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Cycnos, études anglophones
revue électronique éditée sur épi-Revel à Nice
ISSN 1765-3118 ISSN papier 0992-1893

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Critics have long rued the evils of intellectual dualism and the splits between man and God, man and Nature, man and woman, body and soul, head and heart, reason and emotion, and so forth which it entails. Such intellectual dualisms allegedly do violence to the notion of 'wholeness'. Time was (so tell us religious, philosophical, literary, and folkloric myths), when that which is now divided and divorced was originally united. Time will be (so say optimists and utopians, reformers and revolutionaries), when that which is divided will be whole (or 'healed') again. In the field of mental health and medicine, the 'divided self' has been a great focus of attention over the last generation (Laing, 1960). In 'alternative medicine', the very division between the sick person and the doctor is often regarded as undesirable and counterproductive: 'every man his own healer' is a common cry (Inglis, 1964).

Some radical critics have been particularly fierce in blaming the so-called 'Cartesian dualism' for the self-alienating evils besetting modern man, not least for much mental disturbance and disorder (Berman, 1982; Capra, 1982). They advanced that a philosophy of man which insists upon a radical ontological dichotomy between mind and body, which equates consciousness with 'reason' and degrades the body to the level of a mere machine, was bound to create unhealthy, or crazy, concepts of the self: how can it make sense to be forced to think of oneself as the 'ghost in the machine' (Koestler, 1976)?

Worse, this dichotomy has encouraged the emergence of a radical, often rancourous bifurcation within the healing professions themselves (Lain Entralgo, 1955) - on the one hand, the tradition of 'psychological medicine', broadly committed to the notion of mental illness is ultimately organic and best treated by physical means; on the other, the various recent psychotherapeutic movements espousing authentic and non-reductive psychological accounts of mental sickness (Scull, 1989; Scull and Favreau, 1986; Szasz, 1961; Busfield, 1986).

Some scholars have recently argued that it may be inaccurate to father these polarities upon Descartes (Carter, 1983; Brown, 1985). Nevertheless, the divisions are real, and, in the case of the treatment of the sick, can hardly be desirable. The shortcomings of somatic approaches to mental disorder have been particularly emphasized in the past and the present. If all manner of disturbance of thought and feeling, from mere neurosis to full-blown insanity, is viewed as but the secondary symptoms of primary organic lesions and imbalances, are doctors likely to be sympathetic listeners to the 'meanings' of the mental and behavioural worlds of the sufferers (Fullinwider, 1982; Peterson, 1982; Porter, 1987b)?At the very least, such 'meanings' may mean a great deal to those who express them. Furthermore, as studies of 'illness narratives' show, they may provide powerful clues to the psycho- and socio-dynamics of the complaint, and suggest positive strategies for its resolution (Kleinman, 1986).

There is little doubt that, in the non-professional public mind, organic approaches to mental illness are notorious for supposedly being more 'invasive', less 'person-oriented', and above all more *violent*, than psychosomatic approaches. We are often invited to consider the frightening history of the physical therapies in psychiatry: whips, chains, manacles, strait-jackets, psychosurgical techniques such as lobotomy and leucotomy, electro-convulsive therapy, and so forth (Valenstein, 1986). Whether it is today true that organic therapeutics are, indeed, more violent than consciousness-oriented ones, this paper does not venture to decide. Rather I wish to suggest that it would be a mistake automatically to assume that such a dichotomy (psychological = insightful and sympathetic; somatic = reductive, invasive, and violent) applies generally throughout the past. My approach will be highly selective. I shall examine not 'madness' in its totality but just one mental condition: hysteria - itself, of course, through the notion of 'conversion', absolutely central to the mind/body division (Merksey,

1979). Nor shall I attempt a broad historical survey of theories of hysteria (see Trillat, 1986; Wesley, 1979; Micale, 1990), but merely examine a handful of influential somatic and psychological accounts, to see how sympathetic they have respectively been to the tribulations of sufferers.

