HYSTERIA AND ITS DESCENDANTS: A HISTORY OF GENDERED WASTEBASKET DIAGNOSES

HYSTERIA AND ITS DESCENDANTS: A HISTORY OF GENDERED WASTEBASKET DIAGNOSES

By LILY GREEN, B.Arts Sc.

Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree Master of Arts

McMaster University MASTER OF ARTS (2021) Hamilton, Ontario (History)

TITLE: Hysteria and Its Descendants: A History of Gendered Wastebasket Diagnoses

AUTHOR: Lily Green, B.Arts Sc. (McMaster University) SUPERVISOR: Dr. Karen Balcom

PAGES: 188

LAY ABSTRACT

The medical field has long been influenced by its surrounding cultural context. Social factors, including gender, race, and class, all colour the ways in which illnesses are understood and patients are treated. This thesis examines these interactions between medicine and culture in the context of nineteenth-century hysteria and the related diagnoses that arose to replace it in the twentieth century. The disease entity hysteria disappeared in the early twentieth century, but patients continued to experience the symptoms associated with hysteria under a range of diagnostic titles. Situating these illnesses in the historical context of hysteria can help address patient complaints and deconstruct the stigmatizing stereotypes that affect these patients—particularly those stereotypes associated with femininity that were once attributed to hysteria patients.

ABSTRACT

Hysteria has been researched from many different angles, but this thesis focuses on the persistence of gendered medical diagnoses following the demise of hysteria. In Chapter One, I provide an overview of hysteria's long history, beginning with the first reference to the disorder in Ancient Egypt. I then conduct a study of nineteenth-century hysteria in Chapter Two, where I highlight the interactions between medicine and culture that characterized the hysteria epidemic in Victorian Britain and America. Chapter Three continues this discussion of nineteenth-century hysteria, detailing the rise of psychological explanations for hysteria in Europe. My most important research, however, comes in Chapters Four and Five where I chronicle the rise of specific diagnoses that replaced hysteria in the twentieth century. I focus on gendered wastebasket diagnoses—illnesses that predominantly affect women, are categorized based on shared symptoms rather than causes, and are defined in relation to femininity. In the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the descriptions of certain psychiatric conditions that are more frequently diagnosed in women contain stigmatizing language used to describe hysteria, especially in the nineteenth century. Outside of the psychiatric realm, chronic fatigue syndrome and fibromyalgia are also wastebasket diagnoses that are described by both doctors and academics using the dismissive language of earlier descriptions of hysteria. I argue that throughout all of this history, the mutual influence of medical theory and cultural assumptions—particularly about gender and femininity—has allowed women's mysterious medical complaints to remain unexplained. The ambiguous nature of conditions descended from hysteria and their association with femininity causes doctors to return to long-standing stereotypes that diminish the suffering of these patients. Many patients with these conditions struggle to access effective treatments for their symptoms. Understanding these illnesses in the historical context of hysteria can help explain and address these experiences.

ACKNOWLEDGEMENTS

I would first like to thank my supervisor, Dr. Karen Balcom, for supporting and guiding me over the past two years, through the creation of this thesis and my undergraduate thesis that preceded it. Her input has been invaluable to my research and writing and her continuous kindness, encouragement, and patience have allowed me to thrive despite challenges and produce work that I am proud of.

I would also like to thank the rest of my supervisory committee, Dr. Juanita De Barros and Dr. Megan Armstrong, for their suggestions at the time of my initial project proposal and the final defence. Finally I would like to thank Dr. Catherine Anderson for acting as an external reader on this thesis and offering input at my defence and Dr. Tracy Macdonald for chairing the defence.

TABLE OF CONTENTS

INTRODUCTION: CONTEXTUALIZING HYSTERIA

The term "hysteria" likely calls to mind an image of a dramatic, emotional, aristocratic white woman swooning within the confines of a Victorian mansion. This image of the hysterical woman has long been a subject of fascination in popular culture. On one hand, the hysterical woman is romanticized—a beautiful damsel in distress for some, to be pitied and protected; a heroine for others, rising against the constraints of the patriarchy. Simultaneously, she is demonized as a deceptive, demanding narcissist who mistreats men and will do anything to be in the spotlight. The way the word "hysterical" is used in everyday language reflects this unfavourable perspective. The term has a negative connotation, evoking emotional volatility and irrationality. Sigmund Freud's vivid descriptions of hysteria patients in his early work on psychoanalysis and Jean-Martin Charcot's photographs of women in the midst of theatrical displays of emotion made these dichotomous images famous. The hysterical woman was also immortalized in iconic films and works of literature. Gustave Flaubert's *Madame Bovary*[1] and Charlotte Perkins Gilman's "The Yellow Wallpaper"[2] constituted some of the most famous depictions of hysteria and helped to solidify these tropes. Reminiscing about the famous hysterics in history, Jacques Lacan pondered, "Where are the hysterics of former times, those magnificent women, the Anna O.s and Emmy von N.s?"[3] For many, hysteria is tied to these sensationalized images that have been cultivated by the media—images that are indicative of society's desire to reduce women to some artistic depiction, either an icon or a caricature. Portrayals of hysteria in popular culture effectively diminish patients' suffering and overlook complex mental health issues in order to admire or ridicule these women from a distance.

---

[1] Gustave Flaubert, *Madame Bovary*, trans. Alan Russell (Harmondsworth, Middlesex, England: Penguin Books Ltd, 1950).
[2] Charlotte Perkins Gilman, "The Yellow Wallpaper," in *The Yellow Wallpaper and Other Stories* (Mineola, New York: Dover Publications, Inc., 1997).
[3] Jacques Lacan quoted in Mark S. Micale, "On the 'Disappearance' of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis," *Isis* 84, no. 3 (September 1993), 498, https://www.jstor.org/stable/235644.

The archetypal hysteric reflects a particular moment in the history of this disease when hysteria reached epidemic proportions, a moment that marked a turning point in the trajectory of hysterical illness. In the latter half of the nineteenth century, hysteria reached unprecedented pervasiveness before rapidly disappearing at the beginning of the twentieth century. Mark S. Micale, one of the most prominent historians of hysteria, has described the late nineteenth century as a time where "All of the major previous paradigms of the disorder—gynecological, neurological, psychological, and characterological—found expression."[4] During this period, Victorian social values led to new understandings of and approaches to hysteria, which resulted in the mass institutionalization of hysteria patients and new therapies such as hypnotism and psychoanalysis. Hysteria patients—primarily women—were almost exclusively treated by male doctors after physicians pushed for more power over the treatment of mental patients around the middle of the century.[5] Mental illness in general, and hysteria in particular, were medicalized and gendered to a greater extent than ever before.

Specific cultural factors in Victorian society contributed to the intensity of the hysteria epidemic. The rise of Evangelical Christianity instigated a new focus on "morality" that was enforced through strict gender, familial, and class roles.[6] Men and women were expected to display "self-control, self-discipline, and outward conformity" as well as "[p]ersonal responsibility, probity, and piety."[7] At the same time, colonialism, industrialization, and capitalism in late nineteenth-century societies transformed social relationships and created a complex environment of intersecting forces. Given this context, some feminist scholars writing in the late twentieth century interpreted nineteenth-century hysteria as a natural reaction to—or a form of protest against—an oppressive, patriarchal

[4] Micale, "On the 'Disappearance' of Hysteria," 503.
[5] Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (Harmondsworth, Middlesex, England: Penguin Books Ltd, 1985), 53-54.
[6] Nancy F. Cott, "Passionlessness: An Interpretation of Victorian Sexual Ideology, 1790-1850," *Signs* 4, no. 2 (Winter 1978): 223, https://www.jstor.org/stable/3173022.
[7] Roy Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," in *Hysteria Beyond Freud* (Berkeley and Los Angeles, California: University of California Press, 1993), 229.

society.[8] Others, like the historian Edward Shorter, have focused on the physical symptoms of hysteria and argued that hysteria represented a "medicalization of women's internal sensations."[9] Nineteenth-century physician Robert Carter explained hysteria through a theory of "repression" that attributed hysteria symptoms to the act of internalizing emotions and impulses.[10] Shorter expands on Carter's ideas in his "somatization" model of hysteria. He suggests that hysteria is an example of a psychosomatic illness—a condition that expresses emotional distress through physical symptoms. He further explains that psychosomatic symptoms are formed by current medical conceptions of disease and that hysteria's history of shifting symptomatic expressions indicates that this disorder is highly sensitive to cultural forces.[11]

The history of hysteria—and its association with femininity—stretches back long before the nineteenth century. Hysteria has existed in many social climates throughout its history, taking on new forms to align with cultural values and conceptions of disease. Micale has noted that "The disease entity hysteria has a history as colorful as it is long and venerable," a history that is "less linear than it is cyclical."[12] This thesis explores hysteria's long, venerable, and colourful history across cultural settings, from its first description in ancient Egypt to today. I expose the cyclical nature of hysteria's history, drawing attention to recurring themes that persist despite doctors' attempts to reframe and redefine the disorder. Hysteria offered a way of grouping, but not explaining, poorly understood symptoms that were common among women.[13] The diagnostic title described a wide range of symptoms, but

[8] Showalter, *The Female Malady*, 4-5.
[9] Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York, NY: The Free Press, 1992), 51.
[10] Robert Carter in Showalter, *The Female Malady*, 132.
[11] Shorter, *From Paralysis to Fatigue*, 1.
[12] Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton University Press, 1995), 19.
[13] I describe gender in binary terms throughout this thesis, but I acknowledge that the categories of male and female do not adequately represent the many ways of experiencing and expressing gender. For most of the period covered by this study, gender was considered inseparable from biological sex and the binary between man/woman and male/female was deeply entrenched and often unquestioned in society. The sources I consult

these symptoms were not united based on etiology. Rather, hysteria was defined by symptoms that were often found together among similar types of patients. Because of this quality, Elaine Showalter has called hysteria a "wastebasket diagnosis," a common term in medical discourse denoting a vague diagnosis not rooted in medical knowledge—a diagnostic label given for the sake of labelling. Shorter and psychiatrist Conrad Rieger (1896) have also used this term to describe the related conditions of irritation and neurasthenia.[14] In Showalter's words, hysteria was "the term doctors used when they didn't know what they were seeing but wanted to say something."[15] This notion of the *wastebasket diagnosis* ties together the narrative of hysteria throughout history and acts as a foundational concept in this thesis. More specifically, this thesis focuses on how doctors repeatedly returned to cultural understandings of femininity in order to construct hysteria as a vague, poorly defined, gendered wastebasket diagnosis. Hysteria was not a useful diagnostic title because it gave the illusion of a medical explanation, but in reality, it was a wastebasket of symptoms that doctors did not fully understand.

The earliest reference to hysteria-like symptoms is on an Egyptian papyrus that dates back to 1900 BCE.[16] This ancient medical document describes a physical disorder characterized by the movement of the uterus out of its normal position. Although no symptoms were listed directly in this account, Ilza Veith has suggested that "certain behavioral disorders" were so strongly associated with the displaced uterus that "no other explanation for the symptoms was so much as suggested."[17] However, the document refers to several specific cases that illustrate physical symptoms, including fatigue; pain in the teeth,

---

similarly adhere to binary conceptions of gender, and I echo their language throughout this thesis. It is worth noting, however, that hysteria was continuously constructed through conflation of certain aspects of female-sexed bodies with womanhood. This thesis is in many ways a direct critique of binary notions of gender, as I deconstruct the bioessentialist notions of femininity that characterized the hysteria diagnosis and continue to underlie medical theory.

[14] Shorter, *From Paralysis to Fatigue*, 32; Conrad Rieger quoted in Shorter, *From Paralysis to Fatigue*, 222.

[15] Elaine Showalter, *Hystories: Hysterical Epidemics and Modern Culture* (London, UK: Picador, 1997), 16.

[16] Micale, *Approaching Hysteria*, 19.

[17] Ilza Veith, *Hysteria: The History of a Disease* (Chicago, IL: The University of Chicago Press, 1965), 3.

jaws, neck, limbs, and eye sockets; and even lockjaw.[18] The ancient Greek physician Hippocrates coined the term "hysteria" to describe the movement of the womb; a word derived from the Greek *hystera*, meaning uterus.[19] According to this theory, the uterus migrated to different areas of the body, causing complications related to the specific organ to which it had attached itself.[20] Over time, the symptoms included in the hysteria diagnosis diversified and the term came to describe a wide assortment of "female" symptoms, including gynecological, neurological, and psychological complaints. The origin of these symptoms was constantly debated in the medical community, but even after the "uterine" theory of hysteria was abandoned in favour of neurological and psychological explanations, hysteria remained a "women's disorder." Its association with womanhood was embedded in the word itself.

The challenge in recounting the history of hysteria is how to actually define the term "hysteria." Unlike other diseases, hysteria has never had an agreed-upon set of symptoms or a definitive etiology. Up to the point when diagnosis fell out of favour in the early twentieth century, hysteria remained poorly understood and vaguely defined. The symptoms included within the disease entity hysteria varied over time and were ambiguous even at specific historical moments. At different points, "hysteria" has described convulsions, paralysis, loss of motor function, loss of sensation, *globus hystericus* (the sensation of a ball in the throat), *clavus hystericus* ("feeling as if a nail were being driven into the forehead"[21]), sensory disturbances, dizziness, pain, fatigue, mutism, delirium, dramatic behaviour, emotional volatility, excessive displays of emotions, "hysterical paroxysm," anxiety, melancholia, mania, mood swings, hypersexuality, and disturbances in consciousness like dissociation,

[18] Veith, *Hysteria: The History of a Disease*, 3.
[19] Veith, *Hysteria: The History of a Disease*, 10.
[20] Veith, *Hysteria: The History of a Disease*, 10.
[21] Micale, *Approaching Hysteria*, 22.

amnesia, dissociative fugue, trances, and multiple personality, among other symptoms.[22] The seemingly unrelated nature of these symptoms supports the theory that hysteria was effectively a wastebasket diagnosis.

Therefore, exploring the use of the term "hysteria" in different historical contexts is not sufficient for a complete analysis of hysteria, nor is tracing certain symptoms over time. Approaching the history of hysteria means accepting that "throughout the ages it presents itself as a shifting, changing, mist-enshrouded phenomenon that must, nevertheless, be dealt with as though it were definite and tangible."[23] In order to accurately study hysteria, it is necessary to identify a unifying force that ties together all of the different symptomatic presentations, medical theories, and historical and cultural contexts that influenced how this disorder was conceptualized, diagnosed, and treated. A common thread that runs through the entirety of this complicated history, from ancient Egypt to today, is the notion of hysteria as an all-encompassing diagnostic category for medically unexplained women's ailments—a wastebasket diagnosis. Throughout its entire history as a diagnostic entity, hysteria symptoms could never be attributed to a singular cause. As a result, patients were grouped together based on shared characteristics—diverse and subjective somatic and psychological complaints and, most importantly, womanhood.

Poorly understood symptoms that predominantly affected women were historically blamed on the most obvious anatomical difference between male and female bodies: the reproductive system. Up until the twentieth century, physicians had limited knowledge of the female reproductive system and viewed it as "an inferior, imperfect inversion of the male."[24] This belief about the female body reflects a bias that has always characterized the medical field. Scientific research centres the white male body as the standard for "normalcy" and

[22] Gathered from multiple sources, most notably Micale, *Approaching Hysteria* and Veith, *Hysteria: The History of a Disease*.
[23] Veith, *Hysteria: The History of a Disease*, 1.
[24] Porter, "The Body and the Mind, the Doctor and the Patient," 250.

presumes that these findings can be projected onto all other bodies with only slight adjustments. Instead of endeavouring to understand the female body in its own right, physicians assumed that everything could be understood within the male model with the exception of the reproductive anatomy (and even this was defined in relation to its male counterpart).

Hysteria is a historical example of women's bodies being misunderstood and mistreated by the medical field, but many "female" illnesses—especially those that involve hysteria symptoms—remain unexplained. As Micale argues, hysteria did not disappear but was rather replaced by an array of diagnostic titles describing smaller collections of symptoms in the twentieth century.[25] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) classified and described psychological symptoms of hysteria within novel psychiatric diagnoses, such as personality disorders, mood disorders, anxiety disorders, and somatic symptom disorders. Nearly a century after hysteria was discredited as a medical diagnosis, chronic fatigue syndrome and fibromyalgia constituted a resurgence of hysteria-like illnesses outside the realm of psychiatry.

However, in many cases, recategorizing hysteria symptoms did not allow doctors to accurately describe the associated etiological processes or offer effective treatments. Many disorders descended from hysteria have continued to be defined by shared symptoms rather than a common cause. This strategy has often resulted in a similar outcome to the hysteria diagnosis, wherein many different illnesses—some biological, some psychological, and some the result of cultural factors—are included under the same heading. Although today, hysteria is no longer a valid medical diagnosis, many of these symptoms continue to be described by diagnostic categories that give the illusion of a medical explanation.[26] These diagnostic titles *appear to represent* distinct disorders, but many patients diagnosed with these conditions

[25] Micale, "On the 'Disappearance' of Hysteria," 502.
[26] Showalter, *Hystories*, 16.

would have been classified as hysterical in the past. Hysteria remains hidden within newly defined diagnoses, many of which act as wastebaskets for misunderstood symptoms and are informed by cultural assumptions about femininity. In addition, it is worth questioning whether wastebasket diagnoses that primarily affect women are elusive because women are naturally predisposed to emotionality and somatic symptom production (either inherently or due to cultural forces), or because women's value in society has led to their medical complaints being understudied.

These wastebasket diagnoses arise from cultural understandings of gender in a few different ways. First, patriarchal definitions of femininity may lead to a pathologization of "undesirable" traits associated with women. Alternatively, the oppressive social structure could exacerbate women's distress to the point of clinical significance. Finally, sexist assumptions about women and a disregard for women's suffering may lead to a neglect of women's health within the medical field. In Roy Porter's words, "History, anatomy, destiny, evolution—all were conscripted to clamp women in their place."[27]

In addition to its inherent connection with womanhood, hysteria and its modern-day counterparts have been shaped by other societal forces. The relationship between race and hysteria significantly impacted how the disorder was conceptualized and how different patients were treated. Darwin's notion of "civilization" was intertwined with nineteenth-century hysteria. However, the racism embedded in academia and medicine has caused this important aspect of hysteria's history to be often glazed over in the literature. As a result, there is limited information about the role of race in hysteria and in more recent disorders compared to the wealth of literature on the role of gender.[28] Social class is also often overlooked to accommodate further analysis of gender. However, the changing nature of

[27] Porter, "The Body and the Mind, the Doctor and the Patient," 248.
[28] Laura Briggs, "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology," *American Quarterly* 52, no. 2 (June 2000): 249, https://www.jstor.org/stable/30041838.

class relations as a result of industrialization and capitalism were deeply implicated in the nineteenth-century hysteria epidemic. These elements continue to shape how medical disorders are defined and diagnosed today. In addition, the intersections of race, class, and gender have historically determined—and continue to determine—who is able to receive a diagnosis and access medical treatment and how diagnoses are perceived based on the patient demographic.

This thesis will not be a discussion of the cultural representations of hysteria, a task that has been taken on by other historians.[29] It is, instead, more of an intellectual history, drawing attention to the changing medical definitions of hysteria and perceptions of hysterical patients within the medical field and academia. It also explores how these ideas have been interwoven with social norms and values at different points in history. Specifically, I investigate how gender roles and expectations influenced medical understandings of hysteria, dominant treatments and therapies, and the relationship between patients and their doctors in the nineteenth century. I then extend this discussion to certain gendered medical diagnoses today and argue that many disorders continue to uphold and be informed by feminine stereotypes. I further contend that although hysteria disappeared as a diagnosis after its peak in the late nineteenth century, the condition continues to exist today in a collection of distinct disorders. The vague, all-encompassing wastebasket of hysteria was broken down into organic and psychological illnesses that retain certain features of the former diagnosis. However, many of these descendant disorders also continue to dismiss women's medical complaints and group them within symptoms-based wastebasket categories that remain poorly understood.

To support these arguments, I conduct an in-depth examination of relevant psychiatric disorders described in the *DSM*. I document hysteria's dispersion throughout the twentieth

[29] Elaine Showalter, Mark S. Micale, Sander Gilman, and others have explored this topic in detail.

century, tracing the disorders that evolved directly from hysteria and investigating current diagnoses that include symptoms of hysteria. I expose how diagnostic categories were renamed and reorganized in successive editions of the *DSM* and show that the language used to describe these conditions and patients resembles how doctors discussed hysteria in the nineteenth century. I do this by comparing quotations from nineteenth-century medical documents and textbooks to the *DSM*. I dedicate the final chapter of this thesis to a discussion of women's illnesses outside the psychiatric realm, using the related conditions of chronic fatigue syndrome and fibromyalgia as a case study for how women's health issues continue to be dismissed and understudied.

I argue that the ways in which societal expectations and norms seep into these medical theories have been particularly detrimental to understanding and treating conditions that disproportionately affect women, today and throughout history. Conversely, the disregard for women's health problems has continued to uphold misogynistic stereotypes by pathologizing "undesirable" traits associated with femininity.

Historiography

Hysteria resurfaced in academic discourse in the second half of the twentieth century. Historians began to study hysteria in the past while cultural and literary theorists commented on hysteria's ongoing influence in society. Although historical accounts of hysteria were written in France as early as the 1890s,[30] Ilza Veith's extensive intellectual history of hysteria, *Hysteria: The History of a Disease* (1965), marked the beginning of a renewed interest in hysteria that peaked in the 1980s and 1990s. Veith's book begins with ancient Egypt and documents the major developments in hysteria's history, focusing on important figures and competing theories. Veith's work has faced criticism for its teleological arc

[30] Micale, *Approaching Hysteria*, 33-34.

toward Sigmund Freud, and Roy Porter describes the work as a "heroes-and-villains history."[31] Nonetheless, *Hysteria: The History of a Disease* remains the most comprehensive historical account of hysteria.[32] Therefore, it is a vital source of information, especially for the earlier time periods. In addition, this book explores the history of hysteria for its own sake (while other texts discuss hysteria in service of a separate argument or goal), making it a valuable starting point to contextualize other perspectives. Veith's text also includes abundant references to primary sources, which have allowed me to access primary source material through her work.

Historian Mark S. Micale's work on hysteria provides a strong historical and critical foundation for the major ideas and arguments explored in this project. His book *Approaching Hysteria: Disease and Its Interpretations* (1995) begins with a succinct historical overview of hysteria that complements Veith's more expansive and detailed study. Micale then addresses the explosion of interest in the history of hysteria in the second half of the twentieth century.[33] He highlights important texts written in the 25 years prior and discusses current perspectives, debates, and issues in the history of hysteria. Micale provides important information about the history of hysteria and its relationship to cultural factors, especially gender. However, his most essential contribution for the purposes of this study is his argument (outlined in Chapter Two of *Approaching Hysteria*[34] and discussed more extensively in his 1993 article, "On the 'Disappearance' of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis") that hysteria no longer exists in medical literature today because it has been recategorized into a range of new disorders.[35] My intensive study of the *DSM* in Chapter Four of this thesis responds to Micale's prompt and details the rise of specific psychiatric diagnoses that replaced hysteria.

---

[31] Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," 232.
[32] Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," 232.
[33] Micale, *Approaching Hysteria*, 3-4.
[34] Micale, *Approaching Hysteria*, 169-174.
[35] Micale, "On the 'Disappearance' of Hysteria," 502.

In *Approaching Hysteria*, Micale remarks that "much of the case material that constitutes 'the history of hysteria' would almost certainly be reclassified today either as organic disease, psychotic or borderline disorders, nonhysterical neurosis, or perhaps as no sickness at all."[36] Many of the other texts referenced in this thesis share Micale's view that hysteria never disappeared; however, they approach this conversation from different perspectives. Historian Edward Shorter's book, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (1992), discusses hysteria in the context of psychosomatic illnesses. Shorter argues that hysteria is a prime example of a physical expression of psychological distress and places hysteria within the broader history of medically unexplained symptoms and psychosomatic disorders.

This approach offers a useful lens to consider when analyzing the intellectual history of hysteria. While Micale focuses on the dispersion of hysteria into novel *psychiatric* diagnoses, Shorter discusses its presence in unexplained physical illnesses today. He pays particular attention to chronic fatigue syndrome as a modern-day manifestation of hysteria and traces the development of pseudo-neurological illnesses from the motor symptoms of the nineteenth century to primarily fatigue complaints today. While Chapter Four of this thesis explores the presence of hysteria in the *DSM*, Chapter Five is dedicated to chronic fatigue syndrome and the related condition fibromyalgia. I reference Shorter's ideas in my discussion of chronic fatigue syndrome and fibromyalgia, but I also rely on his perspective in my discussions of the neurological and psychological explanations of hysteria in Chapters Two and Three.

Shorter's analysis centres on the concept of "somatization": the process of creating symptoms to serve a (often subconscious) purpose. According to Shorter, "Patients want to please doctors, in the sense that they do not want the doctor to laugh at them and dismiss their

[36] Micale, *Approaching Hysteria*, 111.

plight as imaginary. Thus they strive to produce symptoms the doctor will recognize."[37] Shorter argues that psychosomatic illnesses mimic medically acceptable symptoms and change over time to keep up with evolving conceptions of disease. For Shorter, hysteria patients displayed *motor* symptoms because they were more likely to be taken seriously by doctors while somatizing patients today often complain of *sensory* symptoms like fatigue and pain. Other articles written in the 1990s echo Shorter's sentiments and add to this discussion. For example, the philosopher Kevin Aho asserts that "functional" or psychosomatic diagnostic labels (such as hysteria and neurasthenia in the nineteenth century and chronic fatigue syndrome and fibromyalgia today) serve to validate patients' concerns as medically and "culturally legitimate."[38]

Shorter also highlights certain characteristics of "somatizing patients," including their resistance to psychological treatment and assumption of what historian and feminist literary critic Elaine Showalter and others have called the "sick role."[39] Other writers like Aho and medical doctor Charles V. Ford have extended this theory to discuss "fashionable" illnesses and "nondisease."[40] All of these authors focus on hysteria as a primary historical example of a psychosomatic disorder, fashionable illness, or nondisease. They also apply these disease models to current conditions, many of which are predominantly diagnosed in women. The ways in which these patients are described in the literature is indicative of common perspectives of women with medically unexplained symptoms who are often treated as undeserving or as deceptive in some way. In a rather striking passage, Ford contends that "persons with 'nondisease' but who have chronic illnesses repetitively seek occupancy of the sick role and its attendant rights and privileges. In the process they generate a large amount of

[37] Shorter, *From Paralysis to Fatigue*, 1.
[38] Kevin Aho, "Neurasthenia Revisited: On Medically Unexplained Syndromes and the Value of Hermeneutic Medicine," *Journal of Applied Hermeneutics* (April 9, 2018), 9.
[39] Showalter, *Hystories*, 117.
[40] Charles V. Ford, "Somatization and Fashionable Diagnoses: Illness as a Way of Life," *Scandinavian Journal of Work, Environment & Health* 23, no. 3 (1997), 7.

medical care expenses, incur costs to society because of lost productivity and disability payments, and inflict psychological and dependent care demands upon those in their environment who must care for them."[41] This statement conveys a perspective that I wish to challenge in this thesis. Hysteria patients were perceived as attention-seeking, narcissistic, and dramatic in the nineteenth century, and the primarily female patients with the conditions I explore in the rest of the thesis are characterized the same way.

Elaine Showalter is the author of two important books on the history of hysteria that have informed this thesis. The first of these, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (1985), is fundamental to my analysis of nineteenth-century hysteria in Chapter Two. This text explores the proximity of mental illness to femininity from the nineteenth century to 1980s. Although it does not focus solely on hysteria, it offers an intriguing analysis of "madness" as a women's disorder. The ideas in this book inform my own commentary on nineteenth-century hysteria and its relationship to cultural factors, especially gender.

The second and far more controversial of the two texts is *Hystories: Hysterical Epidemics and Modern Culture* (1997), which echoes many of Ford's ideas about fashionable diagnoses and the sick role. This book explores the history of hysteria and then applies ideas about hysteria to contemporary illnesses. Showalter highlights six conditions that were widespread at the end of the twentieth century as modern-day manifestations of hysteria: chronic fatigue syndrome, Gulf War Syndrome, recovered memory, multiple personality syndrome, satanic ritual abuse, and alien abduction. She describes these conditions as outward expressions of heightened stress, which she attributes to the tumultuous nature of late twentieth-century society and anxiety associated with the coming of the new millennium. Showalter contends that "hysteria is part of everyday life"[42] and that it "mimics culturally

[41] Ford, "Somatization and Fashionable Diagnoses," 7.
[42] Showalter, *Hystories*, 13.

permissible expressions of distress."[43] However, she argues that the hysteria outbreak of the late twentieth century is unique due to the presence of the media and self-help literature, which she believes perpetuate hysteria. In the process, she cultivates a negative caricature of patients diagnosed with these conditions as accessing medical treatment for their ailments as a way of protecting their self-esteem and obtaining the "privileges of the sick role."[44]

Upon its publication, *Hystories* was criticized for equating dissimilar disorders and failing to recognize how these conditions are often shaped by the interplay of cultural, biological, and psychological factors. Both individuals with these diagnoses and scholars responding to Showalter have suggested that placing all of these conditions within a uniform category is a misleading simplification.[45] Advocates for some of the conditions Showalter addresses—especially chronic fatigue syndrome, Gulf War Syndrome, and multiple personality syndrome (now dissociative identity disorder)—have also criticized the book as being ignorant and invalidating of patient experiences. Just as Chapter Four of this thesis responds to Micale's arguments about the reclassification of hysteria in the twentieth century, Chapter Five addresses and critiques the ideas in *Hystories*, along with other texts that hold similar views including the writings of Ford, Aho, and Shorter.

Carroll Smith-Rosenberg's book *Disorderly Conduct: Visions of Gender in Victorian America* (1985) explores many aspects of the nineteenth-century social structure in America. Two chapters in particular, "The Hysterical Woman: Sex Roles and Role Conflict in Nineteenth-Century America" and "Puberty to Menopause: The Cycle of Femininity in Nineteenth-Century America" are crucial to my discussion of gender and medicine in Victorian society. While Showalter's *The Female Malady* explores the relationship between mental illness and culture in Victorian England, "The Hysterical Woman" provides the

[43] Showalter, *Hystories*, 15.
[44] Showalter, *Hystories*, 117.
[45] Virginia T. Bemis, "*Hystories: Hysterical Epidemics and Modern Culture*," *NWSA Journal* 10, no. 1 (1998): 173, https://www.jstor.org/stable/4316561.

American context. Smith-Rosenberg considers how hysteria was influenced by social factors like gender, class, and race. Through this discussion, she presents important background information for understanding the rise of neurasthenia and dispersion of hysteria symptoms in twentieth-century America. In "Puberty to Menopause," she draws attention to the perceived power of women's menstrual cycles in nineteenth-century America and explains how women's lives were defined by their reproductive ability. In Chapter Two, I draw from her insights as I explore the relationship between medicine and culture in the context of nineteenth-century hysteria.

In addition, Smith-Rosenberg and Showalter both draw from the broader intellectual tradition at the time, placing hysteria within the conversations around civilization, colonialism, Darwinism, industrialization, and capitalism at the time. Laura Briggs' article, "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology" (2000), supplements these analyses, emphasizing the role of race in addition to gender and class. Although other texts mention race and hysteria, Briggs' text offers the most in-depth discussion of race that will support this analysis, particularly in Chapter Two.

Chapter Overview and Sources

Each of these secondary sources offers a unique perspective on nineteenth-century hysteria and its aftermath. Taken together, these texts provide a rich foundation for exploring the evolution of hysteria on an intellectual and a cultural level. In addition to these secondary sources, I explore a range of primary sources to provide a detailed picture of hysteria in the nineteenth century and beyond. This thesis is divided into five chapters that explore different topics and, for the most part, different time periods. As such, each chapter includes a different type of primary source analysis.

Chapter One provides a broad overview of hysteria's history up until the nineteenth century. I trace the usage of the term "hysteria" and the evolution of hysteria symptoms over time. Because Chapter One encompasses such a long time range—ancient Egypt to the nineteenth century—the most efficient way to access primary source material is through secondary sources. Due to the time constraints and scope of this project, I rely heavily on Veith for quotations from important figures in Chapter One.[46]

Chapter Two is an in-depth look at the hysteria in the nineteenth century, when hysteria reached epidemic proportions and unprecedented levels of cultural relevance. I explore hysteria's place within the complex cultural and medical atmospheres in the nineteenth century, drawing attention to the intersections of medicine, sexuality, gender, race, and class at this essential moment in the history of hysteria. As part of this discussion, I also chronicle the rise of the neurasthenia diagnosis as the first important diversion from hysteria that I explore in this thesis. I explore the origins of neurasthenia in the work of American neurologist George M. Beard, its spread to Britain, and its relationship to culture and biology.

This chapter focuses on hysteria in the social contexts of Victorian England and America. A combination of several factors in these cultural settings—most notably the influence of Darwinism and colonialism, Evangelical Christianity, and industrialization and changing class relationships—created a unique environment for the hysteria epidemic. Hysteria has been especially tied to British culture in the historical literature, but the American contribution of neurasthenia altered the trajectory of hysteria's history. In addition, Chapter Four will examine the twentieth-century psychiatric disorders that relate to hysteria through the *DSM*, an American psychiatric resource. It is therefore vital to establish the American as well as the British context of nineteenth-century hysteria. The influence of

[46] In addition, this thesis was written during the COVID-19 pandemic, which further limited my access to primary source material.

Victorian British and American society on the hysteria diagnosis is the foundation for the rest of my analysis.

The primary source material in this chapter takes the form of nineteenth-century medical textbooks and documents written by British and American physicians. This is because I am particularly interested in the nature of nineteenth-century hysteria within these contexts, with the added benefit that I am able to read these sources in their original text without a need for translation. The majority of the writing on hysteria referenced in this chapter comes from Britain, mainly because the most important contributions to hysteria research during this period were from British doctors. The literature on neurasthenia, on the other hand, was written primarily by American doctors, most notably George M. Beard, who first defined the condition. Although I will be focusing on Britain and America, I at times reference other influential figures that shaped understandings of hysteria during this period. The intellectual climates in France, Germany, and Austria greatly advanced hysteria research. For example, the French neurologist Jean-Martin Charcot is essential to any discussion of nineteenth-century hysteria. I will draw on these external ideas, but only in support of my primary focus on the Anglo-American world.

Chapter Three details the rise of psychology in the late nineteenth century, a development that occurred alongside the neurological explanations of hysteria and arose out of hysteria research. In this chapter, I turn my attention to prominent figures who laid the foundations for the psychiatric discipline. In this case, research was driven by physicians and psychologists from France, Germany and Austria, most notably Sigmund Freud, Pierre Janet, and Emil Kraepelin. For the primary source analysis, I include material from Freud's work on hysteria and his psychological theories that came out of this research. The analysis centres on Freud and Breuer's pivotal book *Studies on Hysteria* (1895) and two essays written by Freud, "The Neuro-Psychoses of Defense" (1894) and "On the Grounds for Detaching a Particular

Syndrome from Neurasthenia under the Description 'Anxiety Neurosis'" (1895). These texts feature some of Freud's revolutionary ideas that reframed hysteria as a collection of mental disorders.

Chapter Four resumes Chapter One's investigation of hysteria's evolution over time, following the disorder after its nineteenth century peak and the influence of psychology. Chapter Four traces hysteria through its descendant conditions in the successive editions of the *DSM*. Hysteria in late Victorian England and America provides an interesting case of the interaction between culture and medicine. In Chapter Four, I continue to draw attention to this relationship, but focus mainly on the restructuring of medical (specifically, psychiatric) diagnoses over the course of the twentieth century. I examine each edition of the *DSM* and compare the language used to describe conditions and the evolution of how diagnoses were labelled and categorized.

The *DSM* is an American classification system, influenced primarily by American culture; however, it is an excellent case study of shifting diagnostic categories to serve as a starting point for this kind of analysis. More research on other classification systems—for example, the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (*ICD*)—would help to provide a more well-rounded study of shifting understandings of mental disorders. In the context of this study, the relationship between the *DSM* and the specific cultural context of the United States bolsters the overall argument that the interaction between medicine and culture has implications for conceptions of disease, patient treatment, and the broader society.

Chapter Five returns to the conflict between biological and psychological frameworks for explaining hysteria that characterized nineteenth-century research on the disease. The chapter presents a case study of two more recent diagnoses, chronic fatigue syndrome and fibromyalgia, whose status as biological disorders has been disputed. Patients with these

conditions maintain that their symptoms are physical in origin, but some medical professionals consider the disorders to be psychosomatic. The medical adherence to a naturalistic conception of disease has caused patients with these disorders to be neglected when no organic cause for their symptoms can be determined. These illnesses involve symptoms once associated with hysteria and, to an even greater extent, neurasthenia. In addition, the perceptions of the diseases and their patients among doctors and outside of medical contexts resemble nineteenth-century judgments about hysteria.

The selection of primary sources in Chapter Five is more complicated than those of the preceding chapters. I revisit texts that I relied upon as secondary sources in my historical analysis of hysteria. However, in this chapter, I focus on how these works exemplify academic views on hysteria at a specific moment in history. At the end of the twentieth century, hysteria was once again at the forefront of cultural discussions. Beginning in the 1960s, hysteria was the subject of historical analyses, but by the 1990s, scholarly attention had turned to conditions that were believed to be modern-day manifestations of hysteria. I critique the positions of these authors, drawing attention especially to the implications of the language used to describe these conditions and patients. For example, although I rely on *The Female Malady* in the narrative of nineteenth-century hysteria, I dedicate a considerable section of Chapter Four to critiquing Showalter's other book, *Hystories*. I also apply a critical perspective to the analysis in Shorter's *From Paralysis to Fatigue*, which serves as the foundation for much of my earlier discussion of psychosomatic illness and nineteenth-century medical theory. By analyzing these prominent texts along with other articles written in the late twentieth century, I highlight the ongoing dismissive approaches to medically unexplained illnesses and show how these attitudes perpetuate the same neglect of women's health that characterized the hysteria epidemic in the nineteenth century. I also explore medical perspectives on chronic fatigue syndrome and fibromyalgia in the 1990s and

compare these doctors' assumptions and judgments to the beliefs held by nineteenth-century physicians writing about hysteria.

Conclusion

This thesis examines hysteria as a gendered wastebasket diagnosis describing unexplained symptoms in women. I explore how the legacy of hysteria continues today by diving into Micale's proposal that hysteria never truly disappeared and was instead reclassified as a range of new diagnostic titles. I use nineteenth-century hysteria as a case study for the interaction between medicine and society and the impacts of this relationship, especially on female patients. I then extend this discussion, exploring how the interplay between medical theory and cultural values continues to harm women today. I argue that hysteria continues to exist in a range of psychiatric conditions and wastebasket diagnoses defined in relation to femininity, and that patients with these illnesses today continue to face judgment and mistreatment at the hands of medical professionals.

CHAPTER ONE: A BRIEF HISTORY OF HYSTERIA

One of the most intriguing aspects of hysteria is the simultaneous pervasiveness and ambiguity of this diagnosis. Through social change and scientific advancement, hysteria never seems to disappear. And yet, physicians have struggled to clearly define the condition. Across time periods, hysteria has been associated with numerous and varying symptoms and with conflicting explanations. The word "hysteria" first arose in ancient Greece but a similar illness was described much earlier, in ancient Egypt.[1] Over the following centuries, doctors built on previous understandings of hysteria and contributed their own theories. However, these developments occurred in what Micale calls a "less linear than… cyclical"[2] fashion: despite scientific advancements, doctors frequently returned to ancient ideas about the disease.

The task of defining hysteria was complicated by the interaction of medical theory and cultural forces. Hysteria was often portrayed as a unified condition, but further analysis reveals the disorder's heterogeneity. Historically, when physicians discussed hysteria, they tended to have a specific or model patient in mind that was constructed based on culturally-informed assumptions about gender, class, and race. Hysteria was historically associated with aristocratic white women, especially in the nineteenth century, but the disorder affected many other demographic groups, including men and people of diverse social classes, races, and geographical locations. Hysteria also described a wide range of patient experiences. Its extensive list of symptoms meant that the disorder could present very differently in individual patients. Nonetheless, cultural ideas about femininity remained central to the ways in which hysteria was portrayed and understood throughout the ages. Because of its etymological connection to the female reproductive system, physicians frequently failed to separate

[1] Ilza Veith, *Hysteria: The History of a Disease* (Chicago, IL: The University of Chicago Press, 1965), 2; Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton University Press, 1995), 19.
[2] Micale, *Approaching Hysteria*, 19.

hysteria from womanhood. Hysteria was so deeply intertwined with the female body that it was sometimes viewed as an almost inevitable by-product of women's inherent physical inferiority.[3] Approaches to understanding, diagnosing, and treating the disorder were informed by the fact that hysteria was defined as a women's illness.

This chapter traces the existence of hysteria from the ancient world to the nineteenth century in order to contextualize developments covered in subsequent chapters. I begin with the first mention of hysteria-like symptoms in ancient Egypt, the origins of the word "hysteria" in ancient Greece, and early theories about the disease in ancient Rome and the Middle Ages. I then explore the intellectual discourse around hysteria and the social contexts that influenced medical theories from the Renaissance through the Scientific Revolution to the Enlightenment. Finally, I discuss how these historical developments set the stage for the hysteria epidemic of the nineteenth century and contemporary gendered understandings of disease. I argue that throughout expansions in medical knowledge and changing definitions of the disorder, hysteria retained its overall status as a gendered wastebasket diagnosis. Such gendered (and often derisive) understandings of hysteria upheld sexist stereotypes and a patriarchal power structure within the medical field and in society as a whole. The history of hysteria illustrates the interplay between medicine, misogyny, and society.

No period in hysteria's history more explicitly demonstrates the potential consequences of cultural bias in medicine than nineteenth-century hysteria. The historical background provided in this chapter reveals how the apex of hysteria in the nineteenth century was a culmination of thousands of years of cultural and medical interactions. In addition, the long history of hysteria laid the groundwork for contemporary perceptions of women's health and the ongoing use of wastebasket diagnoses as pseudo-explanations for women's medical complaints.

[3] Roy Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," in *Hysteria Beyond Freud* (Berkeley and Los Angeles, California: University of California Press, 1993)," 250.

The Ancient World and the Beginnings of Hysteria

Historians of medicine have traced the existence of hysteria all the way back to ancient Egypt. The *Kahun Papyrus* from 1900 BCE—one of the oldest medical documents in existence—describes the movement of the uterus up out of its normal position, causing an array of symptoms, including pain and fatigue.[4] As treatment, the author of the document recommended the use of certain substances to return the uterus to its normal position. Herbs and aromatic substances near the vaginal opening were believed to attract the uterus downward and repulsive substances were ingested or inhaled to drive the uterus back down to its natural place.[5]

In ancient Greece, Hippocrates (c. 460-375 BCE) coined the term "hysteria" to describe this idea of a "wandering womb."[6] The term came directly from the Greek word *hystera*, meaning uterus.[7] Greek physicians believed that the uterus moved throughout the female body, causing localized symptoms. Hysteria was also used as an adjective alongside other conditions to indicate a uterine origin. For example, *globus hystericus* (a choking sensation) was believed to be caused by a dried-out uterus seeking moisture and rising to the throat. Other hysterical conditions included convulsions due to the uterus rising to the hypochondrium; anxiety and vomiting caused by the uterus attaching itself to the heart; loss of voice, gritting of teeth, and ashen complexion as a result of the uterus interacting with the liver; a lump in the side of the body from the uterus in the loins; and facial pain, "drowsiness," and "lethargy" when the uterus rose to the head.[8] The movement of the uterus was linked to sexual deprivation, and widows and spinsters were considered more likely to suffer from these conditions. Greek physicians prescribed similar treatments to those used in

[4] Veith, *Hysteria: The History of a Disease*, 2; Micale, *Approaching Hysteria*, 19.
[5] Veith, *Hysteria: The History of a Disease*, 3; Micale, *Approaching Hysteria*, 19.
[6] Veith, *Hysteria: The History of a Disease*, 2.
[7] Veith, *Hysteria: The History of a Disease*, 10.
[8] Veith, *Hysteria: The History of a Disease*, 10.

