

Nymphomania: The Historical Construction of Female Sexuality

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Introduction

The term nymphomania resonates with a sense of the insatiable sexuality of women, devouring, depraved, diseased. It conjures up an aggressively sexual female who both terrifies and titillates men. Surrounded by myth, hyperbole, and fantasy, the twentieth-century notion of a nymphomaniac is embedded in the popular culture: referred to in films, novels, music videos, and sex-addiction manuals, as well as in locker rooms and boardrooms. In the nineteenth century, however, nymphomania was believed to be a specific organic disease, classifiable, with an assumed set of symptoms, causes, and treatments. Like alcoholism, kleptomania, and pyromania - diseases that were identified in the mid-nineteenth century - a diagnosis of nymphomania was based on exhibited behavior. "Excessive" female sexual desire is, however, a much more ambiguous concept than habitual drunkenness, shoplifting, or setting fires. Consider the following cases of nymphomania diagnosed in the second half of the nineteenth century.

"Mrs. B.," age twenty-four and married to a much older man, sought the help of Dr. Horatio Storer, a gynaecologist and the future president of the American Medical Association, because of lascivious dreams. He reported that she "can hardly meet or converse with a gentleman but that the next night she fancies she has intercourse with him, ...though thinks she would at once repel an improper advance on the part of any man" (Storer 1856, 384). In fact, she "enjoys intercourse greatly" (with her husband) and has had sex with him nightly for the seven years of their marriage. The husband "has of late complained that he found physical obstruction to intercourse on her part, though she thinks it rather an increasing failure by him in erection" (Storer 1856,384). In this "Case of Nymphomania," Storer directed Mrs. B. to separate temporarily from her husband as well as to restrict her intake of meat and abstain from brandy and all stimulants to lessen her sexual desire, to replace the feather mattress and pillows with ones made of hair to limit the sensual quality of her sleep, and to take cold enemas and sponge baths and swab her vagina with borax solution to cool her passions. "If she continued in her present habits of indulgence," Storer argued, "it would probably become necessary to send her to an asylum" (Storer 1856, 385). At the time he presented the case before the Boston Society for Medical Observation in 1856, the woman's husband was still absent and her lascivious dreams had not occurred for several days. The doctor was "hopeful as regards the mental symptoms, which, however, will for some time require decided enforcement of very strict laws" (Storer 1856, 386).

In another case, the mother of a seventeen-year-old girl contacted Dr. John Tompkins Walton in 1856 because the girl, Catherine, was having "a fit." "This paroxysm," according to Walton, "was peculiar and specific ...in the lascivious leer of her eye and lips, the contortions of her mouth and tongue, the insanity of lust which disfigured [her], ...as well as in the positions she assumed and the movements which could not be restrained" (Walton 1857, 47). He judged her to be "in a condition of ungovernable sexual excitement" and was convinced that the primary cause of the disease was seated in her "animal organization," which he deduced from her small eyes, large, broad nose and chin, thick lips, and the disproportionate size of the posterior portion of her head (Walton 1857, 47).

(An enlarged cerebellum was believed by some doctors to indicate increased "amativeness" or sexual desire.) Moralism and science - and class bias - combined in Walton's belief that Catherine was infected by "the exposure and contagion incident to several families living in one house, with a hydrant and water closet shared by all the court, and [by] the immorality of the youths who lounged about the place" (Walton 1857,48). Ultimately, the girl admitted that she was a "wanton" and that her sexual appetite was insatiable. Walton rendered her "emasculate for a time" (although he does not describe his method), prescribed a vegetable diet, various drugs, cold hip baths, and leeches to the perineum.¹

The case description continued with the cryptic statement that Catherine was later intercepted in coitu; paroxysms and additional treatment followed. Although the doctor assured her that he would "render her sexually fit to assume the duties of a wife whenever such services were needed," Catherine denounced him more than once during this time for "having destroyed her virility" (Walton 1857, 50). Seven months after the beginning of treatment, Dr. Walton concluded that the girl "has no inclination to resume her old habits, and renew the disease" (Walton 1857, 50). Yet another case of nymphomania, reported in 1895, was that of "Mrs. L.," thirty-five years old, married with three children. Reflecting the influence of Richard von Krafft-Ebing's ([1886] 1965) major work on the classification of psychopathology published in 1886, Dr. L. M. Phillips of Penn Yann, New York, diagnosed Mrs. L.'s problem as "acquired anaesthesia sexualis episodiac ...[seemingly] ...paranoia erotica episodiac manifesting itself as nymphomania" (1895, 469). It seems that Mrs. L. attended a New York theatre party where a fashionable tableau vivant took place in which women posed semi-nude as living statues. Filled with disgust but also fascinated, Mrs. L. returned repeatedly that night to the room where the living statues displayed themselves. Following this experience, she lost interest in sex with her husband for two years, then recovered it for eighteen months, during which time "it burned with such intensity that it very nearly wrecked the physical well-being" of the couple (Phillips 1895, 468). She repeated these episodes of asexuality and "sexual pyrotechnics" over the ensuing six years before seeking the doctor's help. Phillips found no physical abnormalities - describing Mrs. L. as a "perfect woman" - and instead relied on a psychopathological diagnosis in which he argued that the psychosexual sphere of the brain and spinal cord had been indelibly imprinted with a hypnotic suggestive impression. In effect, Mrs. L. was compelled by this image to return to the attractive, yet repellent, scene, thus inducing nymphomania. Phillips did not describe the treatment he provided Mrs. L. but did state that she would have developed brain disease if she had not sought his help (Phillips 1895, 470). While his diagnosis foreshadowed the twentieth-century shift from a strictly organic to a more psychological explanation of nymphomania, it also hearkened back to the Renaissance belief that madness could occur when an impression of the unattainable beloved became seared upon the brain²

This amazing confusion about the nature of nymphomania can be found throughout more than one hundred case studies - ranging from short references about a particular patient to full-scale examinations of specific instances of the disease - published in American and European medical journals and texts from the late eighteenth to the early twentieth centuries.³ Nymphomania is variously described as too much coitus (either wanting it or having it), too much desire, and too much masturbation.⁴ Simultaneously, it was seen as a symptom, a cause, and a disease in its own right. Its aetiologies, symptoms, and treatments often overlapped with those of erotomania, hysteria, hystero-epilepsy, and ovarioomania, despite doctors' attempts to classify each as a distinct "disease." For example, while symptoms such as convulsions, the appearance of strangulation, paralysis, and blindness were more likely to be associated with hysteria, a patient exhibiting these symptoms as well as "excessive" sexual desire or activity might have been diagnosed as a nymphomaniac subject to hysterical attacks or a hysteric with nymphomaniacal manifestations.

Indeed, nymphomania assumed a myriad of forms in these nineteenth-century medical reports, including a woman's desire for gynaecological examinations, her introducing pins and other foreign objects into her urethra, vagina, or uterus, and her orgasm at the mere sight of a man. Nymphomania was also diagnosed by Krafft-Ebing in the case of a mother's incestuous desire for her son, while Chicago neurologist James G. Kiernan diagnosed nymphomania in cases of three schoolgirls who masturbated together and two women who lived together as "man and wife" (Krafft-Ebing [1886] 1965, 502; Kiernan 1891, 202). Cases were reported of puerperal nymphomania (relating to or occurring during childbirth), malarial nymphomania, mild or true nymphomania, homosexual nymphomania, platonic nymphomania, and nymphomania brought on by pulmonary consumption and by opium.⁵ One doctor claimed that women with blond hair between the ages of sixteen and twenty-five were the most likely candidates (Howe 1883, 108), while others saw it as a disease of widows, virgins, or pubescent adolescents.

