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Can the Clitoris Speak: Reframing Female Desire and Subjectivity in Victorian Gynecology

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<1>The expulsion of Dr. Isaac Baker Brown from the London Obstetrical Society in the spring of 1867 was a threshold moment in the history of Victorian gynecology. Brown was a trained gynecologist and obstetrician, and founded the London Home for Surgical Diseases of Women in 1858 to 'cure' female hysteria through clitoridectomy. His 1866 monograph *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females* described female desire and subjectivity in a manner that took the *British Medical Journal* and *Lancet* by storm. Established medical professionals such as Henry Maudsley and Holmes-Coote began to distance themselves from Brown's belief that excessive stimulation of the clitoris could render women violent, manic, and rebellious. He excised the clitoris of several patients who suffered from 'symptoms' like restlessness and a distaste for conjugal intercourse. He made detailed observations of their 'pathological' behaviours and published patient testimonies. Divested of the clitoris, Brown alleged that his patients recovered from the "involuntary itch" they experienced in the pubic area. He claimed that they no longer displayed hysteric symptoms and became paragons of virtue and docility. But the controversy arose when some of Brown's patients sued him for 'unsexing' them. Many women remained 'incurable' by Brown's estimation, and a few died of post-operative hemorrhage.

<2>Brown's conversational tone in the monograph concealed the horrors of the actual procedure. He elaborated how his patients were placed under chloroform and the clitoris was excised "freely" using a pair of sterile scissors. However, the account provided in an April 1867 report printed in the *British Medical Journal* presents another picture:

> The clitoris was seized by the forceps in the usual manner. The thin edge of the red-hot iron was then passed around its base until the organ was severed from its attachment, being partly cut or sawn, and partly torn away. After the clitoris was removed, the nymphae on each side were severed in a similar way by a sawing motion of the hot iron. After the clitoris and nymphae were got rid of, the operation was brought to a close by taking the back of the iron and sawing the surfaces of the labia and the other parts of the vulva which had escaped the cautery, and the instrument was rubbed down backwards and forwards till the parts were more effectually destroyed than when Mr. Brown uses the scissors to effect the same result. (*BMJ* 395)

In an 1891 review of clitoridectomy, Brown's contemporary Thomas Spencer Wells compared his procedure to that of the "aboriginal spayers of New Zealand" (Moscucci 1). Even as gynecologists like Robert Harling argued that the desire to touch the clitoris was sensual, Brown insisted that volition had no role to play in female masturbation. Upon being told that one of his patients could not have masturbated as she was "very religious," Brown clarified that masturbation was a "peripheral itch" (Brown 34). He denied charges of unsexing his patients by defining the clitoris as a vestigial organ. When his peers questioned why not cut off the patient's hands, Brown responded that his procedure was more 'humane.'

<3>There is no denying that Brown's theory of curing hysteria relied on certain phallocentric conceptions of female desire and subjectivity. But we cannot overlook the rare insight he provides into the nuances of female desire. This essay revisits the clitoridectomy debate of the 1860s with a view to reframe Brown's representation of female desire and subjectivity. The testimonies of his 'hysteric' patients, in particular, merit a theoretical re-examination. Using feminist and psychoanalytic theory, I categorize these testimonies as a tenuous but critical admission of female desire in Victorian England. Precisely by highlighting the clitoris and giving space to the hysteric patient to 'speak,' I show how Brown unwittingly 'discovered' multiple erogenous zones in his monograph. This new discourse of female sexuality necessitated the invention of medical jargon to encourage candour among patients. Perhaps the real threat Brown's monograph posed to the London Obstetrical Society was that it bore witness to the incurable desires of respectable middle-class English women.

1 Towards a Testamental Symptomatology

<4>By professing that an excessive stimulation of the clitoris diminished women's desire to procreate, Brown promoted clitoridectomy with the promise of renewed

interest in marriage and conjugal intercourse. His remarks on the value of subjecting dissenting wives to clitoridectomy are deeply phallocentric – "may not it be typical of many others where there is a judicial separation of husband and wife, with all the attendant domestic miseries, and where, if medical and surgical treatment were brought to bear, all such unhappy measures would be obviated?" (Brown 84). But rather than targetting Brown, it must be noted how gender shaped gynecology which further reinforced gender stereotypes in the Victorian age. The erasure of the erotic function of the clitoris was crucial if Brown could justify removing this "deep-seated centre of nerve irritation" (Brown 4). His discursive unsexing of the clitoris achieved two purposes. First, it enabled Brown to deflect charges of castrating his patients, which was a significant part of the Obstetrical Society's objections to his procedure. The clitoris had to be removed, like the foreskin in routine male circumcisions, in order to benefit the patient's physical and arguably, 'mental' health. Quoting Dr. Handfield Jones's "inhibitory theory" of nervous exhaustion in females from the Lumleian Lectures of 1865, Brown defined the urge to stimulate the clitoris as "an impression conveyed to a nervous centre by afferent nerves" (5). Second, it allowed him to examine his patients without harming their 'virtue.' Alongwith doctors like Robert Lee of St George's Hospital, Brown claimed that the use of a speculum to trace "physical evidences of derangement" in women was not "unjustifiable on the grounds of propriety and morality" (Moscucci 114).

