

Diagnosing Unnatural Motherhood

Nineteenth-century Physicians and 'Puerperal Insanity'

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On December 16, 1878, Elizabeth S., age twenty-seven, was admitted to the Dayton Asylum for the Insane. The cause was "puerperal"; the form was "mania." About three weeks before admission she had given birth, and her insanity appeared a few hours after the child was born. When Elizabeth was admitted to the hospital she was "very noisy and excited, clapping her hands and talking incessantly." She would sometimes tear her clothing and "expose her person." She had a poor appetite, did not sleep at night, and was in poor physical condition. Her physician "insisted" that she take plenty of milk and beef-tea every day, gave her iron three times a day, and thirty-five grains of hydrate of chloral (a sedative) at bed time. Under this treatment Elizabeth remained the same for almost two months, except that she rested at night. Near the end of February, she began to improve. She started to "take an interest in things around her, was more neat in her dress; thought she ought to have something better to wear, and would help do the work." She continued to improve and was removed from the institution by her husband on June 19, 1879.¹

The case of Elizabeth S. was one of hundreds reported by physicians in nineteenth-century medical journals. Elizabeth's was a case of puerperal mania, the most common type of puerperal insanity. Physicians also described two other forms of the disease which usually had melancholic

symptoms: “insanity of pregnancy” and “insanity of lactation.” Although doctors described puerperal insanity in various ways and although medical opinion about the nature of the malady changed over the course of the century, most physicians agreed that it was a very common ailment and that it was responsible for at least 10 percent of female asylum admissions. Yet, by World War I the disease had all but disappeared. Except for “postpartum depression,” the twentieth-century re-naming of “insanity of lactation,” puerperal insanity was cured by the World Wars.

Like other nineteenth-century female diseases that have disappeared or been redefined in the twentieth century, puerperal insanity raises many questions about the relationship between the predominantly male medical profession and women patients. Was puerperal insanity an invention of men? Was it an expression of male physicians’ ideas about proper womanly behavior, defining women’s anti-maternal feelings and activities as “insane”? Or was puerperal insanity only incidentally a gender issue; could it be understood as a professional struggle between male gynecologists and male alienists (nineteenth-century psychiatrists) over the treatment of insane women? Given the sexual politics involved when women’s illness is named and treated by a male medical establishment, can physicians’ accounts of puerperal insanity provide valid information about the meaning of the disease for women? If so, was puerperal insanity an indication of dissatisfaction with motherhood, disappointment with marriage or anguish over abandonment or financial problems? In short, was puerperal insanity an expression of sexual ideology, medical professionalization struggles or gender tension?

These questions cannot be answered adequately using either the traditional approaches to the history of insanity or the more critical approaches taken by historians interested in the history of women and madness. Both traditionalists and critics explain nineteenth-century insanity (or specific insanities) from one of three perspectives: that of the disease, the physician/medical institution or the patient. Each vantage point is important, but incomplete.

Although concentrating on the disease itself can provide information essential to interpretation, disease-focused studies deal with the disease either as an idea or as an essence gradually becoming known/named. Treating insanity or insanities as histories of ideas is interesting and useful, but this approach sidesteps questions of power.² Understanding how the idea of puerperal insanity changed over time and how it related to other insanities is essential, for example, but this understanding does not begin to answer the questions posed earlier about gender and power. Similarly, it would be a mistake to see puerperal insanity as a “real” disease, misunderstood or misnamed by nineteenth-century physicians, but understood and rightly differentiated by twentieth-century psychiatry.³ This approach to insanity or insanities ends up begging all the questions of the meaning of

insanity: why was this set of symptoms seen in a particular way at this particular time? why was this group of patients seen as “at risk”? why was this disease named one way in 1850 and another way in 1910? Interpreting changing insanities as a change in medical nomenclature leaves all of the important questions not only unanswered, but also unasked.

Interpreting the history of insanity from the perspective of physicians or medical institutions is more fruitful than the disease-centered approach because focusing on the medical establishment demands that insanity be situated within a specific socioeconomic setting. From this point of view the “reality” of the disease is questioned or ignored, as the historian concentrates on the role of professional and institutional politics or individual physicians in the creation of insanity. Perhaps the most well known example of this approach is *Madness and Civilization* in which Michel Foucault argues that medical discourse on insanity helped to define “reason” by medicalizing and silencing an ever-increasing category of “unreason.”⁴ Similarly, many twentieth-century medical sociologists see insanity as a “label” applied by a powerful medical establishment to society’s deviants.⁵ Historians writing about nineteenth-century insanity have also noted the role of professional rivalries between alienists and neurologists in defining the nature of insanity, as well as the role of individual physicians (such as Charles Beard and S. Weir Mitchell) in discovering, classifying, and treating insanities.⁶ What all of these approaches share is an emphasis on the power of organized medicine to define certain behavior as “insane” or “neurotic.”

Many feminist historians and sociologist writing about women’s insanity have concentrated on the power of physicians to categorize women’s behavior as normal, neurotic or insane, and have pointed out how such categorizations both reflect and help maintain gender stereotypes and the imbalance of power between women and men.⁷ While this perspective is superior to a disease-focused approach because it makes visible the sexual politics of medicine, there are problems with the physician-oriented interpretation. A major difficulty with concentrating on the medical establishment as the creator of insanity categories, or as the agent of “Society” in its quest to control deviants, is that patients/the public/women are seen as passive victims of medical definition. Reducing insanity to a behavior pattern defined as “sick” by a powerful profession tells us little about the meaning of that behavior in the lives of the patients.

Since Carroll Smith-Rosenberg’s early article on hysteria, some feminist historians have interpreted women’s insanity from the point of view of the patient, asking what the symptoms meant to the women afflicted. Like the physician-oriented perspective, concentrating on the meaning of the disease for the patient involves situating insanity in a particular cultural location. Smith-Rosenberg’s study, and a later study of anorexia by Joan Jacobs Brumberg, interpret the illness within a specific family dynamic:

woman as wife or daughter in a constricted or contradictory life pattern.⁸ This patient orientation moves away from the “essence” of the disease and the politics of defining it, and instead asks why a woman might have behaved in a certain way. When trying to understand women’s insanity it is absolutely essential to focus on the meaning of the behavior within the context of women’s lives, but there are at least two risks involved in relying solely on this perspective. Insane behavior might be misconstrued as heroic, as the only “sane” thing to do when confronted with a particular life situation. And, in concentrating on the family dynamics or the specific gender constraints of the patient, one might miss the medical dynamic and the process of defining/labeling behavior as insane or abnormal.

In order to understand the relationship between gender and insanity in general, and puerperal insanity in particular, we need a method of analysis that will encompass all three perspectives—that of the disease, the physician/medical establishment and the patient—and will describe the three in dynamic interrelationship. We need an interpretation that will be able to offer an explanation of both the meaning of symptoms in the lives of patients and the translation of symptoms into disease categories by medical professionals. What follows is an interpretation of puerperal insanity that divides the symptoms into “illness” and “disease,” and sees both as social constructions.⁹ The illness of puerperal insanity was a behavior pattern expressing dissatisfaction or even despair over the constraints of womanhood in a particular time; while the disease of puerperal insanity was a definition given by physicians to the illness symptoms, a definition which both legitimized the behavior pattern and played a role in medical specialization. As both illness and disease, puerperal insanity involved relationships: between the woman and her family, between the woman and her doctor, between the husband and the doctor and between different medical specialists. Puerperal insanity can be interpreted as a socially-constructed disease, reflecting both the gender constraints of the nineteenth century and the professional battles accompanying medical specialization. Male physicians and their female patients, together, created puerperal insanity; and that creation both reflected and contributed to sexual ideology and medical specialization.