Hysteria

The standard English-language history of hysteria, Ilza Veith's *Hysteria. The History of a Disease* (1965) advances a clear-cut thesis. From the Greeks onwards, organic interpretations of the condition dominated, seeing it either as a disease of the female reproductive system, or, alternatively, as seated in the nervous system. These, Veith argues, were mistaken, retarding the progress of our understanding of the malady. Fortunately, Veith continues, a counter-interpretation emerged, albeit by fits and starts. Brave spirits such as Paracelsus, Edward Jorden, Thomas Sydenham, Franz Mesmer, Philippe Pinel, Ernst von Feuchtersleben and Robert Carter began to develop 'anticipations' of the insight - finally triumphant with Freud - that hysteria was psychogenic (Veith, 1965: p. viii). Believing that Freud had 'solved' the problem, Veith concludes her book with his contribution.

Among the most 'sterile' approaches, according to Veith, was the attempt, pioneered by the eighteenth century physician, George Cheyne, and his circle (Cheyne: 1733; Veith: 1949) to view hysteria as a disease of the nervous constitution, centered upon the digestion. Cheyne subsumed hysteria - which covered a multitude of symptoms ranging 'from Yawning and stretching up to a mortal Fit of an Apoplexy' - under the umbrella of nervous diseases, it being due to 'a Relaxation and the Want of a sufficient Force and Elasticity in the Solids in general and the *Nerves* in particular' (Cheyne, 1733: p. 14).

Fashionable physicians in the age of the Enlightenment had many reasons for claiming the seat of 'hysteria' and similar disorders such as the 'vapours' was organic. Not least, they wanted to share in the glories of Newtonian mechanical science (Doughty, 1926; Rousseau, 1976, 1980). But these 'nerve doctors' also made this move out of an empathetic consideration for their patients. If 'hysteria' was construed as a 'nervous disease', sufferers could not be accused of being full-blown lunatics, diabolically possessed, or mere malingerers (Porter, 1987a, ch. 2).

Such physicians were well versed in bedside diplomacy. Handling wealthy and powerful parients, they learnt that finding *le mot juste* in which to couch a diagnosis was essential to their art; the blunt John Radcliffe was allegedly dismissed from Queen Anne's service after telling her Majesty she was suffering from 'vapours': in elevated circles at least, it would seem, that term implied the perhaps imaginary malady of a touchy milady. Confronted with ambivalent ailments, the problem of negotiating diagnoses acceptable to doctor and patient alike was pondered by Cheyne. Physicians were commonly put on the spot by 'nervous cases', he noted, because such conditions were easily dismissed by the 'vulgar' as marks of 'peevishness', or, when ladies were afflicted, of 'fantasticalness' or 'coquetry' (Cheyne, 1733: p. 170). As we shall see, many Victorian physicians - unlike their more sympathetic or judicious Georgian forebears - would endorse the 'vulgar' discrediting of the hysteric as a coquette.

Cheyne believed his own somatizing categories were, however, music to his patients' ears, for they craved diagnoses that rendered their disorders real. The vulgar masses might suppose that hysteria, the spleen and all that family of disorders were 'nothing but the effect of Fancy, and a delusive Imagination'; such a charge was ill-founded, however, because 'the consequent Sufferings are without doubt real and unfeigned' (Cheyne, p. 8).

His fashionable contemporary, Richard Blackmore, experienced equivalent difficulties. 'This Disease, called Vapours in Women, and the Spleen in Men, is what neither Sex are pleased to own', he emphasized, for a doctor:

> cannot ordinarily make his Court worse, than by suggesting to such patients the true Nature and Name of their Distemper.... One great Reason why these patients are unwilling their Disease should go by its right Name, is, I imagine, this, that the spleen and Vapours are, by those that never felt their Symptoms, looked upon as an imaginary and fantastick Sickness of the Brain, filled with odd and irregular Ideas.... This Distemper, by a great Mistake, becoming thus an Object of Derision and Contempt: the persons who feel it are unwilling to own a Disease that will expose them to Dishonour and Reproach (Blackmore, 1725, p. 47).

The longterm solution these physicians proposed was to invest such labels with copper-bottomed organic connotations - for example, by speaking of 'hysterick colic' or 'hysterick gout'. This one woman Cheyne treated had a 'hysterick lowness', another 'frequent hysterick fits' (1733, p. 272). The physician would thereby spare himself the accusation of merely trading in words, and imputations of shamming would equally be scotched, as, Dr Nicholas Robinson insisted, such disroders were not 'imaginary Whims and Fancies, but real Affections of Matter and Motion', for 'neither the Fancy, nor Imagination, nor even Reason itself... can feign a.... Disease that has no Foundation in Nature' (1729, p. 107; see also Wright, 1980; Jobe, 1976; Boss, 1979).

