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THE SALPETRIERE HYSTERIC — A FOUCAULDIAN VIEW

Hysteria has received wide attention in recent historical scholarship (for an extensive review of historical studies on hysteria, see Micale, 1989), and it has often been used to mirror some basic features of the cultural context and the contemporary gender-system in general. In this paper, I shall not take up such large perspectives. Instead, I shall focus on one particular clinical and discursive location, the Salpêtrière school of the 1880s.

I have derived the theoretical and - in the broadest sense of the term - methodological inspiration for this exploration from Michel Foucault's work, above all from his *History of Sexuality* I (1980), Foucault's methodological blueprint for his grand unrealized study of "modern sexualities".[1] In the heart of the approach that Foucault advocates in this book lies the contention that sex, as a cluster of practices, traits and attributes pertaining to both sexuality and gender, is a highly context-specific phenomenon. A historian writing about sexuality should reject all half-hearted biologism and study sexual identities, attitudes, roles etc. as constructed within various, context-specific networks of power relations and different discursive practices. (It should be mentioned, however, that Foucault himself occasionally seems to find it hard to do completely without universals. See e.g. Foucault, 1980: 157) My paper seeks, by and large, to support this basic contention and to point towards its fruitfulness for historical studies on the gender system in general.

Foucault himself discusses neither the Salpêtrière nor hysteria as a diagnostic category at any length in the *History of Sexuality* I. Instead, he uses the notion of the "hysterization of the female body" in a very broad sense, as referring to the construction of the female body as being thoroughly pathological and sexualized, and, consequently, in constant need of expert intervention. (Foucault, 1980: 104, 121). What relates the Salpêtrière practice - with its many admittedly idiosyncratic features - to the main current of nineteenth-century scientific discourses on sexuality is exactly this tendency of connecting, on several levels, sexuality to pathology and pathological sexuality to femininity (as the female "nature"). It is the purpose of this article to look into a set of ways in which this (in its own time self-evident) network of meanings was built up and put into use within one restricted context.

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The setting

The Salpêtrière school derives its name from *La Salpêtrière*, one of the biggest and oldest hospitals of Paris and France. Beginning from the middle of the 17th century, the Salpêtrière had functioned as a part of the notorious *Hôpital Général* of Paris. For almost two centuries, it housed a heterogenous population of deviant and indigent people (mostly women), and it served administrative and regressive purposes above all others. Only in the course of the 19th century was the Salpêtrière gradually transformed into a more distinctly medical and therapeutic institution. The 19th-century Salpêtrière specialized in mental disorders (in the wide and still somewhat vague 19th-century meaning of the word) and it continued to house predominantly female patients.

The late nineteenth-century Salpêtrière was a huge complex of buildings, a "city within a city in the seventeenth-century style, consisting of about 45 buildings with streets, squares, gardens, and an old beautiful church" (Ellenberger, 1970: 93). 4383 people resided or worked there in 1873. 580 of them were employees, and 853 were classified as "aliénée". The rest of the population was made up of children and various categories of mentally or physically handicapped people. (Didi-Huberman, 1982: 17) The institution had by no means lost all of its prison-like and correctional features by the latter half of the nineteenth century. However, during the 1870s and 1880s several new functions were integrated into the Salpêtrière practice, some of which brought it closer to general medical practice and academic medicine. As compared with preceding forms of institutional psychiatry, the Salpêtrière practice spelled a well-marked multiplication of "surfaces of emergence"[2] for the psychiatric discourse. The outlook of the old asylum was enriched with e.g. an outpatient clinic, an auditorium, and several laboratories.

The so-called Salpêtrière school was formed around Jean Martin Charcot (1825 - 1893) early in the 1870s. Charcot had been occupied at the Salpêtrière since 1862. (Guillain, 1959: 9) When the hospital was reorganized in 1870, he was assigned a ward accommodating women who were not classified as mad, but who suffered from violent convulsions and had been diagnosed either as hysterical or as epileptic. It was amongst these "middle categories" between full-blown insanity and somatic illness that Charcot started his work on hysteria and, slightly later, on hypnosis. By the 1880s, he was looked upon as the leading French authority on hysteria and hypnosis, and, for roughly fifteen years, the Salpêtrière became the most important site for study on hysteria in France, and perhaps even in Europe. (Ellenberger, 1970: 89-90; Copley, 1989: 136-7)

The Salpêtrière hospital wards provided Charcot and his disciples with the human material which their great construction work required. Charcot referred to the hospital as a "living pathological museum", and noted with satisfaction its "considerable [amount] of material" and "resources" (Charcot, 1890: 3-4). This material consisted almost exclusively of women. According to Jan Goldstein, 89 women who "were diagnosed as hysterical or as manifesting some hysterical symptoms" were admitted into Salpêtrière in 1882/83. Depending on the manner of counting, these women made up from 17.8 to 20.5 percent of the total number of admissions. (Goldstein, 1987: 322)

The women who resided in Salpêtrière wards at this time were "virtually all" of working-class origins. (Goldstein, 1987: 327) As early as 1859, in his *Traité clinique et thérapeutique de l'hystérie*, Pierre Briquet (1796 - 1881), Charcot's most important 19th-century French predecessor in hysteria research, had statistically indicated the commonness of hysteria among the lower classes. (Goldstein, 1987: 218) Thus, although it may have been, as Foucault claims, the "idle" woman of the bourgeoisie whose body first became "hysterized" (Foucault, 1980: 121), hysteria as a *diagnostic category* was certainly applied in a fairly democratic manner in the heyday of the Salpêtrière school.

It may even be argued, based on an earlier work by Foucault, *The Birth of the Clinic* (1973), that Charcot's scientification of hysteria could hardly have been accomplished without the acknowledgment of proletarian hysteria. This

is because acceptable psychopathological theorizing at this time required - as did general clinical medicine - routinized clinical observations, statistical studies, and experimental practices. These practices, in turn, required both large numbers of patients and a high degree of "scientific" recklessness towards patients; the latter were reduced to "cases", visually displayed to students and lay audiences, presented to the reading public in photographic publications, and experimented upon. Thus what was needed were large public hospitals with a predominantly lower-class clientele. (See Foucault, 1973: 82-5)

However, the doctors of the Salpêtrière school were not confined to dealing only with the proletarian hysteria of the hospital wards. The introduction of a public consultation service in 1879 provided them with socially more heterogeneous human material. The service was extended, thanks to its popularity, into a regular outpatient clinic two years later. (Goldstein, 1987: 337) This organizational innovation correlated with contemporaneous changes in the professional outlook of psychiatry. In the 1820s and 30s, alienists had extended their sphere of competence outside of the asylum by entering the criminal courts as forensic experts. Nevertheless, during the first half of the century, the asylum had remained the main locus of the development of psychiatry. Yet in the later half of the century, the professionally expansive and theoretically most progressive sections of French psychiatry no longer invested their hopes primarily in asylums. Several reasons may be found for this change in outlook and attitude.