Before elaborating this interpretation, a more thorough examination of puerperal insanity is in order. As mentioned earlier, most physicians believed puerperal insanity manifested itself differently in the three phases of the reproductive process. Milton Hardy, the medical superintendent of the Utah State Insane Asylum, defined puerperal insanity as a condition developing “during the time of and by the critical functions of gestation, parturition, or lactation, assuming maniacal or melancholic types in general” and characterized by “a rapid sequence of psychic and somatic symptoms which are characteristic not individually, but in their collective groupings.”¹⁰ Some physicians preferred to classify puerperal insanity as mania-

cal, melancholic or depressive, instead of dividing it according to reproductive phase; but in both groups there was consensus as to the type of insanity most associated with pregnancy, parturition and lactation.

Insanity of pregnancy was thought to be the rarest of the three, and usually involved melancholic (and suicidal) symptoms or depressive symptoms. Nineteenth-century physicians described patients as "melancholic" who appeared to be apathetic, hopeless and prone to suicide; while "depressive" patients were those with "low spirits." In cases of insanity of pregnancy, the symptoms sometimes lasted only a few weeks or months, but in other cases the patient was cured only by childbirth. Insanity of pregnancy was thought to occur most often with first pregnancies; however, some women who had developed symptoms once would develop symptoms in subsequent pregnancies. This form of puerperal insanity was rarely fatal.¹¹

Lactation insanity was similar to gestation insanity in its symptoms, melancholic and depressive, but was seen as more frequent. Lactation insanity differed from insanity of gestation and parturition in that it seemed to occur most often in women who had several children rather than in women going through their first pregnancies. In some cases of lactation insanity, the melancholy ended in dementia and life-long commitment to an asylum, but most cases recovered in under six months.¹²

Insanity of parturition was considered the most common type of puerperal insanity and was associated with maniacal symptoms. Usually puerperal mania began within fourteen days of childbirth, but some cases started up to six weeks later. Like the insanity of pregnancy and lactation, puerperal mania was rarely fatal and usually lasted only a few months. Of the three forms of puerperal insanity, puerperal mania was the most baffling to medical writers in the nineteenth century. Indeed, most of the medical literature on puerperal insanity was a description of puerperal mania. Characteristic symptoms included: incessant talking, sometimes coherent and sometimes not; an abnormal state of excitement, so that the patient would not sit or lie quietly; inability to sleep, with some patients having little or no sleep for weeks; refusal of food or medicine, so that many patients were fed by force; aversion to the child and/or the husband, sometimes expressed in homicidal attempts; a general meanness toward caretakers; and obscenity in language and sometimes behavior.¹³

Until the end of the century when doctors began to express suspicion about puerperal insanity as a specific illness, there was widespread agreement about its frequency, duration and prognosis. A physician writing in 1875 asserted that puerperal insanity was a "class of cases to be met with in the practice of nearly every physician," others cited asylum records indicating that the disease was responsible for "a very large proportion of the female admissions to hospitals," and still others claimed that puerperal insanity affected anywhere between 1 in 400 or 1 in 1000 pregnant

women.¹⁴ Doctors also agreed that most cases of puerperal insanity lasted only a few months, with most recovering completely within six months.¹⁵ Except for those cases with suicidal or homicidal tendencies, the prognosis was good for patients suffering from puerperal insanity, and doctors asserted that most cases could be, and were, treated at home.¹⁶

Treatment for puerperal insanity remained mostly the same over the course of the century, and the change reflected a more general change in medical therapeutics. In the first part of the century, bleeding was considered the proper treatment, no matter if the symptoms were manic or melancholic. By mid-century, that treatment was no longer recommended, and instead physicians were treating puerperal insanity patients with rest, food, a little purging and sedation. Most physicians also recommended that patients be restrained or watched closely and that family and friends be kept away.¹⁷

One of the first explanations of puerperal insanity to occur to an historian sensitive to gender as a category of analysis is that the disease represented male physicians' definitions of proper womanly behavior.¹⁸ To nineteenth-century men, a woman who rejected her child, neglected her household duties, expressed no care for her personal appearance and frequently spoke in obscenities had to be "insane." Certainly there is much in the medical literature to support this explanation. Many physicians wrote in very sentimental terms about the mysterious beauty of motherhood being defiled by insanity. Dr. R. M. Wigginton wrote of the special horror of puerperal insanity: "The loving and affectionate mother, who has so recently had charge of her household, has suddenly been deprived of her reason; and instead of being able to throw around her family that halo of former love, she is now a violent maniac, and feared by all."¹⁹ Physicians commented on a woman's "letting herself go" or being "indifferent to cleanliness" as symptoms, and many listed willingness and ability to perform household tasks as evidence of a cure.²⁰

By far the most shocking symptoms of puerperal insanity were women's indifference or hostility to children and/or husbands and women's tendency to obscene expressions. The first upset physicians' ideas about women's maternal and wifely devotion, while the second undermined doctors' assumptions about feminine purity. Allan McLane Hamilton described a patient who before her labor was "a loving and devoted wife, but shortly after lost all of her amiability, and treated her husband and mother with marked coldness, and sometimes with decided rudeness."²¹ Even more difficult to explain than coldness was a woman's "thrusting the baby from the bed, disclaiming it altogether, striking her husband," a woman who looks at her baby "and then turns away," or a woman who "commenced to abuse it [the newborn child] by pinching it, sticking in pins, etc." So frequent was "hostility or aversion to husband and child" noted in cases of puerperal insanity that this was considered one of the defining character-

istics of the disease, and physicians recommended that the woman not be left alone with her infant.²²

If doctors were horrified at women's treatment of husbands and children, they were equally shocked at women's obscene words and behavior during an attack of puerperal insanity. "The astonishing familiarity of refined women with words and objects and practices of obscene and filthy character, displayed in the ravings of puerperal mania, gives a fearful suggestion of impressions which must have been made upon their minds at some period of life," wrote George Byrd Harrison, a Washington, D. C. physician. W. D. Haines of Cincinnati described a case in which the woman would repeat one word a dozen or so times "then break forth into a continuous flow of profanity. The subject of venery was discussed by her in a manner that astounded her friends and disgusted the attendants." Another doctor wrote of the typical puerperal mania patient "tearing her clothes, swearing, or pouring out a stream of obscenity so foul that you wonder how in her heart of hearts such phrases ever found lodgment." An Atlanta physician expressed similar puzzlement: "it is odd that women who have been delicately brought up, and chastely educated, should have such rubbish in their minds." And still another physician described this symptom as "a disposition to mingle obscene words with broken sentences ... modest women use words which in health are never permitted to issue from their lips, but in puerperal insanity this is so common an occurrence, and is done in so gross a manner, that it is very characteristic." W. G. Stearns, a Chicago physician, went so far as to note that in "all such cases [puerperal mania] there is a tendency to obscenity of language, indecent exposure, and lascivious conduct."²³

Clearly, these physicians were shocked and dismayed by their patients' "indecent" behavior and use of language, as well as by their hostility toward husbands and infants, their neglect of household duties and their refusal to pay attention to personal appearance. Even in their empirical reporting of patients' symptoms doctors revealed their disgust and horror over such unwomanly women. In naming their behavior "puerperal insanity," physicians were both reflecting and supporting nineteenth-century sexual ideology.