The Mechanical Tradition

In explicating hysteria, and the related condition, hypochondria, iatromechanist physicians from the pioneer neurologist, Thomas Willis to Cheyne and his successors, did not seek altogether to deny the contribution of consciousness, and certainly did not aim to reduce mind to body, man to *l'homme machine.* But their aspirations as scientific doctors treating enlightened people disposed them to insist upon the primacy of physical stimuli, as part of a two-pronged strategy of winning the confidence both of their patients and of their scientific peers.

Such a strategy was not restricted to rich patients. From the mid-eighteenth century clinical wards developed at the Edinburgh Infirmary to serve the needs of the highly successful Edinburgh Medical School. As Guenter Risse (1988) has demonstrated, a quota of female patients was regularly admitted to that hospital as 'hysteria' cases. These women (entirely working-class, some married, others not) presented with a range of common physical symptoms - breathing difficulties, nervous coughs, bronchial problems, trouble in swallowing, menstrual troubles, chest constriction, motor disturbances and seizures, general muscular feebleness - exacerbated by emotional irregularities (weeping, depression, etc.). They were humanely perceived as run down, exhausted, undernourished labouring women, suffering from weakened systems, amenorrhoea, and emotional stress. The hysteria diagnosis secured them a few weeks' valuable recuperative bedrest, supplemented by a nourishing diet, and in some cases by electrical treatment. The organic substrate implied in constituting their hysteria as 'nervous' safeguarded such patients from serious intimations of shamming.

Leading medical theorists, such as Robert Whytt at Edinburgh, professed bafflement at the Sphinxian-riddles of the impact of the body upon the mind and back again (Whytt, 1767; French, 1969). 'The action of the mind on the body, and of the body on the mind,' noted an authority on madness, 'after all that has been written, is as little understood as it is universally felt' (Faulkner, 1789, p. i). This suspended judgment surely supported that respect with which the post-Sydenham hysteric was treated in a private practice milieu in which, as Jewson has stressed (1974, 1976), some rough-and-ready parity governed patient/practitioner relationships. Thus, the great clinician William Heberden was thoroughly familiar with the *symptoms* of hysteria, a condition all too readily provoked by the 'slightest affection of the sense of fancy, beginning with some uneasiness of the stomach or bowels'. 'Hypochondriac men and hysteric women' suffered acidities, wind, and choking, leading to 'giddiness, confusion, stupidity, inattention, forgetfulness, and irresolution', all proof that the 'animal

functions are not longer under proper command' (Heberden, 1802, p. 225). But, a man of his time, he was loth to dogmatize as to the root-cause. For

> our great ignorance of the connexion and sympathies of body and mind, and also of the animal powers, which are exerted in a manner not to be explained by the common law of inanimate matter, makes a great difficulty in the history of all distempers, and particularly this. For hypochondriac and hysteric complaints seem to belong wholly to these unknown parts of the human composition (1802, p. 225).

Like his fellow clinicians, Heberden was prepared to accept mystery as the condition's visiting card. 'I would by no means be understood, by any thing which I have said, to represent the sufferings of the hypochondriac and hysteric patients as imaginary; for I doubt not their arising from as real a cause as any other distemper' (p. 235).

In other words, the historical sociology of Enlightenment hysteria is epitomized by the clinical encounter between sensitive patient and sympathetic physician. Not least, it was unisex: as a disorder of the nerves, hysteria was a disease of men no less than of women (though with men it was called 'hypochondria').

This sympathetic tradition of treating hysteria as a disease of the nerves continued through the nineteenth century. Victorian medicine presents a panorama of affluent, leisured, twitchy types of both sexes being diagnosed as 'hysterical', or, more commonly, by one of its new euphemistic aliases, such as 'neurasthenic', and being treated, by general practitioners ans specialist 'nerve doctors' alike, with a cornucopia of drugs and tonics, moral and behavioural support, indulgence, rest, regimen and discipline (Gosling, 1987).