Egypt, using aromatic substances to reposition the womb. In addition, patients were advised to marry and become pregnant as soon as possible to alleviate symptoms.[9]

When the concept of hysteria reached ancient Rome, Aretaeus of Cappadocia (c. first-second century CE[10]) compared the independently-moving uterus to an animal residing in the female body.[11] Framing the uterus as an autonomous being implied a parasitic relationship between a woman and her reproductive system. Women's bodies themselves became pathologized and were seen as inherently unhealthy when compared to those of men. Galen of Pergamon (129-199 CE) offered an alternative explanation for hysterical symptoms. He argued that the uterus secreted a fluid similar to semen in men and that the retention of this fluid (and the menses) could become "poisonous" and cause hysteria.[12] Galen asserted that "we must consider as totally preposterous the opinion of those who, by means of this reasoning, make the womb into an animal."[13] However, he maintained that the female body was venomous and, therefore, that hysteria in women was almost inevitable.[14] Although he believed that women were more susceptible to hysteria, he suggested that men could experience similar symptoms if they practiced abstinence and suppressed these "fluids."[15]

Graeco-Roman physicians also adopted the humoral model of the body as a physiological explanation for mental and physical symptoms. The humoral model arose in ancient Greece and remained a dominant framework for understanding illness until the mid-nineteenth century.[16] This conception of disease influenced theories about hysteria over the following centuries. According to humoral theory, the body contained four humors: blood, phlegm, yellow bile, and black bile. An excess or deficiency of one or more of the humors

[9] Veith, *Hysteria: The History of a Disease*, 10-11.
[10] Veith, *Hysteria: The History of a Disease*, 22.
[11] Veith, *Hysteria: The History of a Disease*, 23.
[12] Veith, *Hysteria: The History of a Disease*, 37.
[13] Galen quoted in Veith, *Hysteria: The History of a Disease*, 39.
[14] Porter, "The Body and the Mind, the Doctor and the Patient," 250.
[15] Veith, *Hysteria: The History of a Disease*, 39.
[16] Shorter, *From Paralysis to Fatigue*, 15.

would result in an associated set of symptoms.[17] Illnesses were treated by balancing the humors, usually by cleansing the body of toxins. Physicians performed procedures like bloodletting and skin lesions or prescribed drugs to induce excessive salivation, sweating, urinary and bowel excretion.[18] In addition, each of the four humors was associated with a "temperament." These temperaments described certain psychological tendencies that made a person more susceptible to particular mental symptoms. For example, people with a melancholy temperament (represented by black bile) were naturally more likely to develop depressive symptoms.[19] Similarly, a choleric temperament (related to yellow bile) was likely to result in mania, a sanguine temperament (related to blood) could cause psychosis, and a phlegmatic temperament (associated with phlegm) could lead to dementia.[20]

The theory of humoral temperaments explained psychological symptoms through physiological mechanisms.[21] However, this model arose in opposition to existing supernatural and demonological explanations of mental illness in the Graeco-Roman period.[22] At the time, madness was commonly attributed to "ghosts, spirits, and demons," certain deities, and astrological events.[23] Humoralism competed with these ideas, but the fall of the Roman Empire and the rise of Christianity initiated a return to religious and mystical understandings of madness.[24] Micale calls the transition from paganism to Christianity "the first great paradigm shift in the history of hysteria."[25] In the period between the fifth and thirteenth centuries, mental illness became increasingly understood as evil and sinful. St. Augustine

[17] Tina Chakravarty, "Medicalisation of Mental Disorder: Shifting Epistemologies and Beyond," *Sociological Bulletin* 60, no. 2 (August 2011): 269.
[18] Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York, NY: The Free Press, 1992), 15.
[19] Shorter, *From Paralysis to Fatigue*, 15.
[20] Shorter, *From Paralysis to Fatigue*, 15.
[21] Shorter, *From Paralysis to Fatigue*, 15.
[22] Chakravarty, "Medicalisation of Mental Disorder," 269.
[23] Chakravarty, "Medicalisation of Mental Disorder," 269.
[24] Micale, *Approaching Hysteria*, 20.
[25] Micale, *Approaching Hysteria*, 20.

(354-430 CE) reinforced this conception of mental illness. He viewed all human suffering—including mental and physical diseases—as a consequence of original sin.[26]

This philosophy informed conceptions of hysteria at the time. During the Middle Ages, mental disturbances were often explained by demonic possession rather than medical concerns. As a result, exorcism was a common treatment for psychological symptoms.[27] St. Augustine distinguished between possession and madness and argued that while madness could be improved through medical treatments, exorcisms and other earthly interventions would have no effect when a demon or devil invaded a person's body. In these cases, the only option was to wait for a miracle from God.[28]

Hysteria patients were seen as separate from both of these groups. St. Augustine had defined madness as an illness[29] and individuals possessed by demons or the devil were seen as victims of evil forces imposing themselves on unwilling bodies.[30] However, hysteria was not viewed as a legitimate disease—although sometimes women who suffered from hysterical symptoms were believed to be possessed by an evil force, many were designated witches.[31] Witchcraft was viewed very differently from possession. Instead of being victims of external forces beyond their control, witches were seen as inviting evilness to enter them and even conspiring with the devil.[32] As in many periods of hysteria's history, patients were viewed in contradictory ways. During the Middle Ages, individuals who displayed hysteria symptoms were "interpreted alternatively as a victim of bewitchment to be pitied" when they were believed to be possessed and "the devil's soul mate to be despised" when they were accused of witchcraft.[33] The Church deemed witchcraft heretical and as a result, many

[26] Veith, *Hysteria: The History of a Disease*, 49.
[27] Chakravarty, "Medicalisation of Mental Disorder," 270.
[28] Veith, *Hysteria: The History of a Disease*, 47.
[29] Veith, *Hysteria: The History of a Disease*, 47.
[30] Veith, *Hysteria: The History of a Disease*, 56.
[31] Veith, *Hysteria: The History of a Disease*, 56.
[32] Veith, *Hysteria: The History of a Disease*, 57.
[33] Micale, *Approaching Hysteria*, 20.

individuals who suffered from hysteria symptoms in the Middle Ages received prison and death sentences rather than medical attention.

The Renaissance and the Shift Toward Scientific Explanations

In the Middle Ages, mental illness was explained through an intermingling of humoral and supernatural explanations for madness. However, in the Renaissance, medical doctors returned to ancient Greek and Roman conceptions of disease and hysteria was once again understood through classical medical frameworks. These early scientific explanations challenged demonic conceptions of mental illness, although this association did not completely disappear until the eighteenth century.[34] The return to classical modes of thought after the Middle Ages re-established hysteria's connection to the female body: hysteria was once again blamed on the "destructive" or "poisonous" uterus.[35]

French physician François Rabelais (1483-1553) drew on the ideas of Hippocrates, Galen, Plato, and Aristotle in his satirical writings.[36] In his book *Pantagruel*, one of his characters explains that

> if movement, as Aristotle says, is a sure sign of something animate, and if all that moves of itself is to be called an animal, then, Plato was right, when he called [the womb] an animal, having noted in it those movements commonly accompanying suffocation, precipitation, corrugation, and indignation, movements sometimes so violent that the woman is thereby deprived of all other senses and power of motion, as though she had suffered heart-failure, syncope, epilepsy, apoplexy, or something very like death.[37]

Following this description of hysteria-like symptoms, Rabelais continues, "those virtuous women who have lived modestly and blamelessly, and who have had the courage to rein in that unbridled animal and to make it obedient to reason, are deserving of no small praise

[34] Chakravarty,"Medicalisation of Mental Disorder," 270.
[35] Veith, *Hysteria: The History of a Disease*, 105-106.
[36] Veith, *Hysteria: The History of a Disease*, 105.
[37] François Rabelais quoted in Veith, *Hysteria: The History of a Disease*, 108.

indeed."[38] Veith notes that these statements were made "partly in jest and partly seriously"[39] but that they illustrate Rabelais' comparison of the uterus to an animal and, more importantly, his view that women could control this animal and avoid the negative effects of hysteria.[40]

French surgeon Ambroise Paré (1517?-1590), reiterated ancient ideas about hysteria, including the movement of the uterus, humoral theory, and the dangers of sexual repression for women.[41] He described the condition of "strangulation" or "suffocation" of the womb, which he tied to abstinence in women. He described this condition as:

> an interception or stopping of the libertie in breathing or taking winde, becaus that the womb, swoln or puffed up by reason of the access of gross vapors and humors that are contained therein, and also snatched as it were by a convulsive motion, by reason that the vessels and ligaments distended with fulness, are so carried upwards against the midriff and parts of the breast, that it maketh the breath to bee short, and often as if a thing lay upon the breast and pressed it.[42]

He also believed that this suffocation could cause mental and physical symptoms, including fatigue, paralysis, convulsions, depression, mania, and fits involving alternating between weeping and laughing.[43] Paré maintained that suffocation of the womb resulted from either "the suppression of the flowers [menses]" or "the corruption of the seed."[44] He explained that "When shee hath satisfied, and everie waie fulfilled her lust, and then presently on a sudden begin's to contain her self, it is verie likely that shee is suffocated by the suppression of the flowers."[45] Suffocation of the womb became a common diagnosis for women experiencing hysteria-like symptoms up to the end of the seventeenth century and remained prominent in discussions of hysteria until the nineteenth century.[46]

---

[38] François Rabelais quoted in Veith, *Hysteria: The History of a Disease*, 108.
[39] Veith, *Hysteria: The History of a Disease*, 108.
[40] François Rabelais quoted in Veith, *Hysteria: The History of a Disease*, 108.
[41] Veith, *Hysteria: The History of a Disease*, 114.
[42] Ambroise Paré quoted in Veith, *Hysteria: The History of a Disease*, 113.
[43] Veith, *Hysteria: The History of a Disease*, 114.
[44] Veith, *Hysteria: The History of a Disease*, 114.
[45] Ambroise Paré quoted in Veith, *Hysteria: The History of a Disease*, 115.
[46] Sabine Arnaud, *On Hysteria: The Invention of a Medical Category between 1670 and 1820* (Chicago, IL: University of Chicago Press, 2015), 14, 1.

Paré also related this condition to femininity. He characterized women who experienced amenorrhea as masculine, asserting that "Manie women, when their flowers or terms be stopped, degenerate after a manner into a certain manly nature, whence they are called *Viragines*, that is to say, stout, or manly women; therefore their voice is more loud and big, like unto a mans, and they become bearded."[47] Paré's view of women with menstrual dysfunction as less feminine reveals how deeply the female reproductive system was intertwined with femininity and womanhood.

English physician Edward Jorden (1578-1632) addressed the ongoing conflict between the demonological and biological models of mental illness and its implications for "hysterical" women.[48] He wrote *A Briefe Discourse of a Disease Called the Suffocation of the Mother* (1603) in response to one of his patients being imprisoned for witchcraft despite his diagnosis of hysteria.[49] In this treatise, Jorden asserted that "the pricking of the skin and the burning by fire," symptoms often associated with witchcraft, were "so ordinary in fits of the Mother"[50] and identified further symptoms like "insensibility, convulsions, periodicity of the fits, the choking sensation when eating, and the commencement of fits at the sight of specific persons" as caused by disease, not sorcery.[51]

Echoing ancient Greek physicians, Jorden suggested that the uterus migrated around the body and affected other organs. In reference to Plato's model of the tripartite soul, he highlighted the role of the brain, the heart, and the liver in producing specific symptoms. Plato had theorized that the soul was separated into three parts: the brain (which contained the soul's animal faculty), the heart (which controlled the vital faculty), and the liver (which

[47] Ambroise Paré quoted in Veith, *Hysteria: The History of a Disease*, 119.
[48] Mark S. Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, Massachusetts: Harvard University Press, 2008), 12.
[49] Veith, *Hysteria: The History of a Disease*, 120-121.
[50] Edward Jorden quoted in Veith, *Hysteria: The History of a Disease*, 121.
[51] Veith, *Hysteria: The History of a Disease*, 121.

regulated the natural faculty).[52] According to Jorden, each of these organs could be influenced by the uterus, either through vapors emanating from the uterus or through "a sympathetic interaction between the two organs."[53] The affected organ's associated faculty determined the type of symptoms the patient would experience.[54] Jorden suggested that hysteria was primarily a result of the interaction between the uterus and the brain, which controlled psychological and neurological processes.[55]

Jorden's contemporary Robert Burton (1577-1640) expanded Jorden's hypothesis about the brain's role in hysteria's etiology.[56] He focused primarily on "melancholy," a psychological symptom that included everything from sadness and grief to conditions now classified as neuroses and psychoses.[57] Although anyone could become "melancholy," Burton concentrated on "maids', nuns', and virgins' melancholy," a condition that was specific to women.[58] Burton advocated for "diseases of the mind"[59] to be taken as seriously as physical ailments, so psychological patients could also access medical treatment.[60] Following Jorden's and Burton's contributions, physicians began to shift away from the long-standing uterine explanations of hysteria and investigate the role of the brain.

French physician Charles Lepois (1563-1633), also known as Carolus Piso, was the first to declare that hysteria originated in the brain, not the uterus. In 1618, he wrote that "We believe we are correct in concluding that all the hysterical symptoms… have been attributed to the uterus, the stomach and other internal organs for the wrong reason. All [these symptoms] come from the head. It is this part which is affected not by sympathy but

[52] Veith, *Hysteria: The History of a Disease*, 122.
[53] Veith, *Hysteria: The History of a Disease*, 122. The vapors were a newer explanation for hysteria's origin at the time described gaseous fumes rising from the uterus to affect other organs rather than the uterus itself travelling around the body. This notion became prominent in theories about hysteria in the following centuries.
[54] Veith, *Hysteria: The History of a Disease*, 122.
[55] Veith, *Hysteria: The History of a Disease*, 122.
[56] Veith, *Hysteria: The History of a Disease*, 124.
[57] Veith, *Hysteria: The History of a Disease*, 125.
[58] Micale, *Hysterical Men*, 13.
[59] Robert Burton quoted in Veith, *Hysteria: The History of a Disease*, 125.
[60] Veith, *Hysteria: The History of a Disease*, 125.

idiopathically and produces motions which make themselves felt throughout the entire body."[61] As a result of this conclusion, Lepois further asserted that "the hysterical symptoms are almost all common to both men and women."[62] Lepois also maintained that emotions were an important factor in producing hysteria symptoms.[63]

Around the same time, however, English physician William Harvey (1578-1657) championed the gynecological model of hysteria, stating that

> No one of the least experience can be ignorant what grievous symptoms arise when the uterus either rises up or falls down, or is in any way put out of place, or is seized with spasms—how dreadful, then, are the mental aberrations, the delirium, the melancholy, the paroxysms of frenzy, as if the affected person were under the dominion of spells, and all arising from unnatural states of the uterus.[64]

These two conflicting perspectives on the correct classification of hysteria—as emerging from the uterus or the brain—would form the basis of the recurring debates over the following centuries.

The Scientific Revolution and the Rise of Neurological Explanations

In the second half of the 17th century, physiologist and neuroanatomist Thomas Willis (1621-1675) defined hysteria as a *neurological* disease.[65] In *Practice of Physick* (1684), Willis conceded that the uterus could occasionally cause hysteria, but rejected the notion that the uterus could travel through the body.[66] Instead, like Lepois, he believed that hysteria most commonly originated in the brain.[67] He supported his claims with scientific observations, using autopsies to demonstrate that hysteria patients displayed no uterine deformities.[68] He determined that "in the hinder part of the head, the beginning of the nerves

[61] Charles Lepois quoted in Veith, *Hysteria: The History of a Disease*, 129.
[62] Charles Lepois quoted in Veith, *Hysteria: The History of a Disease*, 129.
[63] Micale, *Approaching Hysteria*, 21.
[64] William Harvey quoted in Micale, *Hysterical Men*, 15-16.
[65] Veith, *Hysteria: The History of a Disease*, 132.
[66] Micale, *Hysterical Men*, 17.
[67] Veith, *Hysteria: The History of a Disease*, 132.
[68] Micale, *Hysterical Men*, 17.

[were] moistened and wholly drowned with a sharp serum."[69] Willis also depicted the nervous system as being controlled by "animal spirits."[70] In a description of hysteria, he noted that "Having weighed these and other reasons, we doubt not to assert the Passions, commonly called Hysterical, to arise most often, for that the animal spirits possessing the beginning of the Nerves within the head are infected with some taint."[71] While Lepois had maintained that hysteria could affect either gender, Willis believed that women were much more likely than men to develop hysteria, arguing that "Women, from any sudden terror and great sadness, fall into mighty disorder of spirits, where men from the same occasion are scarcely disturb'd at all."[72]

Thomas Sydenham (1624-1689), also known as "The Great Clinician,"[73] "the father of English medicine"[74] or "the English Hippocrates,"[75] was one of the most important figures in the history of hysteria. In his neuropsychological model of disease, Sydenham described hysteria in terms of interactions between the body and mind.[76] He suggested that the body and the mind each possessed animal spirits and that an imbalance in this relationship caused hysteria.[77] Sydenham articulated that "it is not any corruption of either the semen or the menstrual blood… to which this disease is to be referred. It is rather the faulty disposition of the animal spirits. There is no malignant halitus to the parts affected, no perverse deprivation of the juices, no congestion of acrid humours."[78] Sydenham believed that hysteria presented itself in the weakest points of the body and mind and that symptoms were related to the affected body part.[79]

---

[69] Thomas Willis quoted in Veith, *Hysteria: The History of a Disease*, 133.
[70] Arnaud, *On Hysteria*, 4.
[71] Thomas Willis quoted in Veith, *Hysteria: The History of a Disease*, 133-134.
[72] Thomas Willis quoted in Veith, *Hysteria: The History of a Disease*, 133.
[73] Veith, *Hysteria: The History of a Disease*, 137.
[74] Arnaud, *On Hysteria*, 17.
[75] Arnaud, *On Hysteria*, 17; Veith, *Hysteria: The History of a Disease*, 137.
[76] Micale, *Approaching Hysteria*, 22.
[77] Micale, *Approaching Hysteria*, 22.
[78] Thomas Sydenham quoted in Veith, *Hysteria: The History of a Disease*, 144.
[79] Veith, *Hysteria: The History of a Disease*, 143.

Sydenham was also more sympathetic to his patients' psychological and emotional symptoms than his predecessors.[80] He did not believe his patients to be insane, but rather asserted that "Those who thus suffer are persons of prudent judgment, persons who in their profundity of meditations and the wisdom of their speech far surpass those whose minds have never been exerted by such stimuli."[81] Despite his insistence on his patients' sanity, Sydenham recognized that the mind was involved in producing hysterical symptoms.[82]

Because Sydenham rejected the gynecological model of hysteria,[83] he believed that the disorder occurred in men as well. However, hysteria's etymological connection to the uterus made this prospect too radical for Sydenham's contemporaries. In order for his ideas to be accepted, Sydenham attributed hysterical symptoms in men to an existing diagnosis, "hypochondriasis," reframing this disorder as a male version of hysteria.[84] Sydenham considered these two conditions to be virtually identical, articulating that "however much, antiquity may have laid the blame upon the uterus, hypochondriasis… is as like it, as one egg is to another."[85] With that said, Sydenham maintained that women were more likely to develop hysterical symptoms, although he insisted that this occurrence was not to be attributed to the uterus.[86] The separation of hysteria symptoms into two gendered diagnoses allowed gender stereotypes to continue to affect how these patients were treated.

Sydenham believed hysteria to be a common disorder, especially among women.[87] He also directly addressed the role of class, stating that "As to females, if we except those who lead a hard and hardy life, there is rarely one who is wholly free from [hysterical complaints.]"[88] Throughout history, physicians have upheld this common misconception of

[80] Veith, *Hysteria: The History of a Disease*, 142.
[81] Thomas Sydenham quoted in Veith, *Hysteria: The History of a Disease*, 142.
[82] Veith, *Hysteria: The History of a Disease*, 141.
[83] Veith, *Hysteria: The History of a Disease*, 145.
[84] Veith, *Hysteria: The History of a Disease*, 144.
[85] Thomas Sydenham quoted in Veith, *Hysteria: The History of a Disease*, 141.
[86] Veith, *Hysteria: The History of a Disease*, 141.
[87] Micale, *Approaching Hysteria*, 22.
[88] Thomas Sydenham quoted in Veith, *Hysteria: The History of a Disease*, 141.

hysteria as an upper-class white woman's illness. Burton and Willis, for example, also had this archetype in mind when describing melancholia and hysteria; all three physicians attributed the symptoms they described to the sedentary, superfluous upper-class lifestyle.[89] Sydenham maintained that hypochondriasis was especially related to upper-class life, implying that only "such male subjects as lead a sedentary or studious life, and grow pale over their books and papers" developed hypochondriacal symptoms.[90] This description of hypochondriasis patients exposes another facet of the gendered approach to these conditions. The type of man that Sydenham believed could contract hypochondriasis represented a departure from traditional ideals of masculinity. The typical hypochondriac did not participate in "manly" activities like physical labour or exhibit traditionally masculine traits. Instead of being tough and dominant, these men were depicted as soft and weak, and developed symptoms associated with hysteria as a result. These symptoms remained connected to femininity—in contrast to the ideal masculine gender expression—even when diagnosed in men. The notion of women as inferior to men informed this medicalization of femininity in both men and women.

Italian physician Giorgio Baglivi (1668-1706) furthered Sydenham's work on the psychological nature of hysteria and offered an early conception of psychosomatic illness (physical symptoms caused by psychological processes).[91] In his book, *De praxi medica* (1696), he included hysteria in his chapter on diseases of the mind.[92] He insisted that mental illnesses were worthy of serious attention in the medical field, arguing that

> All men have their own Cares, and every one lies under a bitter Necessity of spending almost all the Periods of his Life, in attending the doubtful Events of his Labour. Now this being true, 'tis equally a Truth obvious to all Men, that a great Part of Diseases

[89] Micale, *Approaching Hysteria*, 155.
[90] Thomas Sydenham quoted in Veith, *Hysteria: The History of a Disease*, 141.
[91] Veith, *Hysteria: The History of a Disease*, 146.
[92] Veith, *Hysteria: The History of a Disease*, 147.

> either take their Rise from, or are fed by that Weight of Care that hangs upon every one's Shoulders…[93]

Sydenham had emphasized his patients' mental symptoms and proposed that the mind played a role in producing hysteria symptoms, but Baglivi suggested that emotional and psychological disturbances directly caused hysteria. He called these disturbances "passions of the mind" and asserted that they could produce mental or physical symptoms.[94] Baglivi agreed with the position that the excess and overindulgence associated with the upper-class lifestyle caused hysteria. Specifically, he maintained that those who lived lavish lifestyles and did not participate in daily physical activity were more likely to be emotionally sensitive and therefore develop hysteria.[95] He therefore prescribed exercise, dietary changes, and travel to combat symptoms.[96] However, Baglivi often failed to account for the presence of organic diseases as potential causes for physical symptoms because he so strongly believed in his theory of psychosomatic illness.[97] Still, Baglivi's idea that both physical *and* psychological symptoms of hysteria originated in the mind shaped discussions of hysteria in the following centuries.[98]

The Enlightenment

The eighteenth century was marked by political, cultural, and intellectual change. In the wake of the scientific revolution, philosophers, scientists, and political figures championed rationality, objectivity, and truth, and these values permeated society.[99] Medical professionals embraced Enlightenment ideals and medicine became centred on observation

[93] Giorgio Baglivi in Veith, *Hysteria: The History of a Disease*, 147.
[94] Veith, *Hysteria: The History of a Disease*, 147.
[95] Veith, *Hysteria: The History of a Disease*, 148.
[96] Veith, *Hysteria: The History of a Disease*, 151.
[97] Veith, *Hysteria: The History of a Disease*, 149.
[98] Micale, *Approaching Hysteria*, 21.
[99] Roy Porter, "Scientific Medicine in the Nineteenth Century," in *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: W. W. Norton & Company, 1997), 304.

and classification.[100] Mental illness was seen as "an inability to use the faculty of reason" and physicians attempted to explain this deficiency within an empiricist framework.[101] They conducted experiments to search for tissue damage in the brain that would provide an observable explanation for psychological symptoms.[102] The ideals cultivated during the Enlightenment era greatly influenced the medical profession, and in particular perspectives on mental illness and its place in medicine.

There were several major players in the eighteenth century development of hysteria. George Chyne (1672-1743) highlighted the role of culture in producing hysteria, echoing previous discussions surrounding class. He believed that "hysteria, hypochondriasis, melancholy, and all similar states which led to a morbid heaviness of spirit" were a "specific trait of the English."[103] He blamed these ailments on the modernization and urbanization of English society and the sedentary, overindulgent lives of wealthy English people. In particular, he cited the rise of spectator sports as a key cause for hysteria because people stopped participating and entertaining themselves and instead expected to be constantly entertained by others.[104] He also believed that crowded cities like London and the lack of sunshine in England contributed to hysteria symptoms.[105]

Scottish physician Robert Whytt (1714-1766) advanced the neurological model of hysteria. After Willis popularized the term "nervous disease," Whytt criticized physicians for "bestow[ing] the character of *nervous* on all those disorders whose nature and causes they were ignorant of."[106] He aimed to clarify the definition of "nervous disease" by explaining neurological theory more accurately and by identifying disorders that were truly caused by dysfunctions of the nervous system. He included hysteria and hypochondriasis in this

[100] Chakravarty,"Medicalisation of Mental Disorder," 273.
[101] Chakravarty,"Medicalisation of Mental Disorder," 270.
[102] Chakravarty,"Medicalisation of Mental Disorder," 274.
[103] Veith, *Hysteria: The History of a Disease*, 157.
[104] Veith, *Hysteria: The History of a Disease*, 157.
[105] Veith, *Hysteria: The History of a Disease*, 158.
[106] Robert Whytt quoted in Veith, *Hysteria: The History of a Disease*, 160.

category of "real" neurological disorders.[107] Whytt extended Baglivi's ideas about the effect of emotional turmoil on the body, claiming that "Nothing makes more sudden or more surprising changes in the body, than the several passions of the mind. These however, act solely by the mediation of the brain, and, in a strong light, shew its sympathy with every part of the system."[108] Whytt further suggested that "certain ideas or affections excited in the mind are always accompanied with corresponding motions or feelings in the body," such as "shame rais[ing] a heat and redness in the face" and "fear [being] attended with a paleness."[109] For Whytt, these physical reactions to emotional stimuli demonstrated the interconnection between the mind and the body. Whytt's ideas recalled Baglivi's notion of psychosomatic illness and suggested that the mind and body influenced each other in both directions. According to Whytt, the nerves bridged the mental and physical realms, and this neural network helped explain the combination of physical and emotional symptoms of hysteria.[110]

Whytt stressed individualized care, focusing on each patient's specific symptoms and medical history.[111] He also cautioned against the common perception among patients and physicians alike that the physician could act as a miracle worker and alleviate all of the patient's complaints. Instead, he advocated for a partnership between the patient and physician, in which each took on a share of the responsibility. The physician was to provide medical expertise, prescribe medicine, and suggest actions for the patient to take; the patient was to engage in regular exercise, follow a healthy diet, and take medications as directed by the physician. The patient's prognosis depended not just on the expertise of the physician, but also on the patient's ability to adhere to guidelines.[112]

[107] Veith, *Hysteria: The History of a Disease*, 160.
[108] Robert Whytt quoted in Veith, *Hysteria: The History of a Disease*, 161.
[109] Robert Whytt quoted in Veith, *Hysteria: The History of a Disease*, 161.
[110] Veith, *Hysteria: The History of a Disease*, 163.
[111] Veith, *Hysteria: The History of a Disease*, 165.
[112] Veith, *Hysteria: The History of a Disease*, 165.

William Cullen (1712-1790) "saw all of life as a function of nervous energy and disease as a nervous disorder."[113] For Cullen, the nerves controlled all aspects of the body and mind, and all illnesses were neurological in nature.[114] He divided these neurological illnesses into four categories: fevers cachexias, local disorders, and neuroses. Cullen's defined the neuroses as conditions that were expressed through "spasm or atony" rather than the form of mental illness the term denotes today.[115] Hysteria was classified as part of this category (under the heading of "spasmotic neuroses") due to its spastic and convulsive aspects.[116] Although Cullen clearly believed in the neurological origin of hysteria, he maintained that hysteria "occurs especially in those females who are liable to Nymphomania." Nymphomania was a separate diagnosis that was characterized by hypersexuality in women. In addition to highlighting the relationship between nymphomania and hysteria, Cullen supported previous physicians' creation of a subtype of hysteria known as "*hysteria libidinosa*,"[117] which shared many symptoms with nymphomania.[118]

While Cullen generally considered hysteria (and all illnesses) to be neurological in nature, he still fell back on certain traditional assumptions. Cullen believed that hysteria was more common in women and asserted that symptoms of the disorder like hypersexuality, paroxysms, delirium, and emotional outbursts were related to menstruation and "passions of the sensitive mind."[119] He even went so far as to state that "the physicians have at all times judged rightly in considering this disease as an affection of the uterus and other parts of the genital system."[120] Cullen added that the ovaries were particularly instrumental in producing hysteria symptoms.[121] These claims muddle Cullen's theory, but his contradictory conception

[113] Veith, *Hysteria: The History of a Disease*, 171.
[114] Veith, *Hysteria: The History of a Disease*, 171.
[115] Veith, *Hysteria: The History of a Disease*, 171.
[116] Micale, *Hysterical Men*, 77.
[117] William Cullen quoted in Veith, *Hysteria: The History of a Disease*, 172.
[118] Veith, *Hysteria: The History of a Disease*, 172.
[119] Veith, *Hysteria: The History of a Disease*, 172.
[120] William Cullen quoted in Veith, *Hysteria: The History of a Disease*, 173.
[121] Veith, *Hysteria: The History of a Disease*, 173.

of hysteria is characteristic of many physicians' attempts to pin down this condition. Veith argues that Cullen's contributions did not further developments in understandings and treatments of hysteria, but rather indicate a regression.[122]

American physician Benjamin Rush (1745-1813) was greatly influenced by Cullen's work. He combined Cullen's conception of hysteria as a neurological disorder with Baglivi's notion of psychosomatic illness and existing theories about the effect of social factors on mental states. In a 1788 essay on the psychological effects of the Revolutionary War, he argued that the war had caused psychological changes that had physical implications.[123] Rush also echoed Baglivi's prescriptions of exercise, diet, and travel, stating, "many persons of infirm and delicate habits, were restored to perfect health, by the change of place or occupation, to which the war exposed them. This was the case in a more especial manner with hysterical women, who were much interested in the successful issue of the contest."[124]

Rush cited departures from humankind's "natural state"—such as modern diet and lifestyle changes—as the cause for increased rates of mental disturbance.[125] He specified that the social factors that cause hysterical responses were characteristic of the upper classes. Rush argued that "hysteria befalls only the well-born and the idle. Servants and laboring persons had neither the time nor the tolerant environment to indulge in hysterical complaints or paroxysms."[126] With that said, he believed that the prevalence of hysteria during this period resulted from "common" people beginning to participate in idle and luxurious lifestyles previously restricted to the upper classes.[127] Although Rush blamed social factors—especially class—for the rise of hysteria, he also maintained that women's sensibilities made them inherently vulnerable to emotional disturbances. According to Rush, "it may perhaps

[122] Veith, *Hysteria: The History of a Disease*, 173.
[123] Veith, *Hysteria: The History of a Disease*, 173.
[124] Benjamin Rush quoted in Veith, *Hysteria: The History of a Disease*, 173.
[125] Veith, *Hysteria: The History of a Disease*, 174.
[126] Benjamin Rush quoted in Veith, *Hysteria: The History of a Disease*, 174.
[127] Veith, *Hysteria: The History of a Disease*, 174.

help to extend our ideas of the influence of the passions upon diseases, to add, that when either love, jealousy, grief, or even devotion, wholly engross the female mind, they seldom fail, in like manner, to cure or to suspend hysterical complaints."[128]

The renowned French physician Philippe Pinel (1745-1826) is credited with forming the foundations of what would eventually become psychiatry.[129] Pinel reimagined Cullen's neuroses (which originally described physical ailments) and associated them with "mental alienation."[130] To Pinel, neuroses could refer to "moral" or "physical" afflictions (or a combination of the two).[131] Although he suspected that physical abnormalities could cause neuroses, he often failed to locate any indication of these disturbances in autopsies.[132] He therefore leaned toward the moral (psychological) origin of hysteria and championed "moral treatment," a type of treatment akin to modern-day psychotherapy.[133]

Pinel advocated for the humane treatment of mental patients.[134] He was known for working directly with patients and attempting to understand their ailments on a deep and intimate level. He distanced hysteria from its physical and neurological explanations and attributed the disorder to inner conflicts and emotional disturbances. For example, the following description of hysteria in a female patient utilizes language centred on the patient's feelings and how these feelings led to physical symptoms:

> In the beginning the imagination is constantly obsessed by lascivious or obscure matters. The patient is in a state of sadness and restlessness; she becomes taciturn, seeks solitude, loses sleep and appetite, conducts a private battle between sentiments of modesty and the impulse toward frantic desires. In the second phase she abandons herself to her voluptuous leanings, she stops fighting them, she forgets all rules of modesty and propriety; her looks and actions are provocative, her gestures indecent; she begins to solicit at the moment of the approach of the first man, she makes efforts to throw herself in his arms. She threatens and flares up if the man tries to resist her. In the third phase her mental alienation is complete. Her obscenity disgusting, her

[128] Benjamin Rush quoted in Veith, *Hysteria: The History of a Disease*, 173-174.
[129] Veith, *Hysteria: The History of a Disease*, 175.
[130] Veith, *Hysteria: The History of a Disease*, 178.
[131] Veith, *Hysteria: The History of a Disease*, 178-179.
[132] Veith, *Hysteria: The History of a Disease*, 179.
[133] Veith, *Hysteria: The History of a Disease*, 179.
[134] Veith, *Hysteria: The History of a Disease*, 175.

> fury blind with the only desire to wound and to revile. She is on fire though without fever, and finally, she manifests all the different symptoms of a violently maniacal condition.[135]

Despite its focus on the patient's mental state, this depiction appears to contradict Pinel's supposedly sympathetic approach to his patients. Although he is credited with developing a moral therapy that explored each patient's individual psyche, much of the language he used to describe his patients was demeaning and contemptuous. His portrayals of hysteria patients also reveal deep-rooted misogyny, both explicitly and implicitly.

Although Pinel considered hysteria to be psychogenic in nature, he maintained that the associated somatic symptoms were real, albeit dependent on the patient's mental state. He cited a natural propensity for emotional instability, overstimulating activities like conversing and reading, and both sexual deprivation and overindulgence as risk factors for a hysterical attack and considered physical manifestations of hysteria to be ultimately caused by mental disturbances.[136] Despite Pinel's progress toward understanding the psychological processes involved in mental disorders, he retained the notion that hysteria was related to the female reproductive system and associated with female sexuality. Within the category of "neuroses," he classified both hysteria and nymphomania as "Genital Neuroses of Women,"[137] which he considered to be "as many and varied as those of the man."[138] Pinel believed that genital neuroses arose at puberty and were informed by a combination of social and biological factors. For instance, he wrote that nymphomania was "most frequently caused by lascivious reading, by severe restraint and secluded life, by the habit of masturbation, an extreme sensitivity of the uterus, and a skin eruption in the genital organs."[139] Pinel's work formed the beginnings of psychiatry while retaining hysteria's association with female sexuality and

[135] Philippe Pinel quoted in Veith, *Hysteria: The History of a Disease*, 179-180.
[136] Veith, *Hysteria: The History of a Disease*, 182.
[137] Veith, *Hysteria: The History of a Disease*, 179.
[138] Philippe Pinel quoted in Veith, *Hysteria: The History of a Disease*, 179. At this time, a separate diagnosis, satyriasis, described a condition similar to nymphomania in men.
[139] Philippe Pinel quoted in Veith, *Hysteria: The History of a Disease*, 179.

physiology. The nineteenth-century conception of hysteria furthered this complicated and contradictory interaction between mental illness, sexuality, gender, and biology.

The Rise of Scientific Medicine

The seventeenth-century focus on observation and the eighteenth-century emphasis on objectivity and reason helped refine scientific practice, making it more methodological and evidence-based. However, the nineteenth century marked the rise of institutional scientific medicine, beginning in post-revolutionary Paris. Following the French Revolution at the end of the eighteenth century, the French government assumed control over hospitals that were previously under the authority of the Church.[140] The French government transformed medical practice in France, funding scientific research in the interest of progress and opening large, publicly-funded research hospitals.[141] The research conducted in these institutions was focused on pathological anatomy and the quantification of results, which became known as "anatomico-pathological medicine."[142] Hospitals became the centre of this research, allowing physicians to perform scientific experiments on a large scale and providing medical training to thousands of students at a time.[143] Treating patients was no longer the main priority of these physicians; rather, they were focused on discovering biological causes and cures for diseases and advancing scientific knowledge. Autopsies of deceased patients became a major component of medical research, as physicians strived to base theories on careful measurement and standardized methods. Following the scientific revolution, physicians placed less emphasis on patient testimonies and instead focused on physical observation and their faculties of reason. The rest of Europe, Britain, and America soon adopted the French model for medical practice and its institutionalization.

[140] Porter, "Scientific Medicine in the Nineteenth Century," 306.
[141] Porter, "Scientific Medicine in the Nineteenth Century," 305.
[142] Porter, "Scientific Medicine in the Nineteenth Century," 306.
[143] Porter, "Scientific Medicine in the Nineteenth Century," 306.

During the Enlightenment, physicians adopted an objective perspective of the human body and mind and searched for the presumed biological origins of both physical and mental disorders.[144] A considerable portion of medical research conducted in the nineteenth century centred on the nervous system, and neurologists, neuropathologists, and neuropsychiatrists employed similar principles to explain diverse disorders.[145] These physicians attempted to explain previously misunderstood conditions as nervous disorders and took a special interest in hysteria. Neurological conceptions of disease arose from hundreds of years of medical history, yet doctors retained ancient ideas about women and female bodies. The hysteria epidemic of the nineteenth century and the rise of neurasthenia as a related but separate disorder occurred against the backdrop of this tension and within the framework of scientific medicine. The next chapter examines nineteenth-century hysteria in greater depth, accounting for the unique collision of medicine and society during this period.

Conclusion

This chapter provides a brief summary of hysteria's long and complicated history, highlighting the most important developments that led to the hysteria epidemic in the nineteenth century. Understandings of hysteria in the nineteenth century existed within the framework of scientific medicine, which arose from a centuries-long evolution of medical thought. In addition, nineteenth-century hysteria was characterized by deeply entrenched ideas about femininity that pervaded the medical field. The larger historical context reveals that these ideas arose from ancient beliefs about the female body that over time came to define femininity as a whole. The long history of hysteria offers insight into the roots of medical and cultural ideas that created the conditions for hysteria's peak at the end of the nineteenth century.

[144] Chakravarty, "Medicalisation of Mental Disorder," 278.
[145] Chakravarty, "Medicalisation of Mental Disorder," 275.

With this history in mind, the next chapter examines the nineteenth century as an essential moment in the history of hysteria. The remaining three chapters reveal how the underlying assumptions about female bodies and femininity that resurfaced throughout the history of hysteria did not disappear when hysteria was no longer a valid medical diagnosis. Symptoms that are primarily experienced by women continue to be poorly understood and categorized within wastebasket diagnoses. The late nineteenth century was a defining moment in the history of hysteria and a remarkable example of the intersection of medicine and society. However, the disease history leading up to this climax reveals that medicine has always been infused with sexism and that hysteria was defined in terms of long-standing beliefs about womanhood. The ensuing chapters explore the implications of this misogyny in nineteenth-century hysteria and in the diagnoses that arose to replace it.

CHAPTER TWO: NINETEENTH-CENTURY HYSTERIA AND THE RISE OF NEURASTHENIA

In 1818, Jean-Baptiste Louyer-Villermay built on research conducted by François Boissier de Sauvages, William Cullen, and Philippe Pinel to reimagine hysteria as a diagnostic category.[1] Louyer-Villermay's contribution to the *Dictionnaire des sciences médicales* (Dictionary of Medical Sciences) authorized hysteria as a scientific medical diagnosis. Louyer-Villermay included twelve previous medical categories under the single heading of hysteria, such as "hystericie, hystericism, hysteralgie, hysteric passion and hysteric affection, uterine affections, suffocation of the womb, strangulation of the uterus, fits of the mother."[2] For centuries, hysteria had gone through many transformations, but Louyer-Villermay's description of the diagnosis placed all of these existing women's illnesses into one category. However, the diagnosis was not as cohesive as it appeared. Because it encompassed so many different afflictions, nineteenth-century hysteria could not be understood in terms of one explanatory model. Some symptoms of "hysteria" indicated uterine diseases, others pointed to disordered nerves, and still others suggested psychological and emotional problems. Despite searching tirelessly for a single explanation for all of these different symptoms, physicians struggled to successfully unite these symptoms under the heading of hysteria. Hysteria had always been an ambiguous and poorly defined diagnosis, but in the nineteenth century it became more elusive and yet more prevalent than ever before. Hysteria continued to exist as a wastebasket diagnosis for women's unexplained health concerns in spite of advancements in medicine that claimed to explain hysteria in objective, scientific terms. At the same time, the unique social setting of Victorian England and

[1] Sabine Arnaud, *On Hysteria: The Invention of a Medical Category between 1670 and 1820* (Chicago, IL: University of Chicago Press, 2015), 9.
[2] Arnaud, *On Hysteria*, 9.

America caused hysteria to take on a new form, one that was more deeply connected with femininity and, especially, female sexuality than ever before.

Scientific medicine emerged in the post-1800 period out of the long-term influence of the scientific revolution, the advent of germ theory in the eighteenth century,[3] and the general focus on empiricism and reason that characterized the Enlightenment.[4] Public hospitals replaced Church-owned institutions,[5] licenses were required to practice medicine,[6] and doctors began to engage in experimental and laboratory medicine. [7] All forms of illness (including insanity) were increasingly explained by anatomical and physiological processes.[8] Medical explanations of the relationship between body and mind became similarly rooted in scientific principles. Specifically, research on neurology led to many illnesses being framed as nervous diseases, especially those that were not well understood. The nerves were seen as the link between the body and mind and neurology replaced humoral theory and theories about specific organs—especially the uterus—as the primary causes for many poorly understood symptoms.[9] Over the course of the nineteenth century, hysteria was definitively separated from the gynecological model and was increasingly explained by neurology. Neurological discoveries and models of disease greatly influenced the intellectual history of hysteria and led to the creation of new diagnostic entities to describe hysteria symptoms as organic diseases, including spinal irritation and neurasthenia. Later, at the end of the century, a rise in psychological and psychiatric research framed hysteria as primarily a mental disorder.

---

[3] Tina Chakravarty, "Medicalisation of Mental Disorder: Shifting Epistemologies and Beyond," *Sociological Bulletin* 60, no. 2 (August 2011), 273.
[4] Roy Porter, "Scientific Medicine in the Nineteenth Century," in *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: W. W. Norton & Company, 1997), 305.
[5] Porter, "Scientific Medicine in the Nineteenth Century," 306.
[6] Porter, "Scientific Medicine in the Nineteenth Century," 316.
[7] Porter, "Scientific Medicine in the Nineteenth Century," 336.
[8] Chakravarty, "Medicalisation of Mental Disorder," 273-274.
[9] Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York, NY: The Free Press, 1992), 14.

Centuries of medical discoveries and shifting philosophical perspectives created the framework for medical discussions surrounding hysteria in the nineteenth century. In addition, the social atmosphere of Victorian England and America transformed an ancient disease into a novel entity that had become intimately entwined with its cultural setting. Darwin's theory of evolution by natural selection greatly influenced the medical field, but even more so shaped Victorian culture and values. The rise of Evangelical Christianity similarly helped construct social norms and expectations and the processes of industrialization and urbanization upended Victorian society. These social factors coupled with the scientific atmosphere of the nineteenth-century medicine produced a unique form of hysteria that must be understood within its social context. Nineteenth-century hysteria illustrates the ways in which medicine and culture can interact to produce unique forms of disease. Late in the nineteenth century, the rise of neurasthenia represented an attempt to medicalize hysterical symptoms that were increasingly bogged down by cultural assumptions. In addition, nineteenth-century hysteria and then neurasthenia illustrated the repeated process of simplifying women's complaints by placing all unexplained symptoms into an all-encompassing, poorly defined diagnostic category. This gave the illusion of a cohesive disorder but failed to actually explain the illness or acknowledge other factors—including social and medical biases—that may have contributed to symptom development. This chapter identifies and explains specific social factors and their relationship to hysteria before turning to attempts by neurologists to frame hysterical symptoms as a more scientific disease entity through the creation of new diagnostic entities like spinal irritation and neurasthenia. However, as we shall see, even these "biological" disorders could not be separated from the cultural factors that shaped their symptoms and the assumptions that coloured medical perceptions of patients.

Social Change and the Influence of Darwinism

Although capitalism had been in development since the sixteenth century, industrialization facilitated dramatic social changes (such as urbanization and a sharply declining birth rate) that constituted a unique cultural moment.[10] The ongoing effects of colonization also greatly influenced nineteenth-century social norms and values. Colonial relationships particularly impacted American society, which in the nineteenth century was marked by the Civil War and the end of slavery. Both British and American society were shaped by Darwin's revolutionary theory of evolution by natural selection and the social Darwinist ideology that arose from his ideas. The notion of "civilization," especially as the end of a progression from "savagery," informed beliefs about race as well as gender and class. In addition, the rise of the urban middle class altered the family institution and class relations.[11]

As Roy Porter argues, the "fiercely competitive economic world" of the nineteenth century demanded "self-control, self-discipline, and outward conformity."[12] During this period, the idealized version of manhood was defined in relation to these social constraints. The middle class Victorian view of appropriate "manliness" was associated with the characteristics required to thrive within the middle-class lifestyle. The middle-class man was expected to remain grounded in the face of changing economic climates and create a comfortable life for himself and his family by maintaining strict self-restraint.[13] People in the nineteenth century referred to the ideal male identity as "manly"; however, near the end of the century, this popular conception of manhood fell out of favour. The middle-class lifestyle of the nineteenth century became less and less attainable as successive economic depressions

[10] Charles E. Rosenberg, "Sexuality, Class and Role in 19th-Century America," *American Quarterly* 25, no. 2 (May 1973): 152, https://www.jstor.org/stable/2711594.
[11] Carroll Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America* (New York, NY: Oxford University Press, 1985), 199.
[12] Roy Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," in *Hysteria Beyond Freud* (Berkeley and Los Angeles, California: University of California Press, 1993)," 228-229.
[13] Gail Bederman, *Manliness & Civilization: A Cultural History of Gender and Race in the United States, 1880-1917* (Chicago: The University of Chicago Press, 1995), 12.

and a growing economic stage made financial and commercial endeavours more precarious. Men had fewer opportunities to embark on their own business ventures and instead increasingly took entry-level jobs with lower chances of promotion.[14] When self-control no longer led to control over one's life, so-called "masculinity" arose to challenge "manliness" with its emphasis on physical strength and toughness.[15] White, middle-class men constructed a framework for male identity that they perceived as returning to the natural state of manhood. They emphasized biological characteristics that they believed were shared by all men, including survival instincts, toughness, and leadership abilities.[16] Instead of focusing on qualities that distinguished them as white and middle-class, these men now mimicked the existing working-class masculinity based on hard work and physical strength and looked to the "primitive" manhood of men of colour as an indication of inherent masculine traits.[17]

And yet, this picture of manhood was complicated by a Darwinian sense of racial hierarchy. Darwin's theory of evolution by natural selection was extended beyond biological adaptation to explain the existence of diverse human societies. Drawing from Darwin's work, scientists and laypeople believed that human society progressed from a state of "savagery" to "barbarism" to its most perfect form, "civilization." These stages of development were associated with different races, and the white race was thought to be the only demographic that had advanced to the level of civilization. Thus, all other races were seen as inferior in ability, intelligence, and inherent value.[18] In *The Descent of Man* (1871), Darwin framed white superiority as a scientific fact derived from biological evolution. He explained that while "Many savages are in the same condition as when first discovered several centuries

[14] Bederman, *Manliness & Civilization*, 12.
[15] Bederman, *Manliness & Civilization*, 13, 17.
[16] Bederman, *Manliness & Civilization*, 22.
[17] Bederman, *Manliness & Civilization*, 17, 22.
[18] Bederman, *Manliness & Civilization*, 25.

ago," the white race became more advanced by adapting to environmental factors.[19] Specifically, he proposed that "it has often been remarked, that a cool climate from leading to industry and the various arts has been highly favourable, or even indispensable for this end."[20] This notion of "civilization" and the idea that white supremacy was evolutionarily predetermined were used to justify the racial hierarchy in nineteenth century society and race-based violence and injustice.