<5>Sarah Rodriguez claims that Victorian gynecologists like Brown were invested mainly in realigning the sexual instinct of white middle-class women "toward loyalty and ardor for her husband" (347). Certain forms of behaviour that indicated female desire and autonomy were listed as symptoms of hysteria:

> The patient becomes restless and excited, or melancholy and retiring; listless and indifferent to the social influences of domestic life. She will be fanciful in her food, sometimes express even a distaste for it, and apparently (as her friends will say) live upon nothing […] On enquiring further, there is found to be disturbance or irregularity in the uterine functions […] Often a great disposition for novelties is exhibited, the patient desiring to escape from home, fond of becoming a nurse in hospitals, "sœur de charité." (Brown 15)

This phallocentric bias in Victorian gynecology may also be seen in the paradoxical coexistence of erotic and inhibitory theories of female masturbation. Where the former propounded in the Galenic model of the clitoris's orgasmic function, the latter focused on unhealthy secretions that could lead to consistent peripheral itching. Rodriguez notes how there were four stages to operating on the clitoral region "removing smegma or adhesions between the clitoris and its hood, removing the

hood (circumcision), or removing the clitoris (clitoridectomy) – in order to correct a woman's sexual instinct in an unhealthy state" (327). Medical tracts like Brown's belonged to the latter category where "the pathogenesis of masturbation, then, was a physiological one: excessive nervous stimulation. The theory, known as reflex neurosis, pictured the body as a nervous web intricately wired together" (334). Brown's monograph listed eight stages of the progression of mental illness in women who masturbated habitually. These were "hysteria, spinal irritation, epileptoid fits or hysterical epilepsy, cataleptic fits, epileptic fits, idiocy, mania, death" (Brown 7). One of Brown's cases apparently died due to "habitual self-excitation." By de-eroticizing the clitoris and portraying it as a vestigial organ detrimental to women's mental and physical health, Brown conveyed his paternalistic concern to rescue them from expiring of "abnormal paroxysms" (8).

<6>Elizabeth Sheehan observes that Brown "wanted it both ways: the clitoris was so unimportant to a normal woman as to not be missed if removed, yet lurking in its tissue was the greatest threat to female welfare ever known" (12). Female desire in its complex psycho-physiological entirety was a relatively understudied matter in Victorian gynecology until Brown brought it to the fore by comparing clitoridectomy to routine male circumcisions. It is curious to see how infrequently a medical tract on clitoridectomy actually prints the word 'clitoris.' Brown referred to it in his first case study "I divided the clitoris subcutaneously" and "clitoris completely excised" but there is no mention of the word in his preface where he provided the rationale for his methods (21-22). Masturbation is referenced as "onanism" – a religious term popularised in medical context by the 1712 treatise *Onania; Or, The Heinous Sin of Self Pollution*. This text became foundational in sexology and gynecology in England from the eighteenth century onwards. Since masturbation was a taboo topic involving the modesty of his patients, Brown used vague statements such as "I operated in the usual manner," or "usual operation performed," and "usual operation" allowing him to withhold the abject details of each cauterization (23-28).

<7>The restriction of the clitoris to an organic existence – as opposed to its orgasmic function in female desire – was essential for Brown's "incitement to discourse." In his celebrated work *The History of Sexuality: The Will to Knowledge*, Michel Foucault observes how the Christian practice of ritual confession evolved into a medical drama in which the gynecologist or sexologist replaced the priest, and the patient replaced the sinner. The latter remained under the original contractual obligation to narrate his/her covert activities through a verbal testimony. The jargon Brown invented for female masturbation allowed his patients to confess their secret 'sins' without inhibition. Note how, when he listed the symptoms of hysteria in his

second chapter, Brown indicated parenthetically that "on enquiring further" his patients confessed to clitoral stimulation. The sheer proliferation of discursive terms that Brown invented to render female masturbation into medical terms – such as "peripheral irritation," "reflex relaxation," "irritation of the pudic nerve," "inhibitory influence," and "paroxysm of abnormal excitement" – became popular in Victorian sexology. It permitted Brown to gather testimonies from married women in a purely clinical and platonic context. Indeed, some of Brown's terms for masturbation such as "reflex reaction" were recapitulated by sexologists in the late 1880s like Richard von Krafft-Ebing in *Psychopathia Sexualis*.