In the nineteenth century, the rest-home, clinic, and sanatorium supplemented the spa to provide new sites for nervous complaints. Above all, by protecting 'neurasthenic' patients within a somatizing diagnostics of 'nervous collapse', 'nervous debility', weakness of the stomach, dyspepsia, atonicity, and so forth, fashionable doctors could forestall suspicions that their respectable patients were either out of their minds - stark mad - or sociopathic malingerers. Not least, 'nerves' precluded moral blame, by hinting at a pathology not even primarily personal, but social, a *Zeitgeist* disease. Early eighteenth century nerve doctors tended to indict cultural volatility: luminous literati and salon sophisticates were victims of vertiginous lifestyles that sapped the nerves. By contrast, in their later recensions of the diseases of civilisation, high Victorian therapists on either side of the Atlantic pointed the accusing finger at the merciless competitiveness of steam-engine capitalism. In North America, George Beard and Weir Mitchell in particular argued that career strains, the rat-race for success in the cockpit of commerce, exhausted young achievers; brain-fagged by stress and tension, they ended up nervously bankrupted, their mental capital overtaxed. Cerebral circuits suffered overload, mental machinery blew fuses, batteries ran down: such metaphors, lifted from the mechanical idioms of industry, science and technology, naturally confirmed that disorders were organic, explaining why go-getting all-American Yale graduates should suffer nervous breakdown no less than their delicate devoted sisters (Beard, 1891; Mitchell, 1881; Gosling, 1987; Rosenberg, 1962; Sicherman, 1977).

It may be argued that experts such as Weir Mitchell truly regarded hysteria as a disorder of the psyche or personality but chose to treat it somatically rather than psychologically, subscribing to the common fear that, encouraged to talk about themselves and their troubles, hysterics would only become yet more morbidly, solipsistically, introspective, with disastrous (and 'interminable') results (Mitchell, 1877; 1881; Clark, 1988). From her Freudian viewpoint, Veith has deplored the fact that Mitchell did not encourage his rest-cure patients to talk through their psycho-sexual problems. Probably the doctor's reticence reflects neither prudery nor shallowness, but strategy: belief that some problems were better left latent, for chewing them over would only irritate morbid tendencies (Veith, 1965: 212). Hence, 'nerve doctors' continued to treat physical symptoms with physical means, steering clear of skirmishing with the mind. If blinkered and complacent, such views were not necessarily

foolish. For the contrasting protocols of the Charcotian tuesday clinic and the Freudian couch arguably hysterized hysteria, in the manner of dousing a fire with gasoline.

Psychodynamics

Sceptical about the value of somatic approaches to hsyteria, historians have hailed the emergence, in the nineteenth century, of psychological interpretations. In Veith's account, the highest praise - before Freud - is reserved to the mid-nineteenth century work of Robert Carter, who helped effect 'a greater stride forward' in understanding hysteria than 'all the advances made since the beginning of its history', thanks to his 'clear insight into the psychopathology of hysteria' and his 'advanced' discovery of sexual aetiology (Veith, 1965: 199, 202; cf. Carlson and Kane, 1982).

Carter was a young general practitioner in the leafy London suburb of Leytonstone when he published his *On the pathology and treatment of hysteria* (Carter, 1853). In it, he reviewed all available somatic theories of the condition - Cullen's and Pinel's view that it was a morbid condition of the uterine nerves; Cheyne's and Parry's indictment of the stomach; Highmore's claim that it followed lung and heart congestion; the notion, associated with Whytt, Tissot, Boerhaave, and Boissier de Sauvage, that it was a disease of the nervous system; Willis's theory, revived by Georget, that it was a morbid condition of the brain; Van Swieten's 'morbid condition of the spinal chord', and so forth. All without exception he judged lacking authenticated foundation; for 'the disease itself is too shifting and variable to depend upon any definite change in any individual organ' (Carter, 1853: 83). Above all, attempts to ground hysteria in 'irritation of the uterus and ovaria [were] ... utterly untenable' - indeed, merely circular (Carter, 1853: 83). Hysteria, in short, was not somatic at all, it was psychological: 'the emotional doctrine affords an easy and complete solution of the difficulty'. Indeed, its aetiology lay specifically in 'the sexual feelings', these being 'both more universal and more constantly concealed than any others' (Carter, 1853: 83).

What was the mechanism of the psychological theory of hysteria? Drawing upon the writings of W.B. Carpenter and other eminent psycho-physiologists, he explained that, within the regular self-adjusting system of the metabolism, strong emotions (fear, joy, etc.) should properly find healthy outlet in physical release such as tears, laughter, flight, etc. Obviously, central amongst the emotions were the sexual passions. Ideally these found natural fulfilment in erotic activity, ultimately in orgasm. Discharging such desires rarely posed problems for males.