The founding of new public asylums came to a halt in 1870, i.e. in the aftermath of the Franco-Prussian war. After 1874 it was no longer compulsory to include money for mental patients in the departmental budget. The somber, barrack-like architecture of asylums built in the 1880s reflects the decline in interest of both administrators and alienists. According to asylum statistics, 7.04 % of the patients were released as cured in 1874, but only 5.21 % were signed out as cured in 1886. This was not even half of the number of patients that died in the asylums that year (10.68 %). In the light of these figures, it became difficult to regard the asylums any longer as efficient "instruments of cure" or as financially sound investments of public funds. (Postel & Quétel, 1983: 316-7, 440-1)

Contemporaneous theoretical developments both manifested and intensified the perception of large public asylums as inefficient. Heredity and degeneration loomed large in the theoretical frameworks of late nineteenth-century French medicine. (See e.g. Dowbiggin, 1985 or Nye, 1984) Consequently, insanity was now more easily regarded as constitutional and thus incurable. On the theoretical level, this tendency is clearly indicated e.g. by the fact that the notion of *chronicity* now became implanted to the psychiatric discourse as a central organizing principle. (Lanteri-Laura 1972) The alienist's skills obviously would be of little help in attending to allegedly incurable patients. Any authoritarian personality could run the practical matters of the asylum, and any doctor could treat the patient's occasional physical illnesses.

It is thus only too natural that psychiatrists turned to more rewarding positions in administration, to hygienic, predominantly preventive, mental medicine, or to private practices and non-institutionalized mental treatments. (Postel and Quétel, 1983: 335) More theoretical and practical interest was consequently accorded to milder nervous disorders, i.e. to the "intermediate zone" between madness and sanity. The founding of the Salpêtrière outpatient clinic exemplifies the new concern for this "intermediate zone". Patients of the outpatient clinic were situated somewhere between the normal, everyday setting of their homes and the pathological space of closed institutions. (Goldstein, 1987: 332-8; Castel, 1976: 266-93)

The Salpêtrière of the 1880s was not only an asylum and a clinic, it was also a center for clinical teaching. This function was all the more important because psychiatry had long been a mere by-lane of academic medicine. The first psychiatric chair in France was not founded until 1878, its remit being defined as "mental pathology and diseases of the brain". Charcot's "Chair of Clinical Studies of the Diseases of

the Nervous System" was created in 1882. (Chertok, 1984: 111) The definition of the 1878 chair was in accord with the more traditional conception of psychiatry, whereas the description of Charcot's chair reflects the new central position given to milder nervous disorders. (Goldstein, 1987: 367-9)[3]

Charcot began to lecture on the diseases of the nervous system in 1882. He taught in the Salpêtrière auditorium rather than at the patient's bedside. Consequently, his discourse could be attended not only by the medical staff of the hospital but by larger and more heterogeneous, partly lay audiences as well. This marked a sharp contrast with traditional clinical practices and teaching in the asylum. Charcot lectured on Tuesdays and Fridays. His Tuesday morning lectures were spontaneous in style; he brought no notes with him, and the patients used for demonstrations were brought in directly from the outpatient clinic and thus were often unknown to him. These lectures turned out to be very popular. Already in 1887, Charcot's disciples started to edit and publish them from their own transcriptions. (Charcot 1887 and Charcot 1889. For a recent English re-edition of the Tuesday lectures, see Charcot, 1987) On the other hand, Charcot's Friday morning lectures were carefully prepared and more formal.

It is easy to understand the popularity of these lectures: Charcot's performances were not merely exceptionally rich in visual detail, but they were also highly dramatic. He demonstrated his views with the help of patients who were brought in during the lectures, often several at a time, from the wards or from the outpatient clinic. He also illustrated his lessons with the help of tables, diagrams, plaster casts, statuettes, photographs - even photographic projections - and by drawing on the blackboard with colored chalk. In addition, the maître himself imitated hysterical symptoms and engaged in dramatic dialogues with the patients. The mostly female patients displayed the whole repertoire of hysterical symptoms from trembling and shaking to paralysis and convulsions (Ellenberger, 1970: 95-6; Charcot, 1987)

Charcot advanced both experimentation and specialization of the clinical space. These features correlate with the general trend of clinical medicine. Around the middle of the century, "laboratory medicine" had emerged in Paris, and by the 1880s it had established its position as the most progressive section of French medicine. (Ackerknecht, 1967: xiii) During Charcot's reign, special sections for ophthalmology, otolaryngology, and electrotherapy were set up in the Salpêtrière, and an anatomopathological museum as well as a photographic laboratory were founded. Charcot's growing interest in the psychological (non-somatic) aspects of hysteria led to the establishing of a psychological laboratory for Pierre Janet in 1890. (Ellenberger, 1970: 93, 341; Postel and Quétel, 1983: 367)

However, the Salpêtrière mental medicine was experimental not only because of its laboratories and special sections: the Salpêtrière itself constituted a giant laboratory where a special type of hysteria was manufactured with the help of the newest and most ingenious means of intervention.

Representing ...

It is often said that Charcot first promoted hysteria to the status of a legitimate mental illness[4] and raised its study to the level of science (this is how Freud presented the matter in "Report on My Studies in Berlin and Paris", Freud SE I: 3-15. Similar opinions can also be found in present-day scholarship. See e.g. Chertok, 1984: 117). The first claim is based on two general requirements that a legitimate mental illness has to meet. First, in order to be regarded as a genuine pathological entity, a mental illness has to have some degree of regularity, i.e. it has to present a structured clinical picture. Part of this requirement is that its temporal development has to follow a more or less predictable course. Second, a genuine mental illness is expected to have a somatic and organic basis even when its symptoms can be recognized as being purely mental or imaginary (as often is the case of hysteria). Charcot's conceptualization of hysteria fulfilled both of these conditions.

In representing hysteria as a somatically

based, clinically regular construction, Charcot followed the model which had been set by the construction of general paralysis (also known as paresis or *dementia paralytica*), "the emblem of a movement in which the organicist ideology had drawn the majority of the nineteenth-century psychiatrists" (Postel and Quétel, 1983: 328). Charcot's hysteria, like Bayle's paralysis[5] was based on an evolving, clinical model with distinct successive stages, each of which displayed a set of typical symptoms. Both diseases were located in the brain, but they could also be explained by resorting to a great number of occasional and predisposing causes.