<8>According to Robert Darby, it was Brown's vocabulary for hysteria and his 'universalization' of masturbation in women that raised concerns among the members of the Obstetrical Society. Darby notes that in addition to being horrified by the cauterizations they witnessed, Brown's detractors did not believe that the procedure restored women their virtue. On the contrary, "imagining themselves in the husband's position, they preferred to have sex with a woman whose genitals had not been surgically reduced or interferred with by another man" (Darby 158). This is why they resisted Brown's theory that clitoridectomy should be made as commonplace as male circumcision. Even as Brown tried to take sexual desire out of the equation, his peers continued to view women as sex-objects. Much of their line of questioning against Brown fixated on the difference between clitoridectomy and circumcision, since male patients were not at risk of losing their virtue to a doctor. Dr. Tyler Smith emphasized that clitoridectomy was not in the least like circumcision "The prepuce was a very unimportant structure as compared with the clitoris. As regarded sensation, the clitoris was the analogue of the male penis, and was the organ of sexual sensibility in the female.... [Its removal] in cases of hysteria and self-abuse could not be justified. We might as well think of removing the penis in cases of masturbation in the male" (Cited in Darby 148).

<9>While this inquisition against Brown's monograph sought to uphold professional ethics, it also claimed to perform a higher duty of preserving public morality. There were four decisive charges made against Brown by colleagues like W. Tyler Smith, Robert Greenhalgh, and Charles West. The most important was the "dialectics of consent" or the "relevance of chivalry" (Darby 156). They charged Brown with forcing his patients to undergo the procedure without being explicit about how it would impact their 'modesty.' Second, and related to the first, Brown's detractors claimed that he had violated professional codes of conduct as he had operated "without the concurrence of the patient's ordinary medical attendant." The collective fear in the obstretrical community was that Brown's monograph would diminish the "public standing of the profession." Related to this was an epistemological confusion

regarding the status of Brown's work within the field of gynecology. Darby notes "there was a rather confused issue over whether Brown had seriously offered to submit his theories to the evaluation of the Obstetrical Society." If he had not officially submitted it for review, the reputation of the field would not be at stake. The widespread "menace of quackery" also made it dangerous for Brown to advertise his procedure as a revolutionary cure for hysteria. Darby concludes that the clitoridectomy controversy was primarily rooted in unresolved questions regarding "the nature and significance of female sexual desire" (156).

<10>Brown's monograph, even as it conformed to these phallocentric biases, is a valuable study of female hysteria. Granted, the patient testimonies published in the monograph were most likely curated, but their sheer presence gives voice to the cultural wound left by the clitoridectomy craze of the 1860s. As per Foucault's analysis, although the medical "incitement to discourse" prompted the pathological individual to confess symptoms, this alone did not count as "truth." The onus lay on the medical professional to translate the confession into scientific evidence using hermeneutic methods. But what's striking about Brown's monograph is how certain testimonies functioned as a medical speech act for hysteria. If a patient simply admitted to habitual excitation of clitoris in Brown's preliminary examination, it was enough to sanction the procedure of clitoridectomy. By giving such emphasis to patient testimonies, Brown could 'rescue' their modesty from having to undergo a needless physical examination.

<11>At this juncture, it is worth posing an important theoretical question using feminist and psychoanalytic concepts of female desire and hysteria . Can the clitoris speak for/be made to speak for the hysteric? Shoshana Felman, in her influential work on testimony, asks "how can one speak from the place of the Other?" (2). Testimony, or the act of bearing witness to a particular event through a written or verbal account, may be traced to quasi-Christian practices of confession. It derives from the Latin root 'testis' meaning the mark or token of a fact. The witness statement laid the foundation for truth-value in Anglo-Saxon jurisprudence as well as Victorian medical discourse. Hysterics were not considered rational or legitimate witnesses in the eyes of the law – *mens rea* presupposed *mens sana*. *Mens sana* implied 'healthy mind' and *mens rea* implied 'rational ability and intent' in medieval Roman law. The religious overtones of anti-masturbatory tracts in the Victorian context evolved from residual concepts of *mens rea*. It guaranteed that the occurrence of a crime required the presence of a rational human agent. There was a clear demarcation between motive – as a product of rational intent – rather than a symptom of inner drives, animal instincts, or excessive passions.According to the Lunacy Laws, an epileptic was deemed unfit to give his/her consent to surgery

(Moscucci 67). By extension, the confessions of hysterics were stripped of 'masculine' reason and volition that were crucial for a witness statement to be deemed valid.

<12>In the inquisition against Brown, Dr. Charles West used the term "cognisance" to imply rational consent "without saying one word to the lady or her husband, or hinting in any way what he was about to do, cut off her clitoris i.e., without the cognisance of the patient" (Cited in Darby 152). Where West and others like Robert Greenhalgh assumed that these women were hapless victims of a medical trial, Brown acknowledged that not all women suffered from the same degree of hysteria. Many of his patients displayed moments of clarity and indeed, were capable of giving their consent to be 'cured.' For example, there is Case 46 who suffered frequently from fits of frenzy: "After a few minutes the mania would subside, and be succeeded, first by a kind of stupor, and then very profuse perspirations. One peculiarity about her is, that when in this state she does or says anything foolish, she knows it, and is afterwards very annoyed and ashamed of her conduct" (Brown 70). Brown's recognition that "she *knows* it" deconstructed the prevalent discourse of hysteria that, according to Felman, was born of "a confrontation between objective data and the subjective testimony of women" (2). First, Felman asks "can the hysteric speak" – where speech implies the capability to present a rational and comprehensible testimony. Second, she asks "can the woman speak" – woman being the Other in medico-legal discourses of the nineteenth century. Felman shows how female desire and madness coalesced as they "belonged to 'the narcissistic economy of the Masculine universal [that] tries to eliminate, under the label "madness," is nothing other than feminine difference" (8).