For women, however, the double standard commonly denied them such relief - a result of high moral expectations and the 'habitual restraint' imposed upon ladies by respectability. Denied the 'safety valve' of direct, physiological outlets, women were forced to bottle up their amatory longings and suffer what Carter called 'repression' (Carter, 1853: 17). Intense personal crises (*e.g.*, a broken engagement) could easily cause that dam to break, however, whereupon indirect tension release was unintentionally gained in hysteria - expressed in outbreaks of uncontrollable sobbing, shaking, fits, temper, and the like. Such hysteria - 'a disease starting with a convulsive paroxysm' - Carter called 'primary'; it was, in a sense, a spontaneous compensatory mechanism designed to make the best of a bad situation (Carter, 1853: 2). Some salutary tension discharge was at least achieved, and eventually the sobbing of tantrum would play themselves out and calm would be restored. Primary hysteria of this kind did not require the physician's services.

Hysteria did not stop there, however. For unfortunately, 'the suggested spontaneous remembrance of the emotions' attending the primary fit could easily provoke further attacks, which Carter termed 'secondary hysteria' (Carter, 1853: 43). Sufferers, relatives, and doctors alike could help forestall such secondary attacks by providing appropriate distractions. Such

prevention was prudent, for patients quickly habituated themselves to ‘secondary hysteria’ finding it provided them with compensatory pleasures - not least, attention.

Worse, such indirect gratifications readily deteriorated into ‘tertiary hysteria’, which Carter defined as a condition ‘designedly excited by the patient herself through the instrumentality of voluntary recollection, and with perfect knowledge of her own power to produce them’ (Carter, 1853: 43). In short, tertiary hysteria - Carter’s prime concern - was an egoistical technique, mobilized by the patient’s will, for tyrannizing others. The tertiary hysteric, in Carter’s view, had thus sunk to appalling depths of moral depravity, contriving to manipulate all around her, so as to gratify her whims and domineering spirit, and enable her to bask in the ‘fuss and parade of illness’ (Carter, 1853: 46). Because this exercise of will was wholly camouflaged in somatic expressions, it naturally compelled sympathy (the patient, after all, appeared dramatically sick), without risking suspicions of shamming. The greater the sympathy it won, the more tyrannical it became. Hysterics grew expert in their art. Thus, to create an effect, Carter noted, ‘hair will often be so fastened as to fall at the slightest touch’, and other theatrical effects would testify to the ‘ingenuity of the performer’ (Carter, 1853: 46).

Such a minx, manipulating a ‘self-produced disease’ in which the patient herself had full ‘power over the paroxysm’, could be overcome only by a battle royal engaged by the physician, willing to enter into a war of wills (Carter, 1853: 51). Defeating the ‘tricks’ of such a monster of ‘selfishness and deceptivity’, possessed of a ‘mendacity that verges on the sublime’, was not, however, an easy matter; for the symptoms of physical illness (including in the extreme case the tacit threat of fasting unto death) were powerful weapons to have in one’s armoury (Carter, 183: 56). Carter knew medical means were utterly irrelevant (no Mesmeric magnets for him). Psychological warfare was needed to defeat ‘the ends which she proposes to herself for attainment’ (Carter, 1853: 96). First, the hysteric had to be separated from her parents and friends and incarcerated in the physician’s home. Once there, under no circumstances should the doctor ‘minister to the hysterical desire’ (Carter, 1853: 129). Every bid of the patient to use hysterical tantrums to command attention had to be steadfastly ignored and thus proven futile: no notice was to be taken of convulsions, fasts, or acts of self-mutilation; above all, the hysteric’s cravings for surrogate sexual gratification, especially through demands for vaginal examinations with a speculum, had to be resisted. Normal, sociable behaviour was, by contrast, to be encouraged and rewarded(Carter, 1853: 67).

No holds were barred. The hysteric was mistress of duplicity, and, in response, the physician would often find it necessary to ‘completely deceive her’ (Carter, 1853: 106). His most difficult task was to find tactful ways of communicating to the hysteric that her wiles had been rumbled and the game was up. Diplomatically done, this would afford her the opportunity to surrender with honour, and put herself ‘completely in the power of her interlocutor’, whereupon she might make a clean breast of things, preparatory to being reincorporated, as the prodigal daughter, into normal, bourgeois life - that life whose constraints and double standards, Carter himself had initially acknowkledged, were responsible for hysteria in the first place (Carter, 1853: 113).