Charcot presented his model of the major hysterical attack (grande hystérie) on several occasions, perhaps most importantly in a book of his disciple Paul Richer (*Étude descriptive de la grande attaque hystéro-épileptique et de ses grandes variétés*, 1879) and during his clinical lectures. According to this model, the first, "epileptoid" phase of hysteria is marked by convulsive movements; the second phase is characterized by "large movements" of extreme violence, accompanied by an arching of the body and wild cries; the third by hallucinations and extravagant expressions of emotions; and the final stage by "delirium". In a clinical lecture from 1888 Charcot himself summarized the course of the attack as follows:

> .. an epileptoid phase with two parts, tonic and clonic, followed by a phase of exotic movements, and then a phase of high emotional pitch, which in this patient, is sad. All these are then followed by these strange contorted postures. (Charcot, 1987: 106)

In a famous lecture of 1882 at the Academy of Sciences Charcot connected his four-stage model of a hysterical attack to a tripartite periodization of the hypnotic state. As exposed in this speech as well as in other occasions, the three successive stages of the hypnotic condition are "lethargy", "catalepsy", and "somnambulism". (See e.g. "Preface to the Translation of Charcot's Tuesday Lectures," in Freud SE II: 13-4)

Hysteria was - and still is - notorious for the multiplicity and ambiguity of its symptoms. Symptoms of hysteria included, for instance, "astasia" (the inability to stand straight), "abasia" (the inability to walk), "paraplegia" (paralysis of the lower parts of the body), "aphonia" (the loss of voice), "anesthesia" (the loss of feeling), "hyperaesthesia" (hypersensitivity), epileptoidic seizures and convulsions, contractions, trances, hallucinations, depression, sobbing and laughing, palpitations of the heart, a strangling feeling in the throat, loss of smell, hearing, or vision, nausea, headaches, and pains. Hysterical symptoms were not only assumed to be extremely numerous, but they were also known for their instability: they were difficult to localize, and easily displaced or transformed.

Charcot managed to integrate many of the traditional symptoms of hysteria into his scheme, and he also tried systematically to solve the problem of locating the hysterical symptoms. Thus he not only listed and categorized the symptoms and stages of a hysterical attack, but he also distinguished between various affected "hysterogenic zones". Although Charcot had begun his studies on hysteria by observing women suffering from epileptic and hysterical convulsions, the symptoms which played the primary role in his demonstrations were anaesthesia, hyperaesthesia, paralysis and contractions. (Micale, 1989: 334) The first two types of symptoms have the advantage of being relatively easy to locate.

The difficulties in locating hysterical symptoms or in finding their invisible, somatic causes had been one of the main reasons for the bad reputation of the illness. Early nineteenth-century doctors often regarded it either as "ungenuine" and uninteresting, or then, like Etienne Esquirol (1772 - 1840), as a mere preamble to full-blown insanity. (Goldstein, 1987: 331; Postel and Quétel, 1983: 358-61) Moreover, hysteria was easily linked to personal fault and deceitfulness at a time when, in order to deserve serious medical attention, mental disturbances in general had "to be clothed in somatic garb if they were to be understood as legitimate by patient and practitioner alike" (Rosenberg, 1989: 195).

With the full authority of a reputed neurologist, Charcot placed the seat of hysteria in the brain. In so doing, he was preceded by, amongst others, Etienne-Jean Georget (1795 - 1828) and Briquet. (Postel and Quétel, 1983: 401, 403) However, the encephalic seat of hysterical complications did not stop Charcot from emphasizing, especially during the late 1880s, that hysterical symptoms can, at the same time, be both genuine and purely psychological. That is, the symptoms were neither directly caused by a localizable physical lesion nor brought about by a voluntary mental act. They were produced either by self-suggestion, traumatic experiences, or hypnosis. Nevertheless, in grave cases of hysteria, "the somatic features abound" (Postel and Quétel, 1983: 406). This ambiguity persisted in Charcot's thought until the end. (Andersson, 1962: 60) The dispersion and number of potential explanatory factors of hysteria was further increased by the contention that the origin of hysteria lies, in the last instance, in an inherited disposition, and that it can be advanced or brought about by several external factors (the so called agents provocateur). (Andersson, 1962: 39)

Displaying simplicity and multiplicity in due proportion, Charcot's model was flexible both as an explanatory scheme and as a descriptive device. The pattern of a hysterical attack was presented merely as an ideal type, or an "archetype" in Charcot's words. (Charcot, 1987: 104) It could seldom - according to the author himself - be seen in its entirety even in the Salpêtrière wards or auditorium. Critics went further and alleged that it had never been encountered outside the walls of the Salpêtrière, that, in other words, the "eternal and immutable laws of hysteria" that Charcot claimed to have discovered were a mere fabrication. (Goldstein, 1987: 215) Despite the critics' skepticism, the Charcotian theory was difficult to refute by means of empirical counter-evidence. It was flexible too as far as etiological explanations were concerned. The explanations could embrace somatic as well as psychological causes and thus refer both to hereditary taint and moral fault.

... and intervening

Charcot took his experimental stage performances to be "pure" representations. When he was criticized for their factitiousness, he compared his research to the alleged objectivity of photography. (Charcot, 1987: 107) In fact, photography was not just a metaphor of clinical perception for Charcot: it was employed at the Salpêtrière quite concretely and on a massive scale. Methodologically, it played a pivotal role as a technique for constructing hysteria. In the words of Georges Didi-Huberman, who has examined the fabrication of visual images of the hysteric in the Salpêtrière, "photography was for him [Charcot] at the same time an experimental procedure (a part of the laboratory equipment), a storing method ([at the service of] scientific archive), and a pedagogic routine (a means of transmission [of knowledge])". (Didi-Huberman, 1982: 33)

The Salpêtrière photographic studio was set up in 1875. Its products were used for preparing personal registers of the patients, for serving as illustrations in Charcot's lectures, and for being included in pictorial publications. By way of these publications, the (female) patients' bodies and pains were exposed not only to students and the audiences of the lecture hall but to larger audiences as well. (Didi-Huberman, 1982: 33, 102-3) The main pictorial publications, collected and commented on by Charcot and his disciples, are *Iconographie photographique de la Salpêtrière I-III* (Bourneville & Régnard, 1876-80), *Nouvelle Iconographie de la Salpêtrière* (beginning from 1888), and *Les démoniaques dans l'art* (Charcot & Richer, 1887. For a recent re-edition, see Charcot & Richer, 1984). The last mentioned book contains reproductions of works of art from different historical periods. They are accompanied by short "diagnoses" of hysterical phenomena, most often of religious ecstasies, which they allegedly depicted. *Les démoniaques* can thus be looked upon as an effort to demonstrate the universality and omnitemporality of the Charcotian law of hysteria.