One incorrect premise was particularly essential to Darwin's suggestion that the white race had advanced more quickly than other races since first contact. During the nineteenth century, biologists' understanding of inheritance was limited: they thought that evolution could occur quickly from one generation to another. According to the Lamarckian model, advancements made within one's lifetime could be passed down to one's offspring.[21] From this idea, biologists and educated members of the public assumed that "primitive races" could not hope to compete with white men because it would take several generations for them to become as "civilized" as the white race.[22]

Followers of Darwin also believed that more evolved white societies included a more pronounced gender hierarchy. White colonizers viewed "savage" men and women as more alike: all non-white people, regardless of gender, were supposedly strong, capable of hard work, emotional, and undisciplined. Both men and women in tribal societies wore skirts and jewellery and yet participated in manual labour and could be "aggressive." Ironically, they suggested that "savage" men were so unable to control their emotions that they frequently raped their women instead of "protecting" them (despite the much more regular phenomenon of white men raping their black female slaves and workers). Conversely, white men were

[19] Charles Darwin, *The Descent of Man, and Selection in Relation to Sex* (Princeton, New Jersey: Princeton University Press, 1981), 166.
[20] Darwin, *The Descent of Man*, 167.
[21] Louise Michele Newman, "Health, Sciences, and Sexualities in Victorian America," in *A Companion to American Women's History*, ed. Nancy A. Hewitt (Hoboken, New Jersey: John Wiley & Sons, Inc., 2002), 207.
[22] Bederman, *Manliness & Civilization*, 29.

intelligent and stoic leaders while white women were fragile, dainty, and submissive. In other words, more equality between the sexes supposedly indicated a less civilized society.[23]

Despite the fact that justifications of racial inequality rested on white women's supposedly more refined state, Darwin also advocated men's superiority over women.[24] In *The Descent of Man*, he used his theory of sexual selection to assert that "man has ultimately become superior to woman" in terms of intellect and disposition.[25] He compared the disparity between men and women to the sexual differences in other species, stating that "No one will dispute the fact that the bull differs in disposition from the cow, the wild-boar from the sow, the stallion from the mare, and, as is well known to the keepers of menageries, the males of the larger apes from the females."[26] As regards *human* men and women, he asserted that "Woman seems to differ from man in mental disposition, chiefly in her greater tenderness and less selfishness."[27] However, he associated these "feminine" features with "the lower races," placing both white women and non-white people below the white man, in "a past and lower state of civilisation."[28]

In terms of mental faculties, he compared historical intellectual contributions of men and women in an attempt to prove that men have achieved

> a higher eminence, in whatever he takes up, than women can attain—whether requiring deep thought, reason, or imagination, or merely the use of the senses and hands. If two lists were made of the most eminent men and women in poetry, painting, sculpture, music,—comprising composition and performance, history, science, and philosophy, with half-a-dozen names under each subject, the two lists would not bear comparison.[29]

The activities Darwin associated with superiority reflected "civilized" Eurocentric and aristocratic values. Although wealthy white men were historically the only demographic to be

[23] Bederman, *Manliness & Civilization*, 25.
[24] Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (Harmondsworth, Middlesex, England: Penguin Books Ltd, 1985), 122.
[25] Darwin, *The Descent of Man*, 328.
[26] Darwin, *The Descent of Man*, 326.
[27] Darwin, *The Descent of Man*, 326.
[28] Darwin, *The Descent of Man*, 327.
[29] Darwin, *The Descent of Man*, 327.

given the opportunity to engage in these activities, Darwin concluded that "if men are capable of decided eminence over women in many subjects, the average standard of mental power in man must be above that of woman."[30] Darwin's concept of civilization remained so central to the dominant nineteenth-century worldview that nothing could truly be separated from race and racism. Even his ideas about gender, which shaped the patriarchal power dynamic in society, were based in the "civilization" discourse. Hysteria emerged as a gendered disease entity within this racist atmosphere.

Women in Victorian Society

Like many aspects of Victorian society, gender roles at the centre of white middle-class society were often contradictory. Again, middle-class values—influenced by Darwin—dominated societal perspectives. The ideal woman was based on a vision of white women as weak and submissive, yet competent and morally virtuous. For much of the century, both men and women were expected to display moral righteousness through self-control. However, men were considered to be fundamentally superior to women in intellect and moral strength. When the new picture of "masculinity" arose toward the end of the century, the new male standard was specifically defined in opposition to traditionally "feminine" characteristics as a reaction against the "effeminate"[31] nineteenth-century "manliness." Men were portrayed as physically strong, dominant, and ambitious. Texts directed towards women and girls such as "children's books, child-rearing manuals, marriage guides, and books of etiquette" dissuaded women from engaging in "masculine" activities like competitive sports or academic pursuits.[32] Instead, women were expected to accommodate and support the men in their lives by being "coquettish, entertaining, non-threatening, and nurturing."[33]

[30] Darwin, *The Descent of Man*, 327.
[31] Bederman, *Manliness & Civilization*, 17.
[32] Smith-Rosenberg, *Disorderly Conduct*, 212.
[33] Smith-Rosenberg, *Disorderly Conduct*, 212.

Motherhood was lauded as the natural destiny of women in Victorian society. Regardless of their diverse interests and talents, all women were expected to marry a man and raise his children.[34] Women were not permitted to pursue their own ambitions and were instead expected to embark on a life of self-sacrifice and service to others, especially men.[35] "Bourgeois matrons" experienced tension between two images of femininity which Smith-Rosenberg calls the True Woman and the Ideal Mother. On one hand, upper- and middle-class white women were expected to be "emotional, dependent, and gentle" followers, while at the same time emulating the "strong, self-reliant, protective" role of the mother.[36] They were simultaneously supposed to display virtue by remaining subordinate to white men and prove their propensity to the essential female experience of motherhood. The typical upbringing and education of these women instilled these conflicting values into young girls in an attempt to produce obedient, submissive wives who were at the same time responsible yet nurturing mothers. From childhood, middle- and upper-class white women were taught to be emotionally sensitive, dependent, and altruistic and were often unprepared for the expectations of marriage and motherhood.[37] In addition to the stress of raising children and the misery of unhappy marriage,[38] these women spent the majority of their time alone, restricted to the domestic sphere.[39]

These contradicting ideas about womanhood go back to the conflict between manliness and masculinity. Toward the end of the nineteenth century, middle- and upper-class white men shifted their perspective and defined manhood according to qualities they

[34] Smith-Rosenberg, *Disorderly Conduct*, 213.
[35] It should be noted that very few people in Victorian society besides the middle- or upper-class white men had the opportunity to pursue their own ambitions.
[36] Smith-Rosenberg, *Disorderly Conduct*, 199.
[37] There have been studies that suggest that girls were more frequently given "love-oriented punishments" while boys received corporal punishments. That is, while boys were physically punished, girls were subjected to guilt trips and threats of abandonment or withdrawal of love from their parents. Many sociologists and social psychologists believe that this form of punishment created anxious, dependent, and self-critical women who were sensitive to real or perceived rejection. See Smith-Rosenberg, *Disorderly Conduct*, 213-214.
[38] Smith-Rosenberg, *Disorderly Conduct*, 215. Smith-Rosenberg also suggests that these factors caused many women to develop hysterical symptoms as a coping mechanism.
[39] Porter, "The Body and the Mind, the Doctor and the Patient," 229.

considered to be shared among all men regardless of race. At the same time, however, they asserted their dominance above non-white men in accordance with Darwin's analysis. Similarly, middle- and upper-class white women were expected to exhibit the characteristics of frailty and passiveness that were used to justify white superiority while simultaneously embodying the innate essence of womanhood that was shared by all women regardless of race: a "primitive" maternal instinct.[40] White women became the icons of white supremacy with their delicate, innocent, and submissive qualities. However, white women's aspirations to be as pure and obedient as possible were in conflict with nearly every aspect of motherhood. Mothers were expected to endure the pain of childbirth with stoicism and grace, even risking death and disease; to nurture, educate, and discipline children; and to remain emotionally strong and stable, even in the face of hardship and tragedy. Silas Weir Mitchell, one of the founders of American neurology, noted in the 1880s that "To most women… there seems to come a time when pain is a grim presence in their lives."[41] Mitchell also highlighted the disparity between how men and women were socialized: boys were taught to conceal emotions and remain stoic while girls learned to cope with distress and pain by crying. Women who received such an education were not given the appropriate tools to handle the lives they were expected to lead and frequently reported feeling lonely and depressed.[42] Many middle- and upper-class white women also suffered from hysteria in the nineteenth century, suggesting a potential connection between their typical lives and incidence of hysterical illness.

With that said, middle-class society set the standard for social values but women from other social classes also experienced these pressures. Many lower-class and farm women internalized the idea that women were valuable only as dutiful wives and mothers. Although this traditional role proved fruitful for some of these women, others fell victim to the same

[40] Smith-Rosenberg, *Disorderly Conduct*, 199.
[41] Silas Weir Mitchell quoted in Smith-Rosenberg, *Disorderly Conduct*, 199.
[42] Smith-Rosenberg, *Disorderly Conduct*, 199.

emotional and psychological difficulties as their middle-class counterparts. Many developed hysterical symptoms or became depressed, although these concerns did not attract nearly as much attention or concern as did the tears of upper-class women.[43]

Sexuality in the Victorian Era

Self-restraint was highly valued in Victorian society, but of all the emotions that people were expected to restrict and conceal, lust was the most essential.[44] Sexual repression became an essential characteristic of Victorian culture. The intense disdain for sexuality occurred largely as a result of the Evangelical Christian religious movement, which originated in Britain and had an increasing influence in the United States in the nineteenth century, following the decline of Puritanism in the eighteenth century.[45] Evangelical Protestants asserted that true Christians and moral people exercised chastity and temperance. As Charles Rosenberg articulates, in the nineteenth century "control was the basic building block of personality" and was essential for self-respect.[46] In men, this manifested as the ideal Christian gentleman, who was stoic, chaste, and self-restraining.[47] However, Evangelicals had higher expectations for women. They believed women were naturally more pious and virtuous and looked to them to set an example for the men in their lives and pass their moral values onto the next generation.[48] Furthermore, women were believed to be naturally less sexually desirous than men and therefore "uniquely suited to be a civilizing force" and temper men's passionate tendencies.[49] Evangelical Christians also credited Christianity with "rais[ing] women from slaves in status to moral and intellectual beings" and maintained that

[43] Smith-Rosenberg, *Disorderly Conduct*, 200.
[44] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 137.
[45] Nancy F. Cott, "Passionlessness: An Interpretation of Victorian Sexual Ideology, 1790-1850," *Signs* 4, no. 2 (Winter 1978): 223, https://www.jstor.org/stable/3173022.
[46] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 137.
[47] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 139.
[48] Cott, "Passionlessness," 225.
[49] Carol Groneman, "Nymphomania: The Historical Construction of Female Sexuality," *Signs* 19, no. 2 (1994): 346, https://www.jstor.org/stable/3174802.

the suppression of female sexuality was a key element in women's advancement.[50] In a way, this view could be empowering for certain women as it celebrated their ability to influence others, their moral superiority, and their "passionlessness" and restraint. This view replaced previous contempt for women rooted in perceptions of them as sexually promiscuous and thus immoral.[51]

The ideal of passionlessness was imposed on women from a scientific perspective as well. Until the nineteenth century, biologists maintained that the female orgasm was necessary for a woman to conceive a child.[52] This belief continued to exist among the lay population into the nineteenth century, causing some women to suppress orgasms as a form of birth control.[53] Women's sexual pleasure was accepted for a utilitarian purpose as a requirement for procreation, but outside of this context, female sexuality was considered taboo. This taboo became more entrenched and was applied to all sexual encounters when orgasms were found to have no function in terms of childbearing.[54] When women were increasingly praised for sexual indifference, sexual intercourse came to be seen as a mere obligation for women to satisfy their husbands.[55] Aristocratic etiquette manuals reinforced the idea that women existed solely to please men.[56] On the other hand, women may have repressed sexual pleasure to avoid being seen as less morally virtuous and therefore less valuable.[57]

In keeping with the Christian insistence on abstinence outside of marriage and the view that married women engaged in sex primarily in service of their husbands, certain demographics of women were especially targeted in the policing of women's sexuality. Sexual desire was particularly stigmatized for unmarried women—"adolescent girls,

[50] Cott, "Passionlessness," 227.
[51] Cott, "Passionlessness," 228.
[52] Porter, "The Body and the Mind, the Doctor and the Patient," 250.
[53] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 138-139.
[54] Porter, "The Body and the Mind, the Doctor and the Patient," 251.
[55] Newman, "Health, Sciences, and Sexualities in Victorian America," 207.
[56] Cott, "Passionlessness," 224.
[57] Newman, "Health, Sciences, and Sexualities in Victorian America," 211.

spinsters, and widows."[58] However, within the constraints of marriage, menopausal women were denounced for erotic arousal, and their husbands were advised to not indulge their lust.[59] Women's sexual desire and pleasure were pathologized in the nineteenth century, especially for these populations. Women who exhibited "excessive" sexuality were frequently diagnosed with nymphomania.[60] Hysteria also became increasingly linked to eroticism—hysteria symptoms were often attributed to either sexual indulgence or repression.[61] Women were expected to maintain a delicate balance between sexual enjoyment and indifference. They had to engage in sexual relations with their husbands with the appropriate amount of enthusiasm that would satisfy him and prevent him from seeking sexual gratification elsewhere, but would not display so much pleasure to cause him to worry about her own potential infidelity or illness.[62]

Attempts to impose chastity on both women and men increased over the course of the nineteenth century and led to a fixation on masturbation.[63] Masturbation was condemned both as a display of excessive sexuality and as a waste of energy. At the time, scientists believed that individuals possessed a finite amount of nervous energy and this energy ought to be spent wisely. Women, as the "weaker" gender, were especially encouraged to preserve their energy and channel it into important duties such as nurturing children during and after pregnancy.[64] The "draining" effects of masturbation[65] were believed to negatively affect men's intelligence and strength, causing men to exhibit more feminine, and especially "hysterical," traits.[66]

---

[58] Porter, "The Body and the Mind, the Doctor and the Patient," 251.
[59] Showalter, *The Female Malady*, 75.
[60] Groneman, "Nymphomania: The Historical Construction of Female Sexuality," 340.
[61] Porter, "The Body and the Mind, the Doctor and the Patient," 251.
[62] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 139.
[63] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 134.
[64] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 147.
[65] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 135.
[66] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 145-146.

Excessive sexuality was pathologized for both men and women in the separate but related disorders of satyriasis and nymphomania. However, women were more likely to be diagnosed with nymphomania or hysteria and both of these "female" disorders were considered more common, serious, and difficult to treat than satyriasis.[67] One of the more harrowing treatments for mental symptoms that supposedly arose from hypersexuality was Dr. Isaac Baker Brown's clitoridectomy, or surgical removal of the clitoris.[68] This procedure was intended to prevent masturbation and erotic arousal and reduce women's sexual organs to their presumed purpose: reproduction.[69] As these ideas about sexuality became more entrenched over the course of the century, the definition of hypersexuality expanded and women were diagnosed with nymphomania or hysteria for levels of sexual desire that would now be considered normal.[70]

Race and class also factored into perspectives on sexuality and its pathologization. Hypersexuality was associated with both non-white and lower-class women. Declining birth rates among white women in the nineteenth century were explained by the notion of "overcivilization"—the idea that societies regressed after moving beyond the point of civilization. "Overcivilized" women were seen as "unwilling or incapable of bearing many (or any) children."[71] Conversely, '"savage" women gave birth easily and often, and were hypersexual.'[72] White women were criticized for not being fertile or sexual enough as it potentially removed them from womanhood and was seen as inhibiting the proliferation and advancement of the white race. The constructed dichotomy of the "passionate Lady" and the "sexual Slave" was also used to blame black women for "seducing" the white men who

[67] Groneman, "Nymphomania: The Historical Construction of Female Sexuality," 351.
[68] Showalter, *The Female Malady*, 75.
[69] Showalter, *The Female Malady*, 77.
[70] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 139.
[71] Laura Briggs, "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology," *American Quarterly* 52, no. 2 (June 2000): 249, https://www.jstor.org/stable/30041838.
[72] Briggs, "The Race of Hysteria," 249.

regularly sexually assaulted them.[73] Racialized women were depicted as naturally promiscuous and sexually desirous in contrast to the image of the chaste white woman in order to reinforce the social structure of white dominance over non-white races and white male dominance over white women.[74]

Hypersexuality was also seen as a quintessential trait of lower-class people and part of the reason for their impoverished state. This idea was used to justify ongoing economic inequality as a result of "chronic moral decay."[75] Some doctors reported hysteria among poor women, especially prostitutes and those living in tenement houses, and attributed these symptoms to their "characteristic" sensuality.[76] Some lower-class women used sexual restraint to gain more control over their lives. Women faced greater consequences in sexual encounters with men, especially outside of marriage. They could become pregnant, suffer disease with limited access to medical care, and were more likely to be punished while men could walk away with little to no impact on their lives. Marriage would also place greater constraints on a woman's freedom than her husband's. Refraining from sexual relations could allow a woman to preserve or improve her reputation and access opportunities as a result.[77] In addition, adopting the characteristics of an ideal Christian woman, lower- and lower-middle class women could endeavour to improve their image and circumstances and obtain social security.[78]

The Significance of Reproduction

The characteristic Victorian disdain for female sexuality extended beyond Christian virtues—it was rooted in the existing medical knowledge and assumptions about the female

[73] Newman, "Health, Sciences, and Sexualities in Victorian America," 214.
[74] Newman, "Health, Sciences, and Sexualities in Victorian America," 214.
[75] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 144.
[76] Smith-Rosenberg, *Disorderly Conduct*, 207.
[77] Cott, "Passionlessness," 233.
[78] Rosenberg, "Sexuality, Class and Role in 19th-Century America," 149.

body, specifically the reproductive system. Beginning in ancient Greece, the female reproductive system was viewed as "an inferior, imperfect inversion of the male."[79] Despite centuries of research on the female body, ancient ideas about the power of women's reproductive organs experienced a resurgence during the nineteenth century. However, nineteenth-century medical theory focused on the ovaries as negatively impacting women's judgment.[80] According to Porter, in the nineteenth century, the female reproductive system was seen as beyond "inferior" or "imperfect"—women's bodies were seen as something completely separate, "other," "bizarre."[81] Theories about female anatomy were used to reinforce gender roles and stereotypes[82] as, in Porter's words, "Womb became a synecdoche for woman."[83]

Motherhood was in many ways the essence of what it meant to be a woman in nineteenth-century Anglo-American society. In the same vein, women's lives were defined by their reproductive potential. A woman's life was divided into the stages of pre-puberty, puberty, reproductive age, menopause and postmenopause. The phases were differentiated from each other by changes in menstruation and fertility over the life course and were each associated with specific illnesses. Puberty and menopause were seen as crucial turning points in a woman's life and were the subject of medical and social discourse.[84] While for men puberty was seen to bring "strength, vigor, and muscular development," women were overcome with 'increased bodily weakness, a newfound and biologically rooted timidity and modesty, and the "illness" of menstruation.'[85] In 1879, prominent British psychiatrist Henry Maudsley (1835-1918) remarked that "Girls are more liable to suffer at this period [(puberty)], I think, than youths; and it is not difficult to understand why. In the first place,

[79] Porter, "The Body and the Mind, the Doctor and the Patient," 250.
[80] Smith-Rosenberg, *Disorderly Conduct*, 184.
[81] Porter, "The Body and the Mind, the Doctor and the Patient," 250.
[82] Smith-Rosenberg, *Disorderly Conduct*, 185.
[83] Porter, "The Body and the Mind, the Doctor and the Patient," 250.
[84] Smith-Rosenberg, *Disorderly Conduct*, 183.
[85] Smith-Rosenberg, *Disorderly Conduct*, 186.

the affective life is more developed in proportion to the intellect in the female than in the male sex, and the influence of the reproductive organs upon the mind more powerful."[86] British psychiatrist Charles Mercier (1851-1919) agreed with Maudsley, writing in 1895 that "the access if puberty in woman is a period of far greater strain, of more tumultuous revolution, of more enhanced liability to disorder, than in man."[87] He further asserted that "The access of puberty is… in all women a time of danger… at this period, more or less decided manifestations of hysteria are the rule. The girls who fail to exhibit some hysterical symptom at puberty are few indeed."[88] After puberty, women were seen as constantly ill, at the mercy of their reproductive systems. Menstruation made women "delicate," "passive," and "ill-equipped for the rough and tumble, competitive public world of work and politics."[89] It was the source of the qualities that made women inherently subordinate to men. Men, on the other hand, were seen as in control of their bodies and minds—at no point did men fall victim to their internal organs the way women did each month.[90]

Scientific advancements between 1840 and 1890 shaped perspectives on the female body and its relationship to femininity. During this period, the ovaries became central to beliefs about women's bodies and were seen as evidence of women's inferiority. In 1880, physician William Pepper remarked that "Ovulation fixes woman's place in the animal economy… With the act of menstruation is wound up the whole essential character of her system."[91] Doctors believed that between puberty and menopause, the ovaries took control of a woman's life, dictating her physical and emotional interactions with her environment.[92] British physician Edward Tilt (1815-1893) even encouraged mothers to delay their daughters' menstruation by keeping their daughters in the nursery for as long as possible; avoiding

[86] Henry Maudsley, *The Pathology of Mind* (New York: D. Appleton and Company, 1890), 450.
[87] Charles Mercier, *Sanity and Insanity* (London: Walter Scott, Ltd., 1895), 213.
[88] Mercier, *Sanity and Insanity*, 213.
[89] Groneman, "Nymphomania: The Historical Construction of Female Sexuality," 345-346.
[90] Smith-Rosenberg, *Disorderly Conduct*, 183.
[91] William Pepper quoted in Smith-Rosenberg, *Disorderly Conduct*, 184.
[92] Smith-Rosenberg, *Disorderly Conduct*, 184.

feather beds, novels, and meat; and encouraging them to bathe in cold water and wear drawers.[93]

Puberty and menopause were seen as periods of dramatic change in a woman's life when health problems could easily arise. Ill health during puberty or menopause was often attributed to decreased energy levels in the face of physical transformation. Doctors advised adolescent girls to refrain from overwork, especially intellectual pursuits, which they believed may prevent the reproductive organs from maturing normally and potentially cause infertility.[94] Doctors also discouraged "unfeminine" activities such as physical labour, volunteering, or any work outside of domestic duties and "promiscuous" behaviour like flirting or attending parties or dances.[95] Instead, young women were told to direct their energy solely toward proper reproductive development, a task that involved repressing strong emotions, spending time outside, exercising moderately, avoiding stimulating substances or foods, getting plenty of rest, and participating in domestic duties.[96] Doctors instructed women to follow a similar routine during menopause, characterized by "a regimen of quiet, avoidance of mental activities, the shunning of new activities and a commitment to domesticity."[97]

Menstruation was associated with emotionality in women and menstrual dysfunction was often believed to cause hysteria and other forms of insanity. In the eyes of nineteenth-century doctors, women's natural bodily processes predisposed them to disease.[98] Irish Victorian physician Thomas More-Madden (1838-1902) claimed in 1884 that disordered menstruation or hormonal changes were "almost invariably attended with some manifestation of hysteria" wherein the uterus would redistribute symptoms to "the sympathetic and

[93] Showalter, *The Female Malady*, 75.
[94] Newman, "Health, Sciences, and Sexualities in Victorian America," 207.
[95] Smith-Rosenberg, *Disorderly Conduct*, 187.
[96] Smith-Rosenberg, *Disorderly Conduct*, 187.
[97] Smith-Rosenberg, *Disorderly Conduct*, 193.
[98] Smith-Rosenberg, *Disorderly Conduct*, 206.

vasomotor systems, in the guise of nearly every physical complaint and mental disorder."[99]

He continued,

> The functional connexion between the cerebro-nervous and reproductive systems is illustrated in nearly all chronic uterine and ovarian diseases. The most common of these—namely, chronic endometritis and cervicitis, are usually attended with hysteria. In such cases the general constitution soon sympathises with the local disorder… as the local disease progresses, the mental health begins to suffer as much as the bodily condition. She now becomes nervous, despondent, anxious, excitable, or irritable to the verge of insanity. In other words, hysteria inevitably follows chronic uterine disease.[100]

Hysteria could arise from reproductive dysfunctions, but the disorder was also closely tied to sexuality. Henry Maudsley wrote in 1870, "Outbursts of temper become almost outbreaks of mania, particularly at the menstrual periods. An erotic tinge may be observable in her manner of behaviour; and occasionally there are quasi-ecstatic or cataleptic states."[101] He maintained that these symptoms were "the effect of some condition of the reproductive organs on the brain"[102] and blamed both hysteria and nymphomania on "the irritation of the ovaries or uterus."[103] A patient experiencing hysterical symptoms such as paralysis coupled with inappropriate levels of sexual desire or activity could be diagnosed as either "a nymphomaniac subject to hysterical attacks" or alternatively "a hysteric with nymphomaniacal manifestations."[104] In both cases, Maudsley attributed a wide range of mental and physical symptoms to women's reproductive organs and connected them to sexuality.

Mental Illness as a "Female Malady"

[99] Thomas More-Madden, *On Insanity and Nervous Disorders Peculiar to Women, in Some of Their Medical and Medico-Legal Aspects* (Dublin: Fannin and Co., 1884), 8.
[100] More-Madden, *On Insanity and Nervous Disorders Peculiar to Women*, 9.
[101] Henry Maudsley, *Body and Mind: An Inquiry into Their Connection and Mutual Influence, Specially in Reference to Mental Disorders* (London: MacMillan and Co., 1870), 79-80.
[102] Henry Maudsley quoted in Porter, "The Body and the Mind, the Doctor and the Patient," 254.
[103] Maudsley, *Body and Mind*, 82.
[104] Groneman, "Nymphomania: The Historical Construction of Female Sexuality," 340.

Nineteenth-century beliefs about men and women coloured the ways in which women's illnesses, particularly mental illnesses, were understood and treated. Like most other aspects of women's lives, their mental health was connected to sexuality and reproduction. During the first half of the nineteenth century, understandings of mental illness and the treatment of psychiatric patients changed. Until mid-century, asylum populations were predominantly male. However, after 1850, women were more frequently institutionalized. At the same time, while female proprietors of mental institutions were common before the 1850s, they were gradually replaced by men as male doctors who began to insist that mental illness was a disease and that only they were qualified to treat mental patients through "moral management." Male doctors solidified their authority over psychiatric patients through several legislative reforms until "lunatic asylums [were] increasingly populated by women but supervised by men."[105] As a result, male physicians held power over an increasingly female patient population.[106]

Elaine Showalter has proposed that "madness" is an example of what she calls a "female malady."[107] In her view, there have been two approaches to understanding female insanity throughout history. On one hand, madness was seen as the evilness within women; on the other hand, madness was an intrinsic aspect of femininity, a way to differentiate women from the superior masculine sensibility. The hysteria epidemic in the nineteenth century meant that mental patients were predominantly female, but in Showalter's view the very idea of insanity was feminized.[108] The traditional dualistic perception of men and women attributes traits like "irrationality, silence, nature, and body" to women and "reason, discourse, culture, and mind" to men.[109] These dichotomies separate men from women, but also call to mind the divisions between right and wrong, good and bad, and illness and health.

[105] Showalter, *The Female Malady*, 52-54.
[106] Showalter, *The Female Malady*, 54.
[107] Showalter, *The Female Malady*, 3.
[108] Showalter, *The Female Malady*, 3-4.
[109] Showalter, *The Female Malady*, 3-4.

It is because of this patriarchal understanding of masculinity and femininity that symptoms of mental illness so closely align with traditional understandings of femininity. "Madness," therefore, is in itself a "female malady."[110] Showalter suggests that through exerting control over female patients, male physicians believed they had confirmed the long-standing belief that "women were more vulnerable to insanity than men because the instability of their reproductive systems interfered with their sexual, emotional, and rational control."[111] Smith-Rosenberg substantiates this point, highlighting the fact that many doctors "treated" their patients through punishments such as suffocation, beatings, icy showers, and public humiliation.[112] Doctors frequently viewed the hysteria patient as a weak, inferior "child-woman" and were alternately protective and abusive.[113]

Darwin's influence during this period added to the notion of mental illness as inherently feminine. Psychiatrists applied Darwin's ideas to their own work and claimed that insanity "represented an evolutionary reversal, a regression to a lower nature."[114] These physicians believed that mental illness was inheritable and that insanity indicated that patients were not genetically "fit."[115] A subset of Darwinian psychiatrists sought to apply eugenics to insanity through population control.[116] Darwinian psychiatrists generally viewed insanity as a combination of hereditary and environmental factors: women were naturally vulnerable to mental illness, some people were predisposed to insanity due to genetic factors, and the environment of Victorian society exacerbated these tendencies.[117] They also maintained that puberty was often a precipitating cause of insanity in women.[118]

[110] Showalter, *The Female Malady*, 4.
[111] Showalter, *The Female Malady*, 55.
[112] Smith-Rosenberg, *Disorderly Conduct*, 211.
[113] Smith-Rosenberg, *Disorderly Conduct*, 212.
[114] Showalter, *The Female Malady*, 106.
[115] Showalter, *The Female Malady*, 104.
[116] Showalter, *The Female Malady*, 110.
[117] Showalter, *The Female Malady*, 18.
[118] Showalter, *The Female Malady*, 130.

Hysteria as a Decidedly Sexual "Female Malady"

In keeping with Showalter's notion of madness as a female malady, Smith-Rosenberg argues that hysteria in the nineteenth was a "stark caricature" of femininity.[119] Porter adds that "gynecology and psychophysiology thus joined forces to make female sexuality problematic, highlighting the role of the sexual organs in provoking hysterical conditions widely believed to precipitate moral insanity."[120] In the nineteenth century, female attributes and experiences—their sexuality, reproductive systems, and socialization in Victorian society—were medicalized in hysteria.

The explosion of hysteria and "nervous" illnesses at the end of the nineteenth century corresponded with women's fights for social and political autonomy.[121] In the second half of the nineteenth century, middle-class women began to fight for better access to education, contemplate political issues, and enter the workforce. They placed less emphasis on marriage and childbearing, often delaying or not participating in these social expectations.[122] Declining birth rates, especially in the white upper- and middle-class population, were linked to women choosing to have fewer children, partake in birth control methods and abortions, and pursue education to further their independence. Many physicians and wealthy men viewed these changes as a threat to the Caucasian race and frequently classified these problematic women as insane or hysterical.[123] The hysteria diagnosis was therefore used to uphold the patriarchal power structure by discrediting women who did not conform to white male ideals. Male doctors especially targeted white women who avoided their duty to continue the white race and those who failed to live up to the contradictory expectations of self-restraint, moral virtue, and fertility. In this sense, hysteria was a prime example of a "female malady," constructed in relation to femininity to maintain the social order. The more women failed to

[119] Smith-Rosenberg, *Disorderly Conduct*, 207.
[120] Porter, "The Body and the Mind, the Doctor and the Patient," 251.
[121] Showalter, *The Female Malady*, 18.
[122] Groneman, "Nymphomania: The Historical Construction of Female Sexuality," 341.
[123] Briggs, "The Race of Hysteria," 250.

adhere to social guidelines, the more the medical field was able to justify its authority over female patients.[124] Alternatively, nineteenth-century hysteria could be read as the result of higher stress levels, especially among women, during a period of immense social change and a culmination of decades of patriarchal oppression. Both of these models interpret hysteria as a female disorder, primarily diagnosed in women and defined in relation to femininity and female sexuality.

The hysteria diagnosis targeted symptoms that occurred most commonly in women and were perceived as feminine in nature.[125] For example, dramatic fits were seen as emotional outbursts that no "rational" creature would partake in. Rapid changes in emotion, mood, and activity also upheld long-standing notions that women were changeable, unstable, and unfit to participate in public life beyond the home.[126] Showalter argues that hysterical women in the nineteenth century were seen as, among other things, attention-seeking, dramatic, manipulative, selfish, and immoral. She notes that hysteria took women away from their maternal and domestic duties, placing them in a position where they had to be cared for instead of caring for others. Women's attempts to draw attention to their needs instead of spending their lives in the service of others were met with disdain, especially from medical doctors.[127]

Many physicians were concerned for their patients' health and committed to helping them, yet simultaneously held misogynistic beliefs. According to Smith-Rosenberg, doctors may have felt conflicted over their responsibility to validate and treat their patients and their reluctance to indulge their habits, especially if the patient's male family members opposed the treatment plan.[128] In addition, many physicians, such as Henry Maudsley, Charles

[124] Porter, "The Body and the Mind, the Doctor and the Patient," 248.
[125] Showalter, *The Female Malady*, 129.
[126] Showalter, *The Female Malady*, 129.
[127] Showalter, *The Female Malady*, 133.
[128] Showalter, *The Female Malady*, 133.

Mercier, and Robert Brudenell Carter (1828-1918), believed that the emotional repression expected of women was another common cause of hysteria.[129]

Henry Maudsley contended that restrictions on women's sexuality, activity, and freedom were detrimental to their mental states. He also related these issues back to the "illness" of menstruation.[130] In 1879, Maudsley wrote that

> the range of activity of women is so limited, and their available paths of work in life so few… that they have not… vicarious outlets for feelings in a variety of healthy aims and pursuits… social feelings sanction tacitly for the one sex an illicit indulgence which is utterly forbidden to the other; and… the function of menstruation… brings with it periodical disturbances of the mental tone which border closely on disease in some cases, while the irregularities and suppressing to which it is liable from a variety of mental and bodily causes may affect the mind seriously at any time.[131]

Charles Mercier also observed that hysteria patients, "Unlike their brothers… do not have not those copious and multitudinous channels of outlet for their general activities, which, if freely utilized, draft off such large quantities of activity, lower the nervous tension generally, and so not only diminish the sexual craving, but provide a safety valve for the escape if nervous energy and obviate the likelihood of a dangerous accumulation."[132] In Mercier's estimation, women were prevented from expending energy in a healthy manner. Without an outlet for this "nervous energy," women were forced to repress their inclinations until they presented themselves in hysterical outbursts.

In 1852, British physician Robert Brudenell Carter pointed to a combination of innate and socially determined qualities that he believed made women more vulnerable to hysterical attacks:

> If the relative power of emotion against the sexes be compared in the present day, even without including the erotic passion, it is seen to be considerably greater in the woman than in the man, partly from that natural conformation which causes the

[129] Showalter, *The Female Malady*, 130-132.
[130] Smith-Rosenberg, *Disorderly Conduct*, 186.
[131] Maudsley, *The Pathology of Mind*, 450.
[132] Mercier, *Sanity and Insanity*, 212.

> former to feel, under the circumstances where the latter thinks; and partly because the woman is more often under the necessity of endeavouring to conceal her feelings.[133]

Turning his attention to the role of sexuality, Carter continued, "But when sexual desire is taken into the account, it will add immensely to the forces bearing upon the female, who is often much under its dominion; and who, if unmarried and chaste, is compelled to restrain every manifestation of its sway."[134] As this quotation reveals, doctors in the nineteenth century attributed hysteria to a range of potential causes and many of the theories about these causes appear contradictory. Women were apparently naturally susceptible to hysteria based on their inherent disposition, yet at the same time Carter noted the role of the external social pressure to suppress emotions—especially sexual desire—in producing hysterical symptoms.

However, rather than addressing the social issues that they believed caused hysteria, these physicians advised women to stop pursuing change and resume their proper duties in order to preserve their health. Thomas More-Madden argued that women were naturally better suited to domestic duties and should not trouble themselves with academic pursuits.[135] He denounced "the illdirected tendencies of female education in those cases in which it is sought to force woman's intellect into channels and pursuits which nature has obviously intended for the opposite sex."[136] Mitchell similarly expressed concern about the prevalence of hysteria cases in women's colleges. He advocated that

> The general sense—shall I say the prejudices—of such groups of women is opposed to conceding the belief held by physicians that there are in the physiological life of women disqualifications for continuous labor of mind. Public sentiment is in women's colleges against this belief, and acts as a constant goad for women at times unfit to use their brains.[137]

Mitchell's language clearly displays his disdain for women's education, yet he framed his disapproval as a medical interest. Although these physicians recognized the role that societal

---

[133] Robert Brudenell Carter, *On the Pathology and Treatment of Hysteria* (London: John Churchill, 1853), 33.
[134] Carter, *On the Pathology and Treatment of Hysteria*, 33.
[135] More-Madden, *On Insanity and Nervous Disorders Peculiar to Women*, 20.
[136] More-Madden, *On Insanity and Nervous Disorders Peculiar to Women*, 20.
[137] S. Weir Mitchell, *Lectures on Diseases of the Nervous System Especially in Women*, 2nd ed. (London: J. & A. Churchill, 1885), 15.

limitations played in making women ill, they concluded that the appropriate solution was for women to not fight back against these constraints. Rather, they suggested that women further refrain from anything outside of their prescribed social duties of motherhood and childbearing.

Carter's theory of repression, outlined in his 1853 book, *On the Pathology and Treatment of Hysteria*, became a dominant interpretation of hysteria. For Carter, hysteria was brought on by a combination of the patient's natural temperament, an event or circumstance to trigger hysterical attacks, and the individual's tendency to repress emotional responses.[138] Carter argued that hysteria resulted from a combination of internal and environmental factors. His theory combined traditional beliefs about women, the effects of Victorian society, the role of sexuality, and scientific theory.[139] Carter explained that

> when, in a desperate effort to avoid the external manifestations of feeling, these outlets are wilfully closed; the imprisoned power is driven to seek another opening, and probably discovers one in a part of the system which is usually exempt from emotional influences, but which, under such circumstances, receives their entire shock, and suffers from its consequences in the highest degree.[140]

Carter insisted that strong emotions must be released through some physical expression—for example, through tears, laughter, or fits of rage—but women in Victorian society were more frequently forced to repress their feelings instead of giving them a healthy outlet.[141] For Carter, the higher levels of emotional sensitivity in women also partially accounted for the fact that women were more prone to hysteria than men.[142] Carter emphasized sexual desire as one of the most important emotions and the fact that women were often restricted from engaging in erotic activity and achieving orgasm made them more susceptible to hysterical attacks.[143]

---

[138] Veith, *Hysteria: The History of a Disease*, 201.
[139] Porter, "The Body and the Mind, the Doctor and the Patient," 264.
[140] Carter, *On the Pathology and Treatment of Hysteria*, 18.
[141] Porter, "The Body and the Mind, the Doctor and the Patient," 262.
[142] Veith, *Hysteria: The History of a Disease*, 201.
[143] Porter, "The Body and the Mind, the Doctor and the Patient," 262.

In 1873, Mitchell proposed the "rest cure," which became one of the primary treatments for hysteria. The rest cure involved removing the patient from her immediate surroundings to recuperate in a secluded environment. Patients were advised to avoid expending energy, even in the form of movement, and were often simultaneously treated with massage, electricity, and dietary changes.[144] Although patients were sometimes isolated, some physicians also took patients into their own homes to treat them directly. In this arrangement, doctors intentionally ignored the patients' attempts to garner attention and rewarded positive social behaviour.[145] Mitchell insisted that "once [you] separate the patient from the moral and physical surroundings which have become part of her life of sickness, and you will have made a change which will be in itself beneficial, and will enormously aid in the treatment which is to follow."[146] Carter shared this position, but prescribed "moral treatment" in the form of talk therapy in addition to physical distance from the patient's surrounding environment. Carter's "moral treatment" resembled modern-day psychotherapy and provided an alternative to physical therapies.[147] Through moral treatment, Carter hoped to uncover the repressed emotions that he believed caused—or at least contributed to—hysterical outbreaks.[148]

During the nineteenth century, doctors treated patients differently depending on the patient's position in society.[149] Doctors frequently offered different diagnoses and treatments to men and women, and to upper- and lower-class patients. For example, psychiatrists were less likely to diagnose their wealthy patients as "mad," often preferring to use more palatable terms like "nervous collapse."[150] In addition, the nature of hysteria in particular was predicated on social inequality. First, hysteria was considered by many physicians and writers

[144] Showalter, *The Female Malady*, 138.
[145] Porter, "The Body and the Mind, the Doctor and the Patient," 264.
[146] Silas Weir Mitchell quoted in Veith, *Hysteria*, 216.
[147] Veith, *Hysteria*, 205.
[148] Veith, *Hysteria*, 206.
[149] Janet Oppenheim, *"Shattered Nerves": Doctors, Patients, and Depression in Victorian England* (New York, Oxford: Oxford University Press, 1991), 9.
[150] Oppenheim, "*Shattered Nerves*," 10.

to be a symptom of "overcivilization," a term that arose from Darwinian theories about human social evolution. "Overcivilization" implied a decline in Western society after it had become too civilized.[151] Proponents of this theory contended that the high incidence of infertility and sexual dysfunction as well as declining birth rates among white women signalled that they had strayed too far from the contrasting depiction of "savage" women as hypersexual and fertile. Hysteria was seen as an indication that the white race had advanced to the point where its civilization and superiority was damaging.[152]

Physicians had long believed hysteria to be a disease of affluent white women. Beginning in the seventeenth century, prominent doctors like Thomas Willis and Thomas Sydenham believed that the upper classes were more susceptible to hysteria due to their weakness, indulgence in lavish activities and a sedentary lifestyle that reduced physical activity.[153] Sydenham in particular separated out upper-class women, expressing that all women were particularly susceptible to hysteria "except those who lead a hard and hardy life."[154] Despite the narrative that hysteria was characteristic of middle- and upper-class women, lower-class women also frequently suffered from hysteria, especially in the nineteenth century.[155] As Smith-Rosenberg points out, Victorian physicians attributed hysterical symptoms to supposed defects in both upper and lower classes. She notes that "except when called upon to provide a hypothetical organic etiology, physicians saw hysteria as caused either by the indolent, vapid, and unconstructive life of the fashionable middle- and upper-class woman, or by the ignorant, exhausting, and sensual life of the lower- or working-class woman."[156]

[151] Briggs, "The Race of Hysteria," 246.
[152] Briggs, "The Race of Hysteria," 249.
[153] Micale, *Approaching Hysteria*, 154.
[154] Thomas Sydenham quoted in Micale, *Approaching Hysteria*, 155.
[155] Smith-Rosenberg, *Disorderly Conduct*, 200.
[156] Smith-Rosenberg, *Disorderly Conduct*, 204-205.