To further complicate the study of this disease, certain kinds of behavior were labelled nymphomania that today would be associated with psychosis, such as incessant and uncontrolled masturbation, lewd and lascivious tearing of clothes, and public display of the genitals. In numerous medical reports, physicians described nymphomaniacs in hospitals and mental institutions who made indecent proposals to almost anyone and who masturbated and exposed themselves openly.⁶

At the same time, however, and sometimes even in the same case studies, nineteenth - and early twentieth-century European and American doctors also diagnosed as nymphomaniacs women whose "symptoms" consisted of committing adultery, flirting, being divorced, or feeling more passionate than their husbands.⁷ Physicians writing for a popular audience diagnosed nymphomania in those women who actively tried to attract men by wearing perfume, adorning themselves, or talking of marriage (see, e.g., Talmey [1904] 1912, 112).

In the late nineteenth century, therefore, even minor transgressions of the social strictures that defined "feminine" modesty could be classified as diseased. A convergence of several factors helps to explain this medicalisation of female behavior. Starting in the late eighteenth century, woman's nature was increasingly defined as inextricably bound up with her reproductive organs. This supposedly objective, scientific "fact" created the new framework within which physicians and other authorities found justifications for the limitations of women's social and economic roles. It was thought only natural that women would and should find their fulfilment solely in taking on the roles of wives and mothers.⁸

But the changing realities of women's lives in the second half of the nineteenth century contradicted this formulation. Contrary to their presumed natural passivity, modesty, and domesticity, women were demanding greater access to education, engaging in public debate over issues of prostitution and women's rights, joining the workforce in growing numbers, and marrying later - or not at all - and having fewer children. Although medical and other authorities hoped to define femaleness as fixed and static, it was in fact unstable and fluid.

This paradox was augmented by the contradictions implicit in the Victorian construction of female sexual desire. Women - that is to say white, middle-class women - were supposed to be naturally modest and sexually passive (although not passionless), awaiting the awakening of desire in response to the approaches of men.⁹ And yet, sympathetic medical observers recognised the reality of female heterosexual desire, occasionally bemoaning the effects of the necessary strictures placed on young girls, unmarried women, and widows.

These tensions and contradictions are highlighted in the physicians' case studies of nymphomania. The concept of nymphomania constructs a female sexuality that is totally out of control, both literally and figuratively: out of the control of Mrs. B., Catherine, and Mrs. L.; out of the control of their husbands, mothers, and doctors; and out of the control of the "natural laws" that supposedly determined women's passive response to male desire. This disease - defined as the extreme end of the sexual spectrum - embodied Victorian fears of the dangers of even the smallest transgressions, particularly among middle-class women whose conventional roles as daughters, wives, and mothers were perceived as a necessary bastion against the uncertainties of a changing society.

Within this theoretical context, gynaecology emerged as a medical speciality in the second half of the nineteenth century by focusing particular attention on the generative organs as the source of most women's diseases (Moscucci 1990, 1-6, 10-13).¹⁰ In addition, an increasing medical interest in perversion and deviance and a growing fear by many in the medical profession that these abnormal behaviors and desires were hereditary and incurable led to attempts to organise, classify, and thus gain some control over a myriad of newly defined psychopathologies, including diseases such as nymphomania.

An examination of the medical history of nymphomania allows us to observe the tensions and contradictions inherent in nineteenth-century assumptions about female sexuality during a period of contention over the nature of femaleness. Furthermore, the behavior described in case studies of nymphomania - masturbation, lascivious dreams, lesbian relationships, sexual intercourse, putting objects in the vagina and urethra, clitoral orgasm - however mediated through the doctors' presentations, permits us to glimpse a range of erotic activity of Victorian women that has generally been hidden.

In trying to unravel this history, I will look briefly at earlier notions of nymphomania and examine what is new in the nineteenth century. In particular, I will focus on the shifts and confusions in the medical profession's conceptualization and treatment of this disease to reveal the tensions in the attitudes toward female sexual desire and the nature of female sexuality at the end of the nineteenth century. Finally, I will look at the major shifts in perception, diagnosis, and treatment that begin to occur in the late nineteenth and early twentieth centuries as nymphomania was transformed from a biological to a psychological disease.¹¹

From furor uterinus to nymphomania

Notions of insane love - accompanied by symptoms of uncontrolled sexuality and/or pining away for love - are as old as medical theory. In *On the Diseases of Young Women*, Hippocrates described the melancholy madness that could consume young girls and recommended marriage as the cure (Ferrand [1623] 1990, 264, 505). The second-century Greek physician Galen believed that uterine fury occurred particularly among young widows whose loss of sexual fulfilment could drive them to madness (Ferrand [1623] 1990, 174). Clinical observations of nymphomania or furor uterinus, as it was more likely to be called until the seventeenth century, were discussed by medical theorists as early as the fifteenth century" and numerous medical school dissertations and scholarly texts examining the disease appeared in the sixteenth and seventeenth centuries. Cases of furor uterinus were reported in Italy, France, Spain, Portugal, Germany, and England during these centuries (Louyer-Villermay 1819; Diethelm 1971, 62, 139).¹²

One of the clearest early definitions of the disease can be found in the works of the Italian physician Girolamo Mercuriale, a major contributor to sixteenth-century gynaecological studies. According to him, furor uterinus was an "immoderate burning in the genital area of the female, caused by the surging of hot vapour, bringing about an erection of the clitoris. Because of this burning sensation women were thought to be driven insane" (Ferrand [1623] 1990, 385 -86). Other physicians, such as Pieter van Foreest, whose works were often quoted during the sixteenth century, pointed to the "corrupted imagination" and to the brain alone as the seat of the furor caused by insane love (Diethelm 1971, 63-64). Some writers, such as Felix Platter - in an influential early seventeenth-century text-book in which he described the case of a matron "who was in every other way most honourable, but who invited by the basest words and gestures men and dogs to have intercourse with her" - attributed the cause of this mania to possession by the devil (Diethelm 1971,51). Although mainly discredited, demonology continued to be a factor for a few medical theorists even into the eighteenth century (Diethelm 1971; see also Eccles 1982, 82).

Traditionally, furor uterinus, specifically associated with the generative organs, was thought to differ in some way from the melancholia of insane love believed to be connected solely to the brain. These distinctions were never clear in practice, however; in his magnum opus, *A Treatise on Lovesickness*, the seventeenth-century French physician Jacques Ferrand included both under the rubric of lovesickness, claiming that they differed only in degree. This debate about the nature of insane love - about the differences between pining away for love and sexual fury (or pathological sexuality) - continued into the nineteenth century.