The photographs of the Salpêtrière hysteric can hardly be considered "spontaneous" or

"objective". The pictures were taken in a carefully set environment, the photographic studio, equipped with an estrade, a bed, and a device for making the patient keep an upright and steady pose. (Didi-Huberman, 1982: 47-50, 277-8) The use of wet collodion plates required both time and careful preparations. The exposure time itself was relatively short (approximately 10 seconds, depending of course on the lighting and on the qualities of the lens), but the plate had to be sensitized right before the exposure because it needed to be exposed while still wet, and the occurrence of the "attack" had thus to be carefully premeditated. When the hysteric did not present herself in quite the orthodox manner, the picture would simply be retouched. (Didi-Huberman, 1982: 86-7, 110-1)

Photographic and other visual material was used to produce rather than describe hysteria in another sense, too. Many patients were used time and again in photographic sessions. They knew the poses by heart, and could easily learn what was expected from them. During the lectures, they could hear their cases being explained to the audience, and their performances being evaluated against the exemplary *grande attaque*. Indeed, the leading ladies of the Salpêtrière knew exactly what they had to do, and some - although not many - were able to reproduce the whole *grande attaque* repeatedly in front of live audiences or the camera. (Ellenberger, 1970: 98-9)

Visual and photographic techniques were not the only ones through which the proper form of hysteria was inscribed on the female body and mind. Various mechanical, electric, chemical and psychological experimental techniques were used as well. The hysteric's ability to taste, to hear, to smell, and to feel pain was tested time and again. Her respiration was measured and graphically represented, her attacks were carefully timed and recorded. (Didi-Huberman, 1982: 175-8) "Local faradization" using the "electric pin" was employed to produce local muscular excitation. Use of electricity was "combined with all sorts of magnetizing devices possible and imaginable". (Didi-Huberman, 1982: 195; Trillat, 1986: 143) Magnetizing, admittedly, did not cure, or even make the symptoms disappear, but it "deplaced" and transformed them in experimentally most interesting ways. Chemicals used included ether, chloroform, amyl nitrate, morphine, camphor oil, ethyl, potassium and sodium. (Didi-Huberman, 1982: 208-10, 212-3, 284)

The hypnotized hysteric herself was turned into a mechanical automaton that was steered by different stimulations. Cataleptic states were brought about by sudden flashes of light, or sudden, strong voices. The attack was started by pressing a hysterogenic point, and stopped by "ovarian compression". (See e.g. Charcot, 1987: 104-6) The hypnotized subject was advanced from the lethargic to the somnambulic stage by manipulating her vertex, and from the somnambulic to the lethargic state by pressing her eyeballs. (Didi-Huberman, 1982: 284, 286; Ellenberger, 1970: 750) Hypnosis as a primarily psychological form of manipulation and intervention was an essential component of the Salpêtrière practice since 1878. Hypnosis was primarily used to demonstrate the features of the grand hysterical attack, i.e. as an experimental technique, not as therapeutics. With the help of hypnosis, the attack could be simulated step by step, and hysterical symptoms could be produced at will. Hypnosis also allowed the simulation of pains, of local hypersensitivity or anesthesia, of hallucinations, and of metamorphoses of personality. (Ellenberger, 1970: 90; Widlöcher, 1978: 81; Didi-Huberman, 1982: 286-7)

Charcot provided the layout, and he was the chief architect of the Salpêtrière hysteria. However, he does not seem to have personally taken part in the more technical parts of the construction work. He refrained from active personal intervention as far as the patients bodies and minds were concerned. He did not, according to prevalent opinion, take part in photographic sessions, inject drugs, prepare patients for the performances, or - so it is claimed - even personally hypnotize patients. (Zeldin, 1977: 861; Postel & Quétel, 1983: 604) "The Napoleon of neurosis" thus exerted his all-pervasive influence in the Salpêtrière mainly by writing, lecturing, demonstrating, and diagnosing. He provided the scheme of con-

struction, and his great personal influence on his assistants and disciples made up for the lack of direct influence on patients. It was perhaps this arrangement which allowed him to talk about his work in terms of representation, as opposed to and instead of, active intervention.

The pathological sex

The Charcotian approach has sometimes been taken to have constituted the decisive step towards de-sexualization of hysteria. This view is based on the facts that Charcot acknowledged and stressed the existence of male hysteria, that he definitely rejected the old theory of the centrality of the womb and genitals in the etiology of hysteria, and that he did not like to discuss the role of sexual traumas in the psychogenesis of hysteria. However, the Salpêtrière hysteria remained a sexual and gender-specific ailment regardless of some partial shifts of emphasis that the Salpêtrière school brought to the traditional interpretation of hysteria.

Even the "discovery" of male hysteria is sometimes attributed to Charcot - despite the facts that the first clear statements concerning male hysteria date from the 17th century (Micale, 1990: 366) and that, by Charcot's time, "classical male hysteria ... was accepted by everyone" (Ellenberger, 1970: 439). In any case, hysteria was diagnosed far more often in women than in men, and this in the Salpêtrière as well as elsewhere. Briquet, who conducted the first extensive statistical studies on hysteria, estimated that hysteria was twenty times more frequent in women than in men. Furthermore, he thought that "half of all women were hysterical or 'very impressionable', though only one-fifth of all women actually had attacks or convulsions in their full form". (Zeldin, 1977: 862-3) By and large, Charcot agreed with Briquet's estimate concerning the 1:20 ratio. (Micale, 1990: 376) Hardly surprising, the differences between male and female hysteria were not just numerical. There remained several qualitative links between the character of the ailment and what was taken to be the character of women's reproductive organs, their nerve system and their psychological traits.