Although upper- and lower-class lifestyles were drastically different, both groups of women displayed traits that did not conform to the narrow range of feminine experiences and characteristics that was deemed acceptable in society. Poor women were judged to be overly sexual, resembling the racist depiction of black and other non-white women. Upper-class women exhibited the opposite tendency: their weakness and infertility also deviated from this contradictory and seemingly unattainable female ideal. Despite the similar disdain for and medicalization of these women's distress, many physicians continued to associate hysteria with the archetypal prudish, middle- or upper-class urban white woman of childbearing age. Young, well-off white women were more likely to be diagnosed with hysteria than any other group, and the iconic image of the hysterical woman in popular culture is modelled after this subset of hysteria patients. However, the fact that this group of women received more attention from doctors and from the media does not mean that they were the only people to experience hysteria.[157]

Hysteria and Neurology

The ideas about hysteria discussed thus far have centred on cultural factors, particularly societal perspectives on women. However, the story of hysteria in the nineteenth century is complicated by the prevalence of scientific medicine. Nineteenth-century medicine centred on the concept of naturalism: the idea that all true diseases had an objective, scientific explanation.[158] Progress in neurological research over the course of the nineteenth century meant that many doctors framed hysteria as a neurological disorder stemming from a biological abnormality. According to contemporary philosopher Kevin Aho, naturalism relies on two assumptions: the "epistemological assumption" that detached, objective research

[157] Smith-Rosenberg, *Disorderly Conduct*, 200.
[158] Rafaela Teixeira Zorzanelli, "Fatigue and Its Disturbances: Conditions of Possibility and the Rise and Fall of Twentieth-Century Neurasthenia," *História, Ciências, Saúde-Manguinhos* 16, no. 3 (2009): 610, http://www.scielo.br/scielo.php?script=sci_abstract&pid=S0104-59702009000300002&lng=en&nrm=iso&tlng=en.

would lead to the most accurate, scientific understanding of the body and the "metaphysical assumption" that through this scientific research, all bodily interactions could be understood in terms of empiricism and mathematics.[159] In order for a disease to be considered "real," it had to be related to an observable organic dysfunction and a scientific explanation for symptoms.[160] Nervous diseases were divided into two distinct categories as a result: those with demonstrable structural lesions (such as neurosyphilis and multiple sclerosis) and those for which no organic cause could be found (such as epilepsy, hysteria, and hypochondriasis). Diseases in the latter category were presumed to result from an undiscovered "functional" lesion.[161] Physicians believed that functional lesions could occur in response to the environment, allowing for the role of social factors in disease production.[162]

Many psychiatrists, influenced by both Darwinism and naturalism, framed mental disorders as organic diseases. In "Treatise on Insanity, Its Classification, Diagnosis and Treatment," (1883) American neurologist Edward Charles Spitzka (1852-1913) defined insanity as "a term applied to certain results of brain disease and brain defect which invalidate mental integrity."[163] According to Spitzka, "It is inaccurate to state that insanity is itself a disease. It is, strictly speaking, merely a symptom which may be due to many different morbid conditions, having this one feature in common: that they involve the organ of the mind."[164] However, physicians struggled to fit mental disorders into the scientific model that would validate psychological symptoms as medical concerns. Spitzka admitted that "in the present state of our knowledge, it is impossible to frame a definition of insanity

[159] Kevin Aho, "Neurasthenia Revisited: On Medically Unexplained Syndromes and the Value of Hermeneutic Medicine," *Journal of Applied Hermeneutics* (April 9, 2018), 3.
[160] Aho, "Neurasthenia Revisited," 3.
[161] Shorter, *From Paralysis to Fatigue*, 215.
[162] Zorzanelli, "Fatigue and Its Disturbances," 611.
[163] E. C. Spitzka, *Insanity: Its Classification, Diagnosis and Treatment* (New York: Bermingham & Co., 1883), 17.
[164] Spitzka, *Insanity: Its Classification, Diagnosis and Treatment*, 17.

which, while it meets the practical every-day requirements, is constructed on *scientific* principles."[165]

Alternatively, historian Edward Shorter has discussed the role of "somatization" in hysteria. In his view, hysteria is an example of a psychosomatic illness: a disorder that is caused by internal conflict but presents physically, imitating symptoms deemed medically legitimate.[166] Shorter suggests that the list of acceptable symptoms varies across cultural contexts where conceptions of disease are influenced by social factors and available medical knowledge.[167] He calls the set of symptoms tied to a given social climate the "symptom pool."[168] Historian Roy Porter argues that the socially unacceptable but justified responses of anger and resentment were often "rerouted" into a "legitimate" cause for concern: physical illness.[169] In the case of hysteria, many historians share the retrospective belief that hysterical women were attempting to "opt out" of their undesirable situations by being sick.[170]

In his research on hysteria, nineteenth century physician Robert Carter described three distinct forms of hysteria. The primary attack was the initial seizure or paroxysm that may or may not be repeated; any attacks that followed the initial hysterical incident were classified as secondary hysterical attacks; and tertiary hysteria was defined as incidents that were intentionally performed by the patient.[171] Carter proposed that the attention-seeking motives of tertiary hysteria patients were not present in all hysteria patients, but were rather characteristic of this subgroup. Tertiary hysteria patients, he explained, were determined to seek attention to soothe their pain of feeling neglected.[172] However, he depicted these patients as being fully aware of their actions and the fact that they were feigning symptoms.[173] Carter

[165] Spitzka, *Insanity: Its Classification, Diagnosis and Treatment*, 18.
[166] Shorter, *From Paralysis to Fatigue*, 1.
[167] Shorter, *From Paralysis to Fatigue*, 1.
[168] Shorter, *From Paralysis to Fatigue*, 2.
[169] Porter, "The Body and the Mind, the Doctor and the Patient," 229.
[170] Porter, "The Body and the Mind, the Doctor and the Patient," 229.
[171] Veith, *Hysteria: The History of a Disease*, 203.
[172] Veith, *Hysteria: The History of a Disease*, 203.
[173] Porter, "The Body and the Mind, the Doctor and the Patient," 263.

suggested that some of the mental and physical manifestations of hysteria were biological, while others originated in the mind.[174]

According to historian Porter, the construction of hysteria as a psychological disorder "reduced hysteria from a disease into a deceit."[175] Carter believed that only tertiary hysteria patients exhibited the stereotypically manipulative nature of hysteria patients.[176] However, many other physicians held negative perceptions of hysteria patients and suggested that they were all "pretending to be ill"[177] or, as Showalter would say, inhabiting the "sick role."[178] In 1895, Maudsley criticized hysteria patients who, "believing or pretending that they cannot stand or walk, lie in bed… all day… objects of attentive sympathy on the part of their anxious relatives, when all the while their only paralysis is a paralysis of will." He stated that such women were "perfect examples of the subtlest deceit, the most ingenious lying, the most diabolic cunning, in the service of vicious impulses."[179]

French neurologist Jean-Martin Charcot (1825-1893) was famous for his work with hysteria patients at the Salpêtrière hospital in Paris. Charcot focused on the physical and neurological symptoms of hysteria and treated hysteria patients alongside patients diagnosed with epilepsy rather than mental illnesses.[180] When placed in the same ward as epileptic patients, hysteria patients experienced increased instances of epileptic seizures. When he first observed this phenomenon, Charcot classified this condition as a distinct and clearly neurological form of hysteria, "hystero-epilepsy." He devoted much of his time to studying and treating hystero-epilepsy before turning his attention to hysteria more generally.[181] Charcot treated hysteria patients with a combination of hypnotism, psychologically-focused treatments that involved removing the patient from her "moral environment," and physical

[174] Veith, *Hysteria: The History of a Disease*, 204.
[175] Porter, "The Body and the Mind, the Doctor and the Patient," 261.
[176] Porter, "The Body and the Mind, the Doctor and the Patient," 263.
[177] Porter, "The Body and the Mind, the Doctor and the Patient," 262.
[178] Showalter, *Hystories*, 117.
[179] Maudsley, *Pathology of Mind*, 397-398.
[180] Veith, *Hysteria: The History of a Disease*, 230.
[181] Veith, *Hysteria: The History of a Disease*, 230-231.

therapy.[182] Although he substantiated the perception of hysteria patients as deceitful, especially toward physicians,[183] Charcot separated hysteria patients from malingerers (patients who intentionally produced false symptoms) and insisted that hysteria was a real neurological illness.[184] He described hysteria as a "neurosis," a type of physical nervous disorder.[185] Charcot aimed to prove that hysteria was an organic neurological disorder by removing its association with white, aristocratic culture. He deliberately worked with patients of both genders and various ages, ethnicities, and social classes in order to affirm the scientific nature of hysteria.[186] Due to his status as an eminent neurologist in late nineteenth-century medicine, Charcot's scientific study of hysteria helped legitimize the disorder. His work was immensely influential in neurological research on hysteria and inspired early psychological theory.

Developments in Neurological Theory and the Rise of "Irritation"

Nineteenth-century developments in neurological theory shaped medical understandings of hysteria. After the reflex arc was accurately explained in 1822, physicians finally understood the relationship between motor and sensory functions: nerves transported sensory information toward the central nervous system and from there carried motor signals to the rest of the body.[187] Soon after, physicians began to use the reflex arc as a model for nervous disease. The "reflex paradigm," as Shorter calls it, was the most eminent theory for neurological illness until 1870.[188]

---

[182] Veith, *Hysteria: The History of a Disease*, 236.
[183] Veith, *Hysteria: The History of a Disease*, 235.
[184] Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper & Row, 1974), 23.
[185] Veith, *Hysteria: The History of a Disease*, 232.
[186] Porter, "The Body and the Mind, the Doctor and the Patient," 257.
[187] Shorter, *From Paralysis to Fatigue*, 23. Building on the previous work of doctors including Georg Prochaska (1784) and Charles Bell (1811), François Magendie added the final piece to reflex theory when he "[demonstrated] that the posterior spinal roots had sensory functions."
[188] Shorter, *From Paralysis to Fatigue*, 201.

However, knowledge about the nervous system increased over the course of the nineteenth century. As it was initially understood, the reflex arc interpreted sensory symptoms and produced motor symptoms, but further study indicated that the central nervous system could also generate sensory signals.[189] After 1870, doctors began to describe nervous diseases in terms of what Shorter calls the "central nervous paradigm," which highlighted the role of the brain and spinal cord in symptom production.[190] Shorter has argued that these disease models shaped the symptom pool for somatizing patients in Victorian society. As a result, many patients began to display sensory neurological symptoms. Even hysteria patients shifted from presenting the motor symptoms that characterized hysterical fits and Charcot's hystero-epilepsy to sensory symptoms like pain, fatigue, nausea, loss of sensation, paralysis, and affected senses of taste, smell, hearing, or vision.[191]

The concept of "irritation" presented a biological explanation for symptoms associated with hysteria. In 1828, Scottish physician Thomas Brown invented the diagnostic category spinal irritation to describe a spinal cord dysfunction that produced a range of confusing symptoms across the body.[192] The primary symptom of spinal irritation, however, was referred pain to other areas of the body when pressure was applied to specific tender points along the spinal cord.[193] Although spinal irritation was a physical disorder, no observable injury or abnormality existed to prove an organic etiology. In addition, organic spinal disorders (such as spinal tuberculosis) were typically common in both sexes; but spinal irritation was "almost exclusive to young women"—the same population that was most frequently diagnosed with hysteria.[194]

[189] Shorter, *From Paralysis to Fatigue*, 201.
[190] Shorter, *From Paralysis to Fatigue*, 212.
[191] Shorter, *From Paralysis to Fatigue*, 267; Smith-Rosenberg, *Disorderly Conduct*, 201-202.
[192] Shorter, *From Paralysis to Fatigue*, 27.
[193] Shorter, *From Paralysis to Fatigue*, 27.
[194] Shorter, *From Paralysis to Fatigue*, 25.

In fact, spinal irritation was so closely linked to hysteria that British surgeon Benjamin Brodie (1783-1862) considered spinal irritation to be a form of "local hysteria."[195] He highlighted the perplexing and inconsistent nature of the pain associated with spinal irritation:

> the patient complains of pain and tenderness of the back… The pain in the back is seldom confined to a single spot, but it extends to different regions of the spine, and it not infrequently shifts its place from one part to another. The tenderness of the spine is peculiar. The morbid sensibility is chiefly in the skin, and the patient for the most part flinches more when the skin is even slightly pinched than when pressure is made on the vertebrae themselves. The pain is in the majority of cases more severe than in those of real vertebral diseases.[196]

Spinal irritation could affect a single nerve on the spinal cord, or it could take on the form Brodie described, where the entire spine was irritated and different points on the spine could be tender at different times. The latter category, which appears to be more severe, more complex, and less clearly defined, was only diagnosed in women and was related to the female reproductive system.[197] Ovarian and uterine irritation became common explanations for unexplained symptoms in women alongside spinal irritation.[198]

The concept of "irritable weakness" arose out of these discussions; it built on the previous diagnosis of spinal irritation, but involved irritation of the brain.[199] Fatigue was the primary concern, but according to German neurologist Wilhelm Greisinger (1817-1868), irritable weakness led to

> easy exhaustibility, a tendency to quicker and more widespread but simultaneously less energetic movements, and a heightened tendency to convulsions… greater physical sensitivity, an easier susceptibility to psychic pain, the condition wherein every thought causes some emotional agitation. This in turn causes a rapid and unopposed change of self-image and mood, also weakness and lack of consequence of the will, lack of energy in all affairs combined with rapidly alternating desires.[200]

---

[195] Benjamin Brodie quoted in Shorter, *From Paralysis to Fatigue*, 31.
[196] Benjamin Brodie quoted in Shorter, *From Paralysis to Fatigue*, 31.
[197] Shorter, *From Paralysis to Fatigue*, 27.
[198] Shorter, *From Paralysis to Fatigue*, 42-44.
[199] Shorter, *From Paralysis to Fatigue*, 208.
[200] Shorter, *From Paralysis to Fatigue*, 209.

Irritable weakness blamed these symptoms of exhaustibility and fatigue on a physical abnormality in the brain.[201] The late nineteenth century was marked by a growing number of patients suffering from fatigue: hysteria patients began to complain of exhaustion and a new disorder, neurasthenia, arose to describe pseudo-hysterical symptoms with a particular emphasis on lack of energy.

From Hysteria to Neurasthenia

Naturalistic conceptions of disease, Darwinian ideas about human nature and civilization, and the increasingly precarious state of Victorian society together produced a new diagnostic entity. Neurasthenia, a disease that arose within the specific social conditions of late nineteenth-century America, closely resembled hysteria but was viewed rather differently. In 1869, American neurologist George Miller Beard (1839-1883) published an article, "Neurasthenia, or Nervous Exhaustion," which popularized the term "neurasthenia" as a more "scientific" adaptation of the existing diagnosis "nervous exhaustion."[202] Nervous exhaustion was a late nineteenth-century term for depression and was characterized by "tired nerves" or lack of energy.[203] Neurasthenia became more established in the 1880s following the publication of Beard's two volumes on the topic, *A Practical Treatise on Nervous Exhaustion (Neurasthenia)* in 1880 and *American Nervousness: Its Causes and Consequences* in 1881.[204]

Beard defined neurasthenia as the depletion of the body's limited energy reserves, or "nerve force," which gave rise to an extensive list of symptoms,[205] including:

> general malaise, debility of all the functions, poor appetite, abiding weakness in the back and spine, fugitive neuralgic pains, hysteria, insomnia, hypochondriases,

[201] Shorter, *From Paralysis to Fatigue*, 210.
[202] Stephen E. Straus, "History of Chronic Fatigue Syndrome," *Reviews of Infectious Diseases* 13 (1991): 2, accessed March 17, 2021, https://www.jstor.org/stable/4455795.
[203] Shorter, *From Paralysis to Fatigue*, 226.
[204] Zorzanelli, "Fatigue and Its Disturbances," 605.
[205] Aho, "Neurasthenia Revisited," 2; Oppenheim, *Shattered Nerves*, 95.

> disinclination for consecutive mental labor, severe and weakening attacks of sick headache, and other analogous symptoms, and at the same time gives no evidence of anemia or of any organic disease.[206]

Fatigue was a primary concern, especially when it was not improved with sleep or rest.[207] However, Beard listed hysteria as a potential manifestation of neurasthenia, highlighting the relationship between the two conditions. Neurasthenia also involved psychological symptoms that had been attributed to hysteria, including "general nervousness," psychosis, depression, and anxiety.[208] As Showalter points out, neurasthenia "shared so many of hysteria's symptoms that even specialists could not always distinguish between the two."[209] Like hysteria, neurasthenia can be described as a wastebasket diagnosis. In addition to its long list of symptoms, neurasthenia was not linked to an observable cause and was often diagnosed only when the symptoms could not be attributed to any other disorder.[210] In Beard's words, "The diagnosis of the neurasthenic condition is sometimes entirely clear, and again is quite difficult. The diagnosis is obtained partly by positive symptoms, and partly by exclusion."[211]

However, one key difference between neurasthenia and hysteria is that neurasthenia was not defined in relation to femininity in the same way. Gender constructs continued to play a role, but many neurasthenia patients were men, and descriptions of the disorder tended to centre masculinity rather than femininity. Showalter points out that neurasthenia implied hard work, industriousness, and high social respectability among men, but the majority of patients with neurasthenia were in fact educated, urban, middle-class women.[212] Neurasthenia took several hysteria symptoms and repackaged them as a nervous disorder, removing their association with the female reproductive system. Shorter highlights one positive outcome of

---

[206] George M. Beard, *American Nervousness: Its Causes and Consequences* (New York: G. P. Putnam's Sons, 1881), ix-x.
[207] Zorzanelli, "Fatigue and Its Disturbances," 605.
[208] Showalter, *The Female Malady*, 134; Oppenheim, "*Shattered Nerves*," 81; Shorter, *From Paralysis to Fatigue*, 222.
[209] Showalter, *The Female Malady*, 134.
[210] Oppenheim, "*Shattered Nerves*," 95.
[211] Straus, "History of Chronic Fatigue Syndrome," 2.
[212] Showalter, *The Female Malady*, 135-136.

the creation of the neurasthenia diagnosis. He argues that the new diagnostic category drew attention to—and medicalized—the previously unacknowledged psychiatric problems of working-class men.[213] Men who experienced psychological and psychosomatic symptoms were able to access treatments that were previously only available to women.[214] However, it should be noted that this was not necessarily a major victory for men, given the poor quality of treatments available to hysteria patients at the time.

Biological Explanations of Neurasthenia and the Concept of "Nerve Force"

Within the medical culture of naturalism, Beard attempted to frame neurasthenia as a biological disease in order to earn the respect of the medical community.[215] Despite their efforts, Beard and his colleagues struggled to uncover an organic lesion that would demonstrate a biological origin for neurasthenia symptoms. As a result, neurasthenia was considered a functional nervous disease—it was presumed to have an organic cause, but this cause could not yet be determined with the available medical knowledge and resources.[216] In addition, functional lesions could be caused by environmental factors, making the disorder malleable to external influences.[217]

The notion of nervous exhaustion had existed for centuries, with theories about its mechanism evolving over time.[218] In ancient Greece, Galen had proposed that sensory and motor activity came from the body's "animal spirits." In the seventeenth century, physicians adopted the view of nerves as fluids that travel through the body carrying messages.[219] According to this view, exhaustion occurred when the nervous fluids had "run dry."[220] Alternatively, nineteenth-century physicians adhered to an electric theory of the nervous

[213] Shorter, *From Paralysis to Fatigue*, 224.
[214] Shorter, *From Paralysis to Fatigue*, 226.
[215] Zorzanelli, "Fatigue and Its Disturbances," 610.
[216] Zorzanelli, "Fatigue and Its Disturbances," 605.
[217] Zorzanelli, "Fatigue and Its Disturbances," 611.
[218] Oppenheim, "*Shattered Nerves*," 81.
[219] Oppenheim, "*Shattered Nerves*," 79.
[220] Oppenheim, "*Shattered Nerves*," 81.

system that first arose in the eighteenth century.[221] This model suggested that the nerve force acted as a battery that could run out of charge: too much exertion could lead to the entire nervous system's ineffectiveness, even when only one part of the body was overworked. The central tenet of the electric model of the nervous system was that every person possessed a limited amount of nerve force which ought to be spent wisely.[222] Beard postulated that in neurasthenia, "the central nervous system becomes dephosphorized, or, perhaps, loses somewhat of its solid constituents; probably also undergoes slight, undetectable, morbid changes in its chemical structure, and, as a consequence, becomes more or less impoverished in the quantity and quality of its nervous force."[223]

Janet Oppenheim has highlighted the importance of metaphor in nineteenth-century medical explanations, particularly regarding poorly understood aspects of the human body.[224] She notes that mechanical, musical, and water imagery were used to explain nervous function, but emphasizes economic parallels as the most prevalent metaphors used to explain neurasthenia. Victorian physicians compared nerve force to capital, suggesting that it could be saved, spent wisely, or spent recklessly at the risk of "bankruptcy."[225] However, Beard and his supporters believed that each individual was born with a finite amount of nerve force determined by genetic factors: some individuals were endowed with naturally high energy levels while others were susceptible to nervous disease. Physicians "unanimously agreed" that while a nervous temperament could be acquired during an individual's lifetime even in the absence of genetic vulnerabilities, there was no way to increase energy levels.[226] Rather, medical advice centred on the notion that individuals could "maximize strength and minimize weakness" when it came to their nerves, in spite of inherited "nervous temperaments" or

[221] Oppenheim, "*Shattered Nerves*," 80.
[222] Oppenheim, "*Shattered Nerves*," 81.
[223] George M. Beard, "Neurasthenia, or Nervous Exhaustion," *The Boston Medical and Surgical Journal* III, no. 13 (April 29, 1869): 218.
[224] Oppenheim, "*Shattered Nerves*," 83.
[225] Oppenheim, "*Shattered Nerves*," 84.
[226] Oppenheim, "*Shattered Nerves*," 91; Zorzanelli, "Fatigue and Its Disturbances," 607.

predispositions to nervous illness.[227] Thus, while the economic model of nerve force centred on the notion of "spending" energy, the nature of energy levels resembled inherited wealth to be retained rather than capitalist notions of profit or consumerism.[228]

Although some physicians warned that this level of nerve force could not be restored, many of the therapies developed to help with neurasthenia depended on the notion that patients could improve their nervous constitution through rest and certain actions.[229] Weir Mitchell's rest cure was often prescribed for neurasthenia patients, encouraging rest and recovery away from harmful stimuli and unhealthy situations.[230] When individuals did expend energy, certain activities were considered more justifiable than others and were seen as fair exchanges. For example, work and procreation were acceptable ways to spend energy because the benefits (to society) outweighed the costs (to the nervous system). However, other activities were not seen as worth the unnecessary exertion and were instead viewed as a waste of nervous energy. Such unacceptable activities included improper sexual acts and masturbation.[231] In order to prevent the onset of neurasthenia, physicians encouraged moderation in every respect.[232] Physical or emotional shocks to the system, overworking, and "indulgence of imprudent habits" could all diminish nerve force.[233]

Neurasthenia and Social Factors

Although neurasthenia was classified as an organic disease, Beard emphasized the role of social factors in producing symptoms.[234] He maintained that increasing modernization, industrialization, urbanization, and "civilization" contributed to the rise in nervous illness. In general, Beard and his colleagues asserted that the quick pace of everyday

[227] Oppenheim, "*Shattered Nerves*," 90.
[228] Oppenheim, "*Shattered Nerves*," 85-86.
[229] Oppenheim, "*Shattered Nerves*," 82-83.
[230] Showalter, *The Female Malady*, 138.
[231] Zorzanelli, "Fatigue and Its Disturbances," 607.
[232] Oppenheim, "*Shattered Nerves*," 91.
[233] Oppenheim, "*Shattered Nerves*," 91.
[234] Aho, "Neurasthenia Revisited," 2; Showalter, *The Female Malady*, 135.

life and the emphasis on competition and endless productivity increased the public's risk for nervous disease.[235] More specifically, Beard drew attention to new technology, including timekeeping and communication devices; the shift from manual labour to office-based occupations; and women's access to higher education and ability to enter the workforce.[236] According to Beard, all of these dramatic social changes made it increasingly difficult for members of the public—especially middle-class men and women, who were most impacted by such changes—to find time to rest.[237]

Beard wrote about neurasthenia as a symptom of American society in particular and believed that the United States was the most affected by these social changes and nervous ailments.[238] However, European physicians later adapted Beard's theories to their own societies and contributed to the growing knowledge of nervous disease.[239] British physicians especially embraced and expanded on neurasthenia as a diagnostic entity. They regarded neurasthenia as a new, all-encompassing name for a set of symptoms that they had already identified under neurological diagnoses such as "spinal irritation, neuralgic disease, or nervous weakness."[240] British physicians also turned their focus back to female patients, and primarily associated this new diagnosis with young women.[241]

An important aspect of Beard's theories on neurasthenia was their connection to Darwinism. Beard saw neurasthenia as resulting from society progressing too far, or becoming "overcivilized."[242] He did not believe that people from other societies that he considered less advanced could experience the same symptoms as white Americans. He further asserted that rural communities were not plagued by nervous disorders the way that

[235] Oppenheim, "*Shattered Nerves*," 100.
[236] Aho, "Neurasthenia Revisited," 2.
[237] Zorzanelli, "Fatigue and Its Disturbances," 609; Oppenheim, "*Shattered Nerves*," 93.
[238] Oppenheim, "*Shattered Nerves*," 93.
[239] Aho, "Neurasthenia Revisited," 2.
[240] Showalter, *The Female Malady*, 136.
[241] Showalter, *The Female Malady*, 136.
[242] Showalter, *The Female Malady*, 135; Briggs, "The Race of Hysteria," 255.

cities were.[243] Western civilization's urban centres were seen as the main culprit for elevated levels of nervous disease, as they confined the population to a small area and were associated with "filth."[244] Filth—both physical and moral—was seen as an intrinsic quality of urban life. The streets were supposedly rife with disease and brimming with vice.[245] However, it was the upper classes' luxurious lifestyles that indicated a societal regression following excessive civilization. Parties, sexual indulgence, drug and alcohol addiction, overeating, and even excessive entertainment in the form of novels or theatrical performances apparently revealed the degenerate state of American society.[246] Physicians suggested that modern civilization had caused higher levels of stress, anxiety, and nervous disease.[247]

Ironically, yet in keeping with the Victorian tendency toward contradiction, the presence of neurasthenia was simultaneously seen as an indication of white superiority. Madness and nervous illnesses were believed to be diseases that appeared as societies "advanced."[248] As a result, neurasthenia sometimes had a positive connotation.[249] Neurasthenia's association with an over-evolved or over-developed civilization painted neurasthenic patients as refined and civilized.[250] This idea was necessarily defined in opposition to stereotypes about "savage" societies.[251] However, when neurasthenia eventually became the dominant diagnosis for nervous ailments, British physicians left behind much of Beard's theory that neurasthenia was caused by "overcivilization" and the affluent lifestyle. Instead, they maintained that neurasthenia could affect anyone, regardless of race, culture, or social status.[252]

---

[243] Showalter, *The Female Malady*, 135.
[244] Oppenheim, "*Shattered Nerves*," 102.
[245] Oppenheim, "*Shattered Nerves*," 102.
[246] Oppenheim, "*Shattered Nerves*," 91.
[247] Oppenheim, "*Shattered Nerves*," 100.
[248] Oppenheim, "*Shattered Nerves*," 101.
[249] Aho, "Neurasthenia Revisited," 4.
[250] Aho, "Neurasthenia Revisited," 4.
[251] Briggs, "The Race of Hysteria," 255.
[252] Oppenheim, *Shattered Nerves*, 105.

Neurasthenia and Gender

Perceptions of neurasthenic men and women were drastically different. Neurasthenic men were often seen as hardworking and embodying the capitalist values of ambition, productivity, and "industriousness."[253] They were respected for their ability to adapt to the demands of modern society. On the other hand, neurasthenia in women was viewed as evidence of their inherent weakness and their rightful place in the home. At the time, women's pursuit of white collar jobs and post-secondary education afforded them more of a presence in the public sphere. Any illness that supposedly resulted from these radical advancements confirmed the fact that women were not equipped for these traditionally masculine endeavours.[254] In addition, nervous illness was often used to reinforce negative stereotypes toward women—they were seen as having naturally more sensitive nervous systems and were therefore predisposed to nervous diseases.[255] Although neurasthenia was not explicitly connected to the uterus, the diagnosis was still used to establish women's biological inferiority.

Showalter defined insanity as a "female malady" in order to draw attention to the ways in which madness has been constructed to emulate traditionally feminine traits.[256] Hysteria exemplified the notion of a female malady, as it encompassed numerous negative stereotypes about women and was, more than most other mental disorders, associated with a deep-rooted social stigma. By contrast, neurasthenia was associated with masculinity and positive social ideals. As a result, although neurasthenia and hysteria were very similar conditions, neurasthenia avoided the stigma attached to hysteria and to mental illness in general.[257] The social implications of neurasthenia and the fact that the disorder was diagnosed in men as well as women helped legitimize the disorder by pulling it away from

[253] Aho, "Neurasthenia Revisited," 4.
[254] Aho, "Neurasthenia Revisited," 11.
[255] Shorter, *From Paralysis to Fatigue*, 213.
[256] Showalter, *The Female Malady*, 5.
[257] Aho, "Neurasthenia Revisited," 4.

femininity.[258] Still, the majority of neurasthenia patients were women. Although male patients made neurasthenia a more valid and respectable diagnosis than hysteria, many female patients continued to face barriers that their male counterparts did not.[259]

Conclusion

Hysteria and neurasthenia both declined rapidly at the beginning of the twentieth century. Growing medical knowledge brought the existence of functional disorders into question and physicians began to reconsider the usefulness of wastebasket diagnoses to describe diverse symptoms.[260] Instead, physicians suggested that these conditions may in reality include many distinct disorders with different causes.[261] Some symptoms of hysteria and neurasthenia were eventually explained by biological mechanisms, but the end of the nineteenth century was also characterized by advancements in the field of psychology that brought new perspectives to these two illnesses. Hysteria in particular was at the centre of this growing psychological research, but the related condition of neurasthenia was also re-examined with new psychological theory in mind. The next chapter will detail these developments, focusing on the contributions of prominent psychologists like Sigmund Freud, Pierre Janet, and Emil Kraepelin. Chapter Four will then explore how the symptoms associated with hysteria and neurasthenia were redefined as psychiatric disorders in the twentieth century following the late nineteenth-century psychological research. Finally, Chapter Five will pick up the notion of wastebasket diagnoses to examine two contemporary conditions, chronic fatigue syndrome and fibromyalgia. Like hysteria and neurasthenia, these two illnesses encompass a range of neurological and psychological symptoms but lack a

[258] Susan E. Abbey and Paul E. Garfinkel, "Neurasthenia and Chronic Fatigue Syndrome: The Role of Culture in the Making of a Diagnosis," *American Journal of Psychiatry* 148, no. 12 (1991): 1643.
[259] Aho, "Neurasthenia Revisited," 11; Showalter, *The Female Malady*, 136; Abbey and Garfinkel, "Neurasthenia and Chronic Fatigue Syndrome," 1643.
[260] Oppenheim, "*Shattered Nerves*," 95.
[261] Oppenheim, "*Shattered Nerves*," 97.

unifying cause. All of these discussions will centre on the interaction between culture and medicine, a relationship that is perhaps most clearly exhibited by nineteenth-century hysteria and neurasthenia.

Hysteria and neurasthenia were intimately connected to certain aspects of Victorian culture, including the dichotomies of "success and failure, civilization and barbarism, order and chaos, masculinity and femininity."[262] Over time, the medical field has come to accept the reality that many illnesses result from a combination of biological and social causes.[263] However, disorders that do not fall neatly into the categories of psychological or biological illness remain stigmatized. In addition, conceptions of disease continue to be informed by opposing gender roles. Disorders defined in relation to masculinity and femininity are treated very differently by the medical field. This thesis will continue to focus on illnesses constructed in accordance with constructed ideas of femininity and those that are disproportionately diagnosed in women. Using the perspective gained from nineteenth-century hysteria, I will continue to explore "female maladies" and how patients with these conditions are misunderstood and mistreated.

[262] Oppenheim, "*Shattered Nerves*," 3.
[263] Oppenheim, "*Shattered Nerves*," 4.

CHAPTER THREE: THE RISE OF PSYCHOLOGICAL EXPLANATIONS AND THE DISPERSION OF HYSTERIA

After 1870, psychological theories about the nature of hysteria arose to contend with existing neurological explanations. The conviction that an undiscovered organic lesion was responsible for hysteria symptoms began to wane by the 1890s, especially after Charcot's death in 1893.[1] Growing biomedical knowledge allowed physicians to attribute certain symptoms to biological dysfunctions.[2] For example, epilepsy, syphilis, multiple sclerosis, and cranial injury were separated out from the category of hysteria as organic diseases.[3] In the absence of a definitive biological etiology, psychologists attempted to explain hysteria's physical and mental symptoms through psychological mechanisms.[4] Several prominent psychologists, including some of Charcot's own followers, defined hysteria as a mental rather than a neurological disorder in the years following his death.[5] Between 1895 and 1910, an explosion of new psychiatric diagnoses emerged to describe hysteria symptoms.[6] Hysteria's mental symptoms were redistributed among the psychoses, psychoneuroses, and, later, the mood disorders, personality disorders, and anxiety disorders. Physical symptoms not attributed to an organic disease were described as psychosomatic illnesses. Over time, these new disorders lost their association with hysteria and their connection to one another and were further broken down into many more diagnostic categories.

Many aspects of modern psychological theory are based on hysteria research that occurred around the turn of the twentieth century. Pierre Janet, Sigmund Freud, and Emil Kraepelin were particularly influential in proposing psychological explanations for hysteria

---

[1] Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton University Press, 1995), 25-26.
[2] Micale, *Approaching Hysteria*, 171.
[3] Mark S. Micale, "On the 'Disappearance' of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis," *Isis* 84, no. 3 (September 1993), 525.
[4] Micale, *Approaching Hysteria*, 172-173.
[5] Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York, NY: The Free Press, 1992), 239.
[6] Micale, "On the 'Disappearance' of Hysteria," 525.

symptoms and breaking down this wastebasket category into more precise diagnoses that targeted specific symptoms and etiologies. This chapter moves away from the cultural setting of Victorian Britain and America and focus on Continental intellectual developments, specifically in France, Austria, and Germany, that revolutionized psychology at the end of the nineteenth century. Establishing this basis for twentieth century psychological thought allows me to trace hysteria symptoms in the final two chapters through successive editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and then in the literature around two frequently dismissed and diminished physical ailments: chronic fatigue syndrome and fibromyalgia. In this chapter, however, I argue that late nineteenth-century psychological research transformed understandings of hysteria symptoms. These novel theories about the disease disconnected hysteria from existing biological explanations and initiated the deterioration of hysteria as a diagnostic entity. Furthermore, I begin to argue in this chapter—although the following chapters explore this idea in greater detail—that despite growing medical and psychological knowledge and more targeted diagnostic categories, physicians and psychologists remain unable to accurately explain or treat hysteria symptoms. Several of the new diagnostic categories that arose to replace hysteria continue to be defined by shared symptoms rather than a unifying cause. These more precise titles give the illusion that doctors have gained a greater understanding of hysterical symptoms, but physicians still struggle to explain the mechanisms that underlie these illnesses—especially illnesses that primarily affect women or are defined in relation to femininity.

Hysteria as Madness

Elaine Showalter has described how the nineteenth century was marked by shifts within the psychiatric discipline and in understandings of insanity. In the first half of the nineteenth century, psychiatric institutionalization (especially of women) was on the rise.

Women—including upper-, middle-, and lower-class women—came to be the primary residents of asylums while male proprietors and physicians assumed control over these institutions and care of patients.[7] At the same time, the mental conditions of mania, melancholia, delirium, and dementia were becoming more carefully defined through developments in nosological classification.[8] Wilhelm Griesinger (1845), B. A. Morel (1852-1853; 1860), L. V. Marce (1862), and J. J. Moreau de Tours (1869) described "hysterical insanity" and "hysterical mania" around the middle of the nineteenth century. These terms usually applied to female patients already diagnosed with either nervous or mental disorders but more specifically targeted "dramatic, erratic, or erotic" behaviours.[9] Hysteria thus became explicitly connected to female madness. As hysteria—or at least some forms of hysteria—came to be defined as a female mental illness and men assumed control over an increasingly female patient population, hysteria research and treatment fell into the hands of prominent male physicians and psychologists.[10] From the immense institution of the Salpêtrière hospital to Freud's intimate practice, female patients relied on the support and guidance of powerful men to alleviate their symptoms.[11]

The rise of psychological explanations for hysteria occurred as both a reaction to and an extension of Charcot's school of thought.[12] Charcot (and his contemporaries) had attempted to explain hysteria's motor and sensory symptoms through a neurological lens. Hippolyte Bernheim and the Nancy School posed the first major challenge to Charot's model. This group of psychologists proposed that emotional dysfunction rather than an unidentified neurological lesion preceded sensorimotor symptoms. They suggested that hysteria was not caused by organic disorders of the reproductive or nervous symptoms, but could occur in

[7] Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (Harmondsworth, Middlesex, England: Penguin Books Ltd, 1985), 52.
[8] Showalter, *The Female Malady*, 52-53; Micale, "On the 'Disappearance' of Hysteria," 511.
[9] Micale, "On the 'Disappearance' of Hysteria," 511.
[10] Showalter, *The Female Malady*, 54.
[11] Micale, "On the 'Disappearance' of Hysteria," 516.
[12] Micale, *Approaching Hysteria*, 26.

anyone who experienced high levels of psychological distress. It was heightened suggestibility and exaggerated reactions to psychological trauma that caused hysteria rather than the existing theories relating to irritation, nerve force, and nervous temperament.[13]

Hypnosis

In the late nineteenth century, physicians and psychologists learned more about hysteria through hypnosis as a means of research and treatment. Franz Anton Mesmer's (1734-1815) "animal magnetism" was a foundational theory in the development of hypnotic techniques.[14] Mesmer proposed that a "universal fluid" carried cosmic influence through organisms to form a connection between the individual and the universe. He likened this connection to magnetic attraction and used this relationship to explain disease; Mesmer proposed that magnets could correct a disease-causing imbalance in this universal fluid by reconnecting the patient to the universe. Mesmer's treatment, known as "mesmerism" involved laying the patient in a wooden tub filled with magnetized iron filings floating in water and manipulating magnetic forces with iron rods.[15] This practice was paired with soft music and a relaxing atmosphere to induce a deep sleep or trance that alleviated patients' ailments. Although it was eventually discredited and its results deemed imaginary by an investigation in 1784, his approach influenced later physicians' treatments.[16]

Although Charcot is famously connected with hypnosis in the study of hysteria, he never performed hypnosis himself. Instead, he used hypnosis to *diagnose* hysteria—he believed that vulnerability to hypnosis was a sign of hysteria.[17] Charcot was generally more concerned with understanding the nature of hysteria than helping individual patients. When he did treat patients, he focused mainly on alleviating symptoms and emphasized the role of

[13] Micale, *Approaching Hysteria*, 26.
[14] Ilza Veith, *Hysteria: The History of a Disease* (Chicago, IL: The University of Chicago Press, 1965), 222.
[15] Veith, *Hysteria*, 222.
[16] Veith, *Hysteria*, 223.
[17] Veith, *Hysteria*, 239.

the emotions. Along with Silas Weir Mitchell and Robert Carter, Charcot addressed psychological distress and trauma by removing patients from toxic environments and reassuring them that they could be cured. He addressed physical discomfort by stimulating affected muscles and organs.[18]

Bernheim employed hypnosis as a therapeutic intervention rather than merely a diagnostic tool and built on the previous techniques to address his specific theory of hysteria. While previous physicians had used instruments in their hypnotic therapies—Mesmer had used iron rods and Charcot developed certain devices to manipulate patients' bodies—the Nancy School believed that hypnosis had purely psychological effects and therefore used only words in their hypnosis treatments.[19] Bernheim's concern with hysteria's "suggestibility" led him to propose a modified, targeted version of hypnosis, "desuggestion."[20] Bernheim and his colleagues' desuggestion technique challenged Charcot's approach to hysteria diagnosis and treatment and supported the theory that hysteria was psychological in nature.

Early Psychological Theory

One of Charcot's students, Pierre Janet (1859-1947), built on Charcot's attention to trauma in hysteria and Bernheim's notion of hysteria as a natural result of psychological distress in order to define hysteria as a psychological disorder. Janet emphasized mental symptoms like obsessions, amnesias, abulias, fugue states, trances, and multiple personality and classified hysteria symptoms under the existing headings of "mental stigmata" and "mental accidents."[21] The mental stigmata included "anesthesia, amnesia, abulia, motor disturbance, and modifications of character" while "suggestion and subconscious acts, fixed

[18] Veith, *Hysteria*, 236.
[19] Veith, *Hysteria*, 240.
[20] Micale, *Approaching Hysteria*, 26.
[21] Micale, *Approaching Hysteria*, 26; Veith, *Hysteria*, 249.

ideas, convulsive attacks, somnambulisms, and deliria" were mental accidents.[22] Janet maintained that these and the physical symptoms of hysteria originated in the mind, particularly in response to traumatic events.[23] He believed that patients developed "*idées fixes*" that were embedded into patients' subconscious and informed their actions and emotional responses.[24]

This view challenged the popular perception of hysteria patients as themselves volatile. On the contrary, Janet argued that hysteria patients were almost too unchanging and failed to adapt to new circumstances. He also rejected the common belief that hysteria was an unpredictable disorder: he claimed that hysteria tended to follow a specific pattern in each individual.[25] In addition to these observations about the predictable nature of hysteria and its patients, Janet also challenged the presumed relationship between hysteria and sexuality. Through his research, he determined that "the hystericals are, in general, not any more erotic than normal persons."[26] Janet followed Charcot's lead in focusing on studying rather than treating hysteria. However, when he did treat patients, he prescribed a combination of Charcot's and Bernheim's courses of treatment: he suggested adjusting patients' environments (often by removing them from unhealthy situations) and employed the suggestion-based techniques of the Nancy School.[27] He did move decidedly away from hypnosis, however, and instead emphasized individualized patient care.[28]

Joseph Babinski (1857-1932) also made significant contributions to the ongoing discussions and debates surrounding hysteria. Another of Charcot's students, Babinski remained a disciple of the famous neurologist even after his death in 1893. Unlike Janet, Babinski continued to pursue neurology rather than psychology and was generally

[22] Veith, *Hysteria*, 249-250.
[23] Micale, *Approaching Hysteria*, 26.
[24] Micale, *Approaching Hysteria*, 26.
[25] Veith, *Hysteria*, 251-252.
[26] Pierre Janet quoted in Veith, *Hysteria*, 251.
[27] Veith, *Hysteria*, 254.
[28] Micale, *Approaching Hysteria*, 26.

disinterested in hysteria.[29] After several years of strictly neurological research, Babinski revisited hysteria in 1901 and proposed a new concept, "pithiatism," a term based on the Greek words for "persuasion" and "curable."[30] Babinski believed that hysteria should be eliminated as a diagnosis altogether but proposed pithiatism as an explanation of the origin and nature of hysterical symptoms.[31] Babinski's theory of pithiatism relied on the notion that "Any symptom… could be induced by suggestion and abolished by persuasion."[32] Contrary to Janet's *idées fixes*, Babinski depicted the hysteria patient as vulnerable to external influences to the extent that suggestion could create or cure hysterical illness.

Sigmund Freud and Psychoanalysis

Without a doubt the most famous of the early psychologists attempting to treat hysteria was another of Charcot's former pupils, Sigmund Freud (1856-1939). During his career, Freud revolutionized the discipline of psychology. His research on hysteria in particular served as the foundation for many of his psychological theories.[33] For example, psychoanalysis originally emerged as an explanation for hysteria: Freud believed that the unconscious mind played a major role in producing hysteria symptoms. Specifically, he pointed to repressed memories, especially those relating to sexuality and trauma, as the primary cause of hysteria. Micale describes Freud's work as a "resexualization" of hysteria in the form of an investigation of the unconscious mind, as opposed to an association with reproductive anatomy.[34]

Freud began his work on hysteria alongside the internist Josef Breuer, who described to Freud the particular case of patient Anna O. and his success with hypnotic treatment

[29] Micale, "On the 'Disappearance' of Hysteria," 517.
[30] Micale, "On the 'Disappearance' of Hysteria," 518.
[31] Micale, "On the 'Disappearance' of Hysteria," 518.
[32] Shorter, *From Paralysis to Fatigue*, 198.
[33] Micale, *Approaching Hysteria*, 27.
[34] Micale, *Approaching Hysteria*, 28.

between 1880 and 1882. Breuer alleviated Anna O.'s symptoms by having her discuss events from her past under hypnosis. Through this method—which Anna O. deemed "the talking cure" and Freud called "the cathartic method"—the patient recovered repressed memories.[35] Initially, Freud and Breuer believed that hypnosis was essential to hysteria treatment. They asserted that "*these* [traumatic] *experiences are completely absent from the patients' memory when they are in a normal psychical state, or are only present in a highly summary form.* Not until they have been questioned under hypnosis do these memories emerge with the undiminished vividness of a recent event."[36] However, they attempted to remove the therapist's involvement as much as possible and allow the patient to contend with their disturbing recollections in a state of normal consciousness or under light hypnosis.[37]

Freud and Breuer found great success with this method and reported that "*each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words.*"[38] In the cathartic method, Freud emphasized the release of emotion that coincided with the patient's recollection of traumatic memories.[39] He paid special attention to early childhood memories, which were frequently forgotten by adulthood but which he believed formed the basis of the psyche.[40] While Breuer's approach addressed more general repressed memories, Freud's version of catharsis focused on sexuality as the source of the patient's complaints.[41]

---

[35] Micale, *Approaching Hysteria*, 27.
[36] Josef Breuer and Sigmund Freud, *Studies on Hysteria* (Harmondsworth, UK: Penguin Books Ltd., 1974), 60. Italics in original.
[37] Freud and Breuer, *Studies on Hysteria*, 68.
[38] Freud and Breuer, *Studies on Hysteria*, 57. Italics in original.
[39] Shorter, *From Paralysis to Fatigue*, 253.
[40] Shorter, *From Paralysis to Fatigue*, 253.
[41] Veith, *Hysteria*, 260-261.