In addition, Ferrand argued that lovesickness in all its manifestations was more likely to affect women because they were less rational, more "maniacal," and more libidinous in their love ([1623] 1990, 311~. Up to the Renaissance, physicians had contended that lovesickness was a disease almost exclusively afflicting noblemen; throughout the period, most of the victims discussed in the few detailed case studies of sexual excitement were men (Diethelm 1966, 238, 243, 246). (Literature, painting, and poetry, however, occasionally presented women as victims of lovesickness.) Gradually, the focus of the diseases of morbid love began to shift toward women. According to a recent study titled *Lovesickness in the Middle Ages*, the more specific connection made by some Renaissance medical writers between lovesickness and the sexual organs may have directed particular attention to women as sufferers "since women's ailments received special notice insofar as they were related to sexual physiology" (Wack 1990, 175). Furthermore, Enlightenment discourses on the rationality of man, as distinct from women's irrational nature, may have contributed to this shift toward locating love madness in women and femininity. Whatever the reasons for this change, by the nineteenth century insane love in its various forms was much more likely to be associated with women.

Changes in attitudes toward female sexuality

Belief in female irrationality continued to inform the medical discussions of nymphomania into the nineteenth century; Renaissance notions of the normality of female sexual desire did not. Sweeping changes in the assumptions about female sexuality occurred in the Western world in the late eighteenth and nineteenth centuries. Well into the eighteenth century, both popular notions and medical understanding retained vestiges of the belief that women were as passionate, lewd, and lascivious as men were. While some doctors had begun to question whether female orgasm was necessary for pregnancy, the popular assumption that female pleasure and fertility were connected remained intact (Laqueur 1987). And yet by the nineteenth century, an ideology was firmly established: women by nature were less sexually desirous than men; the wifely and maternal role dominated their identity (Bloch 1978a; Friedli 1988, 235; Copley 1989, 84-85).

Some historians argue that the rise of evangelical Christianity in the late eighteenth century helped to transform attitudes about female sexuality, encouraging an ideology of female "passionlessness." The revitalised churches demanded moral restraint of women as evidence of their noble character. Women themselves, these theories suggest, adopt this link between passionlessness and moral superiority as a means of enhancing their status, gaining some control over their lives, and, ultimately, expanding their opportunities (Cott 1978; Smith-Rosenberg 1985, 302, n. 23).

Economic factors also contributed to this transformation. The development of urban industrial capitalism leading to a separation of work from home resulted in a hardening of the divisions between men's and women's roles, particularly among the middle classes. This growing sexual division of labour was underscored by medical-scientific theories that posited the naturalness of this divide by arguing that women's passive nature left her ill-equipped for the rough and tumble, competitive public world of work and politics. Thus, women's too delicate nervous systems, monthly "illness," smaller brains, and specific reproductive organs all made it unhealthy - indeed unnatural - for women to work, write, vote, go to college, or participate in the public arena (Smith- Rosenberg and Rosenberg 1973; Bloch 1978b; Digby 1989).

At the same time, according to several recent historical studies, a new representation of the female as profoundly different from the male was promulgated. From the Ancient period to the eighteenth century, they argue, the female body was seen simply as an inferior male body, one whose genitals had not descended because of lack of heat. This one-sex model mirrored the cosmological understanding of the social order. As that world view was transformed by revolutions, both scientific and political, a new model of the body that posited difference rather than sameness was created. Profoundly suspicious of passion, Enlightenment and post-Revolutionary writers argued that women had less sexual desire than men and thus were uniquely suited to be a civilising force; male passion would be controlled by the strength of woman's moral virtue (Schiebinger 1987; Laqueur 1990; Moscucci 1990).¹³

Causes and treatments for nymphomania

Treatments prescribed for nymphomania also underwent major changes. Renaissance doctors, working within the context of humoral medicine, treated furor uterinus with bleeding, purges, emetics, and a variety of herbal medicines to restore equilibrium to the body's elements. Bleeding would draw off the noxious and excess humours or remove the "obstruction" caused by too much blood, restore harmony to the body, and cure the disease. One of the most famous cases, repeated in many of the early texts and still cited in the nineteenth century, described a young woman suffering from nymphomania who was bled over thirty times until she died (Diethelm 1971, 66). Later nineteenth-century physicians continued to maintain that menstrual problems were a major cause of diseases such as nymphomania (as well as hysteria and many other female diseases); the cure some of them suggested was to remove the ovaries and stop menstruation.

In the late eighteenth century, while a few physicians continued to recommend the age-old cures of "therapeutic intercourse" with prostitutes for the men who fell victim to lovesickness, virtuous living was more likely to be prescribed, for both men and women, as the necessary anodyne to the diseases of insane love. In a treatise titled *Nymphomania, or a Dissertation concerning the Furor Uterinus*, translated into English in 1775, an obscure French doctor, M. D. T. Bienville, stated emphatically that too much pleasure and high living, rich sauces, and spiced meat made the "blood too abundant" and thus indulgent women were much more likely to succumb to the disease of insane love (1775,

51). The emphasis on the consequences of luxurious living suggests that Bienville was particularly concerned about warning middle-class women not to yield to the excesses of the upper classes.

In keeping with the growing role of medical doctors as arbiters of morality, Bienville argued that physicians, not philosophers, must point out the moral dangers of these acts and show how they will lead to the grave (Bienville 1775,42). These exhortations to moral behavior found in Bienville's writing, while not unknown in the Renaissance, would become even more strident in the decades to come. His work foreshadowed the Victorian conviction that the first false step into this "labyrinth of horrors" led the nymphomaniac-as-fallen-woman inexorably toward her death. Only thirty years earlier, the French physician Jean Astruc, in *A Treatise on the Diseases Incident to Women*, discussed quite dispassionately the pros and cons of recommending sexual indulgence as a cure for *furor uterinus*: "yes" to venereal action when it could be legitimate (i.e., marital intercourse), and "no" to masturbation because he had not seen cases in which it had done any good ((1740] 1743, 168). Bienville, however, appeared to be gripped by a growing and pervasive fear of the dangers of sexuality: "its (nymphomania's] progress becomes every day more rapid and alarming" (1775, xi).

Bienville believed that nymphomania struck a variety of women - young girls of marriage age who did not get the object of their passion, debauched girls who had lived a voluptuous life, married women when united to a husband of feeble or cold temperament, or young widows deprived of a vigorous man. Young girls of the middle classes, however, were his primary concern. Pubescent girls were particularly susceptible, he argued, both because their passions were easily stirred and because the first menses might bring on the disorder (Bienville 1775).

Nineteenth-century conceptions of nymphomania

Bienville's work provides a link between earlier notions of uterine fury and nineteenth-century conceptions of the disease in its greater focus on the nervous system, with less attention paid to the theory of an imbalance of the humours as the cause of insane love.¹⁴ Later in the nineteenth century, a link between the genitals and the brain via the nervous system (through the spinal column) was posited as a more scientific explanation than the earlier notion of vapours rising from the uterus to the brain.

This still did not satisfactorily explain the "seat" or specific location of the disease - the brain or the genitals - and debates over this issue continued throughout the nineteenth century.¹⁵ On the one hand, neurologists, anatomists, phrenologists, and others looked for an organic cause of nymphomania in the brain. Their attempts to establish somatic causes in cerebral lesions, changes in the brain's blood vessels, a thickening of the cranial bones, or overexcited nerve fibres generally came to naught. Autopsies of the brains of those who had been diagnosed with nymphomania led many to conclude that no significant morbid alteration of the brain in these cases was perceptible or that similar abnormalities were found in persons who had died of other diseases (see, e.g., Magendie 1836-37,463-65,505). In a particularly dramatic case, cited throughout the nineteenth century, the theory that a relationship existed between an enlarged or inflamed cerebellum and the sexual appetites was refuted by referring to the case of the nymphomaniacal girl whose autopsy revealed she had no cerebellum (Dunn 1849,321; *Journal of Psychological Medicine and Mental Pathology* 1849b, 539; Shortland 1987).