Although the existence of "classical" male hysteria was widely accepted, "Charcot's traumatic male hysteria ... was the object of heated discussions among neurologists". (Ellenberger, 1970: 439) There was a distinct difference in emphasis between these two types of hysteria. "Classical hysteria" was the more clearly somatic, cerebral and epileptoid form of hysteria, and inherited disposition played a larger role in its etiology. (Ellenberger, 1970: 439) On the other hand, traumatic hysteria referred to hysteria as a functional disorder with psychological origins. It is likely, but difficult to prove, that the resistance to Charcot's notion of male traumatic hysteria bespeaks a more general gender prejudice. In cases where women would have been diagnosed as fully-fledged hysterics, men were often diagnosed as suffering from somatic illness. (See Shorter, 1986: 570 for some individual examples)

Charcot was thus an exception among his contemporaries in that he consistently applied the notion of traumatic hysteria to men as well as to women. However, the above-mentioned qualitative distinction surfaces in his case as well. Even Marc Micale, who has produced the most extensive study so far on the Charcotian conception of male hysteria and has strongly defended Charcot's pioneering contribution on this matter, is willing to admit this much:

> Simplifying somewhat, we can say that the distinction between male hysteria and female hysteria in Charcot's work is the difference between a neuropathological and a psychopathological interpretation of the disorder. (Micale, 1990: 408)

Furthermore, even in those relatively rare cases where men were diagnosed as suffering from traumatic hysteria, there is a gender-biased difference in explanatory tactics: the male trauma was conceived of as an accidental, outward reason (quite often is was a train accident), whereas in women's case it was their "vulnerable emotional natures and inability to control their feelings" that made them ill. (Micale, 1990: 406) The gender bias of the

Charcotian hysteria can also be seen in his contention that the mother contributes "more directly" in the inherited hysterical disposition than the father. (Micale, 1990: 384, 406)

It was possible to make consistently differential use of the hysteria diagnosis even after the theoretical recognition of male hysteria partly because there were more properly "manly" diagnostic alternatives available than hysteria. In the 18th century, the closest alternative had been hypochondria. (Merskey, 1983: 428, 431) In the late 19th century, the most important diagnostic parallel to hysteria was "neurasthenia". The concept was coined by the American doctor George M. Beard in 1869. He regarded neurasthenia as specifically American, and often found it in men working in intellectually demanding and stressful professions like e.g. the medical profession. This diagnostic category turned out to be very popular in America as well as in Europe. (Sicherman, 1977: 33-5, 42) Charcot himself was enthusiastic about neurasthenia. In 1891, it had almost caught up with hysteria as a diagnostic category in the cases of the Salpêtrière outpatient clinic (that also treated men): during the first nine months of the year there were 244 registered cases of hysteria and 214 cases of neurasthenia. (Gelfand, 1989: 134) It also seems that Charcot maintained Beard's social bias when using this pathological category. Micale has compared Charcot's various types of patient registers and learned that " ... private male patients with hysteria-like symptoms were more likely [than working-class patients of the public outpatient clinic] to be absorbed into the neighboring diagnostic category of neurasthenia ... than to be burdened with the dire and disreputable label of hysteria" (Micale, 1990: 379)

Hysteria had been linked to the female reproductive organs by a long tradition of medical writing. These organs were medically represented as being constantly menaced by various pathologies, and as exerting their pathological influence over the whole female life and organism. (See e.g. Poovey, 1988: 145; Smith-Rosenberg and Rosenberg, 1973: 335-7) As will be remembered, Charcot favored the brain to the womb as the seat of hysteria. By and large, psychiatrists and neurologists "tended to follow Briquet's and Charcot's view, [whereas] gynecologists still believed in the sexual psychogenesis of hysteria". (Ellenberger, 1970: 301) However, one did not have to adopt the Hippocratic view of hysteria in order to connect hysterical symptoms in one way or another to the reproductive functions or organs. In Charcot's scheme, for instance, the ovaries and the womb were the most important hysterogenic zones, and the ovarian zone received a great deal of attention during the clinical demonstrations in the Salpêtrière. (See e.g. Zeldin, 1977: 861; Didi-Huberman, 1982: 74-5, 174; Trillat, 1986: 133) Charcot also criticized Briquet for unduly overlooking the ovarian zone. (Mai, 1983: 419-20)

The great vulnerability and excitability of the female nerve system was yet another medical commonplace. The notion of nervous excitability is situated somewhere between the hazy limits of the psychological and the somatic, on the one hand, and midway between the normal and the pathological, on the other hand. Thus it is not surprising that this notion loomed large in the medical construction of the female sex. After all, assuming a low threshold between the normal and the pathological was typical of the medical view of women. (See e.g. Poovey, 1988: 145-8; Smith-Rosenberg, 1985: 206; Smith-Rosenberg and Rosenberg, 1973: 334-5)

The step from nervous excitability to suggestibility is not long, but it meant, nevertheless, a definite move towards non-somatic explanation, and, at the same time, towards questions of personal morality and guilt. This is because suggestibility, in medical as well as other discourses, very easily turned into deceptiveness pure and simple. The relatedness of guilt and suggestibility was dramatically exemplified not only by the sometimes extremely hostile medical statements on the mendacity of hysterics (Poovey, 1988: 153; Ehrenreich and English, 1979: 124; Smith-Rosenberg, 1985: 205; Micale, 1989: 240-1), but it also became an issue in some of the most spectacular belle époque court cases.

A famous example is the Bombard case. It

is well-known partly because it involved a confrontation between the Salpêtrière school and the Nancy school on the questions of hysteria and suggestibility. Gabrielle Bombard and her lover had committed a murder and a robbery in 1890. When Bombard was arrested, she claimed that she had been hypnotized by her lover and committed the crime under "post-hypnotic suggestion". (Harris, 1985: 197-200) Expert witnesses close to the Salpêtrière school denied this possibility, while the Nancians regarded it as at least theoretically plausible. The former presented strong suggestibility, the prerequisite of producing a genuine hypnotic state, as a pathological and rare phenomenon, and were reluctant to extend it to apparently normal subjects like Gabrielle Bombard. The Nancians, on the other hand, saw suggestibility as a normal and universal feature which made any person - at least in principle - hypnotizable. (Harris, 1985: 206, 231; Postel and Quétel, 1983: 405-6) Despite the fact that the Nancians allowed for the possibility of exerting strong suggestion on both men and women, the most anxious tones in the discussion still characteristically "revolved around not only female suggestibility - since women were acknowledged in both the lay and medical discourse as being weak-willed and fickle - but also the subjectibility of the feminine population who required protection from rapacious and unscrupulous sexual violators" (Harris, 1985: 217).