Freud then trained as a neurologist and neuroanatomist in Vienna[42] before moving to Paris to study under Charcot in the winter of 1885-1886.[43] During this time, Freud observed Charcot's work with hysteria patients from a neurological standpoint and this experience at the Salpêtrière influenced Freud's own approach. Freud celebrated Charcot's work and was inspired by his use of hypnosis,[44] especially his research on the "hallucinatory reproduction of a memory" that constituted the third phase of a hysterical attack, "*attitudes passionelles*."[45] Once Freud had gained sufficient experience working with hysteria patients both in his own practice and at the Salpêtrière, he returned to Vienna and proposed to Breuer that they publish their combined findings. Despite Breuer's initial hesitancy, Freud and Breuer went on to describe a collection of hysteria cases (including Anna O.) and their success with the cathartic method in their book *Studies on Hysteria* (1895).[46]

After the publication of *Studies on Hysteria*, however, Freud adopted a new method of treating patients centred on his theory of psychoanalysis. Psychoanalysts later performed treatments that conflated Freud's psychoanalytic theory with the cathartic method, but Freud's original theory was distinct from his work with Breuer.[47] In his description of psychoanalysis, Freud furthered Bernheim and Janet's conviction that hysteria was essentially a psychological disorder that produced both physical and mental symptoms, as opposed to an organic disease.[48] However, Freud extended this idea by proposing a specific mechanism through which hysteria symptoms were produced, based in the unconscious mind. He built upon the conclusions he drew from his research with Breuer and under Charcot and proposed that hysteria symptoms resulted from repressed traumatic memories, often formed

[42] Veith, *Hysteria*, 259.
[43] Micale, *Approaching Hysteria*, 27.
[44] Veith, *Hysteria*, 260.
[45] Freud and Breuer, *Studies on Hysteria*, 64-65. Italics in original.
[46] Micale, *Approaching Hysteria*, 27.
[47] Shorter, *From Paralysis to Fatigue*, 253.
[48] Micale, *Approaching Hysteria*, 27.

in early childhood and often sexual in nature.[49] Freud theorized that these memories were so disturbing that they had to be buried deep within the unconscious mind and could not be expressed in a healthy way.[50] Rather, these individuals became hysterical, developing unhealthy coping mechanisms and experiencing symptoms that ranged from unpleasant to debilitating. The notion that hysteria symptoms were an outward manifestation of repressed emotions had existed throughout the nineteenth century, with Robert Carter's theory of repression solidifying these circulating ideas. However, these previous conceptions of repression had focused on the repression of immediate sexual desires, emotions, or reactions to environmental stimuli and events. Freud emphasized the role of the long-term repression of traumatic memories, especially early childhood experiences and sexual memories and fantasies.

Charcot and Janet had discussed the dissociative symptoms of hysteria at length, but Freud integrated the physical and psychological aspects of hysteria in his theory of hysterical conversion.[51] Disruptions in consciousness like hysterical fits had been a primary concern for centuries and were Charcot's main interest; Janet drew attention to the more psychological manifestations of hysteria and the splitting of consciousness.[52] Freud criticized Janet for his emphasis on the splitting of consciousness, and instead separated hysteria from other neuroses like phobias, obsessions, and dissociative disorders by emphasizing the "*capacity for conversion*."[53] In the process of conversion, he proposed that hysteria patients *converted* their emotional distress into physical expressions. According to Freud's theory, "conversion may be either total or partial" and could involve motor or sensory symptoms. Regardless of the symptomatic expression, Freud viewed hysteria as a complex reaction to traumatic

[49] Micale, *Approaching Hysteria*, 27.
[50] Micale, *Approaching Hysteria*, 27.
[51] Phebe Cramer, "What Has Happened to Hysteria?," *Journal of Nervous & Mental Disease* 207, no. 9 (2019): 705, https://journals.lww.com/10.1097/NMD.0000000000000850; Micale, *Approaching Hysteria*, 27-28.
[52] Sigmund Freud, "The Neuro-Psychoses of Defence," in *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, trans. James Strachey, vol. III (London: The Hogarth Press Ltd., 1962), 46.
[53] Freud, "The Neuro-Psychoses of Defence," 51, 50. Italics in original.

memories.[54] According to Freud, in the process of conversion, "The excitation which is forced into a wrong channel (into somatic innervation) now and then finds its way back to the idea from which it has been detached, and it then compels the subject either to work over the idea associatively or to get rid of it in hysterical attacks."[55] In terms of treatment, Freud pointed to the cathartic method as an effective way of "leading back the excitation in this way from the somatic to the psychical sphere deliberately, and in then forcibly bringing about a settlement of the contradiction by means of thought-activity and a discharge of the excitation by talking."[56]

Freud moved away from the hypnotic techniques and physical therapies employed by some of his predecessors and contemporaries.[57] He found that hypnosis prevented patients from actively recalling and confronting their unconscious memories and motivations because the practitioner unveiled unconscious memories and motivations while the patient lay passively under a trance. Once patients awoke from the trance, they tended to forget the revelations they experienced while unconscious.[58] Similarly, hypnotic suggestion placed power in the hands of the physician rather than requiring patients to revisit uncomfortable memories and draw conclusions on their own.[59] Instead, Freud encouraged patients to lead the sessions through "free association," in which patients retrieved memories that they considered important from their unconscious minds.[60] Freud eventually added dream analysis to his treatment regimen, another patient-driven approach focusing on the significance of dreams.[61] In his psychotherapy, Freud assisted patients in overcoming concerns resulting from the repression of emotional responses, traumatic memories, and sexual desires.[62] Part of

[54] Freud, "The Neuro-Psychoses of Defence," 49; Micale, *Approaching Hysteria*, 28.
[55] Freud, "The Neuro-Psychoses of Defence," 50.
[56] Freud, "The Neuro-Psychoses of Defence," 50.
[57] Micale, *Approaching Hysteria*, 28.
[58] Veith, *Hysteria*, 268.
[59] Veith, *Hysteria*, 269.
[60] Veith, *Hysteria*, 269.
[61] Veith, *Hysteria*, 269.
[62] Veith, *Hysteria*, 269.

the reason he abandoned hypnosis was that he hoped to broaden the scope of his research and treatment beyond hysteria to include nervous disorders in general.[63]

Kevin Aho has noted that Freud's influence, especially the creation of psychoanalysis, pulled mental disorders and neuroses away from the naturalistic paradigm.[64] However, this deviance from the conventional conceptions of disease meant that psychoanalysis was met with controversy within the scientific community.[65] In addition, Freud eventually encountered a major issue with his approach which made it even more controversial: the concern that patients were inventing memories, possibly due to his influence.[66] However, psychoanalysis slowly grew in popularity and the controversy surrounding it diminished between the publication of *Studies on Hysteria* (1895) and the end of WWII as support for Freudian techniques grew and adherence to other paradigms faded.[67]

Neurasthenia and the Neuroses

Neurasthenia emerged in the late nineteenth century to reframe a range of symptoms associated with hysteria as a neurological disorder, but doctors still failed to ascertain an organic etiology. Under the influence of psychology, physicians began to question the organic origin of neurasthenia. George Beard had emphasized the role of culture in neurasthenia even in his earliest descriptions of the disease. However, by the 1930s, his proposed biological explanation—the concept of a weakened nerve force—had been abandoned.[68] Freud had defined the "neuroses" as psychogenic rather than neurological disorders.[69] He used the title "psychoneuroses" to describe psychological conditions that

[63] Veith, *Hysteria*, 269.
[64] Kevin Aho, "Neurasthenia Revisited: On Medically Unexplained Syndromes and the Value of Hermeneutic Medicine," *Journal of Applied Hermeneutics* (April 9, 2018): 6.
[65] Aho, "Neurasthenia Revisited," 6.
[66] Veith, *Hysteria*, 271-271.
[67] Shorter, *From Paralysis to Fatigue*, 254.
[68] Janet Oppenheim, *"Shattered Nerves": Doctors, Patients, and Depression in Victorian England* (New York, Oxford: Oxford University Press, 1991), 109.
[69] Oppenheim, "*Shattered Nerves*," 109.

involved both mental and physical symptoms.[70] A collection of new diagnoses arose within the broader category of the psychoneuroses to replace neurasthenia with more specific explanations for individual symptoms.[71] As this recategorization extended across the twentieth century, neurasthenic symptoms were further broken down into a diverse set of diagnostic titles.[72]

One novel diagnostic category in particular posed a challenge to neurasthenia. In 1894, Freud published an article, "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis,'" in which he argued that neurasthenia was too broad a category to be useful in medical discourse.[73] Freud wrote that

> In my opinion, it can be nothing but a gain to neuropathology if we make an attempt to separate from neurasthenia proper all those neurotic disturbances in which, on the one hand, the symptoms are more firmly linked to one another than to the typical symptoms of neurasthenia (such as intracranial pressure, spinal irritation, and dyspepsia with flatulence and constipation); and which, on the other hand, exhibit essential differences in their aetiology and mechanism from the typical neurasthenic neurosis.[74]

Freud grouped symptoms of neurasthenia that were etiologically and symptomatically related to anxiety and combined them under the heading of "anxiety neurosis."[75] He characterized anxiety neurosis by "general irritability," "anxious expectation" (a kind of paranoia that involved viewing ordinary occurrences as catastrophes), "anxiety attack" (attacks that resembled a mild form hysterical fits), "vertigo," "phobia," "gastrointestinal issues," and

[70] Rafaela Teixeira Zorzanelli, "Fatigue and Its Disturbances: Conditions of Possibility and the Rise and Fall of Twentieth-Century Neurasthenia," *História, Ciências, Saúde-Manguinhos* 16, no. 3 (2009): 615, http://www.scielo.br/scielo.php?script=sci_abstract&pid=S0104-59702009000300002&lng=en&nrm=iso&tlng=en.
[71] Zorzanelli, "Fatigue and its Disturbances," 617.
[72] Zorzanelli, "Fatigue and its Disturbances," 617.
[73] Micale, "On the 'Disappearance' of Hysteria," 520-521.
[74] Sigmund Freud, "On the Grounds for Detaching a Particular Syndrome from Neurasthenia Under the Description 'Anxiety Neurosis,'" in *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, trans. James Strachey, vol. III (London: The Hogarth Press Ltd., 1962), 90.
[75] Freud, "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis,'" 90.

"paresthesias" (sensory symptoms including rheumatism and increased sensitivity to pain).[76] In the article, Freud compared and contrasted anxiety neuroses and hysteria, noting that

> The symptomatology of hysteria and anxiety neurosis show many points in common, which have not yet been sufficiently considered. The appearance of symptoms either in a chronic form or in attacks, the paresthesias, grouped like aurae, the hyperesthesias and pressure-points which are found in certain surrogates of an anxiety attack… these and other features which the two illnesses have in common even allow of a suspicion that not a little of what is attributed to hysteria might with more justice be put to the account of anxiety neurosis.[77]

Nevertheless, Freud maintained that hysteria and anxiety neurosis were distinct disorders. He asserted that the neuroses often overlapped, and referred to these cases as "mixed neuroses."[78] In particular, Freud highlighted the comorbidity of anxiety neurosis with "neurasthenia, hysteria, obsessions, or melancholia."[79]

Interestingly, Freud acknowledged that "In some cases of anxiety neurosis no aetiology at all is to be discovered" and attributed these instances to "a grave hereditary taint."[80] In addition, although he considered neuroses to be responses to emotional and sexual repression, he did not fully abandon the notion of an organic basis. As late as 1925, he argued that "It [sexuality] had a somatic side as well, and it was possible to assign chemical processes to it and to attribute sexual excitement to the presence of some particular, though at present unknown, substances."[81]

Janet also constructed a new diagnostic category, "psychasthenia," to distinguish the psychological aspects of neurasthenia.[82] Specifically, he included symptoms such as phobias, depressions, obsessions, *idées fixes*, irrational fears, and impulsive and compulsive

[76] Freud, "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis,'"
[77] Freud, "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis,'" 114-115.
[78] Freud, "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis,'" 113.
[79] Freud, "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis,'" 112.
[80] Freud, "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis,'" 99.
[81] Sigmund Freud, *An Autobiographical Study*, trans. James Strachey (London: The Hogarth Press Ltd., 1950), 44.
[82] Zorzanelli, "Fatigue and its Disturbances," 615.

behaviours in his description of psychasthenia.[83] Janet defined psychasthenia and hysteria as the two major categories of "psychopathologies," but distinguished the two disorders based on symptoms.[84] While he characterized hysteria as a collection of neurological ailments, Janet's psychasthenia manifested in psychological and emotional expressions.[85] Despite this distinction, Janet admitted that "It is impossible to deny that a very large number of patients belong simultaneously to both classes" and that it was "impossible… to separate these two disorders completely."[86] Although the two disorders were associated with different symptoms, many patients presented signs of both diagnoses.[87] In his comparisons between hysteria and psychasthenia, Janet likened hysterical attacks to anxiety attacks, hysterical anesthesias to depressive episodes, hysterical paralyses to abulia, and hysterical contractures to *idées fixes*.[88] He also designated both psychasthenia and hysteria as "disorders of psychological dissociation,"[89] a term that preceded the psychiatric category of "dissociative disorders."[90] Although Janet grouped together psychological aspects of diseases that straddled the neurological and psychological categories, his diagnosis remained broad and encompassed a wide range of symptoms.

Psychasthenia, like neurasthenia, arose late in the nineteenth century and had disappeared from medical literature by 1915.[91] The rise and fall of this diagnosis—which occurred even more rapidly than the case of neurasthenia—exposes the fluidity of the psychoneuroses at the turn of the century.[92] However, the descriptions of psychasthenia and the anxiety neuroses were important steps in the psychologization of the neuroses. Once the neuroses were no longer believed to be neurological in origin, traditional cures, such as the

[83] Micale, "On the 'Disappearance' of Hysteria," 516.
[84] Micale, "On the 'Disappearance' of Hysteria," 516.
[85] Micale, "On the 'Disappearance' of Hysteria," 516-517.
[86] Pierre Janet quoted in Micale, "On the 'Disappearance' of Hysteria," 517.
[87] Micale, "On the 'Disappearance' of Hysteria," 517.
[88] Micale, "On the 'Disappearance' of Hysteria," 517.
[89] Pierre Janet quoted in Micale, "On the 'Disappearance' of Hysteria," 517.
[90] Micale, "On the 'Disappearance' of Hysteria," 517.
[91] Micale, "On the 'Disappearance' of Hysteria," 517.
[92] Micale, "On the 'Disappearance' of Hysteria," 517.

rest cure, were questioned and eventually replaced by treatments targeting the mind, such as psychotherapy and speech and occupational therapies.[93] In addition, both Freud's and Janet's attempts to disentangle certain disorders from broad diagnostic categories constituted early reconsiderations of nosological classification systems.[94] This reimagining of nervous disease inspired further theories about psychogenic illness.

The Psychoses

Alongside the psychoneuroses, a new category of diagnoses arose to describe a more severe group of mental disorders: the psychoses.[95] American neurologist Charles Dana (1852-1935) discussed the disappearance of neurasthenia and hysteria and the simultaneous emergence of the psychoses in a 1904 journal article: "It is my contention that a large number of these so-called neurasthenias and all the hysterias should be classed as prodromal stages, abortive types, or shadowy imitations of the great psychoses."[96] While the neuroses were not clearly defined and included wide-ranging and overlapping diagnostic categories, the psychoses were more straightforward and easily accepted by the medical community.[97] These disorders were explicitly psychological in nature, involving mental instability and universally believed to be caused by psychological processes. However, physicians still faced the challenge of further classifying the psychoses and defining specific disorders within this broader category.

Referred to by Micale as "the Linnaeus of psychiatry," Emil Kraepelin (1856-1926) developed an innovative classification system for psychiatric illness that was built around the psychoses.[98] He laid out his approach to psychiatric classification in his textbook,

[93] Zorzanelli, "Fatigue and its Disturbances," 12.
[94] Micale, "On the 'Disappearance' of Hysteria," 516.
[95] Micale, "On the 'Disappearance' of Hysteria," 516.
[96] Charles Dana quoted in Micale, "On the 'Disappearance' of Hysteria," 513.
[97] Micale, "On the 'Disappearance' of Hysteria," 516.
[98] Micale, "On the 'Disappearance' of Hysteria," 511.

Psychiatrie: Ein Lehrbuch, and produced eight editions expanding his work between 1883 and 1915.[99] Kraepelin built on previous research on hysterical insanity and narrowed down diagnostic categories to target specific symptoms and mental processes.[100] He based his conclusions on extensive clinical research that focused on individual cases and strived to create a unified classification system for all mental disorders.

Within his classification system, Kraepelin identified and distinguished between two types of psychosis:[101] dementia praecox, a premature deterioration of the mental faculties resulting in psychosis, and manic-depressive psychosis, psychosis brought about by a mood disorder. Kraepelin further divided dementia praecox—which was eventually renamed "schizophrenia"—into three more specific diagnoses: hebephrenic, catatonic, and paranoid dementia praecox. The hebephrenic and catatonic subtypes in particular resembled aspects of hysteria. Hebephrenic dementia praecox included hyperesthesias, hypersexuality, and mood and emotional instability; the catatonic subtype was associated with sensory dysfunctions such as (often auditory) hallucinations, vulnerability to suggestion, impulsivity, and certain physical "movements, mannerisms, and postures."[102] Furthermore, Kraepelin noted women were twice as likely to develop dementia praecox.[103]

Dementia praecox was defined as a "mood-incongruent" disorder, wherein psychosis was not connected to mood.[104] Manic-depressive psychosis, on the other hand, fell under the category of manic-depressive insanity: psychotic symptoms of this designation originated in mood disorders. Within this category, Kraepelin distinguished between mania, depression, and a combination of the two.[105] He maintained that patients with manic-depressive insanity may experience symptoms ranging from minor fluctuations in mood to mania and depression

[99] Micale, "On the 'Disappearance' of Hysteria," 512.
[100] Micale, "On the 'Disappearance' of Hysteria," 513.
[101] Jules Angst and Alex Gamma, "Diagnosis and Course of Affective Psychoses: Was Kraepelin Right?," *European Archives of Psychiatry and Clinical Neuroscience*, no. 258 (2008): 107.
[102] Micale, "On the 'Disappearance' of Hysteria," 513.
[103] Micale, "On the 'Disappearance' of Hysteria," 513.
[104] Angst and Gamma, "Diagnosis and Course of Affective Psychoses," 109.
[105] Angst and Gamma, "Diagnosis and Course of Affective Psychoses," 108.

to psychosis. He also highlighted the fact that symptom severity may vary across an individual's lifetime. In a broader sense, Kraepelin believed that all mental illnesses existed along a continuum of severity. He viewed manic-depressive psychosis as an intense expression of manic-depressive insanity, and all forms of psychosis as the most severe mental disorders. Among those suffering from mental illnesses, symptom expression could vary on a daily or even hourly basis and across a patient's lifetime. For example, a person diagnosed with a psychotic disorder would not constantly experience psychosis. They would experience psychotic episodes interspersed between periods of more manageable symptoms.[106]

Kraepelin acknowledged that determining how to categorize patients was frequently an insurmountable challenge. He did not outline a specific list of signs that differentiated between dementia praecox and manic depressive psychosis, largely because in many cases it was nearly impossible to provide a definitive diagnosis in a clinical setting.[107] Rather, he emphasized understanding all of the factors involved in a particular case and making an informed and individualized diagnosis.[108] He hoped to eventually ground his psychiatric classifications in scientific evidence.[109] However, when his neurological, physiological, biochemical, and genetic research on the role of the brain in mental illness proved fruitless,[110] Kraepelin relied on his clinical research to identify patterns, relationships between symptoms, and possibilities for treatment.[111] Kraepelin's approach differed from those of other physicians in that he "appl[ied] explicitly and systematically a longitudinal, lifetime approach to the description of individual illness."[112] However, his system was not always perfectly executed and the research methods he employed—involving the long-term study of

[106] Angst and Gamma, "Diagnosis and Course of Affective Psychoses," 108-109.
[107] Jablensky, "Living in a Kraepelinian World," 385.
[108] Jablensky, "Living in a Kraepelinian World," 383.
[109] Jablensky, "Living in a Kraepelinian World," 383.
[110] Jablensky, "Living in a Kraepelinian World," 383.
[111] Jablensky, "Living in a Kraepelinian World," 383.
[112] Assen Jablensky, "Living in a Kraepelinian World: Kraepelin's Impact on Modern Psychiatry," *History of Psychiatry* 18, no. 3 (September 1, 2007): 383-384, https://doi.org/10.1177/0957154X07079690.

individual patients—were certainly tedious and could be considered impractical.[113] Despite these shortcomings, Kraepelin's contributions to psychiatric classification laid the groundwork for ongoing attempts to categorize mental illness today.

Psychosomatic Illness

Another development in the early clinical restructuring of hysteria was the rise of psychosomatic illnesses. Throughout the history of hysteria, physicians searched for a single organic explanation for the extensive list of symptoms. With advances in biological medicine, several hysteria symptoms were explained by organic mechanisms, including epilepsy, syphilis, multiple sclerosis, and cranial injury.[114] At the same time, the psychoneuroses and psychoses accounted for many of the mental symptoms of hysteria. As a result, by the early twentieth century, hysteria was rapidly declining as an all-encompassing medical category as more specific disorders grounded in growing medical knowledge arose to replace it.

Certain physical symptoms of hysteria could not be explained by biological processes. As hysteria gradually lost its position as a valid diagnostic category, these conditions remained suspended between the biological and psychological realms, just as they had under the title of hysteria. Kraepelin's and Charcot's attempts to uncover a physical origin for psychological symptoms had furthered the naturalistic assumption that all true illnesses must be explained within a biological framework. However, the rise of psychology offered an increasingly acceptable alternative explanation for these symptoms.[115] Kraepelin's systematic classification of mental disorders improved the status of psychology as a credible, scientific discipline. As a result, doctors began to attribute somatic symptoms to psychological processes, especially following the model of hysterical conversion laid out by Freud.[116]

[113] Jablensky, "Living in a Kraepelinian World," 385.
[114] Micale, "On the 'Disappearance' of Hysteria," 525.
[115] Shorter, *From Paralysis to Fatigue*, 11.
[116] Cramer, "What Has Happened to Hysteria?" 705.

In 1924, Austrian psychoanalyst Wilhelm Stekel (1868-1940), one of Freud's early friends and followers, coined the term "somatization," although he did not develop this concept beyond Freud's existing descriptions of hysterical conversion.[117] In 1943, Franz Alexander (1891-1964), founder of the Chicago Institute for Psychoanalysis,[118] compared simple physical reactions to certain emotions to more complex somatic expressions of psychological distress:

> The vegetative [visceral] concomitants of various emotional states are as different from each other as laughter from weeping—the physical expression of merriment from that of sorrow. It is therefore to be expected that just as the nature of chronic unrelieved emotional state varies, so also will the corresponding vegetative disturbance vary…. Gastric neurotic symptoms have a different psychology from those of emotional diarrhea or constipation; cardiac cases differ in their emotional background from asthmatics.[119]

Certain psychosomatic illnesses, including hypertension, irritable bowel syndrome, asthma, and contact dermatitis, arose from Alexander's research. Although some of these conditions have since been disputed, Alexander's work placed these physical symptoms within the realm of psychology.[120]

Shorter defines somatization as the process through which patients adjust their symptomatic expressions in order to comply with current models of disease. He considers hysteria and neurasthenia to be examples of this phenomenon and designates the two disorders psychosomatic conditions.[121] Shorter argues that physical manifestations of psychological distress have been tied to the prevalence of naturalism in medicine.[122] Historian Janet Oppenheim asserts that the concept of psychosomatic illness presented a new interpretation of medically unexplained symptoms which earlier in the century were attributed to reflex action. She also highlights the interaction between cultural and biological

[117] Shorter, *From Paralysis to Fatigue*, 259-260.
[118] Shorter, *From Paralysis to Fatigue*, 261.
[119] Franz Alexander quoted in Shorter, *From Paralysis to Fatigue*, 260-261.
[120] Shorter, *From Paralysis to Fatigue*, 261.
[121] Shorter, *From Paralysis to Fatigue*, 4.
[122] Aho, "Neurasthenia Revisited," 6.

factors that create psychosomatic symptoms. Oppenheim illustrates this point through the example of neurasthenia. She points out that doctors recognized the role of social influence in producing neurasthenia, but simultaneously attempted to maintain the disorder's status as a legitimate organic disease.[123] Psychosomatic illnesses expose the false dichotomy between naturalism and cultural constructionism.

Porter also highlights the role of culture in shaping symptom expressions by contrasting examples of culturally permissible symptoms for men and women. He suggests that in the nineteenth century, men tended to experience gastric disorders, which were associated with masculinity because they indicated an active lifestyle. Women, on the other hand, were more likely to be diagnosed with hysteria due to a range of symptoms "emblematic of helplessness, enfeeblement, and (with lower limb paralysis) immobilization, acting out thereby, through the sickness paradigm, the sufferer's actual social condition."[124] Psychosomatic illnesses continue to be related to cultural factors, both within the medical field and general social norms.

Charles V. Ford, a modern-day physician and writer, refers to common symptom expressions among somatizing patients at a given time as "fashionable diagnoses." He lists fibromyalgia, multiple chemical sensitivities, and dysautonomia as examples of fashionable diagnoses. All of these disorders are characterized by unexplained physical symptoms. Ford also explores the concept of "nondisease." He cites hysteria as the first example of a somatization disorder, beginning its long history 4000 years ago. According to Ford, fashionable diagnoses come and go and patients who cling to these disease labels "as a rationalization for psychosocial problems or as a coping mechanism" make illness "a way of

[123] Oppenheim, "*Shattered Nerves*," 95.
[124] Roy Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," in *Hysteria Beyond Freud* (Berkeley and Los Angeles, California: University of California Press, 1993)," 229.

life" and occupy what he and many other theorists including Elaine Showalter have termed the "sick role."[125] Ford characterizes somatization disorders by:

> (i) vague, subjective multisystem complaints,
> (ii) a lack of objective laboratory findings,
> (iii) quasi-scientific explanations,
> (iv) overlap from one fashionable diagnosis to another,
> (v) symptoms consistent with depression or anxiety or both,
> (vi) denial of psychosocial distress or attribution of it to the illness.[126]

According to Shorter, patients who identify with somatization disorders typically reject the suggestion that their symptoms arise from a psychological rather than physical origin.[127] These patients are therefore reluctant to visit psychologists or psychiatrists, and instead seek the guidance of internists, neurologists, and gynecologists.[128] Over time, physicians have developed resentment towards these patients, who remain resistant to treatment and unwilling to accept psychological treatments options. Shorter suggests that many doctors end up administering placebo therapies to appease somatizing patients without causing further damage.[129] These patients and their doctors often develop strained relationships as a result of their conflicting perceptions of the illness.

Cultural forces are often presumed to bring about new fashionable diagnoses and psychosomatic expressions of distress. Ford considers hysteria an example of a long-standing somatization disorder,[130] and Showalter adds that hysteria has transformed over time, "mimic[king] culturally permissible expressions of distress."[131] She defines hysteria as a "mimetic disorder" that is highly susceptible to cultural change, increasing in intensity during periods of societal disruption and widespread stress.[132] However, Oppenheim insists that it is

---

[125] Charles V. Ford, "Somatization and Fashionable Diagnoses: Illness as a Way of Life," *Scandinavian Journal of Work, Environment & Health* 23, no. 3 (1997): 7-8.
[126] Ford, "Somatization and Fashionable Diagnoses," 7.
[127] Shorter, *From Paralysis to Fatigue*, 261.
[128] Shorter, *From Paralysis to Fatigue*, 263.
[129] Shorter, *From Paralysis to Fatigue*, 201, 264.
[130] Ford, "Somatization and Fashionable Diagnoses," 7.
[131] Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (Harmondsworth, Middlesex, England: Penguin Books Ltd, 1985), 15.
[132] Showalter, *Hystories*, 19.

important to not overlook the real suffering that these patients experience, regardless of the origin of their symptoms. She notes that although it would be wrong to reduce illness to a biological mechanism (and therefore fail to address disorders without an organic origin), the cultural constructionist approach tends to ignore or minimize patients' experiences and therefore also falls short of providing a nuanced description of disease.[133] Models of disease must account for the complex ways in which biology, psychology, and culture interact with one another in order to accurately explain and treat physical, mental, and psychosomatic illness.

Conclusion

Psychological research on hysteria toward the end of the nineteenth century competed with and eventually replaced neurological disease models. Prominent figures like Sigmund Freud, Josef Breuer, Pierre Janet, Hippolyte Bernheim, Joseph Babinski, and Emil Kraepelin invented new diagnostic titles and treatments to address particular psychological processes. As a result, the all-encompassing disease entity hysteria was broken down into more targeted diagnoses. Some hysteria symptoms were found to be components of physical diseases, while the remaining symptoms were explained by psychological processes. Medically unexplained physical symptoms were attributed to psychological explanations that arose from Freud's theory of hysterical conversion. Following these psychological developments, hysteria continued to exist within these newer categories. Throughout the twentieth and twenty-first centuries, changes between successive editions of the *DSM* have demonstrated the rising and falling of psychiatric diagnoses. In addition, physical disorders that doctors have failed to explain through biomedical knowledge have been dismissed by physicians but not adequately explained by psychologists. Late nineteenth-century psychological research altered the

[133] Oppenheim, *Shattered Nerves*, 4-5.

history of hysteria, which from then on existed in a range of disconnected disorders rather than a unified disease entity. The following two chapters explore the history of hysteria in the twentieth century by tracing its symptoms in psychiatric diagnoses as well as chronic fatigue syndrome and fibromyalgia, two mysterious and controversial disorders that continue to confound both medical doctors and psychologists.

CHAPTER FOUR: THE DISPERSION OF HYSTERIA THROUGH THE *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (*DSM*)

As the symptoms previously understood as hysteria were increasingly explained by biological and psychological mechanisms, new diagnostic categories arose to replace hysteria. By the end of World War I, the term "hysteria" was rarely used as a medical diagnosis. Psychological research at the end of the nineteenth century caused many hysteria symptoms to be absorbed by the professions of psychology and, increasingly, psychiatry. In the twentieth century, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*)—the essential manual of psychiatric diagnoses created by the American Psychiatric Association—described hysteria symptoms through changing psychiatric theories and shifting diagnostic categories. Through successive editions of the *DSM*, published in 1952, 1968, 1980, 1987, 1994, 2000, and 2013, hysteria symptoms were dispersed among an increasing number of diverse psychiatric conditions. In addition, other disorders that have emerged in recent history, such as chronic fatigue syndrome and fibromyalgia, involve unexplained physical symptoms that were once attributed to hysteria.

Many of these "hysterical" diagnoses, in the *DSM* and beyond, continue to be vaguely defined and are often diagnosed primarily in women. This chapter traces hysteria's dispersion through the *DSM* in order to highlight changing understandings of hysteria symptoms. I argue that despite continuous diagnostic reclassifications, symptoms once included under the umbrella of hysteria remain poorly understood. I further contend that medical professionals—in this case psychiatrists—continue to resort to symptoms-based "wastebasket" diagnoses to categorize symptoms for which they have no definitive explanation. In addition, I show that the language used to describe diagnoses that are descended from hysteria evoke the same stereotypes that can be found in nineteenth-century medical writing on hysteria. I argue that

hysteria persists under new names and new forms, and that attempts in the *DSM* to compartmentalize hysterical illness have not resulted in a greater understanding of the condition. Instead, these ambiguous conditions continue to be defined in relation to femininity and women who experience these symptoms continue to be dismissed and neglected by the medical field.

Explanations of Hysteria's Disappearance

The previous chapters deal with the history of hysteria as a diagnostic entity, from its beginnings in the ancient world to its prominent position in medical conversations at the end of the nineteenth century. This chapter picks up the history of hysteria decades after the diagnostic category became obsolete in the early twentieth century.[1] Doctors continued to research symptoms associated with hysteria after the diagnosis was no longer in use. The first edition of the *DSM*, published in 1952, systematically described and categorized the disorders present in American psychiatry for the first time. Historians and scholars have proposed different theories about how hysteria developed from a widely-used diagnostic entity in the nineteenth century, through the ambiguity surrounding the condition in the first half of the twentieth century, to the systematized reorganization of hysteria symptoms in *DSM-I*.[2]

One popular understanding of how and why hysteria "disappeared" frames the disease as a culturally produced epidemic. These scholars argue that hysteria was a psychological reaction to the social conditions of the late nineteenth century.[3] They cite sexual repression and an oppressive social structure as direct causes for hysteria symptoms.[4] Chapter Two explores some of the implications of this approach by analyzing cultural factors that

[1] Mark S. Micale, "On the 'Disappearance' of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis," *Isis* 84, no. 3 (September 1993), 501.
[2] I refer to the first edition of the *DSM* as *DSM-I* to distinguish it from the general title of these volumes. However, the original title was simply *Diagnostic and Statistical Manual of Mental Disorders*.
[3] Micale, "On the 'Disappearance' of Hysteria," 498-499.
[4] Micale, "On the 'Disappearance' of Hysteria," 499.

contributed to symptom production and what this meant for hysteria patients at the time. However, if hysteria is understood as a disease of cultural context, then hysteria symptoms would be expected to disappear once the social situation shifted in the early twentieth century. Women experienced many of the symptoms of hysteria before and after the late nineteenth century, which indicates that while this cultural setting may have created a more intense and widespread version of hysteria, the illness was not entirely produced by social factors.

Mark S. Micale also identifies an "argument from psychological literacy."[5] According to this theory, growing knowledge of the human mind spread through the general public, and patients found new ways to express distress that coincided with new models of mental disease.[6] Shorter would define this phenomenon as a shift in the symptom pool.[7] Rather than somatizing their emotional disturbances, patients began to display more psychological symptoms. Proponents of this theory point to the higher incidence of hysterical neuroses in "rural, lower-class, or third-world environments" and the simultaneous rise of depressive and narcissistic disorders and decline of psychosomatic symptoms in urban upper- and middle-class settings. They suggest that these demographic-based changes in symptom expression reveal that education about psychological processes and medically acceptable symptoms shifts symptom expression.[8] However, this description is not entirely historically accurate—psychosomatic symptoms continued to be present alongside psychological symptoms throughout the twentieth century.

Micale argues, however, that the disappearance of hysteria cannot be explained by ongoing social developments like sexual liberation or the rising prominence of psychology. If these new social developments were the culprit, one would expect to see a gradual decline in

[5] Micale, "On the 'Disappearance' of Hysteria," 499.
[6] Micale, "On the 'Disappearance' of Hysteria," 499.
[7] Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York, NY: The Free Press, 1992), 2.
[8] Micale, "On the 'Disappearance' of Hysteria," 499.

cases of hysteria over a long period of time as these changes took place. However, the hysteria diagnosis was essentially absent from medical discourse twenty years after Charcot's death in 1893.[9] Instead, Micale argues that hysteria did not truly disappear, but was rather reclassified in a series of nosological changes between 1895 and 1910. He views this process as a shift in clinical attitudes toward disease rather than a result of social changes: during this period, physicians began to rethink how they categorized and diagnosed diseases. Hysteria, then, ceased to be a medical diagnosis because it was replaced with other categories that physicians determined to be more accurate and useful in providing treatments.[10] Hysteria seemed to disappear, but actually continued to exist under a collection of different diagnostic titles.

The New "Hysterical" Disorders

The decline of hysteria as a diagnosis coincided with the emergence of disorders that absorbed aspects of hysteria and offered new explanations for mental distress. As we have seen, many of these disorders were based on psychological research in the late nineteenth century. The neuroses came to include a range of diagnoses, including the anxiety neuroses described by Freud, conversion and dissociative disorders, and hypochondriasis. Conversion disorder arose from Freud's concept of hysterical conversion, in which psychological issues are *converted* into physical symptoms. Similarly, the dissociative disorders were an extension of the disruptions in consciousness studied by Charcot and Janet. The psychoses were initially described by Kraepelin and have been present throughout the *DSM* editions in different configurations. Certain personality disorders also retain elements of hysteria, with the *DSM-II* specifically mentioning "hysterical personality" (now histrionic personality disorder) and borderline personality disorder emphasizing the emotional volatility associated

[9] Micale, "On the 'Disappearance' of Hysteria," 501.
[10] Micale, "On the 'Disappearance' of Hysteria," 502.

with hysteria. The majority of these disorders that arose out of hysteria are more frequently diagnosed in women.

Successive editions of the *DSM* reorganized and renamed these illnesses, through cultural changes and evolving psychiatric theory. Over time, diagnostic categories diversified and the descriptions of disorders became specific; each diagnostic title came to describe a narrow collection of symptoms rather than encompassing many different symptom expressions. In later versions of the *DSM*, the diagnostic category of the neuroses was eliminated, conversion and dissociative symptoms were definitively separated, and schizophrenia and mood disorders were no longer united as the "psychoses." Psychosomatic illnesses went through a series of name changes and different approaches to classification throughout the *DSM*, once divided between the neuroses and "psychophysiological disorders" before being redefined as "somatoform disorders" and eventually "somatic symptom disorders." This chapter traces the dispersion of hysteria symptoms and reorganization of mental disorders over the course of the twentieth and twenty-first centuries using specific passages from the *DSM* that highlight changing perspectives in psychiatry as well as ongoing beliefs about these disorders and their (mostly female) patients.

The History of the Diagnostic and Statistical Manual of Mental Disorders

The first edition of the American Psychological Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) was published in 1952 in order to standardize the diagnostic criteria for psychiatric disorders. Many of the disorders described in the *DSM* arose from conversations inspired by hysteria in the late nineteenth century; hysteria symptoms—both physical and psychological—have been included in many of the diagnostic categories. The successive editions of the *DSM* demonstrate evolving nosological approaches

to classifying illnesses and trends in psychiatric thought over the course of the twentieth century.

The use of the term "hysteria" as a diagnostic title was already rapidly declining by the end of the First World War. The first step along the transition to more accurate depictions of illness was the use of "hysterical" as an adjective in front of other diagnostic titles. Swiss psychiatrist Eugen Bleuler (1857-1939) spearheaded this movement. In Bleuler's *Textbook of Psychiatry*, published 1916, there was no specific chapter on hysteria, but across the work Bleuler named a range of "hysterical" disorders, such as "hysterical condition," "hysterical syndrome," "hysterical reactions," "hysterical associations," and "hysterophilic disease."[11] When Bleuler did reference hysteria outside of this adjectival form, he mainly described hysteria as a symptom or expression of other conditions—including both physical and mental illnesses—rather than a primary diagnosis. He also discussed hysteria in a dismissive manner, in quotation marks or using terms such as "the so-called hysterias" and "the pseudo-hysterias" to describe its various forms.[12] This relegation of hysteria to the status of a type of symptom rather than its own clinical entity coincided with the emergence of more specific diagnostic titles to explain hysterical symptoms. As a result, the term hysteria was phased out of medical classification systems.

The structure and methods of the *DSM* were inspired by Kraepelin's work to create a systematic map of the mental disorders, although the nosological approach evolved over time.[13] Each successive version of the *DSM* is substantially longer than the last, expanding on the previous psychiatric knowledge and refining classifications and diagnostic criteria. Although each *DSM* revision added to the previous edition, *DSM-III*, published in 1980, marked what Mayes and Horwitz (2005) have deemed a "Revolution in the Classification of

[11] Micale, "On the 'Disappearance' of Hysteria," 515.
[12] Micale, "On the 'Disappearance' of Hysteria," 515.
[13] Assen Jablensky, "Living in a Kraepelinian World: Kraepelin's Impact on Modern Psychiatry," *History of Psychiatry* 18, no. 3 (September 1, 2007): 385, 383, https://doi.org/10.1177/0957154X07079690.

Mental Illness." They suggest that *DSM-III* resulted from a desire to standardize psychiatric diagnoses and involved classifying mental illnesses according to their symptoms rather than their causes.[14] Aho also notes that *DSM-III* indicated a shift from psychiatry's psychoanalytic foundations to scientific and empirical approaches to mental illness.[15]

The first two editions of the *DSM*, published in 1952 and 1968, retained a psychoanalytic perspective that attributed mental illness to environmental factors. According to this view, anyone could experience the difficult life events and internal conflicts that led to psychological problems. The diagnostic categories described in *DSM-I* and *DSM-II* encompassed broad sets of symptoms and were grouped together based on similar mechanisms rather than symptomatic expressions. Symptoms were seen as ways of conveying inner conflicts that patients were unable to communicate in a healthy manner. The psychiatric theories surrounding *DSM-I* and *DSM-II* indicate a conception of mental health as a spectrum rather than a dichotomy of health vs. illness.[16] This perspective echoed Kraepelin's view of mental illnesses as existing on a continuum of severity.[17] As a result, psychiatrists often struggled to identify truly ill individuals due to the wide range of symptom severity included in *DSM-I* and *DSM-II* disease descriptions.[18]

Beginning in 1980, the discipline of psychiatry began to emphasize clear divisions between sickness and health. Symptoms and diagnostic criteria were described in more extensive detail in order to highlight the differences between disorders. To accommodate more thorough descriptions, *DSM-III* was significantly expanded, increasing the length of the *DSM* from 136 pages to 598 pages. Mayes and Horwitz argue that despite this dramatic change, *DSM-III* neither broadened the domain of psychiatry nor demonstrated an increase in

[14] Rick Mayes and Alan V. Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," *Journal of the History of the Behavioral Sciences* 41, no. 3 (Summer 2005): 249.
[15] Kevin Aho, "Neurasthenia Revisited: On Medically Unexplained Syndromes and the Value of Hermeneutic Medicine," *Journal of Applied Hermeneutics* (April 9, 2018): 6.
[16] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 249-250.
[17] Jules Angst and Alex Gamma, "Diagnosis and Course of Affective Psychoses: Was Kraepelin Right?," *European Archives of Psychiatry and Clinical Neuroscience*, no. 258 (2008): 108.
[18] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 250.

scientific knowledge or medicalization of the psychiatric discipline. Rather, *DSM-III* marked an attempt to characterize psychiatric disorders as distinct disease categories and remove the ambiguity of *DSM-I* and *DSM-II*.[19]

Rising criticisms of psychiatry in the 1970s played a role in the systematization of psychiatric diagnoses. Psychiatrist Thomas Szasz (1920-2012) suggested that the concept of mental illness served as a repressive force, silencing and subduing those who strayed from the state's definition of normalcy. Sociologist Thomas Scheff (b. 1929) argued that mental illness was used as a catch-all for unexplained symptoms and behaviours considered deviant. According to Scheff, diagnosing "patients" disguised psychiatrists' lack of understanding of psychological mechanisms—psychiatry categorized and defined but ultimately failed to truly explain mental illness.[20]

Insurance companies also questioned the medical legitimacy of psychiatry, especially its main treatment at the time, psychotherapy. Psychiatrists had failed to provide consistent empirical evidence to prove that psychotherapy was an effective treatment over the long term. At the same time, sociological studies had brought the effectiveness of psychotherapy into question. A final criticism suggested that psychiatry did not target genuinely sick individuals, but provided care and support for a generally well-off client base suffering from general dissatisfaction or worry.[21] The discipline was perceived as failing to serve the community that most needed its help.

In light of these criticisms, psychiatrists attempted to distinguish themselves from other mental health practitioners who offered psychotherapy in order to assert psychiatry's status as a medical profession.[22] Medication treatments increasingly replaced psychotherapy

[19] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 250-251.
[20] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 252.
[21] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 253-254.
[22] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 255.

as part of the medicalization of psychiatry.[23] The introduction of antipsychotic drugs (beginning with chlorpromazine in 1954) and government programs like Medicare and Medicaid (1965) facilitated the deinstitutionalization of mental patients.[24] Psychiatrists hoped that utilizing a symptom-based structure in *DSM-III* would set psychiatry apart from other mental health professionals, improve its status as a medical discipline, and secure funding from the government and insurance companies.[25]

The emphasis on a standardized categorization of psychiatric disorders in *DSM-III* and beyond reveals that the discipline continued to evolve throughout the twentieth century. Patients that would have been diagnosed with hysteria in the nineteenth century were now depicted and treated very differently. And yet, biases that were present in the late nineteenth-century descriptions of hysteria continue to influence its constituent conditions today. The following sections trace a few of these disorders through the editions of the *DSM* and the corresponding changes in psychiatric thought over the course of the twentieth century. These case descriptions serve to highlight the similarities of these disorders to one another and to an older understanding of hysteria, despite psychiatrists' continued attempts to separate these conditions.

