughing girl, requiring now and then a warning finger to admonish her; there was the quiet young woman, almost well, and soon going out.” Dickens particularly noted the sex ratio in the hospital: “The experience of this asylum did not differ, I found, from that of similar establishments, in proving that insanity is more prevalent among women than among men. Of the eighteen thousand seven hundred and fifty-nine inmates St. Luke’s Hospital has received in the century of its existence, eleven thousand one hundred and sixty-two have been women.”
It is notable that the domestication of insanity and its assimilation by the Victorian institution coincide with its feminization. Although individual doctors such as Richard Napier had seen large numbers of unhappy and mentally disturbed women in their private practice as far back as the seventeenth century, the mid-nineteenth century is the period when the predominance of women among the institutionalized insane first becomes a statistically verifiable phenomenon. Before the middle of the century, in fact, records showed that men were far more likely to be confined as insane. In 1845, a study by John Thurnam, medical superintendent of the York Retreat, had indicated that male asylum patients outnumbered women by about 30 percent. But within a few years after the passage of the Lunatics Act, the situation had changed. Gradually the percentages of women in Victorian asylums increased, and by the 1850s there were more women than men in public institutions. As the asylum population expanded throughout the century, the greater proportion of women remained constant. According to the census of 1871, there were 1,182 female lunatics for every 1,000 male lunatics, and 1,242 female pauper lunatics for every 1,000 male pauper lunatics. By 1872, out of 58,640 certified lunatics in England and Wales, 31,822 were women. There were more female pauper lunatics in county and borough asylums, in licensed houses, in workhouses, and in single care. Men still made up the majority of middle- and upper-class patients in private asylums, but by the 1890s, the predominance of women had spread to include all classes of patients and all types of institutions; female paupers and female private patients were in the majority in licensed houses, registered hospitals, and the county asylums. The only remaining institutions with a majority of male patients were asylums for the criminally insane, military hospitals, and idiot schools. Outside the asylums, too, women were the primary clientele at the surgical clinics, water-cure establishments, and rest-cure homes; they flocked to the new specialists in the "female illnesses" of hysteria and neurasthenia, and to the new marginal therapies such as mesmeric healing. Even in the novel, the madwoman, who started out confined to the Gothic subplot—to the narrative and domestic space that Charlotte Brontë calls "the third story"—by the fin de siècle had taken up residence in the front room. Thus, by the end of the century, women had decisively taken the lead as psychiatric patients, a lead they have retained ever since, and in ever-increasing numbers.

As the number of women patients in Victorian asylums increased,
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moreover, the number of women caring for the insane as madhouse proprietors declined. In the eighteenth century and up to the 1840s, women had often been the licensed proprietors of private madhouses, where they provided care primarily for female patients. Their services were often preferred to those of the large asylums. Thus Mary Lamb, who suffered manic attacks throughout her life, was brought by her brother Charles to a private hospital, where “the good lady of the Madhouse, and her daughter, an elegant sweet behaved young lady, love her and are taken with her amazingly.”5 William Thackeray, whose wife Isabella had developed a postpartum psychosis and attempted suicide after the birth of her third child, was unable to find an English asylum where he could bear to leave her; even the York Retreat seemed too cold and brutalizing. He finally left her in the care of a kindly woman in Camberwell, where she remained until her death.6

Between 1854 and 1870, about one out of five provincial licensed houses and one out of four metropolitan licensed houses still had female proprietors, but the claims of the medical profession that, despite the apparent commonsensical nature of moral management, only doctors were qualified to treat the insane, gradually forced women into marginal, secondary, or volunteer roles, much as the rising profession of obstetrics demoted midwifery. Medical men protested against the common practice of transferring private asylum licenses to the wives or daughters of proprietors. “If insanity is a disease requiring medical treatment,” Bucknill insisted in 1857, “ladies cannot legally or properly undertake the treatment. . . . If private interests . . . are to override public ones, the widow of a clergyman ought on the same principle to hold the rectory of her departed husband, and manage the parochial duties by means of curates.”7 Such arguments led the Commissioners in Lunacy to announce in their 1859 report that they considered granting new licenses for private asylums only to medical men, and women applicants were thereafter discouraged, though not always refused.8 As the number of private licensed houses run by lay proprietors diminished, women played an even smaller role in the treatment of the insane.