On the other hand, especially in the second half of the nineteenth century, the relatively young and growing medical specialization of gynaecology reversed the focus from the brain to the genitals. Diseased ovaries or disordered menstruation, gynaecologists argued, could lead to injury of the

nervous system and of the brain and thus to mental illness.¹⁶ Furthermore, because the etiology of many female disorders, such as nymphomania, was so uncertain, gynaecologists searched for a sign, or a symptom, that could clearly identify the disease. Redness, soreness, or itching of the genitals was often noted, but in particular, an enlarged clitoris or labia was believed to be the pre-eminent indicator of female lasciviousness.¹⁷ A woman's body would yield evidence of behavior to the trained eye of the physician that the woman herself might deny. In this way, gynaecology was able to lay claim to a unique role in the diagnosis and treatment of female disease. Although a study of six thousand French prostitutes, published in English in 1840, refuted the widely-held belief that sexual excess would mark the genitals in some obvious way, gynaecologists throughout the nineteenth century drew attention to the size of the clitoris and continued to diagnose hypertrophy of the clitoris among those women they labelled as nymphomaniacs (Meigs [1848] 1859, 151; Parent-Duchatelet in Gilman 1985, 223).

The diets, drugs, bloodletting, cold baths, or moral treatments of the neurologists, alienists (psychiatrists), and other physicians had not provided a cure for nymphomania, hysteria, and the other diseases connected to women's sexuality in the nineteenth century. Gynaecology, attempting to consolidate its professional status, offered a new and controversial treatment for certain of these diseases - gynaecological surgery.¹⁸ The underlying assumption that women were dominated by their reproductive organs led some physicians to blame virtually all women's diseases and complaints on disorders of these organs. The theory of reflex action posited that "irritation" of the sexual organs - which covered everything from the pain caused by ovarian cysts to an indeterminate "nervous excitability" - could affect the brain and lead to madness. Some argued that because mental disturbances were connected to menstruation, stopping the bleeding by removing the ovaries would cure the illness. Except for this pseudo-humoural explanation, the medical profession was not exactly sure how this "cure" worked. One contention was that the operation's shock value alone cured nymphomania.¹⁹

In addition to "normal ovariectomy" or oophorectomy (terms generally associated with removal of non-diseased ovaries), other gynaecological surgery, such as excision of the clitoris and/or the labia, was also recommended in cases diagnosed as excessive sexual desire.²⁰ The removal of the clitoris was justified because - according to Isaac Baker Brown, one of the major, and ultimately discredited, British proponents of the operation - it supposedly "removed the abnormal peripheral excitement of the pudic nerve," which otherwise would probably lead to insanity and death (1866, 70).

The efficacy of gynaecological surgery for nervous and mental disorders, including nymphomania, was both praised and condemned at major medical congresses and in the pages of leading medical journals throughout the last two decades of the nineteenth century. Not surprisingly, gynaecologists were generally more enthusiastic about the operation than were neurologists, psychiatrists, and other physicians. In fact, one such specialist in female diseases argued that fully 75 percent of those women examined in mental hospitals showed pelvic disease or abnormality (Rohe 1892, 700). Within gynaecological circles, however, the indiscriminate use of oophorectomy was condemned by many. One of the originators of the surgical removal of the ovaries, the eminent British surgeon T. Spencer Wells, argued against the use of the operation in cases of insanity and concluded that "in nymphomania and mental diseases it is, to say the least, unjustifiable" (Wells, Hegar, and Battey 1886, 470).

The nature of female sexuality in the nineteenth century

The debates surrounding the treatment of nymphomania starkly reveal the tensions and ambiguities implicit in the representations of female sexuality and the nature of female desire. One part of the controversy centered on what effect the removal of ovaries would have on women as women. This question was fraught with contradiction: if the productive role in society for which women were biologically determined was motherhood, then removal of the ovaries essentially eliminated woman's reason for being. On the other hand, because the disease of nymphomania raised fears that the intensity of sexual desire would lead a woman to lose all self-control and modesty, some physicians argued that oophorectomy was justified (see, e.g., Stewart 1889). One doctor reported that a twenty-three-year-old unmarried woman, on whom he refused to operate, begged him to remove her ovaries because "she deplored the fact that anyone with sufficient opportunity could prevail over her scruples." Thus, some patients, and their fathers and husbands, assumed along with some doctors that this operation was a cure for the woman's disease of excessive sexual desire (Chunn 1887,121; Cushing 1887,441; Polack 1897, 302).

Another part of the argument over oophorectomy centered on the nature of sexual desire itself. Contrary to the twentieth-century popular notion that the Victorians perceived women as asexual, most nineteenth-century doctors assumed that women's sexual desire was natural, albeit more limited than men's.²¹ What would happen to this sexual desire after the ovaries were removed? Another part of the argument over oophorectomy centered on the nature of sexual desire itself. Contrary to the twentieth-century popular notion that the Victorians perceived women as asexual, most nineteenth-century doctors assumed that women's sexual desire was natural, albeit more limited than men's.²¹ What would happen to this sexual desire after the ovaries were removed? Some argued that oophorectomy did not eliminate desire, claiming that desire resided in the nervous system, not the ovaries. In a discussion led by the gynaecologist B. Sherwood-Dunn and reported in the Transactions of the American Association of obstetricians and Gynaecologists, Rufus Hall of Cincinnati commented that he had tabulated more than four hundred cases (of removal of the ovaries), "and not one of this number has had a total loss of sexual feeling, and only three women, after a period of three years following the operation, have noticed any marked diminution in the sexual feeling" (Sherwood-Dunn 1897, 227). The gynaecologist John M. Duff of Pittsburgh stated that he had performed a vaginal hysterectomy (although it was not clear whether the ovaries were also removed) on a woman who had had no sexual desire prior to the operation and who subsequently developed nymphomania. "After the operation," he continued, "she could hardly be satisfied in that direction. I have had two or three cases in which the sexual appetite developed, but not to the same extent as in this one" (Sherwood-Dunn 1897, 219). Other physicians argued strenuously that oophorectomy "unsexed" women, using terms like "spaying" for the operation. A scathing criticism of the surgical operation was offered by T. Spencer Wells: "But would anyone strip off the penis for a stricture or a gonorrhoea, or castrate a man because he had a hydrocele [an accumulation of fluid in the scrotum], or was a moral delinquent" (Wells, Hegar, and Battey 1886,466).²²

The medical establishment's lack of consensus makes clear that psychogynecological surgery was not based on a scientific, proven understanding of its effects. Rather, this method of treatment reflected the confluence of a particular construction of the female, the development of "safe" and anaesthetised surgery, and the desire by gynaecologists to consolidate their professional position by establishing themselves as the experts who could diagnosis, treat, and cure these elusive female disorders.

Satyriasis: Male nymphomania?