The Psychoses

Kraepelin's work on defining the psychoses was particularly important for developing his influential classification system.[26] The *DSM* continued his efforts to categorize the psychoses alongside other forms of mental illness. In the first two editions of the *DSM*, schizophrenia (formerly dementia praecox) and affective disorders (manic depressive illness)

[23] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 255; Denis Morrison, "The Roots of DSM-III and the Emergence of Neuroscience: Towards 'Mind Meets Brain,'" *Mentalities* 18, no. 2 (January 1, 2004): 2.
[24] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 254-255.
[25] Mayes and Horwitz, "DSM-III and the Revolution in the Classification of Mental Illness," 257.
[26] Jablensky, "Living in Kraepelinian World," 383.

were grouped together based on their psychotic elements. The "Psychotic Disorders" in *DSM-I*[27] and "Psychoses" in *DSM-II*[28] included a range of psychotic "reactions," divided into "Schizophrenic Reactions," "Affective Reactions," and "Paranoid Reactions."[29] All of the versions of the *DSM* retained Kraepelin's distinction between dementia praecox and manic depressive illness, but *DSM-III* de-emphasized the relationship between the two categories. In *DSM-III*, the "Affective Disorders"[30] and "Schizophrenic Disorders"[31] were given separate sections, rather than being classified as subcategories of the "Psychoses."[32] "Paranoid Disorders"[33] and "Psychotic Disorders Not Elsewhere Classified"[34] constituted two other categories no longer included under the heading of "Psychoses." *DSM-III-R* renamed the "Affective Disorders" as "Mood Disorders"[35] and *DSM-5* further divided these diagnoses into "Bipolar and Related Disorders"[36] and "Depressive Disorders."[37]

The meanings of these terms also evolved. Kraepelin's definition of dementia praecox highlighted the "deteriorating course" of the illness.[38] Bleuler and Schneider emphasized other aspects of schizophrenic illness: the "underlying disturbances in certain psychological processes" and "pathognomonic symptoms," respectively.[39] Kraepelin also included three subtypes of dementia praecox: catatonic, hebephrenic, and paranoid.[40] The catatonic and hebephrenic subtypes, in particular, were directly related to the motor and psychological

---

[27] American Psychiatric Association, *Diagnostic and Statistical Manual: Mental Disorders* (Washington, DC: American Psychiatric Association, 1952), 5.
[28] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (Washington, DC: American Psychiatric Association, 1968), 23.
[29] *DSM-I*, 11.
[30] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (Washington, DC: American Psychiatric Association, 1980), 205.
[31] *DSM-III*, 181.
[32] *DSM-III*.
[33] *DSM-III*, 195.
[34] *DSM-III*, 199.
[35] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* (Washington, DC: American Psychiatric Association, 1987), 213.
[36] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (Washington, DC: American Psychiatric Association, 2013), 123.
[37] *DSM-5*, 155.
[38] *DSM-III*, 181.
[39] *DSM-III*, 181.
[40] Micale, "On the 'Disappearance' of Hysteria," 513.

symptoms of hysteria in the nineteenth century, respectively.[41] The catatonic manifestation of schizophrenia (marked by either excessive, excited motor activity or by motor inhibition displaying as, for example, stupor or mutism) remained throughout all of the *DSM* editions.[42] (However, in DSM-5, "catatonia" was defined as a "specifier" that can be associated with other mental disorders besides schizophrenia.[43]) The hebephrenic form (described in *DSM-I* as "characterized by shallow, inappropriate affect, unpredictable giggling, silly behaviour and mannerisms, delusions, often of a somatic nature, hallucinations, and regressive behaviour"[44]) was directly mentioned in *DSM-I* and *DSM-II*, after which it was replaced by the term "Disorganized Type."[45] These two expressions of schizophrenia clearly invoke descriptions of hysteria in the nineteenth century but are classified as schizophrenic illness in the *DSM*.

In *DSM-I*, "manic depression reactions" were characterized primarily by their psychotic features. This title referred to "psychotic reactions which fundamentally are marked by severe mood swings," wherein "accessory symptoms such as illusions, delusions, and hallucinations may be added to the fundamental affective alteration."[46] By *DSM-5*, the mood disorders were no longer defined by their (potential) psychotic elements and were separated into distinct categories rather than being under the same heading.[47] At first, the mood disorders were presented as being manic, depressed, or a combination of the two (either mixed or circular).[48] Later, when bipolar illness was separated from depressive illness, the diagnostic criteria changed: the purely manic reaction was removed and bipolar disorder was defined by the presence of at least one manic (or hypomanic) episode as well as depression.[49]

[41] Micale, "On the 'Disappearance' of Hysteria," 513.
[42] *DSM-I*, 26; *DSM-II*, 33-34.
[43] *DSM-5*, 119.
[44] *DSM-I*, 26.
[45] *DSM-III*, 190.
[46] *DSM-I*, 25.
[47] *DSM-I*, 25.
[48] *DSM-I*, 25.
[49] *DSM-III*, 205.

In a controversial move, premenstrual dysphoric disorder (PMDD) was introduced in *DSM-IV-TR* as a potential diagnosis requiring further study[50] and was added under "Depressive Disorders" in *DSM-5*.[51] Premenstrual dysphoric disorder was defined as "markedly depressed mood, marked anxiety, marked affective lability, and decreased interest in activities" in the days leading up to a menstrual period.[52] Some feminist scholars, including Jane Ussher, have criticized the inclusion of premenstrual dysphoric disorder in the *DSM*. They have argued that this pathologization and, more importantly, *psychologization* of premenstrual symptoms implies there is something wrong with someone who experiences symptoms that are common among many people with uteruses.[53] Premenstrual dysphoric disorder linked symptoms once associated with hysteria back to the female reproductive system.

The Personality Disorders

A discussion of modern-day hysteria would not be complete without mention of the personality disorders, particularly histrionic personality disorder and borderline personality disorder. The term "personality disorder" implies a disturbance of an individual's character; these disorders are usually defined in relation to behavioural patterns. *DSM-I* focused on distinguishing between personality disorders and other forms of mental illness, indicating that in personality disorders, "the personality utilizes primarily a pattern of action or behavior in its adjustment struggle, rather than symptoms in the mental, somatic, or emotional spheres."[54] *DSM-III* defined personality *traits* as "enduring patterns of perceiving, relating to, and

[50] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (Washington, DC: American Psychiatric Association, 2000), 771.
[51] *DSM-5*, 155.
[52] *DSM-IV-TR*, 771.
[53] Jane M Ussher, "Diagnosing Difficult Women and Pathologising Femininity: Gender Bias in Psychiatric Nosology," *Feminism & Psychology* 23, no. 1 (February 1, 2013): 66, https://doi.org/10.1177/0959353512467968.
[54] *DSM-I*, 13.

thinking about the environment and oneself."[55] Personality disorders resulted from "flexible and maladaptive" personality traits that cause "significant impairment in social or occupational functioning or subjective distress."[56]

Perhaps the most interesting and telling definition of the term "personality disorder" was first outlined in *DSM-IV* and continues to be the accepted technical definition. The following description is echoed word for word in *DSM-IV-TR* and *DSM-5*: "A Personality Disorder is an enduring pattern of inner experience and behavior that *deviates markedly from the expectations of the individual's culture*, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."[57] This definition suggests that culture plays a role not in producing symptoms, but in providing a set of experiences and behaviours deemed "normal." Personality *disorders* occur when an individual's experiences and behaviours fall outside of the range of normalcy.

This conception of personality disorders is all the more interesting when considered in the context of the history of hysteria. Like personality disorders, hysteria was a pathology often associated with specific "abnormal" or undesirable behaviours. Histrionic personality disorder—once called "hysterical personality"[58]—developed directly out of hysteria and primarily affects women. Borderline personality disorder, first identified in *DSM-III*, is diagnosed as much as 75% of the time in women, according to *DSM-IV*,[59] and shares many symptoms with hysteria.

The original description of "hysterical personality (histrionic personality disorder)" in *DSM-II* bears a striking resemblance to the common stereotypes about hysteria before the twentieth century. Patients were described as "immature, self-centred, often vain, and usually

[55] *DSM-III*, 305.
[56] *DSM-III*, 305.
[57] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (Washington, DC: American Psychiatric Association, 1994), 629. Italics added.
[58] *DSM-II*, 43.
[59] *DSM-IV*, 652.

dependent on others."[60] The disorder itself involved "excitability, emotional instability, over-reactivity, and self-dramatization" which was "always attention-seeking and often seductive."[61] *DSM-III* went a step further, claiming that patients with histrionic personality disorder "often act out a role, such as the 'victim' or the 'princess,' without being aware of it."[62] The *DSM-III* description also suggested that regardless of the patient's gender, histrionic personality disorder manifested as a "caricature of femininity"; patients were described as "attempt[ing] to control the opposite sex."[63]

DSM-III was also the first edition of the *DSM* to compare rates of histrionic personality disorder in men and women, indicating that the diagnosis was given "far more frequently in females than in males."[64] *DSM-IV* amended this claim, noting that although women were more likely to be diagnosed with histrionic personality disorder, "the sex ratio is not significantly different than the sex ratio of females within the respective clinical setting" and some studies had indicated that the distribution may be more equal than previously supposed.[65] In addition, *DSM-IV* suggested different male and female presentations of the disorder in line with gender stereotypes: "a man with this disorder may dress and behave in a manner often identified as 'macho' and may seek to be the center of attention by bragging about athletic skills, whereas a woman, for example, may choose very feminine clothes and talk about how much she impressed her dance instructor."[66] This wording reveals that histrionic personality disorder is deeply interconnected with constructions of masculinity and femininity in contemporary society, even when diagnosed in men.

DSM-III introduced borderline personality disorder, which involved disturbances in interpersonal relationships, "impulsive and unpredictable behaviour that is potentially self-

[60] *DSM-II*, 43.
[61] *DSM-II*, 43.
[62] *DSM-III*, 313.
[63] *DSM-III*, 314.
[64] *DSM-III*, 315.
[65] *DSM-IV*, 657.
[66] *DSM-IV*, 657.

damaging," and an unstable mood "with marked shifts from a normal mood to a dysphoric mood or with inappropriate, intense anger or lack of control of anger."[67] While *DSM-III* and *DSM-III-R* noted that borderline personality disorder is more common in women, *DSM-IV* specified that 75% of patients with this disorder are female.[68] As per *DSM-IV*, borderline personality disorder is distinguished from histrionic personality disorder by "self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness."[69] Descriptions of these two disorders were not significantly altered or updated in *DSM-5*; they even retained much the same wording.

Hysteria has been discussed as a pathologization of women's expressions of distress at the hands of the patriarchy. Personality disorders describe some dysfunction in "enduring patterns of perceiving, relating to, and thinking about the environment and oneself."[70] The fact that histrionic personality disorder and borderline personality disorder are primarily diagnosed in women and depict patients in ways that align with cultural ideas about femininity indicates a similar pattern of labelling women's reactions and coping mechanisms as disorders. However, the wording in *DSM-IV*, *DSM-IV-TR*, and *DSM-5*, such as the idea that personality disorders are related to "deviat[ions]...from the expectations of the individual's culture,"[71] suggests that the pathologization of women's distress—in this case outward dramatization, emotionality, self-centredness, and self-destructiveness—comes not from cultural forces shaping women's behaviour but the definition of "normalcy" in society and its relation to women's lived experiences.

The Neuroses

[67] *DSM-III*, 321.
[68] *DSM-IV*, 652.
[69] *DSM-IV*, 653.
[70] *DSM-III*, 305.
[71] *DSM-IV*, 629.

Thanks to the contributions of late nineteenth-century psychologists, the term "neurosis" had a completely new connotation by the turn of the century. Once considered a neurological disorder potentially causing some psychological symptoms, "neurosis" came to describe *psychological* disturbances that could present physically or psychologically. *DSM-I* grouped these illnesses under the title of "Psychoneurotic Disorders," which was divided into different "reactions" describing physical and psychological expressions. Within this category, the most significant reactions to the history of hysteria are the anxiety reaction, the dissociative reaction, and the conversion reaction. These "reactions" were later reimagined under different categories of disease, each describing a range of symptomatic expressions and psychological mechanisms.

The anxiety and conversion reactions arose from Freud's research in the 1890s. These new disease entities referred to Freud's anxiety neurosis diagnosis and his concept of hysterical conversion, the mechanism he proposed to explain hysteria's physical symptoms. The dissociative reaction recalled earlier discussions of hysteria, especially Charcot's work at the Salpêtrière hospital on hysterical fits and Janet's notion of the splitting of consciousness. Conversion and dissociation were once considered two sides of hysteria, and this historical connection is clear in the continued overlap between the two "reactions." In later editions of the *DSM*, these terms that formerly described symptomatic expressions of the same disorder were nosologically divorced from one another despite retaining overlapping features.

Throughout the history of the *DSM*, psychiatrists have struggled to classify the neuroses. Initially, *DSM-I* grouped all of these conditions together under the title "Psychoneurotic Disorders."[72] *DSM-II* maintained the all-encompassing heading, although it was given the simple name "Neuroses."[73] *DSM-II* also classified conversion and dissociation

[72] *DSM-I*, 31.
[73] *DSM-II*, 39.

within this category as "types" of "Hysterical Neurosis."[74] In *DSM-III*, the disorders were reorganized: "Dissociative Disorders"[75] were separated from "Anxiety Disorders"[76] and a new category, "Somatoform Disorders,"[77] absorbed "conversion disorder." This classification dispersed the neuroses and detached these disorders from the original unifying term. Each of the following *DSM* editions retained *DSM-III*'s system, though *DSM-5* further isolated "Obsessive-Compulsive Disorders" from the "Anxiety Disorders."[78]

Although the conditions of interest—anxiety, dissociation, and conversion—retained consistent definitions, the overall diagnostic categories identified different distinguishing traits. In *DSM-I*, the "chief characteristic" of the psychoneurotic disorders was "'anxiety' which may be directly felt and expressed or which may be unconsciously and automatically controlled by the utilization of various psychological defense mechanisms."[79] In this first edition of the *DSM*, the divisions between the reactions were not as clearly defined as they were in later versions. For example, anxiety reaction was "characterized by anxious expectation and frequently associated with somatic symptomatology."[80] By comparison, conversion reaction, which was "synonymous with conversion hysteria," was defined by "the impulse causing the anxiety [being] 'converted' into functional symptoms in organs or parts of the body, usually those that are mainly under voluntary control."[81] Both of these conditions involved physical expressions of anxiety. In addition, *DSM-I* indicated that dissociative reaction was "formerly...classified as a type of 'conversion hysteria'" and described the condition as a "deflect[ion]" of anxiety producing symptoms such as "depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc."[82] At this

[74] *DSM-II*, 39.
[75] *DSM-III*, 225.
[76] *DSM-III*, 253.
[77] *DSM-III*, 241.
[78] *DSM-5*, 235. 189.
[79] *DSM-I*, 31.
[80] *DSM-I*, 32.
[81] *DSM-I*, 32-33.
[82] *DSM-I*, 32.

point in the history of classifying mental disorders, the neuroses were vaguely distinguished from one another but shared many common features.

DSM-II's "Neuroses" consisted of "anxiety neurosis,"[83] "hysterical neurosis"[84] (divided into "hysterical neurosis, conversion type"[85] and "hysterical neurosis, dissociative type"[86]) and two new disorders of interest, "neurasthenic neurosis (neurasthenia)"[87] and "hypochondriacal neurosis."[88] Anxiety neurosis was a continuation of the anxiety reaction category in *DSM-I* and the conversion and dissociative types of hysterical neurosis similarly retained the qualities of conversion reaction and dissociative reaction. However, the latter two disorders were now considered types of hysterical neurosis, which was defined by "an involuntary psychogenic loss or disorder of function" that would often "begin and end suddenly in emotionally charged situations" and responded easily to suggestion.[89] The description of the conversion type highlighted "the special senses or voluntary nervous system" as the origin of characteristic symptoms such as "blindness, deafness, anosmia, anaesthesias, paraesthesias, paralyses, ataxias, akinesias, and dyskinesias."[90] Remnants of nineteenth-century notions of hysteria also appeared in this description, which suggested that patients with hysterical neurosis, conversion type obtained the "secondary gains" of sympathy from others and the removal of "unpleasant responsibilities."[91] Hysterical neurosis, dissociative type primarily concerned "alterations… in the patient's state of consciousness or in his identity."[92]

Neurasthenic neurosis, or neurasthenia, reveals confusion regarding the correct approach to classifying mental disorders. A note at the end of the description of this disorder

[83] *DSM-II*, 39.
[84] *DSM-II*, 39.
[85] *DSM-II*, 39-40.
[86] *DSM-II*, 40.
[87] *DSM-II*, 40-41.
[88] *DSM-II*, 41.
[89] *DSM-II*, 39.
[90] *DSM-II*, 39-40.
[91] *DSM-II*, 40.
[92] *DSM-II*, 40.

states that "In *DSM-I* this condition was called 'Psychophysiologic nervous system reaction,'" a psychosomatic illness included in *DSM-I* under the separate category of "Pathophysiologic Disorders."[93] In later editions of the *DSM*, these symptoms were again associated with psychosomatic conditions rather than the neuroses. The creators of *DSM-II* prioritized the historical and etymological connection between "neurasthenia" and "neurosis" over its symptomatic relationship to other existing disorders. Neurasthenic neurosis was defined as "complaints of chronic weakness, easy fatigability, and sometimes exhaustion."[94] It was differentiated from hysterical neurosis, conversion type because "the patient's complaints are genuinely distressing to him and there is no evidence of secondary gain," whereas conversion patients were frequently described as indifferent toward their symptoms.[95] Hypochondriacal neurosis was also characterized by a "preoccupation with the body and… fear of presumed diseases of various organs" in addition to the traditional neurasthenia symptoms.[96]

DSM-III ushered in a dramatic restructuring of the neuroses that formed the current classification system. Beginning in *DSM-III*, the neuroses were no longer united within a single overarching category; instead, these disorders existed under several separate titles. The new category of "Anxiety Disorders" included a range of disorders wherein "anxiety is either the predominant disturbance… or anxiety is experienced if the individual attempts to master the symptoms."[97] Hysterical neurosis, dissociative type now referred to an entire group of disorders called the "Dissociative Disorders." This group of diagnoses, defined by "a sudden, temporary alteration in the normally integrative functions of consciousness, identity, or motor behavior,"[98] included a range of symptoms only briefly listed in the descriptions of

[93] *DSM-II*, 41.
[94] *DSM-II*, 40-41.
[95] *DSM-II*, 40-41.
[96] *DSM-II*, 41.
[97] *DSM-III*, 225.
[98] *DSM-III*, 253.

dissociative illness in *DSM-I* and *DSM-II*. For example, psychogenic amnesia, psychogenic fugue, multiple personality, and depersonalization disorder were classified as distinct disorders in *DSM-III*.[99] Conversion disorder (or hysterical neurosis, conversion type)[100] and hypochondriasis (or hypochondriacal neurosis)[101] were reframed as "Somatoform Disorders."[102] The disorders in this category were characterized by "physical symptoms suggesting physical disorder (hence, Somatoform) for which there are no demonstrable organic findings or known physiological mechanisms and for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts."[103] In classifying conversion disorder and hypochondriasis under this heading, *DSM-III* emphasized the physical symptoms associated with these disorders rather than their presumed origin in anxiety. The neuroses continued to be classified under this system in the following *DSM* editions, including *DSM-5*. The neuroses are a clear extension of nineteenth-century hysteria. Despite continual recategorization, these illnesses remain connected by their shared history and overlapping symptoms.

The Psychosomatic Conditions

Many of the physical symptoms of hysteria were eventually attributed to organic mechanisms. However, the *DSM* describes a range of physical symptoms as psychological in nature. The main category for these disorders was called "Psychophysiologic Disorders" in *DSM-I* and *DSM-II*, "Somatoform Disorders" in *DSM-III* to *DSM-IV-TR*, and "Somatic Symptom and Related Disorders" in *DSM-5*, although adjacent categories like "Factitious Disorders" and "Psychological Factors Affecting Physical Condition" have been present

[99] *DSM-III*, 253-260.
[100] *DSM-III*, 244.
[101] *DSM-III*, 249.
[102] *DSM-III*, 241.
[103] *DSM-III*, 241.

throughout the *DSM* editions. Two of the neuroses, conversion disorder and hypochondriasis, joined the Somatoform Disorders in *DSM-III*.

Prior to their recategorization in *DSM-III*, *DSM-I*'s "Psychophysiologic Autonomic and Visceral Disorders" and *DSM-II*'s "Psychophysiologic Disorders" included dysfunctions of different bodily systems: psychophysiologic skin, musculoskeletal, respiratory, cardiovascular, hemic and lymphatic, gastrointestinal, genito-urinary and endocrine, and nervous system reactions.[104] In *DSM-III*, many of these disorders were reduced to a short section on "Psychological Factors Affecting Physical Condition," which described psychological processes involved in causing or shaping existing somatic conditions.[105] The opening statement of this section reads: "This category enables a clinician to note that psychological factors contribute to the initiation or exacerbation of a physical condition. The physical condition will usually be a physical disorder, but in some instances may be only a single symptom, such as vomiting."[106] The description of this category is vague and includes "any physical condition to which psychological factors are judged to be contributory. It can be used to describe disorders that in the past have been referred to as either 'psychosomatic' or 'psychophysiological.'"[107]

The category "Somatoform Disorders" encompassed a range of psychosomatic illnesses, including several that are particularly relevant to the history of hysteria. As mentioned above, conversion disorder and hypochondriasis joined this category after being classified among the psychoneuroses in the first two editions of the *DSM*. "Somatization disorder" and "psychogenic pain disorder" are other important descendants of hysteria that are found under this heading. Somatization disorder, renamed "somatic symptom disorder" in *DSM-5*, has been the first disorder listed in this category in each *DSM* and clearly evokes

[104] *DSM-I*, 29-31.
[105] *DSM-III*, 303.
[106] *DSM-III*, 303.
[107] *DSM-III*, 303.

Shorter's concept of somatization. Described as "a common and chronic polysymptomatic disorder that begins early in life," somatization disorder evolved directly from hysteria.[108] The disorder was even explicitly described as "previously referred to as either Hysteria or Briquet's Syndrome" in *DSM-III*.[109] The depiction of hysteria patients as "dramatic" resurfaced in the *DSM-III* description of somatization disorder, which claimed that "Complaints are often presented in a dramatic, vague, or exaggerated way."[110] Examples of symptoms listed in *DSM-III* included paralysis, blindness, abdominal pain, painful menstruation, sexual indifference, back pain, and dizziness, all of which were once associated with hysteria.[111] *DSM-III* also suggested that somatization disorder was frequently observed alongside histrionic personality disorder.[112] In addition, the disorder was "rarely diagnosed in males," while 1% of women were believed to be diagnosed with the condition.[113]

The updated definition of somatization disorder in *DSM-IV* suggested that the disorder was "characterized by a *combination* of pain, gastrointestinal, sexual, and pseudoneurological symptoms," not just these symptoms individually.[114] Again, *DSM-IV* reiterated that patients with somatization disorder "usually describe their complaints in colorful, exaggerated terms, but specific factual information is often lacking."[115] *DSM-5* took a new perspective and insisted that somatic symptom disorder (as it was now called) must be diagnosed based on "positive symptoms and signs… rather than the absence of a medical explanation."[116] In addition, the authors of *DSM-5* suggested that while somatic symptom disorder could be expressed through a combination of symptoms, it could also present as one

[108] *DSM-III*, 241.
[109] *DSM-III*, 241
[110] *DSM-III*, 241.
[111] *DSM-III*, 241.
[112] *DSM-III*, 242.
[113] *DSM-III*, 242.
[114] *DSM-IV*, 445. Italics added.
[115] *DSM-IV*, 446.
[116] *DSM-5*, 309.

severe symptom, most often pain.[117] Through the successive editions of the *DSM*, somatization disorder, or somatic symptom disorder, has retained certain features of hysteria, including both motor and sensory symptoms and an association with excessive emotionality and dramatic reactions. Its broad collection of medically unexplained symptoms, lack of a definitive cause, and predominantly female patient base suggest that somatic symptom disorder is one of the primary examples of modern-day hysteria.

Conversion disorder was originally considered a form of neurosis, but has been included among the psychosomatic disorders since *DSM-III.* The condition is characterized by unexplained physical symptoms that "[express] a psychological conflict or need."[118] A diagnosis of conversion disorder relies on the *unconscious* or *unintentional* "conversion" of psychological dysfunction into physical symptoms.[119] However, in *DSM-III*, patients were seen as benefiting from conversion disorder through the "primary gain" of not contending with psychological distress and the "secondary gain" of avoiding unpleasant activities and obtaining support from those around them.[120]

DSM-IV included a discussion of cultural factors involved in conversion disorder that suggested that "The more medically naive the person, the more implausible are the presenting symptoms" and that "More sophisticated persons tend to have more subtle symptoms and deficits that may closely simulate neurological or other general medical conditions."[121] Aside from the patients' medical knowledge, the authors of *DSM-IV* noted that the diagnosis appeared to be more prevalent in rural and lower-class populations, as well as "developing regions" with "incidence generally declining with increasing development."[122] It was also a gendered disorder, with women being between two and ten times as likely as men to be

[117] *DSM-5*, 311.
[118] *DSM-III*, 244.
[119] *DSM-III*, 244.
[120] *DSM-III*, 244.
[121] *DSM-IV*, 452-453.
[122] *DSM-IV*, 455.

diagnosed.[123] *DSM-IV* reiterated that patients do not intentionally produce symptoms (as in factitious disorder), but added that as part of the "secondary gain," patients often take on what the text describes as a "sick role."[124] While initial definitions of conversion disorder had maintained that patients must exhibit *la belle indifférence*, or a sense of apathy toward their symptoms, *DSM-IV* suggested that patients may also express symptoms "in a dramatic or histrionic fashion."[125] This language is clearly reminiscent of late nineteenth-century medical descriptions of hysteria, which evoked both of these contradictory images of patients, sometimes simultaneously.

Unlike the previous diagnostic criteria, *DSM-5* did not require patients' symptoms to be unintentionally produced.[126] *DSM-5* also minimized other features of the disorder, such as *la belle indifférence* and secondary gain, maintaining that they often occurred alongside other disorders as well and therefore did not provide sufficient grounds for a diagnosis of conversion disorder.[127] *DSM-5* suggested that the disorder is only two to three times more likely to be diagnosed in women, as opposed to the previous claim of up to ten times more likely.[128] Hysteria supposedly disappeared after the nineteenth century—yet Freud's concept of conversion, developed to describe the psychological processes involved in hysteria, is still accepted and constitutes a valid diagnostic category. Conversion disorder is an especially important modern-day hysteria, as it has survived in essentially its original form since Freud first described the condition in the 1890s.

Psychogenic pain disorder (*DSM-III*), somatoform pain disorder (*DSM-III-R*), or simply pain disorder (*DSM-IV, DSM-IV-TR*) has been distinguished from the other

[123] *DSM-IV*, 455.
[124] *DSM-IV*, 454.
[125] *DSM-IV*, 454.
[126] *DSM-5*, 320.
[127] *DSM-5*, 320.
[128] *DSM-5*, 320.

psychosomatic disorders due to its predominant symptom being pain.[129] Psychophysiologic musculoskeletal reaction, outlined in *DSM-I* and *DSM-II*, also described pain symptoms caused by emotional factors, although the term "pain" was not included in the title.[130] In *DSM-III*, patients with these disorders were portrayed as often unwilling to accept psychological treatment for their pain. Instead, these patients were depicted as visiting multiple doctors ("doctor-shopping"), trying various organic remedies, and "assum[ing]... an invalid role."[131] According to *DSM-III*, the disorder tended to affect women and patients appeared relatively unconcerned about their symptoms compared to the pain level they described.[132]

Psychogenic pain disorder was renamed "somatoform pain disorder" in *DSM-III-R* and then "pain disorder" in *DSM-IV*. The *DSM-III-R* description of the disorder suggested that a seemingly "excessive" and "dramatic presentation of organic pain" despite a lack of medical evidence did not necessarily indicate somatoform pain disorder.[133] Rather, these symptoms could be "a function of histrionic personality traits or a culturally-determined style of communication."[134] Once again, psychosomatic symptoms were directly associated with the disorder once known as "hysterical personality." The discussion of "pain disorder" in *DSM-IV* highlighted more comorbid conditions, namely mood and anxiety disorders. *DSM-IV* also noted the common presence of insomnia in pain disorder.[135] *DSM-5* contains no reference to a psychosomatic disorder specifically centred on pain.

Psychophysiologic nervous system reaction fell under the category of "Psychophysiologic Autonomic and Visceral Disorders" in *DSM-I* and included

[129] *DSM-III*, 247.
[130] *DSM-I*, 30.
[131] *DSM-III*, 247-248.
[132] *DSM-III*, 248.
[133] *DSM-III-R*, 266.
[134] *DSM-III-R*, 266.
[135] *DSM-IV*, 459.

"psychophysiologic asthenic reaction" as well as psychogenic convulsive disorders.[136] Hysteria was strongly linked to convulsions, and features of the asthenic reaction, which described "general fatigue," were associated with neurasthenia as well as hysteria.[137] Psychophysiologic nervous system reaction was not present in *DSM-II*, but the second edition contained neurasthenic neurosis and "asthenic personality," which described a "behaviour pattern" of "easy fatigability, low energy level, lack of enthusiasm, marked incapacity for enjoyment, and oversensitivity to physical and emotional stress."[138] *DSM-I* noted that characteristics of pathophysiologic nervous system reaction could also present themselves in conversion disorder.[139] References to a psychosomatic disorder affecting the nervous system disappeared after *DSM-II*, but these symptoms were still present as a part of conversion disorder.

Hypochondriasis has been classified as a psychosomatic disorder since *DSM-III*. This change emphasized the fixation on aspects of the physical body rather than the underlying mechanisms causing the symptoms. *DSM-5* renamed hypochondriasis "illness anxiety disorder,"[140] seemingly acknowledging the causative role of anxiety. Like the other psychosomatic disorders, hypochondriasis/illness anxiety disorder has been associated with an insistence on the physical nature of symptoms and reluctance to accept psychiatric treatment.[141] The disorder has been characterized by "a history of 'doctor-shopping' and deterioration in 'doctor-patient' relationships, with frustration and anger on both sides."[142]

Factitious disorder has a similar history and perception. Although it was included in the Somatic Symptom and Associated Disorders in *DSM-5*, the Factitious Disorders constituted their own category in the previous editions of the *DSM*. This disorder, or

[136] *DSM-I*, 31.
[137] *DSM-I*, 31.
[138] *DSM-I*, 43.
[139] *DSM-I*, 31.
[140] *DSM-III*, 250.
[141] *DSM-III*, 250.
[142] *DSM-5*, 315.

collection of disorders, is characterized by an intentional production of physical symptoms. Factitious disorder has been distinguished from other psychosomatic disorders by the presence of "deception," though patients are said to obtain the same "benefits" associated with the "sick role."[143]

The diagnostic criteria for psychosomatic disorders in *DSM-5* were much more ambiguous and open to interpretation compared to earlier editions. According to *DSM-5*, "The previous criteria overemphasized the centrality of medically unexplained symptoms" but "grounding a diagnosis on the absence of an explanation is problematic and reinforces mind-body dualism."[144] *DSM-5* stressed the importance of recognizing positive symptoms indicating the presence of a psychosomatic disorder, rather than providing a diagnosis based on the absence of certain features.[145] However, some diagnoses, such as conversion disorder, required evidence that physical mechanisms were not the primary cause of symptoms.[146] This new perspective on psychosomatic disorders suggests that psychiatry may finally be questioning the use of wastebasket diagnoses to group together medically unexplained symptoms.

Chapter Five explores in depth the nature and history of two disorders that are characterized by medically unexplained physical symptoms: fibromyalgia and chronic fatigue syndrome. These disorders have never been included in the *DSM*, but their status as biological illnesses has been disputed. Many critics, including those in the medical field, have speculated that fibromyalgia and chronic fatigue syndrome ought to be classified as psychosomatic disorders. Indeed, it is difficult to distinguish between these diagnoses and those included in the *DSM*—they share many symptoms and the mechanisms producing these symptoms are unclear in both cases. Like the psychosomatic illnesses in the *DSM*, chronic

[143] *DSM-IV*, 471.
[144] *DSM-5*, 309.
[145] *DSM-5*, 309.
[146] *DSM-5*, 309-310.

fatigue syndrome and fibromyalgia can be considered modern-day manifestations of hysteria. All of these disorders remain suspended between the biological and psychological realms, are poorly defined and understood, describe an extensive list of disparate symptoms, and disproportionately affect women.

Debates Surrounding DSM *Classification*

The *DSM* classification system has been subject to criticism. The similarities between diagnostic categories and the high rates of comorbidity between disorders have called into question the effectiveness of a symptoms-based approach to disease classification. For example, Phebe Cramer (2019) has drawn attention to the comorbid relationships within two groups of disorders: conversion disorder and dissociative disorder and borderline personality disorder and depression, anxiety, and somatization disorder. According to Cramer, patients with each of these disorders (particularly dissociative, conversion, somatoform, and borderline personality disorder) experience many of the same symptoms, suggesting a "common underlying pathology."[147] Cramer questions the separation of these illnesses—which were once included in the hysteria diagnosis—into different diagnostic categories.

Rost et al.'s 1992 study also highlighted comorbidities among diagnoses related to hysteria, focusing on the presence of personality disorders in somatization disorder. According to their research, 60.6% of patients with somatization disorder were diagnosed with at least one personality disorder, with 37.2% of participants having more than one. The authors indicate that avoidant (26.7%), paranoid (21.3%), self-defeating (19.1%), and obsessive compulsive (17.0%) disorders are most prevalent among somatization disorder

[147] Phebe Cramer, "What Has Happened to Hysteria?," *Journal of Nervous & Mental Disease* 207, no. 9 (2019): 705–706, https://journals.lww.com/10.1097/NMD.0000000000000850.

patients.[148] In the study's sample (of which 85.1% of participants were women and 76.8% were white), only 12.8% of patients had histrionic personality disorder, which the authors cite as the most extensively studied comorbid condition "because hysteria is noted to be the forerunner of modern-day [somatization disorder]."[149]

However, this finding contradicted previous studies on the subject, which suggested that the disorder is diagnosed in between 54.1% and 81.8% of somatization disorder patients.[150] To account for this discrepancy, Rost et al. posit that patients diagnosed with histrionic personality disorder were not present in their sample of primary care settings because these patients may be more likely to receive psychiatric therapies as opposed to medical care. The authors suggest that the dramatic nature of histrionic personality disorder may cause doctors to perceive the somatic symptoms of somatization disorder as mental disturbances rather than physical illnesses. Rost et al. view this fact positively, noting that histrionic symptoms may result in "earlier identification of the patient's psychiatric problems and treatment in the mental health care setting."[151] However, this phenomenon also attests to doctor's preconceived ideas about histrionic or "hysterical" patients and their place in the realm of psychology.

Brown et al. (2007) explore the controversy around the classification of dissociative disorder and conversion disorder. The authors argue that the symptoms-focused approach to mental illness classification first established in *DSM-III* has failed to account for the processes that produce these symptoms.[152] Brown et al. assert that the classification of conversion disorder as a psychosomatic condition and dissociative disorder as a distinct class

[148] Kathryn M. Rost et al., "The Comorbidity of DSM-III-R Personality Disorders in Somatization Disorder," *General Hospital Psychiatry* 14, no. 5 (1992): 323, https://journals.scholarsportal.info/details/01638343/v14i0005/322_tcodpdisd.xml.
[149] Rost et al., "The Comorbidity of DSM-III-R Personality Disorders in Somatization Disorder," 322.
[150] Rost et al., "The Comorbidity of DSM-III-R Personality Disorders in Somatization Disorder," 322.
[151] Rost et al., "The Comorbidity of DSM-III-R Personality Disorders in Somatization Disorder," 324.
[152] Richard J. Brown et al., "Should Conversion Disorder Be Reclassified as a Dissociative Disorder in DSM-V?," *Psychosomatics* 48, no. 5 (September 1, 2007): 370, https://www.sciencedirect.com/science/article/pii/S0033318207709994.

of diagnoses was a practical rather than conceptual decision. Although the authors recognize that conversion disorder and dissociative disorder have decidedly different symptoms, they suggest that the choice to detach the two disorders fails to account for their historical and potential etiological connection. Because conversion disorder is now defined by its physical symptoms, the condition is often diagnosed based on the absence of a biological explanation for symptoms rather than a psychological basis.[153]

There is evidence for a potential shared etiology between dissociative disorder and conversion disorder, potentially related to trauma. Brown et al. question whether dissociation and conversion should be considered different outward expressions of the same underlying disorder and even suggest the possibility of classifying conversion disorder under the "Dissociative Disorders" category in *DSM-5*.[154] Conversion disorder and dissociative disorder both have roots in hysteria. Although physicians struggled to uncover a common etiology for hysteria, the overlap between these symptoms and their shared history suggests that there is a connection between these disorders. The debates surrounding the correct classification of conversion and dissociation attest to the continued lack of knowledge about hysterical symptoms and the potentially arbitrary nature of psychiatric nosology. These factors call into question the usefulness of such categories, especially for the effective treatment of these patients when their illnesses are so poorly understood.

Jonathan Y. Tsou also maintains that mental illnesses should be differentiated based on their causes rather than their symptoms. He contends that certain mental disorders are "natural kinds" which ought to be considered separately from disorders that arise from purely psychological or emotional dysfunction.[155] For Tsou, disorders like schizophrenia and mood disorders that are biological in origin would be more accurately classified and understood if

[153] Brown et al., "Should Conversion Disorder Be Reclassified as a Dissociative Disorder in DSM-V?" 371.
[154] Brown et al., "Should Conversion Disorder Be Reclassified as a Dissociative Disorder in DSM-V?" 371-372.
[155] Jonathan Y Tsou, "Natural Kinds, Psychiatric Classification and the History of the DSM," *History of Psychiatry* 27, no. 4 (December 1, 2016): 406, https://doi.org/10.1177/0957154X16656580.

the *DSM* employed a "theoretical and causal" rather than "descriptive" approach to classification.[156] Tsou recommends a return to the Kraepelinian principles of etiological classification to provide more precise categories based on underlying biological and psychological processes.[157]

Conclusion

Hysteria in the nineteenth century was explicitly tied to gender and many of the newer disorders associated with the dispersion of hysteria maintain this gendered framework. Jane M. Ussher (2013) directly addresses gender bias in psychiatric diagnosis in her article, "Diagnosing Difficult Women and Pathologising Femininity: Gender Bias in Psychiatric Nosology." Ussher focuses on borderline personality disorder and premenstrual dysphoric disorder (a severe form of premenstrual syndrome that is considered a psychiatric diagnosis). She argues that the women who receive these diagnoses are the same "outspoken, difficult" women who were "castigated as [witches]" in the sixteenth century and diagnosed hysterics in the nineteenth century.[158] She claims that these diagnoses "are irrevocably tied to what it means to be a 'woman' at a particular point in history."[159] Ussher indicates that all of these disorders are characterized by an "exaggerated femininity," but that borderline personality disorder also includes masculine traits such as "inappropriate intense anger."[160] According to Ussher, borderline personality disorder is distinguished from hysteria by the conception of the two types of patients: "if the hysteric was a damaged woman, the borderline woman is a dangerous one,"[161] but the prevalence of comorbid borderline personality disorder and

[156] Tsou, "Natural Kinds, Psychiatric Classification and the History of the DSM," 406.
[157] Tsou, "Natural Kinds, Psychiatric Classification and the History of the DSM," 407.
[158] Ussher, "Diagnosing Difficult Women and Pathologising Femininity," 67.
[159] Ussher, "Diagnosing Difficult Women and Pathologising Femininity," 67.
[160] Ussher, "Diagnosing Difficult Women and Pathologising Femininity," 65.
[161] Jimenez quoted in Ussher, "Diagnosing Difficult Women and Pathologising Femininity," 65-66.

histrionic (hysterical) personality disorder implies that "many women are clearly seen as both damaged and dangerous."[162]

The inclusion of premenstrual dysphoric disorder in *DSM-IV* was criticized by many feminists.[163] These scholars argue that the classification of premenstrual symptoms as a mental illness (especially when the mood symptoms are typically only observed in Western cultures) pathologizes female reactions to a natural and unavoidable experience of suffering and, in practice, limits women's freedom to participate fully in society.[164] The medicalization of the female reproductive system was a hallmark of the hysteria diagnosis. However, Ussher maintains that despite shifting gender roles, psychiatry has continued the medicalization of womanhood. Time and time again, medical practitioners have been perplexed by these women who defy cultural expectations of femininity. The current official definition of "personality disorder," first articulated in *DSM-IV*, describes the condition as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture."[165] One could argue that in the case of borderline and histrionic personality disorders in particular, the patriarchal society has carved out a definition of "acceptable" female experiences and designated "deviations" from the prescribed version of femininity and womanhood as madness.

Beyond the personality disorders and premenstrual dysphoric disorder, many of the other diagnoses discussed in this chapter retain characteristics of hysteria and are more frequently diagnosed in women. Ussher's analysis can be extended to these other disorders, although the precise relationship to femininity may be different in each diagnosis. One common perception repeated in many descriptions of these illnesses is attention-seeking behaviour, "doctor-shopping," and the assumption of the "sick role." In many cases, these

[162] Ussher, "Diagnosing Difficult Women and Pathologising Femininity," 65-66.
[163] Ussher, "Diagnosing Difficult Women and Pathologising Femininity," 66.
[164] Ussher, "Diagnosing Difficult Women and Pathologising Femininity," 66.
[165] *DSM-IV*, 629. (italics mine)

stereotypes—which are presented as *diagnostic criteria* for mental disorders—judge, criticize, and medicalize women's reactions to emotional and physical pain and attempts to get help. In the cases of fibromyalgia and chronic fatigue syndrome, the two conditions discussed in Chapter Five, primarily female patients have been repeatedly dismissed for maintaining that they are experiencing a biological disease and their insistence has been pathologized as madness. The concept of "doctor-shopping" is particularly harmful as it suppresses women's attempts to advocate for themselves. The idea of the "hysterical woman" is not a distant memory; its influence on the medical field and Western society persists today.

Part of the reason physicians struggled to treat hysteria in the nineteenth century was that the diagnosis brought together mental and physical symptoms with no evidence of a shared origin. Today, diagnostic categories outlined in the *DSM* have once again been linked by symptoms rather than causes. Despite the meticulous descriptions of these disorders that give the illusion of increased knowledge and understanding of mental disorders, overlapping symptoms and comorbidity—particularly in the case of disorders descended from hysteria—blur the lines between diagnostic categories. The poorly defined and arguably arbitrary nature of these diagnostic categories reveals that although these conditions are more narrowly defined, physicians continue to describe hysterical illness through wastebasket diagnoses. Sexism plays a role in this ambiguity: women's minds and bodies are not as well understood by the male doctors and professionals behind the classification of mental disorders. As a result, femininity is still medicalized more than 100 years after hysteria's peak.

CHAPTER FIVE: CHRONIC FATIGUE SYNDROME AND FIBROMYALGIA AS DESCENDANTS OF HYSTERIA AND NEURASTHENIA

As discussed in Chapter Four, many of the symptoms previously associated with hysteria were reorganized in the twentieth century into a range of distinct psychiatric disorders. In this chapter, I consider two recent diagnoses—chronic fatigue syndrome (also known as myalgic encephalomyelitis in the United Kingdom) and fibromyalgia—in the historical context of hysteria. First identified in the second half of the twentieth century, these two novel disease categories are characterized by subjective somatic complaints and predominantly female patient populations. In both cases, medical professionals have found it impossible to identify a definitive cause. Fibromyalgia and chronic fatigue syndrome share many symptoms and features with hysteria, but the two are even more frequently compared to neurasthenia. Chronic fatigue syndrome in particular has been called an extension or revival of neurasthenia:[1] it was identified first as a definitively organic disease caused by environmental factors and one which shares neurasthenia's primary symptom, fatigue.[2] Fibromyalgia has also been compared to neurasthenia in terms of symptomatology and diagnostic criteria.[3] In fact, fibromyalgia and chronic fatigue syndrome share core symptoms, all of which were once related to neurasthenia. For example, patients with both conditions

[1] Rafaela Teixeira Zorzanelli, "Fatigue and Its Disturbances: Conditions of Possibility and the Rise and Fall of Twentieth-Century Neurasthenia," *História, Ciências, Saúde-Manguinhos* 16, no. 3 (2009): 618, http://www.scielo.br/scielo.php?script=sci_abstract&pid=S0104-59702009000300002&lng=en&nrm=iso&tlng=en.
[2] Thomas J. Lane, Peter Manu, and Dale A. Matthews, "Depression and Somatization in the Chronic Fatigue Syndrome," *The American Journal of Medicine* 91, no. 4 (1991): 342, https://journals.scholarsportal.info/details/00029343/v91i0004/335_dasitcfs.xml.
[3] S. Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It. A Short History of a Controversial Syndrome," *Reumatismo* 64, no. 4 (September 28, 2012): 188, https://www.reumatismo.org/index.php/reuma/article/view/reumatismo.2012.186.

commonly report widespread pain and fatigue as well as psychological symptoms, cognitive dysfunction, gastrointestinal issues, and poor sleep.[4]

Like their predecessors neurasthenia and hysteria, chronic fatigue syndrome and fibromyalgia are discussed in both medical and cultural terms. Contemporary medicine is dominated by naturalistic notions of illness that prioritize biological diseases. By contrast, psychological illnesses are highly stigmatized.[5] Medical disorders are typically classified as either somatogenic or psychogenic, leaving no room for complex conditions that may straddle the two illness designations or may exist as entirely separate from either category. Like hysteria and neurasthenia in the nineteenth century, chronic fatigue syndrome and fibromyalgia in the twentieth and twenty-first centuries are associated with both physical and psychological symptoms, yet no definitive unifying cause has been determined for any of these conditions. These illnesses remain poorly understood and patients are frequently left behind by medical professionals who adhere to a somatogenic/psychogenic dichotomy.[6]

The 1980s and especially the 1990s saw a renewed interest in hysteria and an intense concentration of historical, cultural, and literary writing on the disorder. Many of the texts written about hysteria during this period were inspired by and often directly discussed modern-day illnesses that the author(s) considered to be manifestations of hysteria. Chronic fatigue syndrome was a particularly common subject of cultural and historical analysis in the late twentieth century. However, much of the writing on chronic fatigue syndrome and fibromyalgia from this time evoked images of hysteria patients in the nineteenth century. Earlier in this thesis, I relied heavily on the historical work published in the late twentieth century as secondary source material to support my historical analysis of hysteria. Now, I re-

[4] Stefan M. van Geelen et al., "Personality and Chronic Fatigue Syndrome: Methodological and Conceptual Issues," *Clinical Psychology Review* 27, no. 8 (December 1, 2007): 886, https://www.sciencedirect.com/science/article/pii/S0272735807000311; Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It," 188; Fatma Inancini and Muhammad B. Yunus, "History of Fibromyalgia: Past to Present," *Current Pain and Headache Reports* 8, no. 5 (October 2004): 373-374.
[5] Kevin Aho, "Neurasthenia Revisited: On Medically Unexplained Syndromes and the Value of Hermeneutic Medicine," *Journal of Applied Hermeneutics* (April 9, 2018): 10.
[6] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 342.

evaluate work from some of the same authors to locate their discussions of hysteria, neurasthenia, fibromyalgia and chronic fatigue syndrome in the late twentieth century cultural and medical context.[7]

In this chapter, I highlight and critique end-of-century discussions about hysteria. I situate chronic fatigue syndrome and fibromyalgia in the historical context of hysteria and discuss medical and cultural perceptions of illnesses descended from hysteria, a century after the hysteria peak of the late nineteenth century. I begin with the respective histories of chronic fatigue syndrome and fibromyalgia, before examining prominent cultural and literary writing on the illnesses. Finally, I present physicians' theories about the origin of these conditions and I consider potential avenues for improving patient treatment. Although the sources I reference draw parallels between chronic fatigue syndrome, fibromyalgia, and hysteria, emphasize other points of comparison. I disagree with these authors' perception of chronic fatigue syndrome and fibromyalgia as exaggerated responses to stress rather than legitimate illnesses. Instead, I argue that these very perspectives are what link the disorders to their predecessor: the language used to describe chronic fatigue syndrome and fibromyalgia recalls depictions of hysteria at the end of the nineteenth century. A century after the peak of hysteria, these 1990s writers invoke similar stereotypes about gender, femininity, illness, and health. I argue that chronic fatigue syndrome and fibromyalgia mirror hysteria and neurasthenia symptomatically and in the ways these patients are viewed and treated in medical settings. I further argue that chronic fatigue syndrome and fibromyalgia, like hysteria and neurasthenia, are wastebasket diagnoses that result from the interaction of medicine and culture. The adherence to a mind-body dualism despite the influence of cultural factors and the use of wastebasket diagnoses as pseudo-explanations for mysterious symptoms leads to a medical disregard for primarily female patients.