Public asylums had always had male superintendents, but by the middle of the century, vigorous campaigning by doctors had led to a series of legislative reforms that placed control in the hands of the medical profession. The Madhouse Act of 1828 stipulated that a resident medical superintendent had to be employed when an asylum held more than a hundred patients. In all asylums, moreover, a doctor had to visit
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the patients at least once a week, and sign a weekly register. The Lunatics Act of 1845 required that asylums keep records of medical visits and treatments. At the same time as doctors established a monopoly on the treatment of the insane, women were denied access to medical education. Furthermore, in their effort to upgrade the status of the psychiatric profession, some doctors denigrated the supportive work done by women in public administration. In the early part of the century, the wives of asylum superintendents had also acted as matrons, with responsibility for the women's side. Conolly's wife, however, did not accompany him to Hanwell, and Bucknill campaigned to have the position of matron in the county asylums abolished. His sarcastic suggestion that matrons, if absolutely required, should be selected by weight, was a thinly veiled insult to the stout Charlotte Walker, whose maternal concern for patients had been praised by Dickens at St. Luke's. In the end, Bucknill was forced to apologize in the Journal of Mental Science. Matrons, female nurses, and attendants were paid on a much lower scale than male workers, were regarded as less reliable, and were subject to more rules and restrictions. Any effort to equalize their status encountered intense opposition, as when John Arlidge indignantly protested that in one asylum the matron was as well paid as the doctors. Conolly maintained that matrons often tried to "usurp authority" from the medical superintendent. Victorian psychiatry thus established lunatic asylums increasingly populated by women but supervised by men.

The reasons for the increase in female insanity were the subject of fierce debate among Victorian reformers and asylum superintendents. Some doctors denied that any real gender differences in the insane population existed. In their view the larger number of women in the asylum was not a proof that the incidence of mental disease was higher among women, but rather reflected the fact that women patients outlived men and were less likely to be discharged as cured. Others argued that the shift reflected the "feminization" of Victorian poverty. Poverty was, after all, one of the moral causes of insanity. Women were the majority of recipients of poor-law relief, and poor people were more likely to be committed to institutions than people from the middle or upper class. Furthermore, diseases caused by poverty could lead to madness. "Lactational insanity," for example, was the name given to the delirium of poor mothers who nursed their babies for long periods in order to save money and to prevent conception; it was caused by malnutrition and anemia. A third point of view held that not all women
in asylums were actually insane; asylum populations also included many women who were senile, tubercular, epileptic, physically handicapped, mentally retarded, or otherwise unable to care for themselves. The medical superintendent at Colney Hatch in 1869 declared that he "could discharge more than 100 of the females without the slightest hesitation and at once if I could ensure for them outside the most reasonable consideration for their condition and infirmity."15

Of course, doctors' expectations may also have determined patient supply. St. Luke's had remodeled its dormitories in the 1830s on the assumption that the number of women patients would always exceed the number of men; and W. A. F. Browne recommended "that in the case of a public asylum, a larger portion of the building should be allotted to females, as their numbers almost always predominate."16 Throughout the century, more dormitory spaces were planned for female than for male patients, and more private asylums limited their clientele to women. The availability of institutional space, as Andrew Scull has argued, made the option of confining helpless, troublesome, or destitute family members a realistic alternative to home care and thus encouraged institutionalization of marginal cases.17 Finally, the rise of the Victorian madwoman may have been linked to the rise of the psychiatric profession, with its attitudes towards women and its monopoly by men. As one female lunatic sardonically remarked to her asylum physician: "Well, Sir A——, since I have had the pleasure of seeing you last, I have been benighted and you have been knighted."18