Several aspects of Carter’s account of how to tame a hysterical shrew, and bring her to ‘humiliation and shame’, are worth noting (Carter, 1853: 111). For one thing, his psychological reading of hysteria drew heavily upon the idiom and premisses of early nineteenth century psychiatry; Carter explicitly valued ‘moral management’ and ‘moral therapy’ (Carter, 1853: 95; Scull, 1989). He proposed turning his own abode into a hysterics’ asylum, in whose gothic isolation the battle for the mind could be waged. One might gloss this by noting that as a young general practitioner, Carter was in no position to contemplate the laborious investigation of the laws of hysteria as undertaken by the eminent Professor

Charcot at the Salpétrière. Economics forced Carter - as to some degree Freud after him - to be concerned with cure rather than scientific exploration, and to have an eye to fees.
Drawing upon contemporary asylum psychiatry, Carter forged a conceptual triangle of elective affinities, profoundly pregnant for the future, linking (1) psychological explanation with (2) female nature and (3) a sexual aetiology ('sexual emotions are those most concerned in the production of the disease') (Carter, 1853: 35). In other words, in its grave forms, hysteria was a matter of *mental* acts (frauds), perpetrated by *women* in order to achieve surrogate *sexual* gratification. By contrast to earlier uterine theories, Carter's hypothesis did not, however, lay principal blame at the door of the female anatomy: rather what Hack Tuke later called a 'paralysis of the will' was at fault. Although Carter noted that 'if the state of society permitted [the] free expression' of female sexual desires, hysteria might dissolve away, he produced not a critical sociology of hysteria but a moralizing theory, condemning self-indulgent women (Carter, 1853: 26). In this, his language explicitly echoed the witchhunt, as when he remarked that the hysteric who made a hash of faking disease thereby 'betrays the cloven foot' (Carter, 1853: 122).

Discussion

The social history of Victorian medicine on the one hand, and of the 'woman problem' on the other, leave it surely no accident that the first psychogenic theory of hysteria was misogynistic and victim-blaming. For the *raison d'être* of psychologizing hysteria was precisely to deny its authenticity as a malady, exposing it as fraud involving a terrible 'degree of perversion of the moral sense' (Carter, 1853: 107). In the history of hysteria, sexual aetiologies, genderedness and victim-blaming have ever gone together; psychological theories have been deeply implicated.
Carter developed a psychological theory of hysteria, which treated the sufferer as capable of exercising power over others through manipulation of her body to mimic true illness, with all the attendant 'secondary gains' of the 'sick role'. There are a multitude of ways, of course, in which it would be quite absurd to compare Carter to Freud. Carter's book fell stillborn from the press; he proved of not the slightest importance in the subsequent history of hysteria. He shows no sympathetic interest (despite his preliminary statements about women's position in society) in probing the reasons why his patients became hysterics, other than their own moral delinquency. And, above all, it would be a travesty to compare his conception of the wanton malice of the hysterical mind to Freud's vision of the almost unfathomable dynamics of a multi-layered psyche, involved from birth in tangled struggles over desire and denial, typically screening and shielding consciousness from the full glare of consciousness. Carter might possibly have believed, along with Freud, that hysterical patients suffer from reminiscences, but he would have meant something radically different. Carter's hysterics know all too well what they are doing. They just would not own up; Freud's hysterics did not even know what they had to confess (Breuer and Freud, 1959; McGrath, 1986).
Nevertheless, recent scholarship on Freud - particularly the work of feminists - has made us highly conscious of the degree to which the psycho-analytical accounts he pioneered of the psychogenesis of neurosis carried moral and personal overtones freighted with stigma, especially in respect to female sexuality (Decker, 1981; Bernheimer and Kahane, 1985; Showalter, 1986; Hunter, 1983; Masson, 1983). We should not regard somatic and psychological notions of disease aetiology and nature as essentially entailing particular moral judgments upon the sick (stigmatizing, sympathetic, or exculpating). The implications of such approaches depend upon the cultural and historical contexts within which they are advanced.
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