As authoritative spokesmen for the new scientific view of the nature of humanity, physicians were also helping to *create* sexual ideology in their explanations of puerperal insanity. Many doctors wrote of insanity as a logical by-product of women's reproductive function. George Rohe, a Maryland physician, asserted that "women are especially subject to mental disturbances dependent upon their sexual nature at three different epochs of life: the period of puberty when the menstrual function is established, the childbearing period and the menopause."²⁴ Dr. Rohe regarded insanity as an ever-present danger to all women throughout their adult lives. Other doctors, however, wrote of pregnancy as a special challenge to women's

mental balance, asserting that most women suffer mild forms of mental illness throughout their pregnancies. "In females of nervous temperament, the equilibrium of nerve force existing between these two organs [the brain and the uterus] is of the most delicate nature," wrote a Denver physician. He went on to say that "pregnancy is sufficient to produce insanity."²⁵ Probably the clearest statement along these lines was made by a professor of gynecology who wrote: "From the very inception of impregnation to the completion of gestation, some women are always insane, who are otherwise perfectly sane." He went on to say that others "manifest defective mental integrity in the form of whimsical longings for the gratification of a supposed depraved appetite."²⁶

It would seem that nineteenth-century physicians' views of proper womanly behavior, along with their ideas about the power of the uterus to disrupt women's mental balance influenced their perception and definition of puerperal insanity. It would be a mistake, however, to conclude that puerperal insanity was simply an indication that male doctors reflected their time or that the medical establishment influenced sexual ideology. Focusing too closely on the obvious ideological content of physicians' accounts of puerperal insanity, one might overlook that physicians' guesses about the nature of the disease were very much in keeping with nineteenth-century ideas about insanity in general and that many physicians offered what late-twentieth-century people would call "sociological" explanations for women's behavior. Indeed, much of the medical discourse on puerperal insanity seems to have been influenced very little by male doctors' concepts of femininity, but instead reflected the state of medical knowledge about insanity, on the one hand, and a jurisdictional dispute between alienists and gynecologists over the treatment of insane women, on the other.

For example, throughout the nineteenth century physicians asserted that mental illness in general, not just women's mental illness, reflected a connection between mind and body; if the mind was unbalanced, a brain lesion was responsible, and the "exciting" cause of the brain lesion could be physical or emotional.²⁷ Indeed, this argument was one of the ways physicians convinced the public that mental illness was a medical problem. From the general assumption of a mind/body link as part of the nature of mental disease, it was logical to conclude that puerperal insanity was in some way caused by the physical state of pregnancy, parturition or lactation. Doctors reasoned that the physical system was taxed by the reproductive process and that this added strain could be an "exciting" cause of insanity. A Pennsylvania physician wrote that "[t]here is no organ or portion of viscera which is not intimately connected with the brain through the sympathetic nervous system," and the Ohio physician who admitted Elizabeth S. to the Dayton Asylum noted more specifically about puerperal insanity: "the physical derangements attendant upon pregnancy, child-bear-

ing and nursing, are the principal causes of the insanity, which would be equally produced by any other physical suffering or constitutional disturbance of the same intensity.”²⁸ Another indication of this line of reasoning was physicians’ notation of any physical problem associated with labor as the probable cause of the insanity. If there was infection or a mild fever, if the labor was unusually long or difficult, if the woman required forceps, if her perineum was torn: these were seen as explanations for the puerperal insanity.²⁹

Physicians also cited “heredity” as a primary cause of puerperal insanity, especially by the middle of the century. Like the mind/body theme, this too reflected a more general trend in medical ideas about the nature of mental illness. If there was insanity in a woman’s family, regardless of how remote a relationship, this was considered a “predisposition” to mental unbalance. In such a case, pregnancy, childbirth or lactation was seen as the stress that pushed the already unstable mind over the edge.³⁰

Finally, many physicians argued that puerperal insanity was caused by situation, what the nineteenth-century writer called “moral” factors and what the late-twentieth-century writer would call “sociological” factors. This too was in keeping with nineteenth-century theories about insanity in general. Just as financial problems or job stress were seen as possible causes of insanity in men, women were thought to develop puerperal insanity sometimes because of being abandoned or poorly treated by husbands, being pregnant and unmarried, being overburdened with too many children and household cares or being emotionally drained because of grief or fear. In such cases physicians were very clear that the woman’s insanity was brought on by her situation, and that the puerperal state simply lowered the woman’s strength so that she could no longer deal with the adverse environmental conditions. Kindness, rest and reassurance was the best treatment.³¹

The mind/body connection and the possibility that physical or moral factors could be the “exciting cause” of puerperal insanity were both stressed throughout the century, but by the 1870s gynecologists began to emphasize the physical causes. The earliest proponent of this point of view, cited later as a man ahead of his time, was Horatio Storer. He argued as early as 1864 that most insanity in women is “reflex” insanity; that is, the primary cause of the insanity is a malfunction of the reproductive organs. For Storer and his post-Civil War followers, this meant that women’s insanity could be prevented, treated and cured by medical and/or surgical means.³² It also meant that a gynecologist should be consulted in any case of female insanity. Medical ideas about the nature, cause and treatment of puerperal insanity were complicated by this professional struggle. Because it was in their best interest to link women’s insanity with their reproductive organs, gynecologists “saw” a connection that other physicians saw less clearly. Furthermore, they wrote authoritatively, as the

medical “experts” on women, and assumed disagreement was the result of ignorance. Charles Reed, professor at the Cincinnati College of Medicine, expressed surprise to hear any dissent from “the long-recognized doctrine of the genital origin of insanity in the female sex.”³³ One Washington, D. C. physician claimed that puerperal insanity could be prevented only by good pre-natal care.³⁴ These gynecologists directed their arguments to general practitioners and to alienists, who ran asylums. Many, though not all, of the gynecologists’ articles about puerperal insanity or about women’s insanity in general concluded that asylums should employ gynecologists—a clear expression of the professional struggle influencing medical perceptions of women’s insanity.³⁵

The medical discourse among gynecologists, alienists and general practitioners about the nature of female insanity affected practice, which in turn affected discourse. From the mid-1870s to the 1890s gynecologists practiced their medical and increasingly surgical techniques on private patients and institutionalized women. Increasingly diseases of the reproductive system were listed as the cause for the insane symptoms of women admitted to asylums.³⁶ More and more asylums employed gynecologists to examine female patients upon admission, and physicians found a variety of gynecological disorders among the women. Believing that there was a direct connection between these disorders and the women’s insanity, the doctors administered medical and surgical cures. In the surgical category, removal of the ovaries was the most popular operation, but more and less extreme operative procedures were also tried, such as hysterectomy and birth repair surgery.³⁷