For despite their awareness of poverty, dependency, and illness as factors, the prevailing view among Victorian psychiatrists was that the statistics proved what they had suspected all along: that women were more vulnerable to insanity than men because the instability of their reproductive systems interfered with their sexual, emotional, and rational control. In contrast to the rather vague and uncertain concepts of insanity in general which Victorian psychiatry produced, theories of female insanity were specifically and confidently linked to the biological crises of the female life-cycle—puberty, pregnancy, childbirth, menopause—during which the mind would be weakened and the symptoms of insanity might emerge. This connection between the female reproductive and nervous systems led to the condition nineteenth-century physicians called "reflex insanity in women." The "special law" that made women "the victim of periodicity" led to a distinctive set of mental illnesses that had "neither homologue nor analogue in man."19

According to G. Fielding Blandford, "Women become insane during
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pregnancy, after parturition, during lactation; at the age when the catamenia [menses] first appear and when they disappear. . . . The sympathetic connection existing between the brain and the uterus is plainly seen by the most casual observer." And George Man Burrows wrote: "The functions of the brain are so intimately connected with the uterine system, that the interruption of any one process which the latter has to perform in the human economy may implicate the former." Given so shaky a constitution, it seemed a wonder that any woman could hope for a lifetime of sanity, and psychiatric experts often expressed their surprise that female insanity was not even more frequent.

Although a relatively small percentage of women patients were admitted to asylums during their adolescent years, doctors regarded puberty as one of the most psychologically dangerous periods of the female life-cycle. Doctors argued that the menstrual discharge in itself predisposed women to insanity. Either an abnormal quantity or quality of the blood, according to this theory, could affect the brain; thus psychiatric physicians attempted to control the blood by diet and venesection. Late, irregular, or "suppressed" menstruation was regarded as a dangerous condition and was treated with purgatives, forcing medicines, hip baths, and leeches applied to the thighs.

The proper establishment of the menstrual function was viewed as essential to female mental health, not only for the adolescent years but for the woman's entire life-span. Menarche was the first stage of mental danger, requiring anxious supervision from mothers if daughters were to emerge unscathed. Doctors warned that moral insanity could easily begin at adolescence, when "the pet of the family" became inexplicably "irreligious, selfish, slanderous, false, malicious, devoid of affection . . . self-willed and quarrelsome." Dr. Edward Tilt described female adolescence as indeed a state of "miniature insanity," when previously well-behaved girls turned "snappish, fretful . . . full of deceit and mischief."

Obviously, puberty was a turbulent period for Victorian girls, a potentially traumatic transition from the freedom of androgynous childhood to the confines of the adult feminine role. Prudery and embarrassment prevented many mothers from preparing their daughters for menarche, so that the unsuspecting girls were "left in culpable innocence . . . terrified at what they could only construe as vaginal hemorrhaging." Tilt reported that 25 percent of his female patients had been left totally ignorant of the menstrual cycle. When their first men-
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Menstruation occurred, many were frightened, screamed, or even went into fits. Some thought themselves wounded and frantically tried to wash the blood away.36

There were other psychological problems faced by Victorian girls at the onset of menses. Up until this point, their lives were not too radically unlike those of their brothers. But menstruation sharply marked the beginning of a different and more limited existence. Simply to manage the hygiene of menstruation in a household where it could not be acknowledged or revealed created a sense of anxiety and shame. Physical activities, traveling, exercise, and study were curtailed or forbidden. While their brothers went away to school, most middle-class girls were educated at home, their social life outside the home restricted to a few safe contacts with other girls, clergymen, or local philanthropies.37 No wonder that, as one Victorian doctor observed, “puberty, which gives man the knowledge of greater power, gives to woman the conviction of her dependence.”38