<13>It must also be noted that Brown was expelled from the Obstetrical Society because his published monograph made it difficult to distinguish between a hysteric and a 'virtuous' woman. Previously, doctors like Holmes-Coote and Maudsley had limited the 'malady' of masturbation to a minority of hysterical women. But Brown's monograph appreciated the ubiquity of the "itch." In a December 1866 article in the *British Medical Journal*, Holmes-Coote said "the operation is based upon a double error: first, the supposed prevalence of the vice, particularly in the female sex; and secondly, the mistaken function of the organ which is removed. That self-abuse prevails among the inmates of lunatic asylums, is most true; it produces great nervous prostration, and finally death. But such cases are readily recognised, and are treated accordingly" (*BMJ* 705-8). In the same article, Maudsley affirmed that "self-abuse was not a cause, but a consequence of insanity."

<14>In contrast, Brown argued that stimulating the clitoris was not a malady in and of itself, but only in a 'nymphomaniac' or recidivist could it affect the development of the brain. Carol Groneman writes "Nymphomania is variously described as too much coitus (either wanting it or having it), too much desire, and too much masturbation. Simultaneously, it was seen as a symptom, a cause and a disease in its own right" (340). Dr. John Tompkins Walton had a case in 1856 where the patient possessed a "lascivious leer of the eye," "contortions of the mouth and tongue," and admitted to having an "insatiable sexual appetite" (50). Walton traced her nymphomania to an abnormal cerebellum and subjected her to cold hip baths and applied leeches to her perineum. He corroborated Maudsley and Holmes-Coote's opinion that masturbation occurred exclusively in women who already suffered from hysteria.

<15>As opposed to his detractors, Brown postulated that the need to masturbate was a physiological need, like the need to urinate and did not originate in sexual desire at all. He operated only on women who came to him with complaints of "constant," "incessant," or "great restlessness," "heaviness," and "irritation" of the genital region. Brown began by looking for "physical evidences of derangement" in his patients (Brown 16). Case 1 was brought to Brown's operating table simply because of her pale face and attenuated body. Case 38 was completely healthy until a "severe fright" activated her epilepsy and headaches (61). But it remains clear in the monograph that excessive masturbation was the cause, not the consequence of hysteria. While Victorian gynecologists drew heavily from neurology to explain pathological behaviors, they also claimed that the relation worked in reverse; excessive masturbation could lead to epilepsy and cerebral disorders:

> On the one hand, neurologists, anatomists, phrenologists, and others looked for the cause of nymphomania in the brain. Their attempts to establish somatic causes in cerebral lesions, changes in the brain's blood, a thickening of the cranial bones, or overexcited nerve fibers generally came to naught […] On the other hand, especially in the second half of the nineteenth century, the relatively young and growing medical specialization of gynecology reversed the focus from the brain to the genitals. Diseased ovaries or disordered menstruation, gynecologists argued, could lead to the injury of the nervous system and of the brain and thus to mental illness. (Groneman 348)

By emphasizing this discrepancy in these gynecological theories, Groneman aptly questions whether the connection between female masturbation and hysteria was sustainable at all. If the patient admitted to engaging in repeated masturbation, her testimony was held against her. If the patient denied masturbation, she was subjected

to invasive physical examinations that 'proved' her insanity. It was a testamental double-bind that trapped the hysteric. The confession of her 'secret sin' was a product of medico-legal discourses that forced female masturbation "into hiding so as to make possible their discovery" (Foucault 42).

<16>There are three identifiable categories of patient testimonies in Brown's monograph that he considered to be evidence for a "cognisance" of masturbation. They may be categorised as *prosecutions*, *recommendations*, and *confessions*. The first kind of testimony was presented by friends and family who institutionalized the patient. Their tone ranged from accusatory to anxious, bemused to terrified, and gentle recrimination to outright moral condemnation of the patient's 'deviant' behaviour. Case 44 was an unmarried thirty-four-year-old woman who had "never had an offer of marriage." She was brought by her friends who looked on her behaviour as "strange and eccentric":

> She was vacant and dreamy; talked of flowers which she called her friends; said 'people's faces were masks; that she was quite unable to rouse or employ herself, as she was changed;' very uncertain in appetite, going a day without her food; not sleeping at night, and for the last few nights showing such great excitement and passion, that her sisters were required to sleep with her. […] She sits up in bed, nursing the pillow, and talking to it as if it were a baby; says 'that she died last Sunday' – 'is lost'- 'is buried.' When out of doors, great difficulty is experienced in getting her in again; she wishes to wander away, without aim or purpose. (Brown 72-74)

There is no mention of a physical examination and Brown prints this testimony to show that the patient's hysteria originated in "long-continued reflex excitation." Post the surgery, the patient took almost three months to show a level of improvement that her friends could appreciate, though Brown conceded her incurability "her mental state is, however, weak—what might better be called foolish, with some amount of wilful obstinacy." Another case where the patient was brought by a family member is Case 45. Brown transcribed the mother's complete testimony in his monograph, who committed her seventeen-year-old daughter to the Home in June 1861: "The first night after her return home she went to one of her sister's rooms and began to talk of being married; did not sleep at all that night […]. Was found to be rather wild in the morning; was taken out for a drive during the day; did not sleep that night from constant excitement of the genitals." Brown also examined this patient under chloroform and found that her hymen was absent "In one of her paroxysms she had stuffed a pocket handkerchief into her vagina" (75).