Some physicians reported patients being cured of insanity as a result of a gynecological procedure, and puerperal insanity was said to be especially responsive to physically oriented therapy. However, as gynecologists treated more insane women, in and out of asylums, medical discourse reflected their growing disillusionment with surgical and medical treatment. Even those physicians who supported operative treatment reported disappointing cure rates.³⁸ By the 1890s there was lively debate over surgical treatment of insane women, with some physicians denouncing “mischievous operative interference” and others asserting that only physical (not mental) symptoms should prompt a surgical response. What made the debate different from the earlier one in which gynecologists successfully fought for the right to treat insane women was that the later debate was based on empirical studies. Having won access to asylum patients, gynecologists generated the numerical evidence against their own case. Two Minnesota physicians working at the state hospital at St. Peter found a large number of women asylum patients with serious pelvic disease in whom “there was not only no apparent relation between the pelvic disease and the mental disturbance, but there was no complaint or evidence of physical discomfort.” They called this finding “the most unexpected result

of our investigation.”³⁹ Other physicians recorded the effect of surgery on women’s insanity and found no significant link between operations and cures. Although they argued that gynecological problems could add to a woman’s worry and discomfort and that all women (in and out of asylums) should have those problems treated, most gynecologists by the end of the century no longer claimed that women’s diseased reproductive organs caused their insanity.⁴⁰

If the empirical evidence, most of it gathered by gynecologists themselves, would not support a straight physiological explanation of women’s insanity, how were physicians to account for puerperal insanity? Gradually, beginning in the 1890s, puerperal insanity was seen as a suspect category, and the emerging specialty of psychiatry emphasized the similarity between puerperal mania and any other mania, between the melancholy some women experienced during pregnancy or lactation and any other melancholy.⁴¹ The particular physiological process was seen as less and less significant, and so the very term “puerperal” insanity was eventually dropped. Just as its appearance and growth was complicated by struggles of medical specialization, the disappearance of puerperal insanity from medical discourse was due to the empirical studies of one specialty and the reconceptualization of insanity that accompanied the rise of a new specialty (psychiatry).

Seen from this angle, puerperal insanity was not simply an expression or creation of sexual ideology by the medical profession. Certainly gynecologists were able to convince other physicians of the physiological basis of women’s insanity (and puerperal insanity) because the argument fit common ideas about woman’s nature. Physicians “saw” mad women in a particular way because of generally held cultural ideas. That medical discourse was altered by empirical investigation at a time when most Americans, including feminists, believed in a biologically determined “woman’s nature” indicates that gender was not a simple factor in the medical debate. Perhaps the most significant way gender affected the medical construction of puerperal insanity is in the absence of women from the professional discourse until the late nineteenth century. There is no way to measure the impact of women’s silence, but it is interesting to note that women physicians in the 1880s and 1890s were overrepresented in the group of doctors gathering evidence that separated women’s insanity from their reproductive organs and eroded the assumptive framework for puerperal insanity as a specific illness.⁴² It is safe to assume that the exclusion of women from medicine in the early and mid-nineteenth century affected the “scientific” view of women’s mental (and physical) illness.

But what of the women who were diagnosed as having puerperal insanity? So far we have been concentrating on physicians, and the ideological and professional issues influencing their conception of puerperal insanity. The medical discourse, however, also offers a way to understand

the women who were patients. Most medical articles dealing with puerperal insanity included case studies, detailed descriptions of the situation, behavior and treatment of the patients. Of course, what doctors selected as important information and what they recorded and did not record of patients' speech and behavior was subjective. Yet they were attempting "objective" observation. Although we cannot take case studies as the "complete picture" or as an entirely unbiased account, they reveal much about the possible meaning of puerperal insanity to the women who were so diagnosed and they also provide a somewhat blurry snapshot of the doctor/patient dynamic.⁴³

On the most literal and superficial level, case studies of puerperal insanity indicate that many women responded with melancholic or maniacal behavior to situations that they found unbearable. Illegitimacy, the fear that often accompanied first pregnancies, a traumatic birth experience or a stillborn infant, infection following birth and extreme cruelty of husbands—were all cited in case studies, sometimes with the doctor attributing the insanity to the situation and other times not. One woman developed maniacal symptoms after her baby was delivered with forceps ("the head was extracted with considerable difficulty") and she suffered physical damage in this her first delivery. Another woman "frail and feeble" developed insane symptoms after her infant died a few days after birth. A woman whose symptoms included disclaiming her infant, striking her husband if he came near and accusing people of trying to kill her was unimproved after five months in an asylum; her baby had died two months earlier and her husband, it turned out, had been continually abusive to her during her pregnancy.⁴⁴

Other situational difficulties also appeared in case studies, such as women having many children in very few years and seemingly overburdened with work and responsibility. One woman, Mrs. S. who was thirty-five and had had five children, three of them within five years, developed "anxiety and slight confusion of ideas" during her last pregnancy. After the child was born she went into a "furious delirium . . . tried to leap from the window to avoid imaginary pursuers." A few days later she was no better; she said she "expects to be tortured soon, remonstrates bitterly." By the tenth day she was a little better: "Talks less and sleeps better. Tries to explain her sickness but cannot."⁴⁵ In another case a twenty-two-year-old woman was melancholic after the birth of her fourth child; her husband confined her and abandoned her once she was hospitalized.⁴⁶

Case studies of puerperal insanity almost always included some physical or situational problem that late-twentieth-century readers would see as cause enough for insane behavior, even when the physicians failed to note the connection. But while we may conclude that these women had good reason to act strangely for a few months, the meaning of puerperal insanity is more complicated than this. The symptoms provide a clue to the

meaning of the disease for women and also point to the doctor/patient relationship as a key factor in the waxing and waning of puerperal insanity.

Whether on a conscious or unconscious level, women who suffered from puerperal insanity were rebelling against the constraints of gender. The symptoms clearly indicate that rebellion. Case studies document that women refused to act in a maternal fashion by denying their infant nourishment or actively attempting to harm the child. Many women "did not recognize" the child, "ignored" its presence or denied that that child belong to them.⁴⁷ Similarly, women refused to act in a wifely fashion; they claimed not to know their husbands, expressed fear that the husband wanted to murder them and sometimes struck out physically at their husbands.⁴⁸ Women were refusing the role of wife/mother, a role that most nineteenth-century Americans saw as the essence of "true womanhood."

Moreover women suffering from puerperal insanity were not acting like women at all. They were "apathetic," "irritable," "gloomy" and "violent," instead of tuned in to the needs of those around them. In fact, these women required that others pay attention to them, in their constant talking and pacing the floor and in their refusal to care for themselves in the simplest ways, such as feeding themselves and keeping themselves clean. In a time when modesty was thought to be a defining characteristic of femininity, women with puerperal insanity "laughed immodestly," tore their clothing in the company of men and used obscene language. Rebellion against cultural notions of "true womanhood" was the one thing tying together the various symptoms of puerperal insanity.

Physicians, new to the lying-in chamber, made these rebellious symptoms legitimate by defining them within a medical framework. Doctors responded to women's behavior with a name: puerperal insanity. That naming was the result not only of the general ideas of the culture and the specific professionalization struggles of physicians, but also was related to doctors' new relationship with women patients: as birth attendants. From the late eighteenth century, male physicians had begun to describe pregnancy and childbirth as a traumatic ordeal. Even doctors who did not think of birth as a sickness, but described it as a natural phenomenon, expressed a mixture of amazement, disgust and respect at women's ability to undergo all the physiological changes associated with pregnancy, birth and lactation. The assumptions of nineteenth-century physicians provided a framework both for their acceptance of women's strange behavior as a side-effect of reproduction and their definition of that behavior as, mostly temporary, insanity.