After Charcot had given hypnosis a pivotal position in the Salpêtrière practice, the role of purely psychological components in hysteria was bound to come more to the fore. Charcot ended up speaking about hysteria in terms of suggestibility rather than somatic lesions or heredity though he was reluctant to take the final step towards non-somatic explanations. This step was taken by his one-time assistant, Joseph Babinski (1857 - 1932), in 1901. This is when Babinski coined the term "pithiatisme" to replace hysteria, and to denote a disease that is produced by suggestion and can be cured by persuasion. Pithiatism, alias hysteria, was thus a totally "imaginary" illness. Its name derives from the Greek words meaning "I persuade" and "curable". (Chertok, 1984: 112-3)

As we have seen above in the connection of the male hysteria, Charcot also fully acknowledged the role of traumatic experiences in the etiology of hysterical complications. (Trillat, 1986: 147-53) There are some indications that he also recognized the significance of sexual traumas (although the game rules of the Salpêtrière lectures did not allow one to talk about them): Charcot's famous private remark to Freud about "these genital reasons" is well known (Freud *SE XIV*: 14), and, in describing the *grande hystérie* in close cooperation with the master, one of Charcot's closest disciples, Paul Richer (1849 - 1933), did not fail to note that the hysterical attack is typically "a reenactment of a psychic, often sexual, trauma". (Ellenberger, 1970: 753, 143)

Hysteria had thus been linked to sexual behavior and emotions long before Freud. Nevertheless, the late nineteenth-century discussions were ambiguous on the question as to whether hysteria should be connected to sexual lack or sexual excesses. According to Micale, the latter explanation dominated. (Micale, 1989: 244. On this ambiguity, see also Smith-Rosenberg, 1985: 202, 207; Smith-Rosenberg and Rosenberg, 1973: 336; Showalter, 1985: 130-2) Masturbation and other forms of unproductive sex were evoked both as a cause and as a symptom of hysteria or hysterical constitution. One reason why the ambiguity persisted was that sexuality could be spoken of either in terms of actual behavior, or in terms of personal predisposition. Thus even when sexual excesses were evoked as the ultimate cause of hysteria, the aspect of sexual deprivation could be brought back into the picture by referring to trauma-inducing discrepancies between a constitution tending towards excesses, and actual occasions for sexual gratification.[6]

The persistance of this ambiguity was, therefore, in part due to the tendency to conceptualize sexuality in terms of sexual "essences" rather than acts. It was not so much what the person *did* but what she *was* that eventually made her a "hysteric personality". This ten-

dency parallels what Foucault and other writers have noted in the case of the "perverts", and particularly, the male "inverts": In the late nineteenth century, homosexuality was no longer discussed in terms of acts but predominantly in terms of innate tendencies and dispositions. Homosexual preferences became incorporated in, and a basis of, the specification of individuals. (Foucault, 1980: 42-3)

Finally, the Salpêtrière hysteria was a sexual ailment not only in the sense that is was strongly gender-specific, but also in the sense that the Salpêtrière practice comprised a strong erotic component. Whereas the sexual aspects of the Salpêtrière hysteria were not allowed to surface in written accounts, they appear all the more drastically in the visual image of the Salpêtrière hysteric. Indeed, there could hardly be a more convincing instance of what Foucault refers to as the sensual "pleasures of analysis" than André Brouillet's famous picture of Charcot lecturing at the Salpêtrière ("Une leçon clinique à la Salpêtrière", 1887). The painting contains three complementary and contrasting elements: the dark-clothed, attentive and exited male audience, formed by identifiable Salpêtrière doctors; the dramatically lighted, scantily clad female hysteric in the middle of a seizure (with an arched body and a blissful rather than afflicted expression). The style of Brouillet's picture tallies with other preserved representations of the Salpêtrière hysteric. Many of the clinical photographs were semi-pornographic by the standards of the day, depicting scantily dressed, young women in passionate poses. (See Bourneville & Régnard, 1876-80, or the reprints in Didi-Huberman, 1982: 120-1, 135-45, 242-3 and Showalter, 1985: 150-4).

The hysteric identity

Looked upon in social and critical terms, hysteria can be and has been viewed as a gender and culture specific form of female deviance and resistance. It has been called a "way to escape ... reproductive and domestic duties", a "way of rebellion", "one option or tactic offering particular women ... a chance to redefine or restructure their place within the family", and a "reaction against ... supervision". (Ehrenreich and English, 1979: 123, 125; Smith-Rosenberg, 1985: 200; Smith-Rosenberg & Rosenberg, 1973: 354-5, note 51; Showalter, 1985: 133) In other words, some writers suspect that some of the hysteric's symptoms and actions might be more or less unconscious and often unsuccessful efforts to restructure the very relations of power that have imposed a hysterical identity upon her.

The social power network to which this form of resistance belonged was the privatized family where the role of the hysteric often functioned as an alternative to the role of the (future) mother. Consequently, the hysteric embodied, in medical as well as other discourses, a host of non-maternal features: active (i.e. virile), destructive and unproductive sexuality, mendacity, deceptiveness and selfishness. As Foucault notes, the hysteric thus presented the "negative image" of the mother. (Foucault, 1980: 104)

Both the aspect of social power and the role of the family in the construction of hysteria were often tacitly recognized in medical discourses, although proper theoretical explanations were naturally sought elsewhere. Late nineteenth-century doctors often referred - like the advocates of moral treatment had done before, and Freud would do after them - to the relationship between themselves and the hysteric as a power struggle. They spoke about the necessity of "obtaining control", evoking "childlike obedience", resorting to the "sedative influence of fear", assuming a "tone of authority which will of itself almost compel submission", and using ridicule as a "powerful weapon" in the "moral management" of the hysteric. (Ehrenreich and English, 1979: 120, 125; Sicherman, 1977: 50; Smith-Rosenberg, 1985: 210-1; Micale, 1989: 241; Showalter, 1985: 133)

Removal from the family power network was frequently presented as one of the essentials of the treatment of the hysteric. To name but a few examples, James Brudenell Carter regcommended strict isolation from the family, and the hysteric's transfer to an institution where

she would be totally and exclusively under the authority of the doctor. (Micale, 1989: 241) S. Weir Mitchell, the perhaps most prominent American nerve specialist during the late nineteenth century, developed the so-called "rest cure" which was widely used both in the USA and elsewhere. Basically, "rest cure" meant that the patient was kept apart from the rest of the family and from domestic life (although the cure could be conducted at home), restrained from all activity, and made to eat lots of fattening food. The only stimulations allowed during the rest cure were a daily massage, and visits of the doctor. (Sicherman, 1977: 49-52) Thus the necessary counterpart of the isolation from the family again was the strengthened and undisturbed authority of the doctor over the hysteric. Likewise, in a lecture of 1885, "Charcot argued that the isolation of young people was *the* necessary condition, and often a sufficient condition, for the cure of even the most complex hysterical symptoms" (Forrester, 1980: 10).