[7] Thus, in this chapter, many of the secondary sources used elsewhere in the thesis are now treated as primary sources that reveal cultural understandings of hysteria at the end of the twentieth century.

Hystories

Elaine Showalter's controversial book *Hystories: Epidemics and Modern Culture* (1997) linked hysteria outbreaks to heightened anxiety at the end of centuries. In the book, Showalter argued that the 1990s (like the late nineteenth century) were again marked by a resurgence of hysteria. But, in the 1990s, modern technology and media had made hysteria more "contagious" than ever before. Showalter described six conditions as modern-day manifestations of hysteria: chronic fatigue syndrome, Gulf War syndrome, recovered memory of childhood abuse, multiple personality syndrome, and stories of satanic ritual abuse and alien abduction. She viewed these conditions not as the result of organic disease or traumatic experiences, but rather as responses to stress that "[mimic] culturally permissible expressions of distress."[8]

Showalter dedicated a chapter to each of her six conditions of interest, describing the illnesses, patients, and controversies. There was widespread backlash following the book's publication. Although *Hystories* was intended for a small academic audience, it garnered significant public attention.[9] Chronic fatigue syndrome patients were particularly offended by the book and resented the inclusion of this disorder in a list of modern-day "hysterias" that included alien abduction and satanic ritual abuse stories. *Hystories* also faced criticism within academic circles, especially for simplifying complex conditions by using literary theory to interpret medical issues.[10]

Hystories does contain some scathing descriptions of patients suffering from these conditions, especially chronic fatigue syndrome. For example, Showalter pointed out that myalgic encephalomyelitis (another name for chronic fatigue syndrome more commonly used

[8] Elaine Showalter, *Hystories: Hysterical Epidemics and Modern Culture* (London, UK: Picador, 1997), 15.
[9] Virginia T. Bemis, "*Hystories: Hysterical Epidemics and Modern Culture*," *NWSA Journal* 10, no. 1 (1998): 173, https://www.jstor.org/stable/4316561.
[10] Bemis, "*Hystories: Hysterical Epidemics and Modern Culture*," 173.

in the United Kingdom) was often abbreviated to ME, which she claimed "ironically emphasizes the patient's self-absorption."[11] One of her main arguments was that patients with chronic fatigue syndrome, in particular, produce symptoms to serve a purpose—whether conscious or unconscious:

> [P]atients with chronic fatigue live in a culture that still looks down on psychogenic illness, that does not recognize or respect its reality. The self-esteem of the patients depends on having the physiological nature of the illness accepted. The culture forces people to deny the psychological, circumstantial, or emotional sources of their symptoms and to insist that they must be biological and beyond their control in order for them to view themselves as legitimately ill and entitled to the privileges of the sick role.[12]

Comments like these are reminiscent of nineteenth-century writings on hysteria that speculated patients were engaging in attention-seeking behaviour or being otherwise dramatic. The notion that the "sick role" offered some kind of privilege is baffling, yet it appeared across other texts about chronic fatigue syndrome from the 1990s. Showalter attempted to soften her points by claiming that *she* did not deny the experiences of the individuals affected by these conditions—she simply maintained that the symptoms are psychogenic. She further clarified her intention by insisting that while psychogenic illnesses are highly stigmatized, there is no shame in suffering from them. And yet, many members of the chronic fatigue syndrome community found her characterization of the disorder profoundly stigmatizing.

Literary scholar Virginia T. Bemis criticized the "abrasive" language with which Showalter discussed chronic fatigue syndrome and Gulf War syndrome in particular, reducing them to merely "stress-reactions" despite the fact that "the jury is still very much out" on the causes of these illnesses.[13] Bemis accused Showalter of "stretch[ing] parts and lop[ping] off others, to make facts fit the frame."[14] She further asserted that Showalter held

[11] Showalter, *Hystories,* 124.
[12] Showalter, *Hystories,* 117.
[13] Bemis, "*Hystories: Hysterical Epidemics and Modern Culture*," 173.
[14] Bemis, "*Hystories: Hysterical Epidemics and Modern Culture*," 173.

too strongly to her belief that these disorders were hysterical. As a result, Showalter failed to account for diversity within patient populations: "Her tendency to overgeneralize leads to arguing that because some cases are hysterical, all are hysterical."[15]

On the other hand, Mark S. Micale (whose writing on hysteria I have referenced throughout this study) vehemently supported Showalter's conclusions and used similar language to describe these conditions. He praised Showalter and expressed gratitude for "a commentator as sane, courageous, and clear-headed as Elaine Showalter."[16] In his review of *Hystories*, "Strange Signs of the Times," Micale noted that "the mere sequential listing" of the disorders Showalter included in her study "is likely to infuriate those who have experienced any of these—or believe they have."[17] Micale implied that he shared Showalter's view that these conditions are psychosomatic and shaped by modern culture and media. He even supported the way Showalter "qualifies her critique"—by claiming that she did, in fact, believe sufferers' *experiences* (just not their interpretations of these experiences)[18]

Showalter's account of so-called hysterical epidemics at the end of the twentieth century serves as a starting point for the discussion of cultural and medical perspectives on chronic fatigue syndrome and fibromyalgia across the rest of the chapter. Many other academic commentators in 1990s shared Showalter's views, and these ideas can also be seen within medical writing about fibromyalgia and chronic fatigue syndrome.

The History of Chronic Fatigue Syndrome

Chronic fatigue syndrome has been called a contemporary example of hysteria,[19] but it more closely resembles neurasthenia symptomatically.[20] Several historians, most famously

[15] Bemis, "*Hystories: Hysterical Epidemics and Modern Culture*," 173.
[16] Mark S. Micale, "Strange Signs of the Times," *The Times Literary Supplement*, no. 4911 (1997): 7, https://link.gale.com/apps/doc/EX1200486898/TLSH?u=ocul_mcmaster&sid=zotero&xid=918e4903.
[17] Micale, "Strange Signs of the Times," 6.
[18] Micale, "Strange Signs of the Times," 6.
[19] Showalter, *Hystories*, 8.

Edward Shorter, have traced chronic fatigue syndrome directly back to neurasthenia.[21] In terms perhaps too basic for this complex condition, chronic fatigue syndrome has been defined as "a severe, incapacitating fatigue lasting for six months or more, that is not improved by bed rest and that may be exacerbated by physical or mental activity."[22] The 1994 CDC diagnostic criteria for chronic fatigue syndrome required that in addition to this debilitating fatigue, patients experienced four or more of the following additional symptoms: "self-reported impairment in memory or concentration, sore throat, tender cervical lymph nodes, muscle pain, multi-joint pains, headache, unrefreshing sleep, post-exertional malaise lasting 24 h or longer."[23] Other common symptoms that are not required for a diagnosis of chronic fatigue syndrome include gastrointestinal issues, chills, night sweats, brain fog, and chest pain.[24] Chronic fatigue syndrome often occurs alongside other physical and psychological disorders. Physicians have speculated as to whether chronic fatigue syndrome is a psychosomatic condition caused by psychological disturbances, or whether the psychological symptoms result from distress associated with living with chronic fatigue.[25]

The rise of neurasthenia at the end of the nineteenth century repackaged a number of hysteria symptoms under a new diagnostic title. This trend of recategorizing hysteria continued in the twentieth century with the dispersion of hysteria symptoms into an array of psychiatric disorders. Chronic fatigue syndrome can be seen as an extension of the first condition to arise from hysteria, neurasthenia. At the same time, however, chronic fatigue syndrome also evolved separately from the psychiatric disorders in the *DSM*. Chronic fatigue syndrome arose as an explanation for ongoing symptoms after an acute infectious illness and

---

[20] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 342.
[21] Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York, NY: The Free Press, 1992).
[22] Rakesh Kumar and Ritesh Kumar, "Chronic Fatigue Syndrome," *Apollo Medicine* 3, no. 3 (2006): 290, https://journals.scholarsportal.info/details/09760016/v03i0003/290_cfs.xml.
[23] van Geelen et al., "Personality and Chronic Fatigue Syndrome," 886.
[24] Kumar and Kumar, "Chronic Fatigue Syndrome," 293.
[25] van Geelen et al., "Personality and Chronic Fatigue Syndrome," 896.

must be understood in association with infectious disease epidemics and a focus on immunology in the twentieth century.[26]

The creation of the neurasthenia diagnosis coincided with an increase in fatigue complaints at the end of the nineteenth century. This relationship could be interpreted in two different ways: neurasthenia may have emerged in response to rising incidences of fatigue, or the newly defined disorder may have caused more patients to develop fatigue as a psychosomatic symptom.[27] Shorter asserted that both of these explanations were likely. He argued that for many patients, a disorder defined by subjective fatigue allowed them to have their concerns taken seriously as organic illnesses, even without evidence of a physical abnormality.[28]

Beginning in the 1930s, a series of novel infectious disease outbreaks increased the prevalence of fatigue symptoms in the population. These diseases were characterized by subjective sensory symptoms, and many patients who contracted these diseases continued to experience symptoms long after they recovered from the initial illness. However, chronic illness associated with these diseases also became common among people who were not diagnosed with the infectious diseases and did not present biological markers for the conditions. Increasing numbers of patients began to report chronic fatigue and a range of associated symptoms and attribute these symptoms to the lingering effects of novel infectious diseases, even without observable biological abnormalities.[29]

The first such epidemic was chronic brucellosis, caused by the *Brucella* bacteria. American physician Alice Evans first described the condition in 1934 as a chronic infection that could present as chronic fatigue. Many patients with chronic brucellosis no longer displayed evidence of an original bacterial infection. Therefore, patients were diagnosed

[26] Susan E. Abbey and Paul E. Garfinkel, "Neurasthenia and Chronic Fatigue Syndrome: The Role of Culture in the Making of a Diagnosis," *American Journal of Psychiatry* 148, no. 12 (1991): 1641.
[27] Shorter, *From Paralysis to Fatigue*, 277.
[28] Shorter, *From Paralysis to Fatigue*, 267.
[29] Shorter, *From Paralysis to Fatigue*, 307.

based solely on doctors' qualitative assessment.[30] Studies on chronic brucellosis pointed to a relationship between chronic brucellosis and "emotional disturbance[s]." Both Spink (1951) and Imboden (1959) found that patients that sustained chronic fatigue and ongoing symptoms associated with brucellosis were more likely to suffer from psychiatric disturbances. Spink noted that "patients bordering on a personality disorder or emotional disturbance may be tipped over into a functional state of chronic ill health by an attack of acute brucellosis."[31] Imboden and his colleagues similarly asserted that "the emotional disturbance is not merely secondary to the stress of illness, but is more critically related to the pre-illness personality structure."[32] Imboden's 1961 study indicated that "premorbid personality features influence the duration of perceived illness," even beyond chronic brucellosis.[33]

This research challenged the idea that symptoms of chronic brucellosis continued to be caused by a biological dysfunction and suggested that psychological factors could be primarily responsible for the ongoing symptoms. Shorter asserted retroactively that "some of the chronic brucellosis patients were undoubtedly somatizers who had fixed on this particular label."[34] These debates around chronic brucellosis were applied to other infectious disease epidemics and the chronic illnesses that frequently followed them. The diagnosis of chronic fatigue syndrome arose to describe the trend of patients reporting long-term effects of infectious diseases, primarily fatigue complaints. The suggestion was that some patients had never contracted the infection, but rather used the diagnosis to explain and legitimize their symptoms.[35]

The term "myalgic encephalomyelitis" (now the common name for chronic fatigue syndrome in the United Kingdom) first arose in the 1950s to describe the aftereffects of a

[30] Stephen E. Straus, "History of Chronic Fatigue Syndrome," *Reviews of Infectious Diseases* 13 (1991): 3-4, https://www.jstor.org/stable/4455795.
[31] Spink quoted in Straus, "History of Chronic Fatigue Syndrome," 4.
[32] Imboden quoted in Straus, "History of Chronic Fatigue Syndrome," 4.
[33] Straus, "History of Chronic Fatigue Syndrome," 4.
[34] Shorter, *From Paralysis to Fatigue*, 305.
[35] Shorter, *From Paralysis to Fatigue*, 305.

viral encephalitis epidemic in the Royal Free Hospital in London. Also called post viral fatigue syndrome, the organic nature of this condition was not questioned for the first decade of its existence.[36] However, myalgic encephalomyelitis was later used more generally to describe patients who displayed the associated symptoms, including fatigue, but did exhibit biological indicators of an original infection.[37] Myalgic encephalomyelitis was not widely used as another word for chronic fatigue syndrome until the 1980s.[38]

In the 1980s, chronic fatigue in the United States was most often attributed to the long-term effects of Epstein-Barr virus. Many patients with chronic fatigue were found to have higher than normal levels of antibodies against Epstein-Barr virus. As a result, chronic Epstein-Barr virus syndrome became the most popular explanation for vague experiences of fatigue. However, further research concluded that although Epstein-Barr virus could cause ongoing fatigue, chronic fatigue syndrome was a separate disorder.[39] Chronic fatigue syndrome directly replaced chronic Epstein-Barr virus syndrome as the accepted diagnostic title for subjective fatigue complaints.[40] Myalgic encephalomyelitis became more widespread at the same time.[41] Patients initially rejected the term "chronic fatigue syndrome," and instead used their own diagnostic title, "chronic fatigue immune dysfunction syndrome," to frame their symptoms as organic in origin.[42] Doctors and patients continue to disagree over the etiology of chronic fatigue syndrome, with many doctors dismissing patients' claims that

[36] Nigel Speight, "Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Review of History, Clinical Features, and Controversies," *Saudi Journal of Medicine & Medical Sciences* 1, no. 1 (June 2013): 11, https://www.sjmms.net/article.asp?issn=1658-631X;year=2013;volume=1;issue=1;spage=11;epage=13;aulast=Speight.

[37] Shorter, *From Paralysis to Fatigue*, 311.
[38] Simon Wessely, "Chronic Fatigue Syndrome: A 20th Century Illness?," *Scandinavian Journal of Work, Environment & Health* 23, no. 3 (1997): 18.
[39] Straus, "History of Chronic Fatigue Syndrome," 5.
[40] Wessely, "Chronic Fatigue Syndrome: A Twentieth Century Illness?" 18.
[41] Wessely, "Chronic Fatigue Syndrome: A Twentieth Century Illness?" 18.
[42] Shorter, *From Paralysis to Fatigue*, 310.

their illness is biological and instead insisting that chronic fatigue syndrome is a psychosomatic disorder.[43]

In 1990, British psychiatrist Simon Wessely noted that chronic fatigue syndrome and neurasthenia were both considered acceptable conditions when they were attributed to external biological etiologies. However, he pointed out that neurasthenia declined in prominence once the organic explanation began to be replaced by the psychological conception of the disorder. Similarly, chronic fatigue syndrome began to be associated with hysteria once the condition began to be framed as a psychological disorder.[44]

The History of Fibromyalgia

Fibromyalgia shares many symptoms and features with chronic fatigue syndrome, but has historically been associated with rheumatology rather than immunology. Fibromyalgia is defined as chronic widespread musculoskeletal pain that cannot be accounted for by a physical disease. Interestingly, physician Charles V. Ford considered fibromyalgia to be descended from a combination of previous disorders, namely "fibromyositis, neuropsychasthenia, myalgic encephalitis, and chronic Epstein-Barr virus infection."[45] He connected fibromyalgia directly to these other mysterious disorders and considered it the newest iteration of these illnesses. Changing diagnostic criteria have shifted the way fibromyalgia has been understood by focusing on different aspects of the disorder. The 1981 Yunus criteria—the first standardized method of diagnosing fibromyalgia, created by rheumatologist Muhammad B. Yunus—required three locations of pain, aching, or stiffness throughout the body. The listed diagnostic criteria also included additional non-pain symptoms, such as "weather sensitivity, aggravation of symptoms by anxiety or stress, poor

[43] Speight, "Myalgic Encephalomyelitis/Chronic Fatigue Syndrome," 12.
[44] Simon Wessely, "Old Wine in New Bottles: Neurasthenia and 'ME,'" *Psychological Medicine* 20, no. 1 (1990): 35.
[45] Charles V. Ford, "Somatization and Fashionable Diagnoses: Illness as a Way of Life," *Scandinavian Journal of Work, Environment & Health* 23, no. 3 (1997): 10.

sleep, general fatigue or tiredness, anxiety, chronic headache, irritable bowel syndrome, and numbness."[46]

In 1972, physician Hugh Smythe, the "grandfather of modern FMS [(fibromyalgia)]," defined fibromyalgia as a "generalized pain syndrome," in contrast to localized or regional pain.[47] He introduced two essential characteristics of fibromyalgia: widespread pain and tender points.[48] The American College of Rheumatology (ACR) diagnostic criteria in 1990 focused on widespread pain, which specified that pain must exist across the entire body.[49] Assessment of widespread pain centred on tender point examinations, which required patients to experience pain in at least 11 out of a total of 18 specific spots on the body.[50] This approach later faced criticism for potentially overdiagnosing fibromyalgia. The tender point criteria could include patients who experienced pain in several distinct areas across the body, but whose pain was not *diffuse*, or spread across the body. For example, a patient who had suffered multiple injuries and therefore experienced pain in multiple places across the body may pass the tender point examination, but they may not necessarily be experiencing fibromyalgia.[51]

Since the introduction of the ACR criteria in 1990, researchers have aimed to develop diagnostic criteria that only include sufferers whose pain is truly widespread and diffuse; thus, fibromyalgia has become increasingly defined by this idea of widespread pain.[52] Beginning in 2010, the widespread pain index (WPI) replaced the tender point examination, basing fibromyalgia diagnosis on self-reported pain in different regions of the body rather than specific points on the body. The symptom severity scale (SSS) was also introduced to

[46] Frederick Wolfe, "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia," *Scandinavian Journal of Pain* 20, no. 4 (2020): 647, 648, https://www.degruyter.com/document/doi/10.1515/sjpain-2020-0072/html.
[47] Inancini and Yunus, "History of Fibromyalgia: Past to Present," 373.
[48] Inancini and Yunus, "History of Fibromyalgia: Past to Present," 369.
[49] Wolfe, "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia," 647.
[50] Wolfe, "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia," 647.
[51] Wolfe, "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia," 648.
[52] Wolfe, "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia," 647.

assess other somatic and psychological symptoms and their impact on the patient's daily life.[53] Even more recently, in 2018, the ACR highlighted widespread pain as the "central fibromyalgia criterion." The International Classification of Disease (ICD-11) similarly defined fibromyalgia as a "widespread pain disorder" in 2019.[54]

Although fibromyalgia is now closely associated with chronic fatigue syndrome, the two evolved separately. Chronic fatigue syndrome can be traced directly through neurasthenia back to hysteria. However, mysterious pain resembling fibromyalgia existed alongside hysteria for centuries. Fibromyalgia only came to resemble neurasthenia as an unexplained wastebasket of subjective sensory symptoms in the twentieth century. However, the idea of *chronic widespread pain* has its own history, which began long before the terminology came into use, and long before this type of pain was considered to be psychosomatic.

In 410 BCE, Hippocrates proposed his "Rheuma Theory," which resembles one of the current models of fibromyalgia: "central sensitization."[55] Central sensitization refers to the idea that fibromyalgia sufferers have an overactive central nervous system, lowering the pain threshold.[56] Hippocrates contended that pain was a natural occurrence, not a punishment. He hypothesized that the brain circulated a liquid throughout the body and higher levels of this fluid in a certain part of the body, most often the lower limbs, caused rheumatic pain.[57] After early attempts to understand and explain general pain—most notably by Theophrastes (372-287 BCE) and Galien (131-201 CE)—Guillaume de Baillou (1538-1616) was the first to describe "rheumatism" as it is understood today.[58]

[53] Wolfe, "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia," 648.
[54] Wolfe, "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia," 647.
[55] Inanici and Yunus, "History of Fibromyalgia: Past to Present," 369.
[56] Inanici and Yunus, "History of Fibromyalgia: Past to Present," 374.
[57] Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It," 186.
[58] Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It," 186-187.

In the nineteenth century, fibromyalgia-like pain was understood as a muscular disorder. Scottish surgeon William Balfour described a "muscular rheumatism" he named "fibrosistitis" in 1815.[59] Balfour believed that nodules and pain were caused by "inflammation in muscle connective tissue" and was the first to describe tender points in 1824.[60] In 1841, French physician François Louis Isidore Valleix described the concept of trigger points which caused referred pain on other parts of the body.[61] British neurologist William Gowers coined the term "fibrositis" in 1904 to describe "the inflammation of fibrous tissue."[62]

Although fibromyalgia was considered a biological "rheumatic" disorder for the majority of its history, this assumption was questioned with the rise of psychological explanations for physical symptoms beginning in the late nineteenth century. Unexplained pain was a common feature of neurasthenia.[63] As Chapter Four discussed in detail, psychosomatic pain has been described under a variety of diagnostic titles in the *DSM* since its first edition in 1952. However, there is insufficient evidence to unequivocally define fibromyalgia as either biological or psychological in origin. Central sensitization, stress, and psychological factors are the most prominent theories about the origin of fibromyalgia, although many patients reject these suggestions in pursuit of an organic cause.

Smythe was the first to emphasize the role of poor sleep in fibromyalgia, suggesting that "nonrestorative sleep," along with trauma and emotional distress, could be a causal factor in producing fibromyalgia symptoms.[64] Like chronic fatigue syndrome, fibromyalgia is associated with many other symptoms outside of the characteristic diffuse pain and is comorbid with psychological disorders. Additional non-pain symptoms are highly correlated

[59] Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It," 187.
[60] Inancini and Yunus, "History of Fibromyalgia: Past to Present," 369.
[61] Inancini and Yunus, "History of Fibromyalgia: Past to Present," 369.
[62] Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It," 187.
[63] Wessely, "Old Wine in New Bottles," 36.
[64] Inancini and Yunus, "History of Fibromyalgia: Past to Present," 373.

with pain levels. In other words, increased pain corresponds to a greater number of somatic and psychiatric symptoms.[65] Furthermore, fibromyalgia has been linked to other comorbid conditions. In 2000, Yunus suggested that fibromyalgia, myofascial pain syndrome, temporomandibular disorder, tension-type headache, migraine, and chronic fatigue syndrome all fall within the category of "central sensitivity syndromes," implying that these conditions share a causal link.[66]

The mysterious and poorly-defined nature of fibromyalgia, along with the extensive list of varied symptoms and comorbid conditions, places the disorder in the same category as chronic fatigue syndrome, neurasthenia, and hysteria. Like these other conditions, fibromyalgia primarily affects women—in 2000, one study suggested that 90% of fibromyalgia patients were women.[67] Although fibromyalgia and chronic fatigue syndrome are considered distinct disorders and have different histories, they share many of the same somatic and psychological symptoms. Most strikingly, though, these two disorders share their primary characteristics: fatigue is also an essential quality of fibromyalgia, with the disorder often being described by chronic pain *and* fatigue.[68] Meanwhile, the majority of patients with chronic fatigue syndrome report pain as a secondary concern.[69]

Scholarly and Cultural Perspectives on Chronic Fatigue Syndrome and Fibromyalgia

Chronic fatigue syndrome and fibromyalgia are surrounded with more controversy and uncertainty than other disorders descended from hysteria that firmly reside in the psychological realm. Most chronic fatigue syndrome and fibromyalgia patients maintain that their condition is biological in origin, while doctors have speculated that both disorders may be psychosomatic in nature. This disagreement has led to a breakdown in doctor-patient

[65] Wolfe, "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia," 648.
[66] Inancini and Yunus, "History of Fibromyalgia: Past to Present," 374.
[67] Groopman cited in Aho, "Neurasthenia Revisited," 11.
[68] Shorter, *From Paralysis to Fatigue*, 311.
[69] van Geelen et al., "Personality and Chronic Fatigue Syndrome," 886.

relationships, with distrust on both sides. Social scientists, historians, and literary theorists have weighed in on this tension between doctors and patients, applying ideas about somatization and the history of hysteria to these conditions. Many of these academic writers describe chronic fatigue syndrome and fibromyalgia as modern manifestations of hysteria. There was an explosion of literature connecting these conditions to hysteria and—even more directly—to neurasthenia at the end of the twentieth century, especially in the 1990s. However, these historical discussions around chronic fatigue syndrome and fibromyalgia ironically strengthened the connections that the authors drew between fibromyalgia, chronic fatigue syndrome, neurasthenia, and hysteria. The language that these authors used to describe the disorders as well as those suffering from them reinforced the stigma and stereotypes that were once associated with hysteria.[70]

In his 1992 book *From Paralysis to Fatigue*, historian Edward Shorter drew connections between hysteria, neurasthenia, chronic fatigue syndrome, and fibromyalgia. According to Shorter (1992), each of these disorders was characterized by "pathoplasticity," which meant that patients emulated symptoms that were considered medically acceptable at a given time.[71] In the case of chronic fatigue syndrome, Shorter suggested that the rise of immunology following the 1960s provided a new framework for somatization: fixed illness beliefs came to centre on problems with the immune system, and immune dysfunction became the leading explanation for chronic fatigue.[72] Shorter also noted that unexplained sensory symptoms like pain and fatigue became common complaints at the end of the nineteenth and beginning of the twentieth century.[73] These symptoms, he asserted, presented

[70] I will highlight the work of Elaine Showalter (1997), Edward Shorter (1992), Mark Micale (1997), Simon Wessely (1990, 1997), Charles Ford (1997), and Susan E. Abbey and Paul E. Garfinkel (1991), with references to the later work of Rafaela Teixeira Zorzanelli (2009) and Kevin Aho (2018) to provide insight into how ideas about hysterical disorders have or have not changed over time.
[71] Shorter, *From Paralysis to Fatigue*, 318.
[72] Shorter, *From Paralysis to Fatigue*, 314.
[73] Shorter, *From Paralysis to Fatigue*, 267.

psychological distress as organic and therefore medically legitimate as the hysteria diagnosis declined.[74]

Physician and cultural commentator Charles V. Ford (1997) called chronic fatigue syndrome and fibromyalgia "fashionable diagnoses." He asserted that unlike the somatoform disorders described in the *DSM*, patients claiming a fashionable diagnosis imitated the symptoms of disorders that were prominent at a given time. He noted that these disorders were often modeled after diseases with "nonspecific subjective complaints"[75] and were characterized by "heterogeneous collection[s] of physical diseases, somatization, and anxiety or depression."[76] Ford highlighted the interaction of biological, psychological, and social factors in producing such illnesses, noting that some patients with fashionable diagnoses had undiscovered medical conditions or "some element of biological disease," which set these disorders apart from other definitively psychosomatic conditions.[77]

Many late twentieth-century scholars speculated about the social factors that produce somatization disorders and fashionable diagnoses. Psychiatrists Susan E. Abbey and Paul E. Garfinkel (1991) suggested that chronic fatigue syndrome, fibromyalgia, and hysteria all arose during times that were "characterized by public concerns about the fast pace of life and the changing role of women."[78] Showalter (1997) went so far as to say that hysteria is "a part of everyday life" that is simply exacerbated by social factors.[79] She asserted that hysteria (in both historical and contemporary manifestations of the illness) was a "cultural symptom of anxiety and stress."[80] Shorter suggested that in the late twentieth century these symptoms were caused by "a distinctively 'postmodern' disaffiliation from family life."[81] In Shorter's view, the intense intimacy of the nineteenth century family and the increasing focus on

[74] Shorter, *From Paralysis to Fatigue*, 244-245.
[75] Ford, "Somatization and Fashionable Diagnoses," 14.
[76] Ford, "Somatization and Fashionable Diagnoses," 7.
[77] Ford, "Somatization and Fashionable Diagnoses," 14.
[78] Abbey and Garfinkel, "Neurasthenia and Chronic Fatigue Syndrome," 1642.
[79] Showalter, *Hystories*, 13.
[80] Showalter, *Hystories*, 9.
[81] Shorter, *From Paralysis to Fatigue*, 295.

individualism and independence in the late twentieth century family have led to epidemics with similar symptoms. In both cases, Shorter pointed to tensions related to the family as a cause for "hysterical" symptoms.[82]

The majority of these writers believed that patients engaged in somatization to serve a certain purpose, although they disagreed over whether patients intentionally produced their symptoms in service of their goal. Ford suggested that patients were aware of their somatization to different extents. As two examples along the spectrum of self-awareness, he first pointed to patients who knowingly produced symptoms but did not recognize the unconscious motivations behind this decision. Second, he drew attention to patients with conversion disorders, who were not aware that they were producing symptoms or where these symptoms came from.[83] Others have explored the potential benefits of somatization in greater depth, and some have implicitly or explicitly suggested that patients produce symptoms intentionally to serve a specific purpose. The language used in late twentieth century historical literature in particular reveals biases against patients that arose from historical conceptions of hysteria. As they drew connections between these current diagnoses and hysteria, some of these scholars—intentionally or not—constructed a narrative of patient experiences that mirrored Victorian physicians' dismissal and distrust of hysteria patients.

Showalter's perspective in *Hystories* exemplified this phenomenon, but other late twentieth century writers also described chronic fatigue syndrome and fibromyalgia patients as exhibiting qualities associated with hysteria. For instance, in "Strange Signs of the Times" (his review of *Hystories*) Micale depicted the experiences of patients with chronic fatigue syndrome and related disorders in a dismissive and simplistic manner:

> Typically, individuals who are unhappy or unfulfilled in their lives develop diffuse and evolving nervous complaints and eventually seek help. A physician, or some other scientific authority figure, concocts 'a unified field theory providing a clear and coherent explanation for the confusing symptoms,' as well as a new and memorable

[82] Shorter, *From Paralysis to Fatigue*, 295.
[83] Ford, "Somatization and Fashionable Diagnoses," 8.

> name for the syndrome. This explanation draws on contemporary disease theory, usually viral and immunological ideas.[84]

Similarly, Simon Wessely (1997) depicted somatization as "a process by which patients gain access to medical care," implying that patients may have consciously displayed these symptoms for personal gain.[85] Showalter propagated the idea that these patients aimed to inhabit the "sick role" in an attempt to obtain some kind of "privilege."[86] Ford defined somatization as "the seeking of the sick role"[87] in an effort to obtain associated "privileges"[88] or "to resolve intrapsychic, interpersonal, or social problems."[89] Ford described this notion of somatization as beneficial to patients, suggesting that patients with "nondisease[s]" like chronic fatigue syndrome and fibromyalgia neglected their own health and "make illness a way of life."[90] He criticized this group of patients, claiming that they "generate a large amount of medical care expenses, incur costs to society because of lost productivity and disability payments, and inflict psychological and dependent care demands upon those in their environment who must care for them."[91]

In addition to the implication that these patients feign symptoms to seek attention and avoid responsibilities, patients with chronic fatigue syndrome, fibromyalgia, and other conditions deemed somatization disorders were believed to share certain personality traits. Medical and psychological studies have investigated the validity of these stereotypes, which evoke nineteenth-century perceptions of hysteria and neurasthenia patients. In a 2007 review of psychological literature on the role of personality in chronic fatigue syndrome, a group of psychologists led by Stefan van Geelen noted that

> Among clinical psychologists, consulting physicians, scientific researchers and society in general an image has emerged of patients with chronic fatigue syndrome

[84] Micale, "Strange Signs of the Times," 7.
[85] Wessely, "Chronic Fatigue Syndrome: A 20th Century Illness?" 19.
[86] Showalter, *Hystories*, 117.
[87] Ford, "Somatization and Fashionable Diagnoses," 14.
[88] Ford, "Somatization and Fashionable Diagnoses," 7.
[89] Ford, "Somatization and Fashionable Diagnoses," 14.
[90] Ford, "Somatization and Fashionable Diagnoses," 7.
[91] Ford, "Somatization and Fashionable Diagnoses," 7.

> (CFS) as perfectionist, conscientious, hardworking, somewhat neurotic and introverted individuals with high personal standards, a great desire to be socially accepted and with a history of continuously pushing themselves past their limits.[92]

These findings retained older views of chronic fatigue syndrome and fibromyalgia patients. In 1989, Alfici et al. discovered that "dependence, passivity, idealization of family relationships, obsessive-compulsive personality traits, maladaptive responses to losses, and 'workaholic' traits" were common among the fibromyalgia patients they studied.[93] From their findings, they posited that fibromyalgia patients produced physical symptoms in order to "deny depression."[94] Abbey and Garfinkel also described patients with chronic fatigue syndrome as "women and men who feel conflicted about their working lives and the difficulty in balancing their careers with their family obligations and personal wishes" and projected their distress onto medical labels like chronic fatigue syndrome in order to excuse themselves from unpleasant situations.[95] The authors specifically drew attention to "high achievers who are motivated by pleasing others and in midlife reevaluate their priorities and women who are ambivalent about leaving paid employment to stay home with young children" as typical chronic fatigue syndrome sufferers.[96]

After analyzing numerous studies that investigated different traits in chronic fatigue syndrome patients, van Geelen et al. ultimately concluded that there was insufficient evidence to indicate a meaningful connection between chronic fatigue syndrome and the characteristics they referenced, "either as a necessary condition for, or an unavoidable consequence of" chronic fatigue syndrome.[97] The authors pointed out that attributing these specific personality traits to chronic fatigue syndrome patients not only generalized a diverse group of patients, but also minimized the role of culture and interactions with other people in the construction

[92] van Geelen et al., "Personality and Chronic Fatigue Syndrome: Methodological and Conceptual Issues," 885.
[93] Alfici et al. cited in Ford, "Somatization and Fashionable Diagnoses," 11.
[94] Ford, "Somatization and Fashionable Diagnoses," 11.
[95] Abbey and Garfinkel, "Neurasthenia and Chronic Fatigue Syndrome," 1644.
[96] Abbey and Garfinkel, "Neurasthenia and Chronic Fatigue Syndrome," 1644.
[97] van Geelen et al., "Personality and Chronic Fatigue Syndrome: Methodological and Conceptual Issues," 898.

of personality. They maintained that personality is much more complex than this belief presumes.[98] Van Geelen et al. further suggested that certain personality traits—although not all—change as circumstances change. Therefore, it is possible that personality traits could arise as the result of living with a chronic illness like chronic fatigue syndrome, rather than being predisposing factors.[99] It is also possible, they argued, that these traits are associated with the depression that commonly exists alongside chronic fatigue syndrome rather than chronic fatigue syndrome itself. Patients with comorbid depression have been found to be more likely to possess the characteristics attributed to chronic fatigue syndrome patients, at a similar rate to depressed patients in general.[100]

Echoing the convictions of Bernheim, Janet, and Babinski from a century earlier about hysteria patients' vulnerability to suggestion, Showalter maintained that hysteria (and the list of conditions she considered hysterical) was a mimetic disorder that was sensitive to cultural forces. She further argued that the ubiquity of the media made hysterical epidemics in the twentieth century even more pervasive than previous hysterical illnesses. Wessely noted in 1990 that "It seems impossible to open a newspaper without finding a reference to myalgic encephalomyelitis ('ME') or postviral fatigue."[101] Ford, Shorter, and Wessely agreed with Showalter that twentieth-century hysteria spread through the media, as potential patients picked up symptoms after being exposed to patient testimonies.[102] As a result, Ford argued, patients adopt "fashionable" sets of symptoms and diagnostic labels in a manner that appeared to be a resurgence of hysteria.[103] In a more striking statement, Shorter claimed that "the media advocates of CFS seize immunological data as they become available in the lab

[98] van Geelen et al., "Personality and Chronic Fatigue Syndrome: Methodological and Conceptual Issues," 896.
[99] van Geelen et al., "Personality and Chronic Fatigue Syndrome," 898.
[100] van Geelen et al., "Personality and Chronic Fatigue Syndrome," 896.
[101] Wessely, "Old Wine in New Bottles," 35.
[102] Showalter, *Hystories*, 5.
[103] Ford, "Somatization and Fashionable Diagnoses," 14.

and apply them willy-nilly to their pet illnesses."[104] In this view, patients adopted a diagnostic title and attempted to retroactively prove the connection between the organic condition and their symptoms in order to root their illness in a biological—in this case immunological—cause. Shorter proposed that the postmodern emphasis on "individual self-actualization" was exacerbated through the media by removing feedback loops.[105] Without close friends and family to confirm or deny beliefs about their own health, individuals relied on the often "alarmist" media to support their "self-diagnoses."[106] In 1997, Wessely criticized a specific subcategory of self-help literature that dismissed doctors as "ill-informed." He proposed that this writing revealed that such patients were not receptive to physicians' advice when it contradicted the patient's own interpretation.[107] Shorter argued that the ubiquity of the media coupled with the "loss of medical authority" caused patients to cling to "fixed" organic disease labels as explanations for their symptoms.[108]

In 2018, Aho contended that patients tended to prefer the "functional somatic" disease labels—which attribute symptoms to an as-yet-unidentified organic cause—because this designation appeared to legitimize their suffering by associating their symptoms with biology rather than psychology.[109] He suggested that this categorization allowed patients to construct narratives that validated their self-identity, presenting their symptoms as "culturally legitimate" in a medical system (and a general society) that values objectivity and biological explanations over "subjective" patient experiences and psychological explanations.[110] This idea reflects Wessely's claim as far back as 1990 that patients prefer functional somatic diagnoses to avoid the stigma associated with mental illness.[111] Shorter similarly argued in 1992 that the patients' rejection of psychiatric explanations is rooted in their fear of

[104] Shorter, *From Paralysis to Fatigue*, 315.
[105] Shorter, *From Paralysis to Fatigue*, 320-322.
[106] Shorter, *From Paralysis to Fatigue*, 322.
[107] Wessely, "Chronic Fatigue Syndrome: A 20th Century Illness?" 26.
[108] Shorter, *From Paralysis to Fatigue*, 295.
[109] Aho, "Neurasthenia Revisited," 10.
[110] Aho, "Neurasthenia Revisited," 9.
[111] Simon Wessely cited in Aho, "Neurasthenia Revisited," 10.

invalidation. He suggested that these patients clung to organic diagnostic labels in order to avoid accusations that their condition was "imaginary."[112] In Shorter's view, the increased number of patients ascribing their symptoms to functional somatic diseases fed into what he called a "subculture of invalidism."[113] He argued that when compared with hysteria patients of the past, chronic fatigue syndrome and fibromyalgia sufferers tended to be more distrustful of their physicians and of the medical field in general. He believed that these patients were also more likely to reject professional opinions than patients with other medical conditions. Shorter proposed that this resistance to medical authority was a defining quality of such illnesses.[114] Ford also asserted in 1997 that fashionable diagnostic labels "[appeal] to both patient and physician" as an "illusion of explanation for a complex interaction of factors that range from individual differences in sensitivity… to unresolvable issues of social inequalities."[115]

Ford further argued that Shorter and Showalter's conception of chronic fatigue syndrome and fibromyalgia as physical expressions of distress was just as reductive as functional somatic diagnostic labels. He noted that somatization is likely an important factor in determining the severity of these illnesses, but that chronic fatigue syndrome, fibromyalgia, and other "fashionable diagnoses and environmentally related syndromes" cannot be entirely attributed to somatization.[116] These debates about the origin of chronic fatigue syndrome and fibromyalgia—as biological illnesses, psychosomatic reactions, or even malingering—resembled the controversy surrounding hysteria in the nineteenth century as described in historical accounts of the Victorian epidemic. Hysteria has been attributed to Victorian patriarchal social dynamics, psychological distress, neurological illness, and the interaction of these factors: for example, psychological distress could result from social,

[112] Shorter, *From Paralysis to Fatigue*, 317.
[113] Shorter, *From Paralysis to Fatigue*, 318.
[114] Shorter, *From Paralysis to Fatigue*, 317.
[115] Ford, "Somatization and Fashionable Diagnoses," 14.
[116] Ford, "Somatization and Fashionable Diagnoses," 13.

personal, or sexual problems and nervous fatigue was linked to "overcivilization" and changing social norms.[117] Through all of these proposed explanations, hysteria, neurasthenia, chronic fatigue syndrome, and fibromyalgia patients have insisted on the biological nature of their symptoms and have often faced opposition from doctors as a result.

Medical Discourse

Medical writing on chronic fatigue syndrome and fibromyalgia in the late twentieth and twenty-first centuries reveals parallels between chronic fatigue syndrome and fibromyalgia on the one hand and neurasthenia and hysteria on the other. When describing these related disorders, contemporary doctors and medical writers have evoked many of the same stereotypes that were associated with hysteria and neurasthenia a century earlier. Although chronic fatigue syndrome and fibromyalgia have been described as modern-day manifestations of hysteria, their connection to neurasthenia is arguably even more strongly established, especially in medical writing. Abbey and Garfinkel asserted that "Many clinicians have suggested that chronic fatigue syndrome is no more than George Beard's neurasthenia of the nineteenth century."[118] According to Abbey and Garfinkel, this position implied that neurasthenia and chronic fatigue syndrome were both vague diagnostic titles describing a range of symptoms rather than "definite syndrome[s]."[119] Lane et al. (1991) pointed to the shared presumed etiological relationship to environmental factors and overwork. The authors also highlighted common symptoms, including fatigue and psychological symptoms. They further noted that chronic fatigue syndrome is historically and symptomatically related to physical disorders like postviral fatigue syndrome and irritable

[117] See Chapter Two for a more detailed discussion of nineteenth-century hysteria.
[118] Abbey and Garfinkel, "Neurasthenia and Chronic Fatigue Syndrome," 1638.
[119] Abbey and Garfinkel, "Neurasthenia and Chronic Fatigue Syndrome," 1638.

bowel syndrome; psychological disorders like mood, anxiety, and somatization disorders; and fibromyalgia.[120]

Katon and Russo (1992) determined that patients that experienced more somatic symptoms were more likely to have a psychiatric disorder, implying a "linear relationship" between the incidence of physical and psychological symptoms.[121] Some studies have demonstrated that psychiatric disorders appear to cause somatic symptoms, while others have suggested that psychological disturbances appear as a result of living with these chronic illnesses.[122] According to van Geelen et al., the most common psychiatric disorders that occur alongside chronic fatigue syndrome are depression, hypochondriasis, and somatization disorder.[123] However, Wessely (1997) challenged the claim that somatization disorder occurred frequently among chronic fatigue syndrome patients. Interestingly, he argued that the similarity diagnostic criteria for chronic fatigue syndrome and somatization disorder were so similar that doctors tended to perceive more patients as suffering from somatization disorder than actually were.[124] Anxiety and depression are also common among fibromyalgia patients, although somatization disorder has rarely been discussed in relation to fibromyalgia.[125]

Of these comorbid psychiatric disorders, however, the role of depression in chronic fatigue syndrome and fibromyalgia has garnered the most medical and scholarly attention. In 2007, van Geelen et al. described three potential relationships between chronic fatigue syndrome and depression: chronic fatigue syndrome could be a physical manifestation of depression, depression could merely be a predisposing factor for chronic fatigue syndrome, or, conversely, the physical symptoms of chronic fatigue syndrome and these patients'

[120] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 342.
[121] Katon and Russo cited in Wessely, "Chronic Fatigue Syndrome: A 20th Century Illness?" 19.
[122] van Geelen et al., "Personality and Chronic Fatigue Syndrome," 887.
[123] van Geelen et al., "Personality and Chronic Fatigue Syndrome," 887.
[124] Wessely, "Chronic Fatigue Syndrome: A 20th Century Illness?" 19.
[125] Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It," 188.

experiences lead to depression.[126] Fibromyalgia has also been strongly correlated with depression; 71% of fibromyalgia patients in a study conducted by Hudson et al. (1985) and 65% in a study by Alfici et al. (1989) were found to have a history of depression.[127] According to Ford, fibromyalgia patients reject the theory that their symptoms arose from an underlying psychiatric disorder; rather, they see psychological issues as symptoms of a primary physical condition.[128] More recently, Perrot (2012) questioned the basis of a psychiatric etiology for fibromyalgia. He contended that despite perceptions of these patients as difficult and resistant to treatments, studies investigating whether fibromyalgia is a mental disorder have also been inconclusive. He noted that all chronic conditions have higher rates of anxiety and depression than healthy control groups and that "cognitive dysfunction and inefficient coping" were more consistently found among fibromyalgia patients than any "specific psychological feature or traits."[129]

Because of the ambiguity of these disorders and because of high rates of comorbidity with psychiatric disorders, most medical articles written in the 1990s supported the theory of a psychological cause for chronic fatigue syndrome and fibromyalgia. Proponents of the psychosomatic explanation for chronic fatigue syndrome and fibromyalgia extended the notion that these patients with "diffuse and evolving nervous complaints" were seeking physical treatment for feeling "unhappy or unfulfilled."[130] Steven et al. (2000) surveyed physicians and discovered that over two thousand informants doubted that chronic fatigue syndrome was its own condition and believed, rather, that it was probably a physical manifestation of depression.[131] Later studies, like that of Kumar and Kumar (2006), rejected this theory and asserted that the high rates of depression among chronic fatigue syndrome

[126] van Geelen et al., "Personality and Chronic Fatigue Syndrome: Methodological and Conceptual Issues," 896.
[127] Hudson et al. and Alfici et al. cited in Ford, "Somatization and Fashionable Diagnoses," 11.
[128] Ford, "Somatization and Fashionable Diagnoses," 10.
[129] Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It," 188.
[130] Micale, "Strange Signs of the Times," 7.
[131] Steven et al. cited in van Geelen et al., "Personality and Chronic Fatigue Syndrome," 888.

patients constituted a correlation, not a causal relationship.[132] However, studies in the late twentieth century centred on the role of psychology in fibromyalgia and chronic fatigue syndrome. The stigma associated with mental illness further delegitimized these poorly understood disorders. As Wessely noted, psychological disorders (especially depression) are often dismissed as "unreal," "nonexistent," or even imaginary; these illnesses can also be turned around on the patient in the form of "moral judgment[s]" about their "lack of effort" and "poor motivation."[133]

A study conducted by Manu et al. in 1988 investigated the etiology of chronic fatigue syndrome. The authors determined that patients with chronic fatigue syndrome had varied causes for their symptoms. Of the 100 participants, 66 had at least one significant psychiatric disorder that was believed to cause their fatigue symptoms, five patients were suffering from symptoms thought to arise from another medical condition, and the remaining 31 participants had no explanation for their symptoms.[134] Aside from etiology, Manu et al. discussed the prevalence of certain mental disorders in chronic fatigue syndrome more generally. At the beginning of the study, they found that of the patients with comorbid psychiatric conditions, 44 had mood disorders, 10 had somatization disorders, and nine had anxiety disorders. However, during the follow-up evaluations, the authors identified three new cases of mood disorders and five new cases of somatization disorder.[135] Overall, the authors concluded that "chronic fatigue is an expression of somatization (ie, the exaggerated perception of the physical symptom) associated, in the majority of our patients, with three distinct psychiatric conditions: mood disorders, somatoform disorders, and anxiety disorders."[136]

---

[132] Kumar and Kumar, "Chronic Fatigue Syndrome," 291.
[133] Wessely, "Chronic Fatigue Syndrome: A 20th Century Illness?" 24.
[134] Peter Manu, Dale A. Matthews, and Thomas J. Lane, "The Mental Health of Patients With a Chief Complaint of Chronic Fatigue: A Prospective Evaluation and Follow-Up," *Archives of Internal Medicine* 148, no. 10 (October 1, 1988): 2213, https://doi.org/10.1001/archinte.1988.00380100077017.
[135] Manu et al., "The Mental Health of Patients With a Chief Complaint of Chronic Fatigue," 2214.
[136] Manu et al., "The Mental Health of Patients With a Chief Complaint of Chronic Fatigue," 2216.