<17>A fifty-seven-year-old woman was committed to Brown's Home by her husband in December 1861 on the recommendation of Forbes-Winslow, who had failed to cure her symptoms of "hysterical homicidal mania." The patient disavowed conjugal intercourse and attacked her husband in bed: "for the last two or three months she has slept pretty well from 10 p.m. till 2 a.m. when she would suddenly wake, and warn him that a "frenzy" was coming on. This frenzy consisted in her rising up, fighting out with her arms, and scratching or tearing any one near her; in the paroxysm the desire was always to destroy her husband." In addition to the husband's prosecution, the patient herself confessed to engaging in masturbation "She owned with great shame to long-continued pernicious habits." In phrases like "wilful obstinacy" or "making herself ill," Brown argued that some patients performed symptoms of hysteria. He recorded the husband's recommendation in the following conclusion: "express his gratitude for the complete restoration of his wife to health; for whereas before his nights were passed in constant fear, rendering his life most wretched, his home was now one of comfort and happiness both night and day" (78-79). This was a unique case study that combined all three types of testimony – the husband's prosecution and recommendation, and the patient's confession.

<18>Brown did not merely gather these testimonies but transcribed entire letters, conversations, and monologues from hysterical patients and their family. At the end of Case 38, Brown reprinted a letter of recommendation he received from the father of an epileptic patient on 15 August 1864:

> Dear Sir, It would be very unkind in me, and much out of place, to hide from you and the world at large what have been my feelings during the past three weeks. My daughter, C.T. came to your Home, Stanley Terrace, Notting Hill, on the 23rd of June last, to be treated by you for epilepsy, or epileptic fits, having been afflicted for three years and a half […] I am happy to say, and acquaint you, that since her return she has not had a single symptom of fit or hysteria of any kind. Her general health is also very good, and fast improving, and I do hope, by the blessing of God, she may continue so. If you have any desire to see her, I shall feel in duty bound to let her wait upon you. (63)

Ironically, this powerful amalgamation of testimonies ended up defusing Brown's phallocentric theory of female desire . For instance, Case 31, a fifteen-year old girl who joined Brown's Home in September 1861, was so sensitive to "nervous excitation" that "if any one merely touched her bed, or walked across the room, she would immediately be thrown into the cataleptic state." The monograph described that "Before making any personal examination, Mr. Brown ascertained both from

the mother and herself, that she had long indulged in self-excitation of the clitoris, having first been taught by a school-fellow" (52). The mother's allegation thus became a 'fact' and did not necessitate an empirical examination of the patient's body. But Brown's testamental symptomatology was effective only insofar as it was a Faustian pact with the witness. The mother's testimony deconstructed Brown's main hypothesis that the clitoris was irrelevant to female desire. If the patient learnt to masturbate from a friend at school, clearly the itch was not "involuntary." Through these testimonies, Brown inadvertently unearthed an underground economy of female desire where women in intimate spaces could 'infect' each other.

Fiddling fingers and restrung 'fiddles'

<19>The prosecution-recommendation model of evidence that Brown furnished in his monograph was not collected from the patient's friends and family alone. A nurse who presided on the post-operative care of Case 44 also gave her recommendation in a brief testimonial. She claimed that the patient had improved after the surgery and compared the change in her mind to "dividing the tightened strings of a fiddle, and letting them all loose" (Brown 74). This statement must be examined carefully because the metaphor employed is rich with ambiguity. The ravings of a hysterical patient that Brown's nurse witnessed on a daily basis, reminded her of an impaired instrument. According to her, the clitoris – being the tightly wound "strings" of the female body – became cacaphonous when rubbed excessively. The nurse validated Brown's procedure by stating that he had converted discordant hysteric bodies into mellifluous 'feminine' bodies. After two months of rehabilitation, the nurse noted how Case 44 left Brown's Home perfectly 'restrung' "She has gradually improved and become more natural in her habits and ideas; sleeps soundly every night; takes her meals well; walks about without compulsion; takes a pride in making herself neat, and has washed and dressed herself ever since she left her bed, is perfectly modest in manner and conversation" (75). Instead of tracing hysteria to cerebral deformity like Holmes-Coote and Maudsley, the nurse viewed hysteria as a performance of what Felman identified as "feminine difference" (8).