In the Salpêtrière, the main form of active therapeutic intervention was - apart from the negative tactic of isolation - suggestion (Woolsey, 1976: 384; Widlöcher, 1978: 82), which, obviously, is basically a matter of power exercise. Bernheim and the Nancy school explicitly recognized this aspect of suggestion. For them, suggestion was something that is "used in everyday affairs. Suggestion is used by the mother on her child, by the teacher on his pupil, by the state on its citizens" (Bromberg, 1954: 187). Unlike the members of the Nancy school, Charcot insisted on the abnormality of the hysteric's suggestibility. According to Charcot, only a hysteric, or a latent hysteric, could be hypnotized. The fact that a person could be hypnotized thus proved, in the last instance, the existence of her hysteric disposition or of an invisible organic cause. Conceptualizing hypnosis in this manner allowed Charcot to bracket the aspect of social power necessarily interlocked with it. This leaning is visible in both the theory and clinical practice of the Salpêtrière school. In his theoretical texts Charcot never explicitly discussed hypnosis as a form of power exercise, and in his clinical practice he often disregarded the social backgrounds and personal histories of his patients. (Forrester, 1980: 11-2; Didi-Huberman, 1982: 26, 276)

In Charcotian practice, hypnosis therefore served as the ultimate technology by means of which the pathological element was isolated and abstracted from the personality of the hysteric. In principle at least, it allowed the simulation and technical manipulation of the symptoms without any conscious participation of the patient, reduced the hysteric to her symptoms, deprived her of her will and preferences, and bracketed the very social (power) relations that were causally involved in her unhappy disposition. The therapeutic/experimental relation of power was thus conceptualized in a way that made both the subject and the object of the power relationship appear as mere functionaires of the universal laws of the pathological. In this way, the social power over some*one* (the patient) was recasted as mere capacity to effect some*thing* (the pathological phenomena). It lies beyond the scope of this article to estimate whether this type of operation in fact ever was successful, or whether it could ever be that.

As a conclusion, I want to emphasize that I neither consider the pains and anxieties of hysteria patients as mere simulation and deceit nor take the work of the Salpêtrière doctors as an automatic reproduction of the fallacies characteristic of their age, class and gender. In other words, the aim of this paper has not been to explain away the pathological reality of hysteria or nervous disorders, but, instead, to bring to the fore the social and constructive aspects involved in these disorders. In my view, these two levels should not be taken as automatically excluding each other. However, this is all too often what happens in the history of medicine and psychiatry: a methological or heuristic choice favoring a sociological and constructive approach is read and criticized as if it were an ontological rejection of the biological reality of the disaease (and of the effiency of medicine in tackling it). Reasons behind this persistant difficulty to study disease as a multilevel (cultural, social and biological) phenomenon might themselves be worth some pondering.

NOTES

1. Foucault intended to write a "sequence of at least six volumes" on the history of modern sexualities, with titles like The Flesh and the Body; The Children's Crusade; Woman, the Mother and the Hysteric; The Perverts; Population and Races. It is common knowledge, however, that this series of studies remained unwritten as Foucault turned his interest from modern Europe to ancient Greece and Rome. Apart from the History of Sexuality I, the story of Herculine Barbin (Foucault, 1978) remains the only published offshoot from the original plan of research.
2. "Surface of emergence" is a notion that Foucault uses in the Archaeology of Knowledge to denote the pivotal locations for discussing certain scientific objects. See Foucault, 1974: 41.
3. The creation of this chair has retrospectively been referred to either as a milestone in the history of psychiatry or as a turning point in the history of neurology. This ambivalance displayed by present-day accounts is mainly due to the fact that the demarcation line between neurology and psychiatry had not yet taken shape at the time - a fact that is reflected not only in Charcot's institutional affiliation but also in his work and thought as a whole.
4. In Postel and Quétel, 1983: 404, Jacques Corraze writes: "Contrary to what has been claimed (for example by Michel Foucault), hysteria did not become a mental illness until the very last years of the 19th century". Although the author does not specify his reference to Foucault, the criticism is probably based on the fact that Madness and Civilization contains a passage on "classical" hysteria. As such, the criticism is hardly justified. Foucault discusses hysteria under the all- extensive category of "madness", but his account makes it very clear that 17th-century categories of madness and illness could not have comprised a category of "mental illness", even if some of the concepts in use were the same.
5. In 1822, Antoine-Laurent Bayle (1799 - 1858) described a characteristic lesion in the brain of six autopsied mental patients, five of whose insanity had manifested itself in a similar way at the early stages of their illness. For the first time, there was thus a possibility of claiming that a clearly somatic relation existed between a specific form of insanity and a recognizable and observable organic lesion. This discovery had the great benefit of bringing psychiatry somewhat closer to pathological anatomy, which was the privileged branch of more well-established general medicine during the first half of the nineteenth century. This, no doubt, partly explains why general paralysis soon became both a popular diagnostic category and an important conceptual model in psychiatry, although the discovery itself could, strictly speaking, neither advance therapeutic practice nor provide an explanation of the origins of the illness. See e.g. Foucault, 1961: 542; Postel & Quétel, 1983: 323-4.
6. Robert Brudenell Carter, for instance, thought that "the most frequent force in the production of the disorder was 'erotic passion'". Because he also talked explicitly of repression as a causal or pathogenic factor, he expressed - well before Freud - the view that the discrepancy between inner, emotional impulses, and restrictions imposed on their expression, can cause or advance hysteria. (Micale, 1989: 238-9) Lack of sexual relations was also sometimes straightforwardly evoked in courts and in the popular press as a cause of mental disorders. One lawyer in a French murder case in 1872 defended his female client by claiming that "it is a well-known fact in medicine: how many women have gone mad because they could no longer be "wives" in the fullest sense of the term." The quotation is from Hartman, 1977: 51.

REFERENCES

Ackerknecht, E.H.
1967 *Medicine at the Paris Hospital.* Baltimore: Johns Hopkins.

Andersson, O.
1962 *Studies in the Prehistory of Psychoanalysis. The etiology of psychoneurosis and some related themes in Sigmund Freud's scientific writings and letters 1886-1896.* Svenska Bokförlaget/Norsteds.

Bourneville, D.-M. & Régnard, P.
1876-80 *Iconographie photographique de la Salpêtrière,* 3 vols. Paris: Bureaux du progrès médical, Delahaye & Lecrosnier.

Briquet, P.
1859 *Traité de l'hystérie.* Paris: J.B. Baillière.

Bromberg, W.
1954 *Man Above Humanity*: A History of Psychotherapy. Philadelphia, London and Montreal: J.B. Lippington Company.

Castel, R.
1976 *L'ordre psychiatrique: l'âge d'or de l'aliénisme.* Paris: Les Editions de Minuit.

Charcot, J.-M. & Richer, P.
1887 *Les Démoniaques dans l'art.* Paris: Delahaye & Lecrosnier. Reprinted in 1984 (with an introduction by P. Fédida and postface by G. Did-Huberman). Paris: Macula.