Medical discussions of satyriasis, the presumed counterpart of nymphomania, provide additional insights into the construction of femaleness. Professional journals, medical textbooks, and

encyclopaedias often declared that satyriasis was the equivalent of nymphomania, but at the same time most doctors believed that satyriasis occurred far less frequently.²³ In addition, they were much more likely to assume that the vast majority of nymphomaniacs were severely diseased, while positing that many cases of satyriasis were very mild. The consequences predicted for the nymphomaniac were generally worse than those for the satyriasis: the outcome for nymphomaniacs was prostitution or the insane asylum, while satyriasis might go through life without getting into trouble if they learned to control themselves (see, e.g., Parke 1908, 346; Huhner [1916] 1920, 150-65). These "scientific" theories reflected the Victorian assumption that women, by nature, had less sexual desire than men; a "predominating sexual desire in woman arouses a suspicion of its pathological significance" (Krafft-Ebing [1886] 1965, 87).²⁴

Furthermore, as many doctors recognised, it was easier for men to fulfil their sexual desires in "illicit indulgences," which are "openly condemned, secretly practised, and tacitly condoned" (Maudsley 1867, 388). Thus, men have more sexual desire, but less disease of excess; women are less desirous, but more prone to morbid passion. We can see in these discussions that even within the biological framework posited by the medical profession, the social construction of the disease was tacitly recognised.

The case studies of satyriasis vary enormously both in mental institutions and in private treatment; they include a few examples of the use of castration as a cure.²⁵ But castration was never seen as a routine treatment for mental disorders in men, and men's nature - unlike women's - was never primarily defined by their genitalia. In addition, none of the cases articulated male behavior equivalent to the flirting, lascivious glances, wearing of perfume, or the other symptoms of "mild nymphomania" that garner the opprobrium of Victorian medical writers. The standards of behavior for women were, of course, much stricter than those for men. But there is more here than just a case of the Victorian double standard. Some doctors were surprisingly sympathetic to the strictures society placed on women's sexuality. For example, John Charles Bucknill, co-author of an authoritative mid-nineteenth-century textbook on psychological medicine, held that nymphomania could result "from the struggle between mental purity and the physical impulses of sex," as well as from organic causes (Bucknill and Tuke [1858] 1968, 524). In a case discussed before the Boston Gynaecological Society in 1869, one doctor went so far as to suggest, "If this woman could go masked as she is at the present moment [the woman patient was brought before the Society wearing a mask] to a house of prostitution, and spend every night for a fortnight at sexual labour, it might prove her salvation; such a course, however, the physician cannot advise" (Field in Storer 1869, 425).

Nymphomania in the late nineteenth century

Such pragmatic understanding of the effects of the double standard, however, contrasted sharply with the age-old fears of the insatiable female that lurked just beneath the surface of some of the medical rhetoric. Krafft-Ebing epitomised the apocalyptic nature of this concern in *Psychopathia Sexualis* by warning, "woe unto the man who falls into the meshes of such an insatiable Messalina, whose sexual appetite is never appeased" ([1886] 1965, 403). In the latter part of the nineteenth century, the classification (and creation) by Krafft-Ebing and others of a wide variety of psychopathologies, such as sadism, masochism, lesbianism, nymphomania, and satyriasis - combined with the theory that these "perversions" were inheritable - contributed to a climate in which sexual dangers were thought to be rampant. Rather than focus on the sexually deviant act itself, Krafft-Ebing and other serologists began to look to the very character of the person. A nymphomaniac, like a homosexual, was increasingly seen as a particular type of deviant, one whose pathology would be inherited by her daughters. Older notions of moderation-is-best gave way to anxiety that deviance

and perversion would be passed on by defective genes, ineradicably marking the nervous system of the next generation (see, e.g., Maudsley 1873, 76; Krafft-Ebing [1886] 1965, 400-408).

Female sexual desire was believed to be particularly dangerous: women were more easily overwhelmed by the power of their sexual passion because they were closer to nature and thus more volatile and irrational than men. According to one doctor, "when they are touched and excited, a time arrived when, though not intending to sin, they lost all physical control over themselves" (Heywood Smith in Routh 1887,505). Women's potential for explosive sexuality jeopardised the self-discipline and control of desire that the Victorian middle class asserted were the mainstays of civilization. Throughout these discussions, women were presented not only as metaphorically dangerous - to the family, to the moral order, to civilization itself - but literally dangerous as well. Some doctors argued that a nymphomaniac would not just seduce a man but would overpower him and actually force him to satisfy her sexual desires. Female sexuality was thus understood in terms of the male sexual act, a kind of reverse rape fantasy.

Physicians' own anxieties about the nature of sexuality - theirs and their patients' - were brought into sharp focus in these debates. One form this took was warnings to other doctors about the female patient as "seductress": a nymphomaniac who sought to entice the physician into a gynaecological exam, demanding that a speculum or a catheter be inserted as a means of sexual gratification.²⁶ Physicians claimed that these women resorted to remarkable subterfuges to induce handling of the sexual organs, one of the most frequent of which was a pretence of urine retention. In addition, doctors described "hair pins, pencils, crochet needles, small keys, bits of bone, of tobacco pipes, of glass tubing, etc. etc." lodged in the bladder or urethra (Chapman 1883,595). Many of the doctors assumed the women were using these objects, and the subsequent gynaecological examination, as a means of sexual excitement²⁷ None of the physicians suggested that sexual abuse or attempted abortion might be responsible; they saw these women as temptresses, not victims.

Decoding these cases is difficult. It is not implausible that a few women did approach doctors in this manner; others likely came seeking treatment for gynaecological problems and were unfairly perceived to be acting lasciviously. Certainly the gynaecologists' representation of the female patient as seducer reflected anxiety on the part of the physicians. Like male midwives in an earlier period, gynaecologists were perceived by husbands and fathers as potential ravishers of their wives and daughters. Turning this idea on its head, the gynaecologists claimed that they were the victims, preyed upon by wanton women patients. This suggests a complicated web of constructed sexuality. Competing images of women emerge in these debates: the Messalina type, throwing herself on the doctor, spewing lewd and lascivious language, demanding sexual gratification; the previously pure and modest woman, a "good girl," now caught in the throes of uncontrollable sexual urges; and the seductress, duplicitous, luring the unwitting physician with her downcast, languid eyes to insert a speculum or catheter in order to fulfil her perverted desires. In all of these personifications, woman is out of control, inverting the natural order because of her aggressive, powerful sexual demands.

Once again, the nature of female sexuality is at issue here. Physicians expressed surprise and shock at the violent excitement and "loss of control" they witnessed in the doctors' offices during gynaecological examinations. According to one doctor, his patient took "very evident delight" in the gynaecological examination (Payne 1859,569-70). Another commented that female masturbators were easily detectable because "the clitoris will usually be found erect, and on touching it, the patient will almost invariably show her want of self control" (Chapman 1883,457 - 58; see also Poovey 1987). Female orgasm was known and described in the medical literature (albeit with much debate over its nature), and many doctors recognised that the clitoris contributed to that excitement (see,

e.g., Hillary 1883; McCully 1883,845; also Martin 1987,102-17). The ideological assumptions of the period, however, imagined that female desire was passive and latent, connected to true love, marriage, and motherhood. A woman's strong physical response to a doctor's touching the clitoris or labia, or her vaginal contractions upon insertion of a speculum, were interpreted by some as the signs of excessive sexuality, indicative of a masturbator or a nymphomaniac.