A girl’s growing awareness of this social dependence and constraint, the realization of her immobility and disadvantage as compared with her brothers, and other boys, may well have precipitated an emotional crisis. Case histories of mental breakdown attributed to the biological stresses of puberty suggest both gender conflict and protest against sexual repression. “Miss J. V.,” for example, described herself as “a mixture of a nymph and a half-man, half-woman and a boy.” “Miss C. G.,” seventeen years old, was committed to the Royal Edinburgh Asylum because “without showing any previous sign of insanity, except conduct that was called wayward and disobedient, she left her home, wandered to where some workmen lived, a lonely place many miles off, and spent the night with them.”39

Threatening as such delusions and behaviors were to families and physicians who expected that the “pet of the family” would remain docile, the anger, manifest sexuality, and violence of puerperal insanity were worse. Ranging from the mild and short-term symptoms of post-partum depression to incurable psychosis, puerperal insanity accounted for 7 to 10 percent of female asylum admissions. By 1850, puerperal insanity generally was taken to mean mental disorder occurring within the month after confinement. It could take a number of disturbing forms. According to Bucknill and Tuke, the woman suffering from puerperal madness evinced “a total negligence of, and often very strong aversion to, her child and husband . . . explosions of anger occur, with
vociferations and violent gesticulations; and, although the patient may have been remarkable previously for her correct, modest demeanor, and attention to her religious duties, most awful oaths and imprecations are now uttered, and language used which astonishes her friends."

Cases of puerperal insanity seemed to violate all of Victorian culture's most deeply cherished ideals of feminine propriety and maternal love. Women with puerperal mania were indifferent to the usual conventions of politeness and decorum in speech, dress, and behavior; their deviance covered a wide spectrum from eccentricity to infanticide. In a typical mild case, Conolly explained, the young mother might show a "great degree of excitement...with a lively propensity to every kind of mischief." More severe cases, according to Henry Maudsley, displayed "much moral perversion" in craving stimulants. Whereas maternity was viewed by the Victorians as a pure and almost sacred state, violent puerperal maniacs flaunted their sexuality in ways that shocked physicians. As Bucknill and Tuke noted, "Every medical man has observed the extraordinary amount of obscenity in thought and language..."
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pleted, and her control over her behavior diminished. In fact, infanticide did not appear randomly in the population; in middle-class households, where there were nurses and servants to help with child care, puerperal insanity rarely ended in infanticide. As we would expect, child murder was much more likely to occur in conjunction with illegitimacy, poverty, and brutality. These factors, whether or not they were considered by medical specialists, were certainly taken into account by Victorian judges and juries, who were reluctant to sentence infanticidal women to death, and who responded compassionately to the insanity defense generally used in their behalf. Infanticidal women who were committed for life to Bethlem or Broadmoor were also more likely to be released by order of the home secretary than any other group of the criminally insane.37

Humanitarian in its legal effects, the psychiatric definition of puerperal violence nonetheless ignored both the social problems of unmarried, abused, and destitute mothers and the shocks, adjustments, and psychological traumas of the maternal role. Rather than looking at the social meaning of infanticide and at its contexts, doctors, lawyers, and judges categorized it as an isolated and biologically determined phenomenon, an unfortunate product of woman's "nature."

Similarly, psychiatrists ignored the psychological and social impact of aging, and stressed feminine biology to explain insanity in older women. They claimed that the end of women's reproductive life was as profound a mental upheaval as the beginning. "The death of the reproductive faculty," wrote one physician, "is accompanied . . . by struggles which implicate every organ and every function of the body."38 Doctors spoke in violent metaphors of "revolution" in the female economy and of "climacteric paroxysms" creating a "distinct shock to the brain."39 When insanity occurred, it took the form of extreme delusions "that the world is in flames, that it is turned upside down, that everything is changed, or that some very dreadful but undefined calamity has happened or is about to happen."40 Whereas we might interpret such "delusions" as metaphoric female communications about the terrors of a drastically altered and diminished sexual status,41 Victorian psychiatrists were indifferent to the psychological messages of their patients' symptoms, and to the social contexts in which these physical crises took place.