Charcot, J.-M.
1887 *Leçons du mardi à la Salpêtrière. Professeur Charcot. Policlique, 1887-1888. Notes des cours de MM. Blin, Charcot et H. Colin, élèves du service.* Paris: Progrès médicale.
1889 *Leçons du mardi à la Salpêtrière. Professeur Charcot. Policlique, 1887-1888. Notes des cours de MM. Blin, Charcot et H. Colin, élèves du service.* Paris: Progrès médicale.
1890 *Oeuvres complètes de J.M. Charcot,* vol. 3. Paris: Bureaux du progrès médical, Delahaye & Lecrosnier.
1987 *Charcot the Clinician: The Tuesday Lessons; Excerpts from Nine Case Presentations on General Neurology Delivered at the Salpêtrière Hospital in 1887 - 88.* Trans. and commentary by C.G. Goetz. New York: Raven Press.

Chertok, L.
1984 "On the centenary of Charcot: Hysteria, suggestibility and hypnosis". *British Journal of Medical Psychology,* 57, 2: 111-20.

Copley, A.
1989 *Sexual Moralities in France, 1780 - 1980: New Ideas on the Family, Divorce and Homosexuality.* London and New York: Routledge.

Didi-Huberman, G.
1982 *Invention de l'hystérie: Charcot et l'iconographie*

photographique de la Salpêtrière. Paris: Macula.
Dowbiggin, I.
1985 "Degeneration and hereditarianism in French mental medicine, 1840-1890: Psychiatric theory as ideological adaptation." Pp. 188-232 in Bynum et al (ed.), *The Anatomy of Madness: Essays in the History of Psychiatry*, vol. 1. London: Tavistock.
Ehrenreich, B. & English, D.
1979 *For Her Own Good: 150 Years of the Experts' Advice to Women*. London: Pluto Press.
Ellenberger, H.
1970 *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*. New York: Basic Books.
Forrester, J.
1980 *Language and the Origins of Psychoanalysis*. London and Basingstoke: Macmillan.
Foucault, M.
1961 *Folie et déraison. Histoire de la folie à l'âge classique*. Paris: Plon.
1973 *The Birth of the Clinic: An Archaeology of Medical Perception*. Trans. A.M. Sheridan. New York: Tavistock.
1974 *The Archaeology of Knowledge*. Trans. A.M. Sheridan. London: Tavistock, 1974.
1978 *Herculine Barbin dite Alexina B*. Paris: Gallimard, 1978.
1980 *The History of Sexuality I: An Introduction*. Trans. R. Hurley. New York: Vintage, 1980.
Freud, S.
SE *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, 24 vols. London: Hogarth, 1966.
Gelfand, T.
1989 "Tuesdays at the Salpêtrière". *Bulletin of the History of Medicine*, 63: 132-36.
Goldstein, J.
1987 *Console and Classify. The French Psychiatric Profession in the Nineteenth Century*. Cambridge: Cambridge University Press.
Guillain, G.
1959 *J.-M. Charcot 1825 - 1893. His Life - His Work*. Edited and translated by Pearce Bailey. New York: Paul B. Hoeber.
Harris, R.
1985 "Murder under hypnosis in the Case of Gabrielle Bombard: psychiatry in the courtroom in Belle Epoque Paris". Pp. 197-241 in Bynum et al. (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry*, vol. 2. London and New York: Tavistock.
Hartman, M.S.
1977 *Victorian Murderesses: A True History of Thirteen Respectable French and English Women Accused of Unspeakable Crimes*. New York: Schocken Books.
Lanteri-Laura, G.
1972 "La chronicité dans la psychiatrie française moderne. Note d'histoire théorique et sociale." *Annales ESC*, 27, 3: 548-68.
Mai, F.M.
1983 "Pierre Briquet: 19th Century Savant with 20th Century Ideas". *Canadian Journal of Psychiatry*, 28: 418-21.
Merskey, H.
1983 "Hysteria: The History of an Idea." *Canadian Journal of Psychopathology*, 28: 428-33.
Micale, M.S.
1989 "Hysteria and Its Historiography: A Review of Past and Present Writings I-II." *History of Science*, 27, 77-78: 223-61, 319-51.
1990 "Charcot and the idea of hysteria in the male: a study in gender, mental science and medical diagnostics in the late nineteenth-century France." *Medical History*, 34, 4: 363-411.
Nye, R.A.
1984 *Crime, Madness & Politics in Modern France. The Medical Concept of National Decline*. Princeton, N.J.: Princeton University Press.
Postel, J. & Quétel, C.
1983 *Nouvelle histoire de la psychiatrie*. Toulouse: Editions Privat.
Poovey, M.
1987 "'Scenes of an Indelicate Character': The Medical 'Treatment' of Victorian Women." Pp. 137-68 in C. Gallagher & T. Laquer (eds.), *The Making of the Modern Body*. Berkeley: University of California Press.
Richer, P.
1978 "Étude descriptive de la grande attaque hystéro-épileptique et de ses grandes variétés". *The Origins of Psychiatry and Psychoanalysis*, 27. Nendeln, Lichtenstein: Kraus Reprint.
Rosenberg, C.
1989 "Body and Mind in Nineteenth-Century Medicine: Some Clinical Origins of the Neurosis Construct." *Bulletin of the History of Medicine*, 63: 185-97.
Shorter, E.
1986 "Paralysis: The Rise and Fall of a 'Hysterical' Symptom." *Journal of Social History*, 19: 549-82.
Showalter, E.
1985 *The Female Malady: Women, Madness and English Culture, 1830-1980*. New York: Pantheon.
Sicherman, B.
1977 "The Uses of Diagnosis: Doctors, Patients, and Neurasthenia." *Journal of the History of Medicine and Allied Sciences*, 32: 33-54.
Smith-Rosenberg, C.
1985 *Disorderly Conduct: Visions of Gender in Victorian America*. New York: Alfred A. Knopf.
Smith-Rosenberg, C. & Rosenberg, C.
1973 "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *The Journal of American History*, 60: 332-56.
Trillat, E.
1986 *Histoire de l'hystérie*. Paris: Seghers.
Widlöcher, D.
1978 "L'hystérie dépossédée." *Nouvelle revue de psychanalyse*, 17: 73-87.
Woolsey, R.M.
1976 "Hysteria: 1875 to 1975." *Diseases of the Nervous System*, 37: 379-86.
Zeldin, Th.
1977 *France 1848 - 1945. Volume II: Intellect, Taste and Anxiety*. Oxford: Clarendon Press.

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