<20>In her classic study of hysteria *The Knotted Subject: Hysteria and its Discontents*, Elisabeth Bronfen invokes the same metaphor as Brown's nurse, of the hysteric as a tightened or "knotted" subject who presented "a nosological enigma" to Victorian doctors "What makes the metaphor of the knotted subject so compelling to me is precisely that it allows one to move beyond a notion of the subject as exclusively constructed by representations […] even as it doesn't deny the supremacy of symbolic inscription" (xiii). Bronfen calls hysteria "that infamously resilient somatic illness without organic lesions" (xi). If the patient could not confess

in comprehensive medical terms, nonetheless, her "parody of psychosomatic illnesses" was classified as hysteric behaviour. She writes that "hysteria and medical discourse are mutually constitutive" and worked together to produce a knotted female subject in the nineteenth century. Brown tried to unravel this subject through clitoridectomy to render it compliant. But it seems that his own evidentiary insistence on testimonies became his undoing. Instead of a wretched victim who needed to be rescued through surgical 're-tuning,' Brown stumbled upon an intransigent and polymorphously erotogenic female subject that would pave the way for Freud, Breuer, and Charcot's theories of desire. Bronfen states "the language of hysteria forces its investigator to realize he cannot define or identify his subject, and thus it demarcates the limitations of the system of representation that seeks to classify—and also produce hysterical symptomatology" (102).

<21>The women brought to Brown's Home were extraordinarily rebellious. Their confessions broke the bounds of medico-legal testimony and the Foucauldian "incitement to discourse." One confessed to drinking children's blood whereas another attacked her husband in bed "would fly at him and rend his skin, like a tigress" (30). Many of Brown's patients continued to experience sexual desire even after surgery. They could not resist the urge to remove their bandages to pleasure themselves, even at the risk of hemorrhage. Case 45 was found in a state of unceasing masturbation with a "wild expression" on her face and referred to her mother and father as "Monsieur le Diable and "God" (70). A fascinating term that these patients use repeatedly to articulate their hysteric subjectivity is "lost." It recurs in many of the patient testimonies that Brown published in his monograph "if I am not dead, I am lost, or changed," (73) "constantly declaring that her soul was irrevocably lost," (78) and "I have lost my brain" (81). What did these women believe they had lost? How did their hysterical symptoms fit into phallocentric concepts of the woman as the Other? Incurability was nothing more than medical shorthand for the inscrutability of female desire and subjectivity. Therefore, Felman's question "how can one speak from the place of the Other?" in this context, applies not to the violent ravings of a mentally challenged patient but to the voice of the quintessentially desiring Victorian woman. Brown's erotogenic female subjects may be seen as inspirations for Freud's theories of "polymorphous perversity," "psychic hermaphroditism," and "penis envy" in women (Shuker, Levinson, et.al. 2017)

<22>A case that stands out in Brown's monograph is patient 47 – a twenty-three-year-old Irishwoman, who was committed to Brown's center by a friend. Although she had prosecuted the patient, her friend expressed hesitation in the letter to commit "so young a creature in an asylum." She justified her decision by informing Brown that "she made several attempts to injure herself and me" (82). In one of the

lengthiest and most complex case studies published in the monograph, we witness the discursive battle between what Felman called "objective data" and "subjective testimony" (8) in the construction of the hysteric's narrative. Soon after she was committed on 6 February 1864, the Irishwoman suffered from paroxysms and attacked the presiding nurse: "Was seized with a fit, throwing her arms up over her head, and then appearing as if comatose. In about 20 minutes revived: the lips began to quiver, and she gradually became conscious, saying "I want a knife—I want blood!" She asked for the matron's hand that she might bite it off" (80). When Brown visited her in the evening, she lunged and attempted to dislocate his shoulder. This is the only instance in Brown's monograph where a complete post-operativeself-diagnosis is given by the patient:

> Last March, instead of sliding down a slope, I jumped. This caused displacement of my womb. I suffered great agonies. I was fomented with hot water. I thought it was my back that hurt. Since then I have been subject to fainting and weakness. I suffer great irritation about my private parts— cannot keep my hands away. The irritation is worse at night. I am obliged to relieve the irritation by rubbing— sometimes for two or three minutes at a time. There is always a discharge. I feel very depressed afterwards. At times I have lost my brain, and felt as if I did not care for living. I would like to have my hands untied; I will be very quiet. Have been separated from my relatives for three years. I shan't tell you how long I have been married — (a pause). I am very rude— I beg your pardon. I have been married three years. I had a baby two years ago: it was not born at the full time—I think five months. I don't know whether it was alive. I left home with my friend when I was sixteen (?). It is two years since I left him. I am now twenty-three. After the accident, suffered great pain." Mr. Brown here looked at her gums, and she immediately said, "Oh yes; I had mercury given me by Surgeon _____, in Dublin: he said it was my spine. He did not examine my womb. Dr. _____ examined it, said there was great displacement. I have been better for treatment at times. My brain has been affected. I have fought very much. I have wanted a child's blood. I have had it sometimes by sucking the wounds of a child. When in a fit, I don't know what is going on around, or what is being said, but I recognize people's voices. I am not regular. Was kept in bed last September for six weeks for flooding; was so for ten days after I was put in bed. Was the same in Paris last year. I was studying in Paris to fit myself for a governess. (Brown 80-81)

This elusive portrait of female desire serves as a valuable corrective to Brown's phallocentricism and prefigures the psychic universe of Freud's iconic case studies like Dora.