The medicalization of pregnancy, birth and lactation provided a kind of permission for women to express rebellion and desperation in the particular symptoms of puerperal insanity. But if physicians and women patients both participated in the creation of puerperal insanity, the relation-

ship was not a straightforward one. Women played out their rebellion against the male physician, and doctors translated that rebellion into an acceptable medical category. But doctors also “cured” the rebellion with their treatment and systematically silenced women in their case study reporting. In both cases, women were unequal partners in the construction of the disease.

Treatment of puerperal insanity consisted of various levels of constraint and intrusion. In what late-twentieth-century readers would judge the mildest, most humane treatment, women were confined to their rooms, denied the company of family and friends and forced to rest by the admission of tranquilizers. If the woman refused to eat, which happened in an overwhelming majority of puerperal insanity cases, she was force-fed. Indeed, the element of force was characteristic of most treatment plans. One physician recorded force-feeding and threatening to cut the patient’s hair if she continued to refuse food, and others noted that patients were confined to their rooms or their beds if their behavior did not change quickly enough.⁴⁹ In non-surgical cures force-feeding was the most intrusive aspect of the treatment, but surgical cures were penetrating in a more drastic sense. For the doctor, these cures were restoring the unfortunate patient to her rightful and happy role. For the woman? Regardless of how women perceived the cures, and we will never know their perceptions, they certainly gave up their insane behavior usually within a few months. If women were expressing rebellion in puerperal insanity symptoms and male physicians were defining that behavior as medically explainable and therefore legitimate, male physicians were also forcefully putting down the rebellion. In the social construction of puerperal insanity both parties were not equally powerful. A more interesting example of women’s subordinate position in the relationship defining puerperal insanity is the judging and editing of women patients in the male-controlled medical discourse. The language physicians used to describe their women patients was often sympathetic, but more often judgmental. One doctor described a woman before her insanity as having a “naturally obstinate and passionate disposition,” and another wrote of a suicidal mother who tried to harm her four-month-old infant: “she should be hung.”⁵⁰ More subtle than judgments of behavior were descriptions in case studies which substituted judgement for information. Physicians recorded “obstinate” and “indelicate” behavior and “immoderate” laughter. In some cases the physician’s judgmental words were simply reflections of husbands’ accounts of their wives’ behavior; but that acceptance of the husbands’ point of view was very much a part of the sexual politics involved in puerperal insanity. To many male physicians, the women were to blame for their deviant, unwomanly behavior, and physician case studies recorded the blame.

Although women patients and male physicians constructed puerperal insanity together, the clearest indication that men controlled the discourse

was the near absence of women's words from the case studies. Over and over again physicians claimed that women suffering from puerperal insanity "talked incessantly," yet no attempt was made to record what the women talked about. Similarly, some women were said to complain of "imaginary wrongs," with no explanation of the content of those complaints. The most glaring omission in the case studies was physicians' refusal to record women's "obscene" language. An overwhelming majority of case studies referred to one or all of these speech acts, yet no content was provided.

If women were silenced partners in the construction of puerperal insanity, what can we conclude about the meaning of the disease for women? Although women's words were not reported, physicians' accounts of women's behavior and situations indicate that puerperal insanity was an unconscious act of rebellion against gender constraints for many women. The particular symptoms of puerperal insanity involved a denial of motherhood and a reversal of many "feminine" traits. Women presented these symptoms and acted out their rebellion; male physicians who for ideological and professional reasons were disposed to define women's behavior as "insanity," legitimized women's rebellion as illness. Yet part of the meaning of puerperal insanity for women must also have been the curing, the silencing. So many of the symptoms were aggressively, willfully expressive: the tireless pacing, the continuous talking, the laughter, the obscenity—all un-listened-to, unrecorded. It is almost as if women usurped the power of language only to find that it held no power at all. The woman cured of puerperal insanity surrendered these self-assertive symptoms and went back to being the "halo of love" in her family, without having been heard. There is no way of knowing whether she saw herself as victorious or defeated.

In spite of the sexual politics inherent in the doctor/patient relationship defining puerperal insanity and in spite of women's silence in the case studies, women's symptoms were taken seriously enough to constitute a disease, at least until the turn of the twentieth century. What did it mean for women that puerperal insanity disappeared? Certainly it can be argued that the constraints of gender were not as tight in the early twentieth as they had been in the nineteenth century. Women were having fewer children, childbirth was less dangerous and less painful, women had wider opportunities in terms of education and work and women's marriage relationships were more companionate. If puerperal insanity was a rebellion against the constraints of nineteenth-century "true womanhood," women may have had less trouble with the twentieth-century variety and therefore ceased to manifest the symptoms of puerperal insanity.

Although changes in women's situation contributed to the demise of puerperal insanity, changes in the relationship between doctors and women patients also played a part. As we saw earlier, empirical studies and the

rise of psychiatry altered medical perception of mental illness. Reliance on more "objective," "scientific" studies as the basis of medical discourse meant that there was less tolerance for puerperal insanity as a category. Regardless of how much or little women's situation had changed by the twentieth century, the symptoms of puerperal insanity were no longer a legitimate response to pregnancy, birth or lactation in 1910, as they had been in 1870. Changing medical ideas, which had little to do with women patients, meant that physicians would no longer legitimize puerperal insanity as illness.

Elizabeth S. was admitted to the Dayton Asylum for the insane in 1878. Her illness was the product of several intertwined relationships: her own response to her marriage and motherhood; her physician's response to her story; and her story's resonance in the medical and cultural score of the nineteenth century. The interaction of these layers of relationship defined her condition as puerperal insanity. By the twentieth century, changes in all three layers made the disease obsolete. The creation and demise of puerperal insanity illustrates not only the social construction of illness but also the cultural embeddedness of medical categories.

Notes

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1. J. M. Carr, "Puerperal Insanity," *Cincinnati Lancet-Clinic* 7 (1881), 537-542.
2. I do not mean to imply that studies of the history of ideas about insanity are inappropriate. Such studies as Norman Dain, *Concepts of Insanity in the United States, 1789-1865* (New Brunswick, New Jersey, 1964); and Ellen Dwyer, "A Historical Perspective," in Cathy Spatz Widom, ed. *Sex Roles and Psychopathology* (Bloomington, Indiana, 1984), 19-48 are absolutely essential to our understanding of the history of insanity. In her essay, Dwyer goes beyond a history of ideas approach and attempts to test how ideas about gender and insanity related to actual practice. This relationship between ideas and practice deserves more attention. In another study, Dwyer is particularly interested in comparing ideas and practice: Ellen Dwyer, "The Weaker Vessel: Legal Versus Social Reality in Mental Commitments in Nineteenth-Century New York," in D. Kelly Weisberg, ed. *Women and the Law: A Social Historical Perspective*, II (Cambridge, Massachusetts, 1982), 85-106. A twentieth-century study that compares ideas and practice in that same volume is Robert T. Roth and Judith Lerner, "Sex-based Discrimination in the Mental Institutionalization of Women," 107-139.
3. The approach to insanity taken by Mark S. Micale, "On the 'Disappearance' of Hysteria: A Medical and Historical Perspective," paper read at the annual meeting of the American Association for the History of Medicine, Birmingham, April 1989, I believe is not helpful. Micale explains the disappearance of hysteria as due to more specific medical definitions. The real question, however, is how/why definitions change.
4. Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, translated by Richard Howard, (New York, 1965).
5. For discussions of the labeling theory, see: Roy Porter, *A Social History of Madness* (New York, 1987); Agnes Miles, *The Neurotic Woman: The Role of Gender in Psychiatric Illness* (New York, 1988); Elaine Showalter, "Victorian Women and Insanity," in Andrew T. Scull, ed. *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (Philadelphia, 1981), 313-331; Richard W. Fox, *So Far Disor-*

dered in Mind: *Insanity in California, 1870-1930* (Berkeley, 1978); Nancy E. Waxler, "Culture and Mental Illness: A Social Labeling Perspective," *Journal of Nervous and Mental Disease* 159 (1974), 379-395.