A few of the moral managers did recognize that the intellectual and vocational limitations of the female role, especially in the middle
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classes, were as maddening as its biological characteristics. They la-
mented the absence of serious and absorbing mental exercise for “fe-
males of the middle and higher ranks,” who, according to the Reverend
William Moseley, “have no strong motives to exertion . . . no interests
that call forth their mental energies.” While he agreed that feminine
vulnerability to insanity was caused by constitutional weaknesses,
W. A. F. Browne also felt that women’s “imperfect and vicious” edu-
cation deserved some of the blame:

It tends to arrest the development of the body; it overtasks certain
mental powers, it leaves others untouched and untaught; so far as it
is moral it is directed to sordid and selfish feelings, and substitutes a
vapid sentimentalism for a knowledge of the realities and duties of
life. From such a perversion of the means of training, what can be
expected to flow but sickly refinement, weak insipidity, or absolute
disease?  

Conolly too found “the condition of the female mind” deplorable, even
in the highest classes; “the few accomplishments possessed by them
have been taught for display in society, and not for solace in quieter
hours.” Since their education provided them with so little of the self-
discipline and inner resources psychiatrists deemed essential for the
individual’s struggle against moral insanity, women were seen as poor
mental risks.

But if some of the moral managers paid heed to the circumstances of
women’s lives, they nevertheless saw the problems as failures of train-
ing and will. They were no more sensitive than others to the way that
madness expressed conflicts in the feminine role itself, or to how
women experienced their condition. How did women, rather than do-
tors, feel about menarche or menopause? How did the asylum and its
medical superintendents look to female patients? What did women
working in asylums as nurses or matrons think about the causes of
puerperal mania? Such direct witnessing is almost impossible to re-
cover. Women did not have access to the pages of the professional
journals that discussed the statistics and the theories of insanity. There
were no female medical officers to speak about the psychology of
women, and the few women who seem to have had significant careers
as matrons or proprietors of private asylums have not left records.

We do not hear the voices of female lunatic patients, either. Early-
nineteenth-century asylum case histories are not, by and large, revealing documents; they rarely provide much information about the patients' lives, let alone their words. Indeed, following the advice of moral managers like Samuel Tuke, who insisted that it was unwise to allow lunatics to speak ("No advantage has been found to arise from reasoning with them on their particular hallucinations... In regard to melancholics, conversation on the subject of their despondency is found to be highly injudicious"), Victorian asylum superintendents were reluctant to listen to their patients, or to find out how they felt and why. However benevolent their physical care of the patients, moral therapists, Roy Porter reminds us, "were no more interested in entering into the witness of the mad, in negotiating with their testimony, even in exploring and decoding its meanings, than the advocates of mechanical and medical treatment had been." Their cure involved refusing to discuss the lunatic's feelings, ignoring her demands and observations, and instead, diverting her mind from its "delusions" through physical activity and communal recreation.

To find the female perspective on insanity, we must turn to Victorian women's diaries and novels. Although this literature deals exclusively with the experience of middle-class and aristocratic women, the letters and journals of Florence Nightingale, the psychological fiction of Charlotte Brontë, and the sensation novels of Mary E. Braddon give us a more subtle and complex way of understanding the crises of the female life-cycle than the explanations of Victorian psychiatric medicine.

These texts present female insanity in its social contexts, and as a reaction to the limitations of the feminine role itself. Unmarried middle-class women, for example, were widely considered a social problem by the Victorians. Stigmatized by terms like "redundant," "superfluous," and "odd," they were also regarded as peculiarly subject to mental disorders. But while doctors blamed menstrual problems or sexual abnormality, women writers suggested that it was the lack of meaningful work, hope, or companionship that led to depression or breakdown. Dinah Mulock Craik argued that the Anglican religious sisterhoods would be a salvation for the unmarried woman. Better a convent than a madhouse, she urged, for

what does not society suffer from these helpless excrescences upon it—women with no ties, no duties, no ambition—who drone away a hopeless, selfish existence, generally ending in confirmed invalidism,
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or hypochondria, or actual insanity!—for diseased self-absorption is
the very root of madness. It is a strange thing to say—yet I dare to
say it, for I believe it to be true—that entering a Sisterhood, almost
any sort of sisterhood where there was work to be done, authority to
compel the doing of it, and companionship to sweeten the same,
would have saved many a woman from a lunatic asylum. 46