<23>Although it is recorded through the filter of Brown's voice, the Irishwoman's self-diagnosis challenges Brown's de-eroticized clinical vocabulary relating to the clitoris. This powerful testimony functions as a "hysterical mise-en-scène of desire" (Bronfen 153) by providing a solemn picture of the many restrictions that Victorian women faced. Unlike the epileptic or cataleptic woman who displayed one form of compliance or other, the Irishwoman presented an unyieldingand incurable female subjectivity. In line with existing obstetrical theories of hysteria, she traced the etiology of her 'madness' to a physical dislodging of her uterus that 'caused' her brain to be "affected." Brown's influence on her testimony may also be detected where the Irishwoman claimed that her hysterical symptoms originated in a habitual "irritation about my private parts." The confession of her desire to drink the blood of a child makes her a textbook study of hysteria but paradoxically renders her testimony so overdetermined in its sheer variety of illegitimate desires and perversions that it seems medically unconvincing, even poetic.

<24>The Irishwoman's body in Brown's monograph is also abundant in physiological signifiers of "abnormal hypertrophy" that become as overdetermined as the 'abnormality' of her confession. In his empirical examination and diagnosis of this patient, Brown is most detailed. First, he noted that the patient had been pregnant in the recent past and given birth to a child out of wedlock: "Externally, the abdomen showed signs of a child having been born, and the mammae had certainly contained milk" (80). Then, Brown noted the tell-tale "enlarged and hard" clitoris, "long and flabby" nymphae, and discolored vaginal mucus. Note how Brown employed the words "enlarged," "hard," and "swelled" to describe the "deviant clitoris." The routine swelling of the male penis during sexual arousal was compared to the "abnormal hypertrophy" of the clitoris in a hysterical patient (68). The phallocentric misconception that 'normal' women did not experience sexual arousal in the same manner or degree as men, validated itself through countless such medical tracts in the nineteenth century. Moscucci writes that "abnormal hypertrophy" or "clitoral enlargement common in black races and prostitutes" was regarded as abnormal in Victorian gynecology so much so that "By the late eighteenth century, the so-called "Hottentot apron" had come to be regarded as an emblem of the lascivious, ape-like sex appetite attributed to Black women" (Moscucci 70). A 'phallic' clitoris became the locus not only of multiple points of mental disorder in women but also the platform for an elaborate Othering of female desire as 'hysterical,' 'pathological,' 'masculine,' non-Christian, and non-white. These diverse signifiers merged to produce one brilliantly precise image of the hysteric in the nineteenth century. Hysteria was nothing but shorthand for "feminine difference" – a powerful wilful female subject who engaged in non-procreative, wild, and

imaginative self-pleasure … whose very existence challenged medico-legal discourses of female desire.

<25>Through a written testimony from his colleague Warren Diamond, Brown encountered another patient whose hysteria manifested in a desire for constant pleasure "When friends called, would start up and run round the garden, or to the top of the house and back again, giving no reason for it but that she must do it. Always exceedingly irritable and passionate. Unless some excitement was going on, was listless and unable to rouse herself" (Brown 72). Laced with various literary performatives of hysteria, the Irishwoman may be called "a hysterical phantasizer par excellence":

> she not only behaves like a foreign body once she has left the familiar confines of the convent but the sense of strangeness she experiences and imparts to her peers acts as a materialization of the phantasy scenarios that inhabit her inner mental theater. In other words, Adeline's hysteria entails converting into physical symptoms the dissatisfied desire wandering within her psychic apparatus, with this psychosomatic articulation. (Bronfen 155)

Her polymorphously perverse narrative invokes the excessive, emotional, and inarticulate voices of fictional hysterics like the Brontë Sisters' heroines Catherine Earnshaw and Bertha Mason (perhaps even Jane Eyre, who also 'fit' herself for the position of a governess), Anne Radcliffe's Adeline, or Bram Stoker's bloodthirsty Lucy Westenra. The final flourish of the Irishwoman's 'perverse' testimony, however, that has not received adequate critical attention was a "fissure of the rectum" that Brown discovered in his physical examination of her as well as countless other 'incurable' cases. The excision of the clitoris was what Brown became infamous for, but his accompanying "division" or correction of rectal fissures was overlooked completely in the Obstetrical Society's report.