Nymphomaniacs, lesbians, and prostitutes

By the late nineteenth century, physicians tended to group all sexualised women together: nymphomaniacs, lesbians, and prostitutes. The descriptions of lesbians sound remarkably like those of nymphomaniacs. Two physicians in the *Journal of Nervous and Mental Disease* described cases of inversion (homosexuality) by pointing to the patients' morbid excitability of sexual desire and weak, irritable nerves. They said of one thirty-five-year-old (lesbian) woman that she "grew quite passionate, threw things about and used improper language" (Shaw and Ferris, 1883, 189). According to the gynaecologist Carlton Frederick, "All sorts of degenerate practices are followed by some [nymphomaniacs]. One of the most frequent is tribadism - the so-called 'Lesbian Love,' which consists in various degenerate acts between two women in order to stimulate the sexual orgasm" (1907,810). Literature describing "lesbic love" should be kept from "young girls and neuropathic women," the British psychiatrist Daniel Hack Tuke argued, because the sensations aroused would "enslave" them and "nymphomania itself" would be established (Tuke 1892,865; Thoinot 1911,465-68; Chauncey 1982-83).

Nymphomaniacs were driven to prostitution to satisfy their desires; prostitutes were often lesbians²⁸ According to the New York gynaecologist Bernard Talmey, "It is known that Lesbianism is very prevalent among the prostitutes of Paris. ...One-fourth of all the prostitutes in Paris serve as tribadists for the rich women who patronise public houses" ([1904] 1912, 150-51).

Just as physicians assumed that an enlarged clitoris was the sign of nymphomaniacs and prostitutes, they drew attention to hypertrophy of the lesbian's clitoris, which was used, many believed, like a penis in the "imitation of coitus." This construction vividly illustrates the physicians' inability to conceive of the sexual act in any way other than a male, heterosexual model. Indeed, it was the presumed "inversion" of gender role by the "masculine" partner in a lesbian couple that most troubled the Victorians²⁹

The late nineteenth-century medical model of biologically based gender roles meant that women who stepped outside the norm were assumed to be diseased. These atavistic women who evidenced too much sexual desire, excessive sexual activity, or "inversion" of their assigned role severely challenged notions of innate female modesty and passivity. The Victorians believed that sexual restraint and adherence to highly differentiated gender roles were both evidence of and necessary for the continuation of the advanced level of civilization they had achieved. Lesbians, nymphomaniacs, and prostitutes - and by extension, suffragists, feminists, and the modern woman - were considered not only diseased, but dangerous as well (Lombroso and Ferrero 1897, 246; Thoinot 1911,469-70; Chauncey 1982-83).

Physicians were particularly upset by the sexual response of very young girls or old women. Too young or too old to reproduce, little girls' and post-menopausal women's sexual desires were considered by some doctors as signs of disease.³⁰ In a case in 1894, Dr. A. J. Block decided that a thorough physical examination of a nine-year-old girl brought to him by her mother was needed to determine the degree of her perversion (diagnosed as masturbation tending toward nymphomania).

He touched the vagina and labia minora and got no response. "As soon as I reached the clitoris," he reported, "the legs were thrown widely open, the face became pale, the breathing short and rapid, the body twitched from excitement, slight groans came from the patient" (Block 1894, 3). Block stated emphatically that the child's violent response proved that the clitoris alone was responsible for her "disease." He performed a clitoridectomy (Block 1894).

The autobiography of a nymphomaniac

Desperate women patients, embodying the cultural notion of what was appropriate for them to feel sexually, were described in the medical reports as begging doctors to operate on them or on their daughters because excessive sexuality had become unbearable. Unfortunately, these cases are told only from the physician's point of view. I have found only one case in the words of a woman who calls herself a nymphomaniac, and it, too, was mediated through the neurosurgeon, Charles K. Mills's presentation in 1885. The twenty-nine-year-old woman in "A Case of Nymphomania. ..The Patient's History as Told by Herself" incorporated many of the prevailing Victorian notions about nymphomania. She began her story by saying, "I inherited from my mother a morbid disposition" (Mills 1885, 535). She recounted her attempts to exercise her will against the overpowering nature of the desire: "When I felt tempted, I would kneel and honestly pray to be kept from doing wrong, and then get up and do it [masturbate]; not because I wanted to, but because my life could not go on until the excitement was quieted" (Mills 1885,537). She struggled with the feelings, "At times I felt tempted to seek the company of men to gratify my passion, but was too modest" (Mills 1885, 535). She is "treated" by having her clitoris removed, "but it grew again. ...I tormented doctors to operate again" (Mills 1885,535). They did. "Since removal of the ovaries I have been able to control the desire when awake, but at times in my sleep I can feel something like an orgasm taking place" (Mills 1885,536).

Yet she was also aware of how her limited options had shaped her life. "I had not been educated as I wanted. I had earned my living by labour that occupied my hands, while my mind ambitiously dreamed of work that I would have to climb to. [In seven months in the hospital] I was not once troubled with the nymphomania [because she was studying nursing]; but when I had to give it up and go away, crushed with disappointment, with weakness and poverty. ..when I had to again spend my days in work that held no interest for me, the old morbid depression came back and with it the disease" (Mills 1885, 536). In general, however, the autobiography was permeated by her belief that her feelings of sexual desire were a sign of her disease. "[Even] while I was praying my body was so contorted with the disease that I could not get away from it even while seeking God's help" (Mills 1885,537).

Conclusion

By the late nineteenth and early twentieth centuries, discussions about nymphomania reflected increasing concern over the "New Woman's" greater independence and potential opportunity for sexual experience. Commentators feared the "proletarianization of sexuality" - that is, that middle- and upper-class women who left the safe confines of home to work or attend school would become like working-class women, who were perceived as inordinately lustful and as sexual opportunists.³¹

The ideal of marriage itself would be transformed in the early twentieth century. Greater emphasis on female sexual pleasure as a measure of a successful marriage and a growing acceptance of the separation between reproduction and sexuality would lead to heightened concern about the nature of

female sexuality. While Krafft-Ebing had argued in the 1880s that the "normal, untainted wife knows how to control herself" against the urges of unrequited love when a husband does not satisfy her, early twentieth century sexologists were not so sure (Krafft-Ebing [1886] 1965,84). The ideology of companionate marriage with its assumption of mutual sexual satisfaction contained potential risks. Too much sexual desire by the wife - "semi-nymphomania" according to one physician - obviously threatened the husband in ways in which the older notion of female passivity had not (Magian 1922, 76; Freedman 1982, 210; Seidman 1991, 85).