6. See for example: Bonnie Ellen Blustein, "A Hollow Square of Psychological Science": American Neurologists and Psychiatrists in Conflict," in Scull, *Madhouses, Mad-doctors, and Madmen*, 241-270; and Barbara Sickerman, "The Paradox of Prudence: Mental Health in the Gilded Age," in the same volume, 218-240.

7. For example, Waxler, "Culture and Mental Illness;" Showalter, "Victorian Woman and Insanity," and *The Female Malady: Women, Madness, and English Culture, 1830-1980* (New York, 1987); Miles, *The Neurotic Woman*; Dwyer, "The Weaker Vessel."

8. Carroll Smith-Rosenberg, "The Hysterical Woman: Sex Roles and Role Conflict in Nineteenth-Century America," *Social Research* 39 (1972), 562-583; Joan Jacobs Brumberg, *Fasting Girls: The Emergence of Anorexia nervosa as a Modern Disease* (Cambridge, Massachusetts, 1988).

9. For an explanation of "illness" and "disease," see: Arthur Kleinman, *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China* (New Haven, Connecticut, 1986); Claudine Herzlich and Janine Pierret, *Illness and Self in Society*, translated by Elborg Forster (Baltimore, 1987); Arthur Kleinman, *Patients and Healers in the Context of Culture* (Berkeley, 1980); Peter Conrad and Rochelle Kem, eds., *The Sociology of Health and Illness: Critical Perspectives* (New York, 1981); Peter Wright and Andrew Treacher, eds., *The Problem of Medical Knowledge: Examining the Social Construction of Medicine* (Edinburgh, 1982), especially the essays: David Inglesby, "The Social Construction of Mental Illness," 123-141, and Karl Figlio, "How does Illness Mediate Social Relations: Workmen's Compensation and Medico-Legal Practices, 1890-1940," 174-224; Bryan S. Turner, *The Body and Society: Explorations in Social Theory* (Oxford, 1984).

10. Milton H. Hardy, "Puerperal Insanity," *Western Medical Review* 3 (1898), 14.

11. W. H. B. Stoddart, "A Clinical Lecture on Insanity in Relation to the Child-bearing State and the Puerperium," *The Clinical Journal* 14 (1899), 242; Hardy, "Puerperal Insanity," 14; R. M. Wigginton, "Puerperal Insanity," *Transactions of the Wisconsin State Medical Society* 60 (1975), 40; L.R. Landfear, "Puerperal Insanity," *Cincinnati Lancet and Observer* 19 (1876), 54; Harry L. K. Shaw, "A Case of Insanity of Gestation," *Albany Medical Annals* 19 (1898), 459-462; Fleetwood Churchill, "On the Mental Disorders of Pregnancy and Childbed," *American Journal of Insanity* 7 (1850-1851), 297-317.

12. W. F. Menzies, "Puerperal Insanity: An Analysis of One Hundred and Forty Consecutive Cases," *American Journal of Insanity* 50 (1893-1894), 147-185; George H. Rohe, "Lactational Insanity," *Journal of the American Medical Association* 21 (1893), 325-327; W. G. Stearns, "The Psychiatric Aspects of Pregnancy," *Obstetrics* 3 (1901), 23-26, 32-36; Wigginton, "Puerperal Insanity," 41.

13. These symptoms were listed in numerous nineteenth-century articles. Since we will be dealing with the symptoms in more detail later, I will refrain from citing all of the articles here.

14. Landfear, "Puerperal Insanity," 54; Wigginton, "Puerperal Insanity," 41. See also R. E. Houghton, "Puerperal Mania," *Cincinnati Lancet and Observer* 9 (1866), 713; B. C. Hirst, "Six Cases of Puerperal Insanity," *Journal of the American Medical Association* 12 (1889), 29; F. C. Fernald, "Puerperal Insanity," *American Journal of Obstetrics* 20 (1887), 714; George Byrd Harrison, "Puerperal Insanity," *American Journal of Obstetrics* 30 (1894), 530. Arthur C. Jelly, "Puerperal Insanity," *Boston Medical and Surgical Journal* 144 (1901), 271 is the only medical writer I found claiming puerperal insanity was not common.

15. Hirst, "Six Cases of Puerperal Insanity," 29; Landfear, "Puerperal Insanity," 57; Anna Burnet, "Puerperal Insanity: Cause, Symptoms and Treatment," *The Woman's Medical Journal* 9 (1899), 269; "Abstracts," *American Journal of Obstetrics* 13 (1880), 641; T. W. Fisher, "Two Cases of Puerperal Insanity," *Boston Medical and Surgical Journal* 79 (1869), 233-234; Charles E. Ware, "A Case of Puerperal Mania," *American Journal of Medical Sciences* 26 (1853), 346; Churchill, "On the Mental Disorders of Pregnancy and Childbed," 309.

16. On the generally good prognosis expected of puerperal insanity patients, see: Stearns, "The Psychiatric Aspects of Pregnancy," 24; William Mercer Sprigg, "Puerperal Insanity: Prognosis and Treatment," *American Journal of Obstetrics* 30 (1894), 537. On home versus hospital treatment, see: Jelly, "Puerperal Insanity," 275; Wigginton, "Puerperal Insanity," 43; Landfear, "Puerperal Insanity," 59; W. W. Godding, "Puerperal Insanity," *Boston Medical and Surgical Journal* 91 (1874), 318-319.