<26>At this juncture, it is worth highlighting that many of Brown's patients masturbated not just by stimulating their clitoris, but through vaginal and anal self-penetration as well. Recall Case 45 who broke her hymen by stuffing a pocket handkerchief into her vagina and others that complained of painful bowel movements. A rather enriching field of questions regarding female desire opens up through Brown's discursive silence on rectal fissures. Not once did Brown use popular anathemas like 'sodomy' to argue that rectal self-penetration could also produce hysteria. The words "satyriasis," "hyperesthesia," and "priapism" were in fact, quite popular in Victorian discourses on male masturbation, homosexuality, and practices of sadism. Krafft-Ebing proposed the term "oxyuris" to delineate an

"infestation of the rectum and the vagina" in his 1886 work. But no such comparative terms occur in Brown's monograph. Despite the evidence before him, Brown remained within the ambit of inhibitory theories of nervous exhaustion centred on the clitoris. To recognize that the female orgasm – and by consequence, hysteric symptoms – could originate from multiple sources, to admit openly that his patients incontrovertibly 'fiddled' all over their bodies, would require admitting to the Council of the Obstetrical Society that all of his patients were 'incurable' … and indeed perhaps, they were.

<27>A parallel study of clitoridectomy practices in the American gynecological circles of the nineteenth century casually mentions the surgical division of rectal fissures to cure various forms of "neurasthenia" in women. The Chicago-based homeopath and physician Edwin Pratt published a monograph *Orificial Surgery and its Application to the Treatment of Chronical Diseases* in 1887 in which he recommended surgical interventions on the rectum, circumcision, as well as the removal of the hood of the clitoris, and even hysterectomy to cure masturbation and insanity in female patients. Congruent to Brown, Pratt claimed in his monograph:

> In all pathological conditions, surgical or medical, which linger persistently in spite of all efforts at removal, from the delicate derangements of brain-substance that induce insanity, and the various forms of neurasthenia, to the great variety of morbid changes repeatedly found in the coarser structures of the body, there will invariably found more or less irritation of the rectum, or the orifices of the sexual system, or of both. In other words, I believe that all forms of chronic diseases have one common predisposing cause, and that cause is a nerve-waste occasioned by orificial irritation at the lower openings of the body (14).

However, like Brown, Pratt espouses the reflex theory of orificial irritation and removes volition completely from the equation of female desire and hysterical symtoms. Paige Donaghy's work on seventeenth-century discourses of female masturbation is useful in this regard. By constrasting older models of medical and popular knowledge with Victorian theories masturbation, circumcision, and clitoridectomy, Donaghy draws attention to a long tradition of shared desires and intimate vocabulary among women that medical professionals like Pratt and Brown rediscovered in their research, but refused to concede as being volitional . Donaghy removes hysteria from the equation completely and reveals that the link between desire and madness was a product entirely of eighteenth-century medical texts like *Onania*. By so doing, she diversifies the definition of female masturbation to include other acts of non-procreative wilful pleasure such as rubbing the breasts,

night-pollutions, fantasies of lactation, stimulating the clitoris, self-penetrating the vagina and rectum. Donaghy clarifies from the outset "I use the term "masturbation" throughout this article to denote acts or practices resembling self-pleasure, not necessarily limited to the use of one's hand to stimulate the genitals" (188). By working through a range of non-medical but equally relevant sources like midwifery accounts, folk ballads, personal accounts, erotica and lewd poems, and religious tracts, Donaghy argues that seventeenth-century doctors in England had a far more comprehensive understanding of female desire. They recognized the erotic role of the clitoris and the presence of multiple erogenous zones in women, ranging from clitoral stimulation to anal self-penetration.

<28>The fear surrounding unbridled lust in women was mostly restricted to seventeenth-century religious tracts on puberty and accidental emissions that occurred at night. It was the degree of culpability that mattered most, whether the patient had indulged knowingly in an act of self-pleasure or not. Brown observed that majority of his patients either performed or ventriloquized hysterical symptoms to remain 'unwell' "will always be ailing, and complaining of different affections and often a great disposition for novelties is exhibited, the patient desiring to escape from home" (Brown 15). Perhaps, the main issue with his approach was that while hovering so close to the psychological, he remained stubbornly within the ambit of the gynecological. What carries forward from Victorian gynecology into modern psychoanalysis therefore, is a kind of "erotophobic" discourse of female desire. By way of conclusion, George Rousseau definition of "erotophobia" is helpful for this discussion on multiple erogenous zones and hysterical performativity in Victorian gynecological discourses:

> Erotophobia then: approximate to Europhobia, xenophobia, homophobia, and the many other phobias clamping down on our regulatory generation. The force of the word lies in the second root — phobia: an unnatural fear, a repulsion, not merely a benign dislike or gentle recoil. Erotophobia: in the longue durée, no culturally sanctioned mass hysteria developing over several centuries, despite cyclical peaks and valleys, based on the terror of sexual involvement. Hence the phobic basis of the hysteria (3).

Moving away from this erotophobic bias in medical discourses of hysteria, certain female doctors of the period like Mary A. Spink held the lack of education, well-defined ambitions and narrow domesticity to be causes for this "irritation" and "restlessness" in middle-class women. Jane Austen's Anne Elliott also attests to this "restlessness" when she ruefully admits "It is, perhaps, our fate rather than our merit.

We cannot help ourselves. We live at home, quiet, confined, and our feelings prey upon us" (367).

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