Furthermore, some authors began to focus on the potential "masculinization" of women who stepped outside the boundaries of family and home. Career women, feminists, educated women who did not marry - a growing number at the turn of the century - were taking on male roles and potentially acquiring the "masculine" trait of aggressive sexual behavior. This concern about women's masculinization coincided with the development of new psychoanalytic theories that reasserted the essential passivity of female sexuality and underscored the notion that a mature, fulfilling sexual experience for a woman could only be achieved through vaginal orgasm in heterosexual intercourse (Freud [1905] 1962, 86-93). Eventually, those women who did not experience vaginal orgasm but maintained their sexual focus and excitement in the clitoris would be diagnosed by psychoanalysts as "frigid."³²

These new psychodynamic theories opened the way for an understanding of nymphomania as a symptom of a disordered psyche rather than as a biological disease. But they also allowed for a new interpretation of appropriate female sexuality, one in which the threat of a woman's being labelled "not a real woman" could be used to control women's sexual behavior, to shape it in the image of male pleasure, that is, vaginal orgasm.³³

This shift from a physiological to a psychological explanation of nymphomania during the twentieth century, with all its ramifications, remains to be explored. In the early part of the twentieth century, the pervasive belief that female reproductive organs could cause insanity through reflex action between the brain and pelvis began to be replaced by newer physiological models based on endocrinological discoveries. In addition, late nineteenth-century pessimistic psychological theories rooted in deterministic notions of degeneration and heredity would be superseded by more hopeful psychodynamic explanations. Biological models of nymphomania were not totally discarded, but psychological explanations that pointed to nymphomania as a personality disorder took precedence. New causes of nymphomania - such as an inadequate sense of self, repressed homosexuality, or incomplete psychosexual development - were introduced and psychotherapy recommended as the treatment.

Concerns about sexual desire itself were transformed in the twentieth century from a major focus on hypersexuality to a concentration on the syndrome called "ISD," inhibited sexual desire. Medical writers paid increasing attention to the theory that nymphomaniacs were actually frigid and did not experience orgasm, thus their "insatiability." In a future study, I plan to explore nymphomania and the relationship between twentieth-century biological and psychological theories, new constructions of the nature of women, and the changing realities of women's lives.

The medical diagnosis of nymphomania in the nineteenth century, constructed within a social and cultural context as well as within a scientific one, reflected and reproduced prevailing attitudes about appropriate behavior. Physicians, however, did not speak with a single voice: they did not agree on the nature of the disease, its extent, its treatment, or even what constituted normal female sexuality. In the overlapping and contradictory descriptions of nymphomania, in the intertwining of moral and

medical explanations, these physicians reveal much about the nineteenth-century construction and understanding of female sexuality and the nature of women.

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¹ As discussed below, these treatments reflected humoral theories intended to restore the harmony of the elements of the body by cooling that which was overheated or by bleeding the body to eliminate blockage or excess blood. Although humoral theories had been mainly discredited by the medical community, no new paradigms had emerged in their stead; thus treatment based on such theories continued into the nineteenth century.

² Phillips does not comment on Mts. L.'s attraction to the women's bodies in the tableau vivant, even though "nymphomaniacal lesbians" had been discussed in medical literature by this date.

³ I have included only those case studies in which nymphomania was part of the diagnosis. The medical journals I consulted include *Alienist and Neurologist*, *American Gynaecological and Obstetrical Journal*, *American Journal of Insanity*, *American Journal of Medical Science*, *American Journal of Obstetrics and Diseases of Women and Children*, *American Journal of Urology and Sexology*, *American Practitioner*, *Boston Medical and Surgical Journal*, *British Gynaecological Journal*, *Journal of the American Medical Association*, *Journal of Nervous and Mental Disease*, *Journal of Psychological Medicine and Mental Pathology*, *Lancet*, *Medical and Surgical Reporter*, *New York Medical and Physical Journal*, *Transactions of the American Association of Obstetricians and Gynaecologists*, and *Transactions of the American Medical Association*; I also consulted dozens of contemporary texts.

⁴ In a recent book, Edward Shorter states that nymphomania "usually meant chronic masturbation" (1992, 81). The cases that I have read suggest that behaviors over a much wider range were labelled nymphomania.

⁵ *American Journal of Medical Science* 1837; Hor and Sprague 1841; Vaille 1868; Chunn 1887; Francez 1888.

⁶ Of course, these diagnoses are also socially constructed. Physicians interpreted various kinds of behavior as "sexual" when they could have had other meanings. The point here is not that these are "real" nymphomaniacs but, rather, that some of them, at least, were suffering from serious mental illness. See *Lancet* 1825-26; *American Journal of Medical Science* 1837; Payne 1859; *American Journal of Insanity* 1860; Mills 1885; Chunn 1887; Polack 1897; Clouston 1898; Goldberg 1992, 14,57-58. For the eighteenth century, see Porter 1986.

⁷ While considerable differences exist in the attitudes, training, and traditions of the medical professions in various countries, enough similarity exists in their shared ideas about nymphomania to warrant these generalisations; this is evident in the numerous translations of and references to a wide variety of works from England, the United States, France, Germany, and Italy in medical journals and texts.

⁸ Poovey 1987; Digby 1989; Jordanova 1989; Laqueur 1990; Moscucci 1990. The pioneering work in the field is Smith-Rosenberg and Rosenberg 1973.

⁹ Medical theories reflect the class and racial stereotypes of the period. In Europe and the United States, black and lower-class women in general, and in the United States, African-American and immigrant women in particular, were seen by the Victorian middle and upper classes as more promiscuous, animal-like, and unrestrained than white middle-class women. What appears to us as a contradiction between the Victorians' biological construction of "woman" as controlled by her reproductive organs (thus all women would presumably be the same) and the distinctions they drew between middle- and lower-class and black and white women was explained in light of evolutionary theory. The "more highly evolved" white middle-class woman was thought to be more civilized, refined, and moral and consequently to have less sexual desire. Scientific theory was called upon to support these notions; for example, ethnographical, anatomical, phrenological, and other studies of "primitive" societies were used to support arguments about these distinctions. See Gilman 1985; Weeks 1986, 39-40; D'Emilio and Freedman 1988, 35, 86, 142; Russett 1989, 26-28, 51-54; Oppenheim 1991, 205.

¹⁰ In discussing the development of gynaecology as a medical specialization in the nineteenth century, Moscucci argues that gynaecology was mainly the province of midwives up through the eighteenth century and that before 1800 no particular group of practitioners claimed women's diseases as their special province.

¹¹ Nymphomania has received surprisingly little historical study. The most recent full-scale examination (Ellis and Sagarin 1964) is a popular, psychological work that contains a brief historical chapter. Four articles and a dissertation are of interest: Diethelm 1966; Goulemot 1980; Maaskant-Kleibrihk 1980 (my thanks to Sarah Pomeroy for drawing my attention to this article); Rousseau 1982; Goldberg 1992.

¹² The entry on nymphomania (Louyer-Villermay 1819) in the *Dictionnaire des Sciences Medicales* contains an extensive review of earlier theories of the disease.

¹³ See Rousseau 1982 for a discussion of the relationship between the rise of erotic sensibility and the change in attitudes toward sexuality in the late eighteenth and early nineteenth centuries.

¹⁴ Rousseau (1982, 106) is mistaken in stating that William Cullen's *Nosology* (1769) is the first work to refer to nymphomania and that "as late as the seventeenth-century fin-de-siecle, a sexually hysterical woman is still labelled 'possessed demonically,' not called nymphomaniacal or discussed in physiological, neurological or other medical terms." Furthermore, Bienville is not the first writer to refer to a connection between morbid imagination and nymphomania, as Rousseau suggests. See also Foucault 1965, 97-101.

¹⁵ *Journal of Psychological Medicine and Mental Pathology* 1849a, 1849b; *Lancet* 1849; *Acton* 1862, 125; *Transactions of the American Medical Association* 1868; *Tilt* 1869, 96-98; *Ferrari* 1876, 122; *Howe* 1883, 116; *Cussing* 1887; *Clouts* 1898, 339-40; *Shortland* 1987.