17. On bleeding as a treatment for puerperal insanity, see: Sprigg, "Puerperal Insanity: Prognosis and Treatment," 540; Landfear, "Puerperal Insanity," 58; Churchill, "On the Mental Disorders of Pregnancy and Childbed," 315; J. A. Wright, "Puerperal Insanity," *Cincinnati Lancet-Clinic* 23 (1889), 651; Victor H. Coffman, "Puerperal Mania," *Nebraska State Medical Association Proceedings* 4 (1872), 18. On purging as a treatment see:

Haughton, "Puerperal Mania," 729; A. Bryant Clarke, "On the Treatment of Puerperal Mania by Veratrum Viride," *Boston Medical and Surgical Journal* 59 (1859), 237-239; J. MacDonald, "Observations on Puerperal Mania," *New York Medical Journal* 1 and 2 (1831), 279; Thomas Lightfoot, "Puerperal Mania; Its Nature and Treatment," *The Medical Times and Gazette* 21 (1850), 274. Many physicians recommended that the patient be removed from family and friends; for example see: J. A. Reagan, "Puerperal Insanity," *Charlotte Medical Journal* 14 (1899), 309; Fernald, "Puerperal Insanity," 720; J. Thompson Dickson, "A Contribution to the Study of the So-Called Puerperal Insanity," *Journal of Mental Sciences* 16 (1870-1871), 390; C. S. May, "Puerperal Insanity, with Statistics Regarding Sixteen Cases," *Proceedings of the Connecticut State Medical Society* 85 (1877), 106; Carr, "Puerperal Insanity," 540; Wigginton, "Puerperal Insanity," 44; Landfear, "Puerperal Insanity," 59. Nearly every physician who wrote of treatment recommended rest, food, and some form of sedation. For examples not yet cited see: W. S. Armstrong, "Case of Puerperal Mania," *Atlanta Medical and Surgical Journal* 8 (1867), 419; Thomas H. Mayo, "Puerperal Mania," *Southern Medical Record* 4 (1874), 84; J. P. Reynolds, "Puerperal Mania," *Boston Medical and Surgical Journal* 72 (1865), 281; W. A. McPheeters, "Forceps; Puerperal Mania," *New Orleans Medical and Surgical Journal* 16 (1859), 660; Edward Kane, "Puerperal Insanity," *Medical Independent and Monthly Review of Medicine and Surgery* 2 (1856), 156; Horace Palmer, "A Case of Puerperal Mania," *Cincinnati Lancet and Observer* 2 (1859), 5; Horatio Storer, "Puerperal Mania; Recovery," *Boston Medical and Surgical Journal* 55 (1856-1857), 20.

18. See for example the explanation of Elaine Showalter in *The Female Malady*, especially 57-59, 71-72.

19. Wigginton, "Puerperal Insanity," 43.

20. For example, see: W. L. Worcester, "Is Puerperal Insanity a Distinct Clinical Form?" *American Journal of Insanity* 47 (1890-1891), 56; Edward J. III, "A Clinical Contribution to Gynecology," *American Journal of Obstetrics* 16 (1883), 264; Rohe, "Lactational Insanity," 325-326.

21. Allan McLane Hamilton, "Two Cases of Peculiar Mental Trouble Following the Puerperal State," *Boston Medical and Surgical Journal* 94 (1896), 680.

22. Lambert Ott, "Puerperal Mania," *The Clinical News* 1 (1880), 337; W. P. Manton, "Puerperal Hysteria (Insanity?)," *Journal of the American Medical Association* 19 (1892), 61; W. I. Richardson, "Puerperal Septicaemia: Puerperal Mania," *Boston Medical and Surgical Journal* 102 (1880), 448. See also: Carr, "Puerperal Insanity," 538; Fernald, "Puerperal Insanity," 717; W. D. Haines, "Insanity in the Puerperal State," *Cincinnati Lancet-Clinic* 23 (1889), 371; Worcester, "Is Puerperal Insanity a Distinct Clinical Form," 55; Burnet, "Puerperal Insanity: Cause, Symptoms and Treatment," 267-269. This is only a sampling of the articles listing these symptoms.

23. Harrison, "Puerperal Insanity," 532; Haines, "Insanity in the Puerperal State," 371; Godding, "Puerperal Insanity," 317; V. H. Taliaferro, "Puerperal Insanity," *Atlanta Medical and Surgical Journal* 15 (1877), 324; Carr, "Puerperal Insanity," 538; Stearns, "The Psychiatric Aspects of Pregnancy," 25. Almost every physician describing symptoms of puerperal insanity listed obscenity. For example see: Stoddart, "A Clinical Lecture," 242; Reagan, "Puerperal Insanity," 308; Menzies, "Puerperal Insanity," 169; Rohe, "Lactational Insanity," 325; Worcester, "Is Puerperal Insanity a Distinct Clinical Form?" 56; May, "Puerperal Insanity," 106; Wigginton, "Puerperal Insanity," 43; MacDonald, "Observations on Puerperal Mania," 268-270; Clarke, "On the Treatment of Puerperal Mania by Veratrum Viride," 238.

24. George H. Rohe, "Some Causes of Insanity in Women," *American Journal of Obstetrics* 34 (1896), 802. See also John Young Brown, "Pelvic Disease in Its Relationship to Insanity in Women," *American Journal of Obstetrics* 30 (1894), 360; Montrose A. Pallen, "Some Suggestions with Regard to the Insanities of Females," *American Journal of Obstetrics* 10 (1877), 207. Carroll Smith-Rosenberg, "Puberty to Menopause: The Cycle of Femininity in Nineteenth-Century America," *Feminist Studies* 1 (1973), 58-72 is a discussion of this attitude.

25. P. V. Carlin, "Insanity of Pregnancy," *The Denver Medical Times* 3 (1883-1884), 233. See also: Churchill, "On the Mental Disorders of Pregnancy and Childbed," 298; C. P. Lee, "Puerperal Mania," *Kansas Medical Index* 2 (1881), 200.

26. Pallen, "Some Suggestions with Regard to the Insanities of Females," 212.

27. For a clear explanation of this point especially with reference to gender, see Dwyer, "A Historical Perspective."

28. C. C. Hersman, "The Relationship between Uterine Disturbance and Some of the Insanities," *Journal of the American Medical Association* 33 (1899), 709; Carr, "Puerperal Insanity," 537. See also: Edward Jarvis, "Causes of Insanity," *Boston Medical and Surgical Journal* 45 (1851), 289-305; Reagan, "Puerperal Insanity," 309; Kane, "Puerperal Insanity," 147.

29. For example see: Fernald, "Puerperal Insanity," 716; Landfear, "Puerperal Insanity," 56; Jelly, "Puerperal Insanity," 271-272; G. H. Rohe, "The Influence of Parturient Lesions of the Uterus and Vagina, in the Causation of Puerperal Insanity," *Journal of the American Medical Association* 19 (1892), 59-60.

30. About heredity as a factor in puerperal insanity, see: Churchill, "On the Mental Disorders of Pregnancy and Childbed," 305; Fisher, "Two Cases of Puerperal Insanity," 233; Dickson, "A Contribution to the Study of the So-called Puerperal Insanity," 382; Taliaferro, "Puerperal Insanity," 328; May, "Puerperal Insanity," 106; Landfear, "Puerperal Insanity," 55; Fernald, "Puerperal Insanity," 714; Jelly, "Puerperal Insanity," 272; Reagan, "Puerperal Insanity," 309.

31. This point of view was expressed in many of the articles. See for example: Carr, "Puerperal Insanity," 537; Jelly, "Puerperal Insanity," 272; Wigginton, "Puerperal Insanity," 40; Fernald, "Puerperal Insanity," 715; Wright, "Puerperal Insanity," 648; Harrison, "Puerperal Insanity," 532; Menzies, "Puerperal Insanity: An Analysis of One Hundred and Forty Consecutive Cases," 162; Churchill, "On the Mental Disorders of Pregnancy and Childbed," 299-300; Kane, "Puerperal Insanity," 152.

32. Horatio Robinson Storer, "The Medical Management of Insane Women," *Boston Medical and Surgical Journal* 71 (1864), 210-218; Horatio R. Storer, "Cases Illustrative of Obstetric Disease—Deductions Concerning Insanity in Women," *Boston Medical and Surgical Journal* 70 (1864), 189-200.