The same three doctors published another study in 1991, attributed in this case to Lane et al. In this article, they claimed that the psychiatric disorders that often coincided with chronic fatigue syndrome tended to arise before fatigue symptoms.[137] The study compared patients with chronic fatigue syndrome to a control group of patients experiencing fatigue that was not attributed to chronic fatigue syndrome. According to the study, both groups experienced high rates of mental disorder: 82% of participants with chronic fatigue syndrome and 83% of the controls met the criteria for a psychiatric diagnosis, most commonly mood disorders.[138] However, the authors suggested that patients with chronic fatigue syndrome were at least 30 times more likely to have somatization disorder than the general population.[139] This study drew attention to the prevalence of psychiatric diagnoses among patients with chronic fatigue syndrome as compared to those with general fatigue. However, its main argument centred on the etiological relationship between mental disorders and chronic fatigue syndrome.

Lane et al. noted that in their study, patients with chronic fatigue syndrome tended to attribute their symptoms to "a viral or immunologic cause, rather than a mood disorder."[140] The authors postulated that these patients look to external reasons for their symptoms in order to "possibly [protect] them from feelings of guilt and worthlessness and loss of self-esteem."[141] Although these patients and many doctors have maintained that depression results from chronic fatigue syndrome due to the suffering and disability that often ensues, Lane et al. asserted that their research opposed this view. They noted that in their study, "depression generally preceded fatigue or had a simultaneous onset, and we found no relationship between the duration or severity of fatigue and the presence of major depression."[142]

[137] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 335.
[138] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 338.
[139] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 340-341.
[140] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 341.
[141] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 341.
[142] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 341.

Ford asserted that all conditions are influenced by a variety of factors, including "environmentally related stimuli, individual physiological responses, and social factors."[143] Although fibromyalgia and chronic fatigue syndrome lack a unifying cause, reducing these conditions to psychological disorders or modern-day hysteria leaves out important parts of the story. As Ford noted, "these syndromes do not fit into an either/or category in reference to medical versus psychological illness. They are simultaneously medical, psychological, and social phenomena."[144] A case can be made for each of these potential causes, but the reality is that chronic fatigue syndrome and fibromyalgia result from the interaction of these three forces. Physicians and patients alike latch on to "fashionable" diagnostic labels, particularly wastebasket diagnoses, in an attempt to simplify poorly understood symptoms.[145]

The cases of chronic fatigue syndrome and fibromyalgia highlight the shortcomings of focusing solely on the naturalistic paradigm. The emphasis on organic disease leaves little room for alternative narratives and the strict division between body and mind has fostered a social stigma around mental illness.[146] Some of the perspectives highlighted in this discussion have maintained that patients with chronic fatigue syndrome and fibromyalgia reject psychological explanations for their symptoms out of fear of invalidation, while others have maintained that these symptoms cannot be completely attributed to psychological factors.[147]

Wessely asserted that psychiatric treatment is the best course of action for patients with these conditions, and that treating underlying psychological conditions will also address physical complaints—despite the fact that patients tend to reject this solution.[148] Lane et al. also advocated for psychiatric treatment of chronic fatigue syndrome. They insisted that although there were no available treatments for chronic fatigue syndrome, the potentially life-

[143] Ford, "Somatization and Fashionable Diagnoses," 14.
[144] Ford, "Somatization and Fashionable Diagnoses," 14.
[145] Ford, "Somatization and Fashionable Diagnoses," 14.
[146] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 342.
[147] Shorter, *From Paralysis to Fatigue*, 317; Perrot, "If Fibromyalgia Did Not Exist, We Should Have Invented It," 188; Kumar and Kumar, "Chronic Fatigue Syndrome," 291.
[148] Wessely, "Chronic Fatigue Syndrome: A 20th Century Illness?" 19.

threatening risk posed by mood disorders warranted the use of antidepressants when chronic fatigue syndrome coincided with depression.[149] However, Wessely maintained that organic and social factors must be taken together to create an appropriate and effective treatment plan.[150]

Van Geelen et al. suggested that "insufficient attention is being paid to the mostly significant context in which the illness began, and the possible connection between the illness and the patient's life history."[151] As an alternative to the current naturalistic paradigm, Aho has proposed adopting a hermeneutic approach to fibromyalgia and chronic fatigue syndrome. A hermeneutic perspective centres on the idea that "the meanings we give to our suffering are always embedded in a particular sociocultural context."[152] This kind of approach would emphasize social factors and allow more room for patient narratives in diagnosis and treatment. Chronic fatigue syndrome and fibromyalgia are diverse conditions, with a wide range of symptoms that patients can experience very differently. Deconstructing naturalism and adopting a hermeneutic perspective would address these illnesses more fully and allow for more personalized care.

Conclusion

Despite patients' efforts to legitimize their illnesses, chronic fatigue syndrome and fibromyalgia remain highly stigmatized conditions. This is partly due to the medical field's focus on naturalism and partly (yet relatedly) due to the conflict between doctors and patients over the nature of these disorders. While patients insist that their symptoms arise from a biological cause, physicians, failing to discover biological evidence, disregard these claims and propose psychological explanations. In addition to the standard negative attitudes toward

[149] Lane et al., "Depression and Somatization in the Chronic Fatigue Syndrome," 342.
[150] Wessely, "Old Wine in New Bottles," 35.
[151] van Geelen et al., "Personality and Chronic Fatigue Syndrome: Methodological and Conceptual Issues," 897.
[152] Aho, "Neurasthenia Revisited," 8.

mental illnesses, chronic fatigue syndrome and fibromyalgia sufferers face further judgments: patients are often considered by physicians and lay commentators to be difficult, attention-seeking, and resistant to treatment. Patients are especially criticized for being dismissive of physicians' opinions that differ from their own, especially with regard to psychological explanations; for turning to self-help literature and support groups over medical doctors; and for seeking the "privileges" of the "sick role."[153] The negative medical perceptions of chronic fatigue syndrome and fibromyalgia sufferers evoke the stereotypes that nineteenth-century physicians applied to hysteria patients. In addition, the twentieth-century academic discussion of chronic fatigue syndrome and fibromyalgia were frequently expressed within historical texts on hysteria or by their authors. The language used by doctors, historians, and other scholars at the end of the twentieth century reveals that negative stereotypes about hysteria patients remained prevalent a century after the decline of the medical category. The pervasiveness of these views also attests to the extent to which misogyny is entrenched in the medical field. The cases of chronic fatigue syndrome and fibromyalgia continue the pattern of women's unexplained symptoms being categorized together under a single diagnostic title. Physicians continue to dismiss these patients' experiences and simplify complex conditions arising from a collision of social, biological, and psychological factors. As a result, patients who would have once been considered hysterical—and who are now diagnosed with chronic fatigue syndrome and fibromyalgia—struggle to access treatment for their illnesses.

Patients are often blamed for their strained relationships with doctors, but the role of doctors is rarely acknowledged. This tension can be seen as an incompatibility between patients' understandings of their illnesses and physicians' adherence to naturalism. As we saw with the dispersion of hysteria symptoms in the *DSM*, simply recategorizing wastebasket diagnoses does not lead to a greater understanding of these illnesses. Including patient

[153] Showalter, *Hystories*, 117.

experiences could add insight into the nature of the conditions themselves and inform treatment plans. However, such a task would require a consideration of the shortcomings of naturalism, a recognition of the role of sexist stereotypes in constructing these diagnoses, and an appreciation of the historical implications of hysteria.

CONCLUSION

Throughout the history of hysteria, theories about the disorder have been shaped by cultural factors and especially by perceptions of women's bodies and women's social role. Simultaneously, medical conceptions of women's bodies served to reinforce the patriarchal social structure. This interaction between medical theory and social elements plays some role in shaping all medical diagnoses, but hysteria has proven to be particularly responsive to cultural dynamics. Hysteria is an ancient disease, dating back at least as far as 1900 B.C.E.,[1] but it has always been a mysterious and imprecise ailment, describing diverse symptoms seemingly related by their association with the female body and femininity. The disorder mutated over time to align with changing conceptions of disease and social values, but remained a wastebasket for women's unexplained illnesses.

Hysteria reached epidemic proportions in the late nineteenth century. The social climate of Victorian Britain and America resulted in a medical and cultural obsession with hysteria. Following this climax, hysteria was rapidly erased from medical terminology. However, the concept of a wastebasket diagnosis, especially describing women's medical complaints, has persisted. Throughout the twentieth century, symptoms once associated with hysteria were recategorized and redefined into an array of diverse diagnostic titles, many of which continue to describe primarily female patients. These novel diagnoses retained hysteria's connection to femininity, and have often been defined in relation to medical understandings of female bodies and cultural characterizations of womanhood. The sexist stereotypes projected onto hysteria patients, especially in the nineteenth century, continue to be applied to patients diagnosed with hysteria's descendent conditions today. Wastebasket diagnoses, defined by collections of symptoms without an established etiology, offer an

[1] Ilza Veith, *Hysteria: The History of a Disease* (Chicago, IL: The University of Chicago Press, 1965), 2; Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton University Press, 1995), 19.

illusion of greater medical understanding. In reality, however, these conditions remain poorly understood. The ongoing influence of hysteria allows doctors to continue to classify women's suffering in these vague terms while overlooking and mistreating female patients.

Before the nineteenth century, confusion about the nature of hysteria was mainly related to incomplete understandings of the female reproductive system. Physicians attributed diverse and confusing suffering to the uterus, an organ that confounded male doctors. Nineteenth-century physicians attempted to explain hysteria through other avenues. Scientific medicine in the nineteenth century focused on objective and naturalistic approaches to disease, and yet was deeply influenced by cultural forces. For much of the nineteenth century, hysteria symptoms were explained by neurological processes. The final decade of the century, however, witnessed increasing research in the field of psychology. Psychologists like Sigmund Freud, Pierre Janet, and Emil Kraepelin redefined hysteria as a mental disorder but also isolated certain symptoms and groups of symptoms, placing them in new, more precisely defined disease categories.

All of these developments in the nineteenth century took place against a backdrop of changing ideas about human nature, civilization, gender, and race. In addition, the rise of industrial capitalism and its associated class restructuring and demographic changes transformed Victorian society. Darwin's theory of natural selection, first outlined in *On the Origin of Species* (1859) but expanded upon in *The Descent of Man* (1871), influenced nineteenth-century medical theory and informed cultural ideas about race, gender, and class. On another level, Victorian social values were heavily influenced by the teachings of Evangelical Christianity, which emphasized chastity, self-restraint, and "moral virtue." All of these developments came together in the diagnosis, treatment and cultural obsession with hysteria. Nineteenth-century hysteria, then, is a poignant example of interactions between medicine and society.

Toward the end of the nineteenth century, the novel diagnosis of neurasthenia was created to distinguish certain symptoms associated with hysteria as neurological in origin. The different language used to describe neurasthenia (which could affect both men and women) and hysteria (which was directly linked to femininity) illustrates the extent to which these disorders were defined in relation to societal expectations. Furthermore, the creation of neurasthenia began a wider replacement and recategorization of hysteria that continued through the twentieth century. After organic diseases were discovered that could explain certain hysteria symptoms, the burgeoning field of psychiatry attempted to classify other components of hysteria as mental disorders. Eventually, the former disease entity hysteria was divided between mood disorders, schizophrenia, anxiety disorders, personality disorders, and psychosomatic disorders. Between the first edition of the *DSM* in 1952 and the most recent version, published in 2013, the diagnostic categories descended from hysteria were further reorganized and redefined as psychological theory evolved alongside the changing social setting. However, many of these conditions retained key aspects of hysteria, in terms of symptoms, social perception, or both. In addition, and perhaps more significantly, many mental conditions that are descended from hysteria continue to be more frequently diagnosed in female patients and uphold the feminine stereotypes that once defined hysteria. The classification system employed by the *DSM* runs the risk of falling into the same trap as hysteria: defining and describing a collection of symptoms for diagnostic purposes, in effect disguising or overlooking the fact that they are poorly understood.

In Chapter Five, I explore two additional diagnoses that can be understood as extensions of hysteria in the twentieth and twenty-first centuries. Chronic fatigue syndrome and fibromyalgia were initially presumed to be organic diseases—chronic fatigue syndrome was believed to be the long-lasting effects of infectious diseases and fibromyalgia arose within the field of rheumatology to describe unexplained pain. However, doctors in the 1980s

and 1990s began to turn to psychological explanations for these conditions after years of failing to determine a biological cause. The symptoms of fibromyalgia and chronic fatigue syndrome were once associated with hysteria and, even more so, neurasthenia. Both chronic fatigue syndrome and fibromyalgia are wastebasket diagnoses that are poorly understood, often presumed to be psychological in origin, and influenced by social factors. However, the more striking parallels between chronic fatigue syndrome, fibromyalgia, and these former diagnoses lie in the medical and social perceptions of these disorders and their integration with the surrounding culture. When they were extensively studied in the 1980s and 1990s, chronic fatigue syndrome and fibromyalgia were considered to be tied to the specific cultural context from which they arose. Historians and cultural commentators compared these conditions directly to hysteria and medical professionals frequently dismissed patients' complaints as imaginary. Both of these groups reduced patients to a stereotypical image that closely resembled the image of the nineteenth-century hysteric. Despite patients' efforts to legitimize their illnesses, chronic fatigue syndrome and fibromyalgia remain highly stigmatized conditions. This is partly due to the conflict between doctors and patients over the nature of these disorders. While patients insist that their symptoms arise from a biological cause, physicians are quick to disregard these claims and advocate for the psychological explanation.

"Hysteria" appears to be a common label for conditions that are more frequently diagnosed in women, are defined by stereotypically feminine features, and cannot be understood in terms of conventional biomedical knowledge (which historically has centred white male bodies). Among the diagnoses that arose out of hysteria in the psychiatric field and beyond, many continue to be gendered in terms of the disproportionate number of women diagnosed with these disorders, the pathologization of femininity and female experiences, and the perceptions of women who receive these gendered diagnoses. These

primarily female patients tend to be dismissed and accused of being overly dramatic, emotional, narcissistic, and demanding of unnecessary medical attention. These qualities have been applied across the disorders considered modern-day manifestations of hysteria, although different qualities may be emphasized in each condition. For example, patients with histrionic and borderline personality disorders share many qualities with hysteria patients, but these traits are mainly focused on the patient's character. Conversely, patients with psychosomatic disorders—both the somatic symptom and related disorders in the *DSM* and poorly understood somatic conditions like fibromyalgia and chronic fatigue syndrome—have been criticized for resisting psychiatric treatment and "doctor-shopping" in search of a professional who will validate their experiences.

Many of the physicians and cultural commentators I highlight in Chapter Five, including Shorter, Ford, and Showalter, forwarded the narrative that cultural patients adapt themselves to cultural trends to produce symptoms that align with current conceptions of disease.[2] These writers further suggested that patients develop disorders like chronic fatigue syndrome and fibromyalgia, either consciously or unconsciously, to achieve some kind of end.[3] One of the more common suggestions is that patients endeavour to inhabit a "sick role" to avoid duties and receive attention.[4] Similarly dismissive language appears in *DSM* descriptions of "female" illnesses such as personality disorders and somatization disorders. Patients with these conditions have been disregarded by physicians and thought to be producing symptoms to garner attention from those around them. Furthermore, these new iterations of hysteria are defined in relation to cultural understandings of femininity: the symptoms described and associated stereotypes mimic undesirable "female" traits. Because

[2] Elaine Showalter, *Hystories: Hysterical Epidemics and Modern Culture* (London, UK: Picador, 1997), 15; Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York, NY: The Free Press, 1992), 1.
[3] Charles V. Ford, "Somatization and Fashionable Diagnoses: Illness as a Way of Life," *Scandinavian Journal of Work, Environment & Health* 23, no. 3 (1997): 7.
[4] Showalter, *Hystories*, 117.

of the patriarchal power imbalance embedded in the medical field and broader society, doctors are able to dismiss these conditions as imaginary rather than admit their lack of understanding.

Both the hysteria epidemic of the nineteenth century and the diagnostic categories that arose from the disorder in the twentieth century reveal an ongoing struggle within the medical profession to understand the intersection of biology and culture. Broad, symptoms-based diagnostic categories continue to be common, deployed especially to describe women's health complaints that doctors fail to understand. Janet Oppenheim warns that portraying hysteria and hysteria-like symptoms—especially psychological and psychosomatic illnesses—as culturally constructed can overlook or diminish the suffering that these patients experience.[5] She argues that both the naturalistic assumption that disease is essentially biological and the cultural constructionist perspective of disease are equally problematic. In reality, she asserts, both biological and cultural forces play a role in producing illness.[6] Kevin Aho has proposed adopting a hermeneutic perspective when attempting to understand these complex disorders.[7] Employing a hermeneutic approach rather than relying exclusively on naturalistic assumptions would allow physicians to account for cultural as well as biological and psychological factors when attempting to explain and treat these mysterious illnesses. Aho's approach may offer hope for understanding and then relieving these patients' often chronic suffering.

Understanding the relationship between poorly understood conditions like chronic fatigue syndrome and fibromyalgia and the notoriously gendered disease entity hysteria could help decrease the stigma around these illnesses. Further research into the nature of chronic fatigue syndrome and fibromyalgia could allow doctors to develop more effective treatments

[5] Janet Oppenheim, *"Shattered Nerves": Doctors, Patients, and Depression in Victorian England* (New York, Oxford: Oxford University Press, 1991), 4.
[6] Oppenheim, "*Shattered Nerves*," 4.
[7] Kevin Aho, "Neurasthenia Revisited: On Medically Unexplained Syndromes and the Value of Hermeneutic Medicine," *Journal of Applied Hermeneutics* (April 9, 2018): 8.

for these disorders. In conducting this kind of research, it is important to take into account the historical context of these gendered wastebasket diagnoses and consider its potential implications on these newer disorders. We must recognize the patterns that can be traced back to hysteria and uncover assumptions—especially about women—that inform the medical field. In addition, doctors must break away from their adherence to a naturalistic paradigm and avoid enforcing a dichotomy between observable organic illness and "health." These complex conditions cannot be defined in such terms, and require an understanding of and appreciation for cultural forces, psychological processes, and patient experiences to ensure appropriate treatment.

One avenue for future research in this area has recently emerged as a result of the COVID-19 pandemic. The long-term effects of the COVID-19 illness, known formally as Postacute COVID-19 syndrome (PACS) and informally as "long COVID," have been found to resemble fibromyalgia. According to one preliminary study on individuals who had previously contracted and subsequently overcome COVID-19, 30.7% of participants (of which 56.6% were women) met the criteria for fibromyalgia.[8] The same study refers to the illness as post-COVID-19 FM (fibromyalgia) and another article mentions "FibroCOVID."[9] Although it is too early to determine the nature of the connection between fibromyalgia and PACS, the response to this potential relationship has been revealing. The study just described was published with a title that calls fibromyalgia a "Hopeless Label" and the researchers contend that "FM skeptics—of whom there are many—will cringe at the application of the FM label to people with long COVID illnesses."[10] The author(s) worry that such a "dismal" label will only cause COVID patients to despair unnecessarily, as physicians do not have

[8] Francesco Ursini et al., "Fibromyalgia: A New Facet of the Post-COVID-19 Syndrome Spectrum? Results from a Web-Based Survey," *RMD Open* 7, no. 3 (August 1, 2021): e001735, https://rmdopen.bmj.com/content/7/3/e001735.

[9] "Some Long COVID Sufferers Meet the Criteria for Fibromyalgia: But Why Apply a Dismal Label?," *The Back Letter* 36, no. 11 (November 2021): 124–129, https://journals.lww.com/backletter/Citation/2021/11000/Some_Long_COVID_Sufferers_Meet_the_Criteria_for.5.aspx.

[10] "Some Long COVID Sufferers Meet the Criteria for Fibromyalgia: But Why Apply a Dismal Label?" 124.

enough information to determine whether PACS will be as permanent and difficult to treat as fibromyalgia.[11]

It will be interesting to see how scientists and physicians treat this novel disorder, in light of the history of hysteria and the phenomenon of the COVID-19 pandemic. COVID-19 may be the main priority in the medical community at the moment, but will those who continue to suffer from chronic symptoms be taken as seriously once their acute symptoms are treated? What role will gender play in determining future research on PACS and fibromyalgia? Will the current neglect of fibromyalgia research continue and be extended to PACS, or will the gender-neutral patient base and high-profile nature of PACS garner attention that could also benefit fibromyalgia patients? As with the rise of neurasthenia in the late nineteenth century, PACS could legitimize the fibromyalgia disorder—or, alternatively, fibromyalgia could delegitimize PACS and the stereotypes associated with fibromyalgia could be applied to PACS patients.

This thesis has brought together a wide range of topics related to the history of hysteria, over a wide expanse of history. Within the constraints of this project, I have attempted to provide an overview of the history of hysteria before the nineteenth century; examine the nineteenth-century hysteria epidemic as a case study for a gendered wastebasket diagnosis enmeshed with its cultural surroundings; chronicle the rise of psychiatry out of hysteria research; explore and analyze the dispersion of hysteria among psychiatric disorders in the *DSM* in the twentieth century; and consider two other cases of modern-day manifestations of hysteria outside of the *DSM*, chronic fatigue syndrome and fibromyalgia. The most important contribution that this thesis adds to historical discussions of hysteria is the emphasis on the continuity of the disease entity hysteria over time, in terms of symptoms as well as medical and cultural perceptions of the illness. The focus on the recategorization

[11] "Some Long COVID Sufferers Meet the Criteria for Fibromyalgia: But Why Apply a Dismal Label?" 124.

and reframing of hysteria over the twentieth century and comparisons between current disorders and hysteria in terms of medical perspectives and stigma has drawn attention to the potential for considering other illnesses in the context of hysteria. My examination of psychiatric disorders descended from hysteria and case study of chronic fatigue syndrome and fibromyalgia have highlighted specific aspects of these disorders and their relationships to hysteria. Namely, I have underlined the ways in which twentieth-century historians of hysteria, scholars exploring its modern-day counterparts, and medical professionals have discussed these disorders and patients and compared these ideas to the similar perspectives held by nineteenth-century physicians about hysteria. While many of the other historians I cited throughout this thesis appear to maintain stereotypical perceptions of hysteria patients that can be found in nineteenth-century medical texts, I have taken the opposite approach. I have aimed to deconstruct these narratives about hysteria and its descendants and expose how these ideas continue to pervade cultural and medical discussions of hysteria and contemporary gendered wastebasket diagnoses.

Although scholarship on hysteria—particularly historical research—has diminished since the 1990s, I believe it is worth revisiting. There are many more facets of this complex diagnosis to explore, especially in its modern-day counterparts. Hysteria continues to influence the medical field today, and understanding its implications is vital to providing effective care, especially to female patients and those diagnosed with hysteria's descendant conditions or other wastebasket diagnoses.

BIBLIOGRAPHY

Secondary Sources

Abbey, Susan E., and Paul E. Garfinkel. "Neurasthenia and Chronic Fatigue Syndrome: The Role of Culture in the Making of a Diagnosis." *American Journal of Psychiatry* 148, no. 12 (1991): 1638–46.

Angst, Jules, and Alex Gamma. "Diagnosis and Course of Affective Psychoses: Was Kraepelin Right?" *European Archives of Psychiatry and Clinical Neuroscience*, no. 258 (2008): 107–110.

Aho, Kevin. "Neurasthenia Revisited: On Medically Unexplained Syndromes and the Value of Hermeneutic Medicine." *Journal of Applied Hermeneutics*, April 9, 2018, 1–14.

Aragona, Massimiliano, Lorenzo Tarsitani, Serena De Nitto, and Maurizio Inghilleri. "DSM-IV-TR 'Pain Disorder Associated with Psychological Factors' as a Nonhysterical Form of Somatization." *Pain Research & Management : The Journal of the Canadian Pain Society* 13, no. 1 (February 2008): 13–18. https://www.proquest.com/docview/222253367/abstract/B60F1D48A6EC40B2PQ/1.

Arnaud, Sabine. *On Hysteria: The Invention of a Medical Category between 1670 and 1820*. Chicago, IL: University of Chicago Press, 2015.

Barke, Megan, Rebecca Fribush, and Peter N. Stearns. "Nervous Breakdown in 20th-Century American Culture." *Journal of Social History* 33, no. 3 (2000): 565–84.

Bederman, Gail. *Manliness & Civilization: A Cultural History of Gender and Race in the United States, 1880-1917*. Chicago: The University of Chicago Press, 1995.

Bemis, Virginia T. "Hystories: Hysterical Epidemics and Modern Culture." *NWSA Journal* 10, no. 1 (March 22, 1998): 172–74. https://go.gale.com/ps/i.do?p=AONE&sw=w&issn=10400656&v=2.1&it=r&id=GALE%7CA21211644&sid=googleScholar&linkaccess=abs.

Briggs, Laura. "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology." *American Quarterly* 52, no. 2 (June 2000): 246–73. https://www.jstor.org/stable/30041838.

Brown, Richard J., Etzel Cardeña, Ellert Nijenhuis, Vedat Sar, and Onno van der Hart. "Should Conversion Disorder Be Reclassified as a Dissociative Disorder in DSM–V?" *Psychosomatics* 48, no. 5 (September 1, 2007): 369–78. https://doi.org/10.1176/appi.psy.48.5.369.

Chakravarty, Tina. "Medicalisation of Mental Disorder: Shifting Epistemologies and Beyond." *Sociological Bulletin* 60, no. 2 (August 2011): 266–286.

Cohn, Simon. “Taking Time to Smell the Roses: Accounts of People with Chronic Fatigue Syndrome and Their Struggle For Legitimisation.” *Anthropology & Medicine* 6, no. 2 (1999): 195–215.

Corns, Jennifer. “The Inadequacy of Unitary Characterizations of Pain.” *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 169, no. 3 (2014): 355–78. https://www.jstor.org/stable/42920424.

Cramer, Phebe. “What Has Happened to Hysteria?” *Journal of Nervous & Mental Disease* 207, no. 9 (2019): 705–6. https://doi.org/10.1097/NMD.0000000000000850.

Cott, Nancy F. “Passionlessness: An Interpretation of Victorian Sexual Ideology, 1790-1850.” *Signs* 4, no. 2 (Winter 1978): 219–236. https://www.jstor.org/stable/3173022.

Cryle, Peter, and Lisa Downing. “Feminine Sexual Pathologies.” *Journal of the History of Sexuality* 18, no. 1 (2009): 1–7. https://www.jstor.org/stable/20542714.

Csordas, Thomas J. “Somatic Modes of Attention.” *Cultural Anthropology* 8, no. 2 (May 1993): 135–56. https://www.jstor.org/stable/656467.

Davis, N. Ann. “Invisible Disability.” *Ethics* 116, no. 1 (October 2005): 153–213.

Devereux, Cecily. “Hysteria, Feminism, and Gender Revisited: The Case of the Second Wave.” *English Studies in Canada* 40, no. 1 (2014): 19–45. https://www.proquest.com/docview/1630362861/abstract/79216BB71A334AF7PQ/1.

Dodd, Jenifer. “‘The Name Game’: Feminist Protests of the DSM and Diagnostic Labels in the 1980s.” *History of Psychology* 18, no. 3 (2015): 312–23.

Ford, Charles V. “Somatization and Fashionable Diagnoses: Illness as a Way of Life.” *Scandinavian Journal of Work, Environment & Health* 23, no. 3 (1997): 7–16.

Gillon, Raanan, and Simon Wessely. “Medicalisation of Distress.” *RSA Journal* 146, no. 5487 (1998): 78–85.

Groneman, Carol. “Nymphomania: The Historical Construction of Female Sexuality.” *Signs* 19, no. 2 (1994): 337–367. https://www.jstor.org/stable/3174802.

Inancini, Fatma, and Muhammad B. Yunus. “History of Fibromyalgia: Past to Present.” *Current Pain and Headache Reports* 8, no. 5 (October 2004): 369–78.

Jablensky, Assen. “Living in a Kraepelinian World: Kraepelin’s Impact on Modern Psychiatry.” *History of Psychiatry* 18, no. 3 (September 1, 2007): 381–88. https://doi.org/10.1177/0957154X07079690.

Jason, Leonard A., Nicole Porter, Hunnell Jessica, and Abigail Brown. “A Natural History Study of Chronic Fatigue Syndrome.” *Rehabilitation Psychology* 56, no. 1 (2011): 32–42. https://doi.org/10.1037/a0022595.

Kumar, Rakesh, and Ritesh Kumar. "Chronic Fatigue Syndrome." *Apollo Medicine* 3, no. 3 (2006): 290–97. https://doi.org/10.1016/S0976-0016(11)60212-3.

Lane, Thomas J., Peter Manu, and Dale A. Matthews. "Depression and Somatization in the Chronic Fatigue Syndrome." *The American Journal of Medicine* 91, no. 4 (1991): 335–344. Accessed November 26, 2021. https://journals.scholarsportal.info/details/00029343/v91i0004/335_dasitcfs.xml.

Lefèvre, Thomas, Aude Lepresle, and Patrick Chariot. "An Alternative to Current Psychiatric Classifications: A Psychological Landscape Hypothesis Based on an Integrative, Dynamical and Multidimensional Approach." *Philosophy, Ethics, and Humanities in Medicine : PEHM* 9 (2014): 12–12. https://doi.org/10.1186/1747-5341-9-12.

Lempp, Heidi K., Stephani L. Hatch, Serene F. Carville, and Ernest H. Choy. "Patients' Experiences of Living With and Receiving Treatment for Fibromyalgia Syndrome: A Qualitative Study." *BMC Musculoskeletal Disorders* 10 (2009): 1–11. https://doi.org/10.1186/1471-2474-10-124.

Malterud, Kirsti. "Symptoms as a Source of Medical Knowledge: Understanding Medically Unexplained in Women." *Family Medicine* 32, no. 9 (October 2000): 603–10.

Manu, Peter, Dale A. Matthews, and Thomas J. Lane. "The Mental Health of Patients With a Chief Complaint of Chronic Fatigue: A Prospective Evaluation and Follow-Up." *Archives of Internal Medicine* 148, no. 10 (October 1, 1988): 2213–2217. Accessed November 26, 2021. https://doi.org/10.1001/archinte.1988.00380100077017.

Mayes, Rick, and Alan V. Horwitz. "DSM-III and the Revolution in the Classification of Mental Illness." *Journal of the History of the Behavioral Sciences* 41, no. 3 (Summer 2005): 249–267.

Meek, Heather. "Medical Discourse, Women's Writing, and the 'Perplexing Form' of Eighteenth-Century Hysteria." *Early Modern Women: An Interdisciplinary Journal* 11, no. 1 (2016): 177–86. https://doi.org/https://doi.org/10.1353/emw.2016.0051.

Micale, Mark S. *Approaching Hysteria: Disease and Its Interpretations*. Princeton University Press, 1995.

Micale, Mark S. *Hysterical Men: The Hidden History of Male Nervous Illness*. Cambridge, Massachusetts: Harvard University Press, 2008.

Micale, Mark S. "On the 'Disappearance' of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis." *Isis* 84, no. 3 (September 1993): 496–526. https://www.jstor.org/stable/235644.

Micale, Mark S. "Strange Signs of the Times." *The Times Literary Supplement*, May 16, 1997. The Times Literary Supplement Historical Archive. https://link.gale.com/apps/doc/EX1200486898/TLSH?u=ocul_mcmaster&sid=zotero&xid=918e4903.

Micale, Mark S. "The Ten Most Important Changes in Psychiatry since World War II." *History of Psychiatry* 25, no. 4 (December 1, 2014): 485–91. https://doi.org/10.1177/0957154X14547460.

Mitchinson, Wendy. "Hysteria and Insanity in Women: A Nineteenth-Century Canadian Perspective." *Journal of Canadian Studies* 21, no. 3 (1986): 87–105.

Morrison, Denis. "The Roots of DSM-III and the Emergence of Neuroscience: Towards 'Mind Meets Brain.'" *Mentalities* 18, no. 2 (January 1, 2004): 1–6.

Newman, Louise Michele. "Health, Sciences, and Sexualities in Victorian America." In *A Companion to American Women's History*, edited by Nancy A. Hewitt. Hoboken, New Jersey: John Wiley & Sons, Inc., 2002.

Nigel Speight. "Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Review of History, Clinical Features, and Controversies." *Saudi Journal of Medicine & Medical Sciences* 1, no. 1 (June 2013): 11–13. https://www.sjmms.net/article.asp?issn=1658-631X;year=2013;volume=1;issue=1;spage=11;epage=13;aulast=Speight.

Oppenheim, Janet. *"Shattered Nerves": Doctors, Patients, and Depression in Victorian England*. New York, Oxford: Oxford University Press, 1991.

Perrot, S. "If Fibromyalgia Did Not Exist, We Should Have Invented It. A Short History of a Controversial Syndrome." *Reumatismo* 64, no. 4 (September 28, 2012): 186–93. https://doi.org/10.4081/reumatismo.2012.186.

Porter, Roy. "Scientific Medicine in the Nineteenth Century." In *The Greatest Benefit to Mankind: A Medical History of Humanity*. New York: W. W. Norton & Company, 1997.

Porter, Roy. "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria." In *Hysteria Beyond Freud*. Berkeley and Los Angeles, California: University of California Press, 1993.

Rosenberg, Charles E. "Sexuality, Class and Role in 19th-Century America." *American Quarterly* 25, no. 2 (May 1973): 131–53. https://www.jstor.org/stable/2711594.

Rost, Kathryn M., Richard N. Akins, Frank W. Brown, and G.Richard Smith. "The Comorbidity of DSM-III-R Personality Disorders in Somatization Disorder." *General Hospital Psychiatry* 14, no. 5 (1992): 322–26. https://doi.org/10.1016/0163-8343(92)90066-J.

Sandler, Carolina X., and Andrew R. Lloyd. "Chronic Fatigue Syndrome: Progress and Possibilities." *Medical Journal of Australia* 212, no. 9 (2020): 428–33. https://doi.org/https://doi.org/10.5694/mja2.50553.

Schaaf, Marieke E. van der, Floris P. De Lange, Iris C. Schmits, Dirk E. M. Geurts, Karin Roelofs, Jos W. M. van der Meer, Ivan Toni, and Hans Knoop. "Prefrontal Structure Varies as a Function of Pain Symptoms in Chronic Fatigue Syndrome." *Biological Psychiatry*, Depression: Genes, Circuits, and Treatments, 81, no. 4 (February 15, 2017): 358–65. https://doi.org/10.1016/j.biopsych.2016.07.016.

Shorter, Edward. *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era*. New York, NY: The Free Press, 1992.

Showalter, Elaine. *Hystories: Hysterical Epidemics and Modern Culture*. London, UK: Picador, 1997.

Showalter, Elaine. *The Female Malady: Women, Madness, and English Culture, 1830-1980*. Harmondsworth, Middlesex, England: Penguin Books Ltd, 1985.

Smith-Rosenberg, Carroll. *Disorderly Conduct: Visions of Gender in Victorian America*. New York, NY: Oxford University Press, 1985.

Smith-Rosenberg, Carroll. "The Hysterical Woman: Sex Roles and Role Conflict in 19th-Century America." *Social Research* 39, no. 4 (1972): 652–78. https://www.jstor.org/stable/40970115.

"Some Long COVID Sufferers Meet the Criteria for Fibromyalgia: But Why Apply a Dismal Label?" *The Back Letter* 36, no. 11 (November 2021): 124–129. https://journals.lww.com/backletter/Citation/2021/11000/Some_Long_COVID_Sufferers_Meet_the_Criteria_for.5.aspx.

Straus, Stephen E. "History of Chronic Fatigue Syndrome." *Reviews of Infectious Diseases* 13 (1991): S2–7. https://www.jstor.org/stable/4455795.

Stuttaford, Genevieve, Maria Simson and Jeff Zaleski. "Hystories: Hysterical Epidemics and Modern Culture." *Publishers Weekly* 244, no. 8 (February 24, 1997): 74. https://www.proquest.com/docview/197017123/abstract/A84D87898C124717PQ/1.

Szasz, Thomas S. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York: Harper & Row, 1974.

Tsou, Jonathan Y. "Natural Kinds, Psychiatric Classification and the History of the DSM." *History of Psychiatry* 27, no. 4 (December 1, 2016): 406–24. https://doi.org/10.1177/0957154X16656580.

Tsou, Jonathan Y. "Review of Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders." *The British Journal for the Philosophy of Science* 61, no. 2 (2010): 453–57. https://www.jstor.org/stable/40664356.

Ursini, Francesco, Jacopo Ciaffi, Luana Mancarella, Lucia Lisi, Veronica Brusi, Carlotta Cavallari, Martina D'Onghia, et al. "Fibromyalgia: A New Facet of the Post-COVID-19 Syndrome Spectrum? Results from a Web-Based Survey." *RMD Open* 7, no. 3 (August 1, 2021): e001735. Accessed November 26, 2021. https://rmdopen.bmj.com/content/7/3/e001735.

Ussher, Jane M. "Diagnosing Difficult Women and Pathologising Femininity: Gender Bias in Psychiatric Nosology." *Feminism & Psychology* 23, no. 1 (February 1, 2013): 63–69. https://doi.org/10.1177/0959353512467968.

van Geelen, Stefan M., Gerben Sinnema, Hubert J. M. Hermans, and Wietse Kuis. "Personality and Chronic Fatigue Syndrome: Methodological and Conceptual Issues." *Clinical Psychology Review* 27, no. 8 (December 1, 2007): 885–903. https://doi.org/10.1016/j.cpr.2007.01.010.

Veith, Ilza. *Hysteria: The History of a Disease*. Chicago, IL: The University of Chicago Press, 1965.

Wendell, Susan. "Toward a Feminist Theory of Disability." *Hypatia* 4, no. 2 (1989): 104–24. https://www.jstor.org/stable/3809809.

Wessely, Simon. "Chronic Fatigue Syndrome: A 20th Century Illness?" *Scandinavian Journal of Work, Environment & Health* 23, no. 3 (1997): 17–34.

Wessely, Simon. "Neurasthenia and Chronic Fatigue: Theory and Practice in Britain and America." *Transcultural Psychiatry* 31, no. 2 (1994): 173–209. https://doi.org/10.1177/136346159403100206.

Wessely, Simon. "Old Wine in New Bottles: Neurasthenia and 'ME.'" *Psychological Medicine* 20, no. 1 (1990): 35–53.

Wolfe, Frederick. "The History of the Idea of Widespread Pain and Its Relation to Fibromyalgia." *Scandinavian Journal of Pain* 20, no. 4 (October 1, 2020): 647–50. https://doi.org/10.1515/sjpain-2020-0072.

Yrondi, Antoine, Simon Taib, Laetitia Dupuch, Laurent Schmitt, Etienne Very, and Philippe Birmes. "Traumatic Hystero-Neurasthenia in Professor Charcot's Leçons Du Mardi." *Journal of Nervous & Mental Disease* 207, no. 9 (2019): 799–804. https://doi.org/10.1097/NMD.0000000000001093.

Zorzanelli, Rafaela Teixeira. "Fatigue and Its Disturbances: Conditions of Possibility and the Rise and Fall of Twentieth-Century Neurasthenia." *História, Ciências, Saúde-Manguinhos* 16, no. 3 (2009): 605–20. https://doi.org/10.1590/S0104-59702009000300002.

Primary Sources

American Psychiatric Association. *Diagnostic and Statistical Manual: Mental Disorders*. Washington, DC: American Psychiatric Association, 1952.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Second Edition*. Washington, DC: American Psychiatric Association, 1968.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*. Washington, DC: American Psychiatric Association, 1980.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*. Washington, DC: American Psychiatric Association, 1987.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Washington, DC: American Psychiatric Association, 1994.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, DC: American Psychiatric Association, 2000.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association, 2013.

Beard, George M. *American Nervousness: Its Causes and Consequences*. New York: G. P. Putnam's Sons, 1881.

Beard, George M. "Neurasthenia, or Nervous Exhaustion." *The Boston Medical and Surgical Journal* III, no. 13 (April 29, 1869): 217–221.

Breuer, Josef, and Sigmund Freud. *Studies on Hysteria*. Harmondsworth, UK: Penguin Books Ltd., 1974.

Carter, Robert Brudenell. *On the Pathology and Treatment of Hysteria*. London: John Churchill, 1853.

Darwin, Charles. *The Descent of Man, and Selection in Relation to Sex*. Princeton, New Jersey: Princeton University Press, 1981.

Flaubert, Gustave. *Madame Bovary*. Translated by Alan Russell. Harmondsworth, Middlesex, England: Penguin Books Ltd, 1950.

Freud, Sigmund. *An Autobiographical Study*. Translated by James Strachey. London: The Hogarth Press Ltd., 1950.

Freud, Sigmund. "On the Grounds for Detaching a Particular Syndrome from Neurasthenia Under the Description 'Anxiety Neurosis.'" In *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, translated by James Strachey. Vol. III. London: The Hogarth Press Ltd., 1962.

Freud, Sigmund. "The Neuro-Psychoses of Defence." In *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, translated by James Strachey. Vol. III. London: The Hogarth Press Ltd., 1962.

Gilman, Charlotte Perkins. "The Yellow Wallpaper." In *The Yellow Wallpaper and Other Stories*. Mineola, New York: Dover Publications, Inc., 1997.

Maudsley, Henry. *Body and Mind: An Inquiry into Their Connection and Mutual Influence, Specially in Reference to Mental Disorders*. London: MacMillan and Co., 1870.

Maudsley, Henry. *The Pathology of Mind*. New York: D. Appleton and Company, 1890.

Mercier, Charles. *Sanity and Insanity.* London: Walter Scott, Ltd., 1895.

Mitchell, S. Weir. *Lectures on Diseases of the Nervous System Especially in Women*. 2nd ed. London: J. & A. Churchill, 1885.

More-Madden, Thomas. *On Insanity and Nervous Disorders Peculiar to Women, in Some of Their Medical and Medico-Legal Aspects*. Dublin: Fannin and Co., 1884.

Spitzka, E. C. *Insanity: Its Classification, Diagnosis and Treatment*. New York: Bermingham & Co., 1883.