¹⁶ *Wells, Hegar, and Battey* 1886; *Cussing* 1887; *American Journal of Obstetrics and Diseases of Women and Children* 1901; *Buckling and Tuke* (1858) 1968, 212-13; *Smith-Rosenberg and Rosenberg* 1973; *Short* 1986.

¹⁷ *Churchill*, 1857, 70-73; *American Journal of Obstetrics and Diseases of Women and Children* 1873-74; *Chapman* 1883; *Routh* 1886-87; *Wylie* 1901. There was no comparable body of writing about male genitalia even though doctors were also very concerned about male masturbation. See *Dwyer* 1984, 40-41.

¹⁸ *Barker-Benfield* 1976, 80-90; *Showalter* 1985, 74-79; *Scull* 1986; *Moscucci* 1990, 108-9, 131-32; *Perrot* 1990, 600; *Ripa* 1990, 133; *Shorter* 1992, 77-80. The medical historian Nancy Tomes offers an important cautionary note to simplistic theories of male doctors' motivations. "The majority of gynaecological surgery performed by neurologists," she argues, "aimed simply at repairing the

common injuries of childbirth, while asylum doctors rarely did gynaecological exams, much less surgery" (1990, 159- 60). Gynaecology was the only one of the three specialities treating women's mental illness (neurology and psychiatry were the other two) likely to advocate surgical treatment. See also Mitchinson 1982. An article in the British medical journal *Lancet*, titled "Dr. Blundell on the Genital Parts" (1828-29), which recommended the removal of the ovaries in a case of nymphomania, is the earliest that I have found.

¹⁹ Wells, Hegar, and Battey 1886,472; Cushing 1887,442; Church 1893,493; Hunter and Macalpine 1963,861; Esquirol (1845) 1965, 339.

²⁰ Sutcliffe 1889; Scull 1986. In France, according to Perrot (1990, 496), clitoridectomies were rare. The British gynaecologist Heywood Smith (Tait 1888,315) stated that clitoridectomy was "the best, indeed, the only, cure" for those women whose "lives were a misery to them on account of excessive sexual desire" (Heywood Smith in Tait 1888, 315). In Louyer-Villermay 1819 (600), a famous case from 1676 of an operation on a woman begging to have a circumcision because of a large labia is described.

²¹ Martin (1978, 50-62) reviewed Victorian medical opinion concerning female sexuality and concluded that most physicians recognised that women experienced both sexual desire and pleasure in intercourse, although male sexual desire was understood to be stronger. Ellis, in his monumental work *Studies in the Psychology of Sex* ([1906] 1936,1:189-255), provided a lengthy analysis of the views of female sexuality from the Ancients to the twentieth century. See also Degler 1974; Fellman and Fellman 1981.

²² Sarcastically, Wells continued, "Fancy the reflected picture of a coterie of the Marthas of the profession in conclave, promulgating the doctrine that most of the unmanageable maladies of men were to be traced to some morbid change in their genitals, founding societies for the discussion of them and hospitals for the cure of them, one of them sitting in her consultation chair, with her little stove by her side and her irons all hot, searing every man as he passed before her" (Wells, Hegar, and Battey 1886, 470- 71). See also Hegan 1884; Chunn 1887,121; Tait 1888, 315; Smith 1900; *Occidental Medical Times* 1901.

²³ Duprest-Rony 1820; Hammond 1883, 552; Lydston 1889, 283; Huhner (1916) 1920, 159; Fere (1904) 1932, 86.

²⁴ The very opposite of this pathologizing of female sexuality can be seen in a comment by the mid-nineteenth-century American physician and popular medical writer William Alcott, who wrote, "The husband, moreover, in these days, who finds himself united, for life, to a woman whose only defect or weakness is a slight nymphomania, may think himself quite fortunate" ([1866] 1972, 170).

²⁵ Hamilton 1841; Bigelow 1859; Welch 1889; Hamilton 1903. Surgical and pharmacological methods in the treatment of excessive male sexuality, usually masturbation, were widespread in the second half of the nineteenth century, including blistering the prepuce, placing a silver ring through the prepuce, faradization of the spine, infibulation, and others. See Hare 1962, 10-11.

²⁶ In a lengthy discussion of the character of these nymphomaniacal seductresses, the British gynaecologist C. H. F. Routh said they could be identified by the following characteristics: they had a strong neurotic history, had some uterine or ovarian complication (leukorrhoea, ovarian pain, etc.), and were pretty, vain, and decided liars. It was clear that they were liars, he argued, because of the extraordinary stories they told, even about their loved ones, such as brothers who entered their rooms at night and forced them to submit sexually, and fathers who demanded that they live as husband and wife (1887,487-89). Routh's dismissal of these "lies" foreshadowed Freud's revised theory that his female patients had fantasised the sexual abuse by family members described in his case studies.

²⁷ Chapman 1883, 595. See also Sharpe 1874; McCully 1883, 846; Lydston 1889, 282; Block 1894,5; Boston City Hospital 1900; Talmey (1904) 1912, 112; Magian 1922, 78; Bloch (1908) 1928, 430.

²⁸ Schrenk-Notzing 1895,32; Lydston 1904,316; Talmey (1904) 1912,114-15; Huhner (1916) 1920, 164; Forel (1906) 1924,252; Hirschfeld (1944) 1956,92; Krafft-Ebing (1886) 1965, 402-3; Gilman 1989, 299.

²⁹ One gynaecologist described a case in which a "young married woman became pregnant through her married sister who committed the simulacrum of the male act on her, just after copulating with her husband" (Talmey [1904] 1912, 150-51). See also Kiernan 1891,203; Kiernan 1916; Sahli 1979,24-27; Chauncey 1982-83, 132; Greenberg 1988, 404. For an early seventeenth-century discussion of penis-like clitorises, see Ferrand (1623) 1990,231. For a study of presumed gender inversion and lesbians in the twentieth century, see Terry 1990.

³⁰ A few physicians were beginning to recognise sexuality in children, but many would have agreed with the well-known British gynaecologist Robert Lawson Tait, who reported on "four year olds who have powerful erections in whom there could be no sexual desire possibly present" (1888,315). In the same article, C. H. F. Routh stated that although women over seventy were not supposed to possess sexual feelings because their ovaries were atrophied, he had performed a clitoridectomy on a woman of seventy-eight years who had "experienced extreme erotic feelings on going to stool" (315). See also Sloan 1888; Parke 1908, 345.

³¹ For important historical examinations of female sexuality at the turn of the century not already mentioned, see Bullough and Voght 1973; Skultanas 1975; Schlossman and Wallach 1978; Dykstra 1986; Freedman 1987; Lunbeck 1987.

³² Freud and his followers made a connection between frigidity, unconscious refusal of the female role, lesbianism, and the inauthenticity of the clitoral orgasm. See, e.g., Abraham 1922; Fenichel 1933; Homey 1933; Hitschmann and Bergler 1949; Young-Bruehl 1990, 22-24.

³³ One intriguing possibility to explore is whether we might also find women responding to this new construction of female sexuality by a new form of "passionlessness." Did women use the theory of the vaginal orgasm to empower themselves within male-female sexual relations?