33. Charles A. L. Reed, "The Gynecic Element in Psychiatry—with Suggestions for Asylum Reform," *Buffalo Medical and Surgical Journal* 28 (1888-89), 571. See also: Charles F. Folsom, "The Prevalence and Causes of Insanity; Commitments to Asylums," *Boston Medical and Surgical Journal* 103 (1880), 97-100; J. H. McIntyre, "Disease of the Uterus and Adnexa in Relation to Insanity," *Transactions of the Medical Association of Missouri* (1898), 191-195; Pallen, "Some Suggestions with Regard to the Insanities of Females," 207; W. P. Jones, "Insanity Dependent Upon Physical Disease," *Tennessee State Medical Society Transactions* 47 (1880), 97-104.

34. Fernald, "Puerperal Insanity," 719.

35. In addition to Reed, other gynecologists calling for specialists in insane asylums included: Joseph Wiglesworth, "On Uterine Disease and Insanity," *Journal of Mental Sciences* 30 (1884-85), 509-531; I.S. Stone, "Can the Gynecologist Aid the Alienist in Institutions for the Insane," *Journal of the American Medical Association* 16 (1891), 870-873; Ernest Hall, "The Gynecological Treatment of the Insane in Private Practice," *Pacific Medical Journal* 43 (1900), 241-256; Pallen, "Some Suggestions with Regard to the Insanities of Females."

36. Dwyer notes this trend of attributing women's insanity to problems with the female reproductive system in "The Weaker Vessel," "A Historical Perspective," and in her study of two New York asylums, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, New Jersey, 1987).

37. Physicians who described medical and surgical attention to female asylum inmates include: H. A. Tomlinson and Mary E. Bassett, "Association of Pelvic Diseases and Insanity in Women, And the Influence of Treatment on the Local Disease Upon the Mental Condition," *Journal of the American Medical Association* 33 (1899), 827, 831; W. P. Manton, "The Frequency of Pelvic Disorders in Insane Women," *American Journal of Obstetrics* 39 (1899), 54-57; Eugene G. Carpenter, "Pelvic Disease as a Factor of Cause in Insanity of Females and Surgery as a Factory of Cure," *Journal of the American Medical Association* 35 (1900), 545-551; W. J. Williams, "Nervous and Mental Diseases in Relation to Gynecology," *Transactions of the Eighth Annual Meeting of the Western Surgical and Gynecological Association* (Omaha, December, 1898; published 1899), 49-57; W. O. Henry, "Insanity in Women Associated with Pelvic Diseases," *Annals of Gynecology and Pediatrics* 14 (1900-1901), 312-320; W. P. Manton, "Post-Operative Insanity, Especially in Women," *Annals of Gynecology and Pediatrics* 10 (1896-97), 714-719; Hall, "The Gynecological Treatment of the Insane in Private Practice."

38. See for example: Henry, "Insanity in Women Associated with Pelvic Diseases"; Manton, "The Frequency of Pelvic Disorders in Insane Women"; Hall, "The Gynecological Treatment of the Insane in Private Practice"; Rohe, "The Influence of Parturient Lesions of the Uterus and Vagina, in the Causation of Puerperal Insanity." I do not mean to imply that all doctors were treating puerperal insanity with surgery. "Rest and restoration" was probably the most popular therapy throughout the century. See Hardy, "Puerperal Insanity."

39. Tomlinson and Bassett, "Association of Pelvic Diseases and Insanity in Women," 827. See also: Brown, "Pelvic Disease in Its Relationship to Insanity in Women"; Carpenter, "Pelvic Disease as a Factor of Cause in Insanity of Females and Surgery as a Factory of Cure"; and Williams, "Nervous and Mental Diseases in Relation to Gynecology" for examples of the argument that doctors should only resort to surgery when there is physical disease.

40. Stone, "Can the Gynecologist Aid the Alienist in Institutions for the Insane"; Manton, "Post-Operative Insanity, Especially in Women"; Clara Barrus, "Gynecological Disorders and Their Relation to Insanity," *American Journal of Insanity* 51 (1894-95), 475-491; Alice May Farnham, "Uterine Disease as a Factor in the Production of Insanity," *Alienist and Neurologist* 8 (1887), 532-547; Adolf Meyer, "On the Diseases of Women as a Cause of Insanity in the Light of Observations in Sixty-nine Autopsies," *Transactions of the Illinois State Medical Society* (1895), 299-311; C. B. Burr, "The Relation of Gynaecology to Psychiatry," *Transactions of the Michigan Medical Society* 18 (1894), 458-464, 478-487. An excellent article about removal of the ovaries in the nineteenth century is Lawrence D. Longo, "The Rise and Fall of Battley's Operation: A Fashion in Surgery," *Bulletin of the History of Medicine* 53 (1979), 244-267.
41. See for example: Helene Kuhlmann, "A Few Cases of Interest in Gynecology in Relation to Insanity," *State Hospital Bulletin* 1 (New York: 1896), 172-179; Mary D. Jones, "Insanity, Its Causes: Is there in Woman a Correlation of the Sexual Function with Insanity and Crime," *Medical Record* 58 (1900), 925-237; Edward B. Lane, "Puerperal Insanity," *Boston Medical and Surgical Journal* 144 (1901), 606-609; Manton, "Puerperal Hysteria."
42. For example: Jones, "Insanity, Its Causes: Is there in Woman a Correlation of the Sexual Function with Insanity and Crime"; Kuhlmann, "A Few Cases of Interest in Gynecology in Relation to Insanity"; Burnet, "Puerperal Insanity: Cause, Symptoms and Treatment"; and the work of Mary Putnam Jacobi. An important study of women physicians working in asylums is Constance M. McGovern, "Doctors or Ladies? Women Physicians in Psychiatric Institutions, 1872-1900," *Bulletin of the History of Medicine* 55 (1981), 88-107.
43. A creative use of case studies to describe the doctor-patient relationship and the doctor-family relationship is Ellen Dwyer, "The Burden of Illness: Families and Epilepsy," paper read at the annual meeting of the American Association for the History of Medicine, Birmingham, April 1989.
44. McPheeters, "Forceps; Puerperal Mania"; Ware, "A Case of Puerperal Mania"; Lambert, "Puerperal Mania." Numerous case studies included information about cruelty, illness, illegitimacy and stillbirth, although often doctors did not connect the situation to the symptoms. For example: W. H. Parish, "Puerperal Insanity," *Transactions of the Obstetrical Society of Philadelphia* 4-7 (1876-79), 50-54.
45. Fisher, "Two Cases of Puerperal Insanity," 233.
46. Harrison, "Puerperal Insanity," 535.
47. Lee, "Puerperal Mania," 205; Lambert, "Puerperal Mania," 337; Denslow Lewis, "Clinical Lecture on Obstetrics and Gynecology—Mental and Nervous Derangements in Obstetric Practice," *Clinical Review* 11 (1899-1900), 181.
48. This theme of women denying their husbands and/or expressing fear or hatred of their husbands was common in the case studies.
49. Dickson, "A Contribution to the Study of the So-Called Puerperal Insanity," 383.
50. Storer, "Puerperal Mania; Recovery," 20; MacDonald, "Observations on Puerperal Mania," 270.