In a work that explores many of these issues, Florence Nightingale
compared the confinement of women in the family to the circumstances
of the lunatic in the asylum:

It is almost invariable that, when one of a family is decidedly in
advance of all the others, he or she is tyrannized over by the rest, and
declared "quite incapable of doing anything reasonable." A man runs
away from this—a woman cannot... It is not only against those
esteemed physically insane that commissions of lunacy are taken
out. Others have been kept unjustly in confinement by their well-
intentioned relations, as unfit to be trusted with liberty. In fact, in
almost every family, one sees a keeper, or two or three keepers, and
a lunatic. 47

She was writing about her own experience. Madness, she believed,
could be the result of mental atrophy and moral starvation within the
most benevolent home; "there are quite as many who have lost their
reason out of as in a lunatic asylum." 48 Before she made the final break
with her family to become a nurse, Nightingale herself had suffered
from years of agonizing mental depression in which she experienced
dreamlike trances, religious hallucinations, and moments of suicidal
despair.

In a private autobiographical note, Nightingale had recorded "that as
a very young child she had an obsession that she was not like oth-
er people. She was a monster; that was her secret which might at any
moment be found out." 49 In Nightingale's case, as in so many lives
described in women's literature and memoirs, the image of monstrosity
was related to her anger and discontent and to the necessity of conceal-
ing her drives for independence, work, and power. Early in her life, she
learned to cope with family tensions by playing the expected domestic
role and keeping silent about her real feelings and wishes. But by
adolescence the cleavage between the acceptable public image of the
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dutiful daughter and the secret, aspiring “monstrous” self, which seemed to her so much the more essential and creative identity, led to a series of disabling psychic disorders.

In the late 1840s, having refused an offer of marriage from an eligible and attractive man in order to pursue her vocation, but prevented by her mother’s opposition from training as a nurse, Nightingale came close to a breakdown. She fainted frequently, could not concentrate, felt weak and ill. She fell into trances in which she lost all sense of time and place. In daily life she moved like an automaton, unable to remember what had been said or even where she had been. Her agonies of guilt and self-reproach were intensified by the conviction that she was going insane. “My present life is suicide,” she wrote on New Year’s Eve, 1850. “I have no desire but to die.”

Unable to defy her family’s wishes, and confined to the domestic routines of her home, Nightingale channeled all her immense energy, thwarted ambition, anger, and despair into a vast literary project, drawing heavily on her own experience to describe a society in which both mothers and daughters were confined in “the prison which is called a family.” Part of this three-volume work of philosophical and theological critique was an autobiographical novel, which by stages became an essay called Cassandra.

Cassandra is a scathing analysis of the stresses and conventions that drove Victorian middle-class women to silence, depression, illness, even lunatic asylums and death. At the age of thirty, Cassandra realizes that her passion, intellect, and moral energy have been destroyed by the petty obligations, genteel rituals, and religious cant of a mindless social code. Inspired by a divine vision, she tries to emulate the life of Christ, to become the savior whose suffering will awaken other women from their thrall. But society calls her mad and will not listen to her prophecies, and she dies unregarded.

Nightingale’s appropriation of the Cassandra story is revealing. In Greek mythology the Trojan princess Cassandra is cursed by Apollo for having rejected his love: her prophecies, though true, are fated never to be believed. The myth suggests that women who reject sexuality and marriage (the two were synonymous for Victorian women) are muted or even driven mad by social disapproval. Nightingale had once referred to herself as “poor Cassandra.” Feared and scorned, Cassandra stands for Nightingale’s long-hidden monstrosity, her carefully concealed and troubling difference from “normal” women.