

THE WONDERFUL “O”

OR, A SHORT HISTORY OF HYSTERIA

Hysteria. It is one of the oldest diagnostic terms in medicine. The condition it describes first appears in an Egyptian medical papyrus from about 2000 BCE, noting peculiarities in female behavior that were ascribed to a wandering of the uterus, causing disturbance and distress throughout the body. The ancient Greeks gave it its modern name, derived from the Greek *hystera* (“womb”), and in the 4th century BCE, Plato further developed the somewhat horror-film notion of an under-stimulated uterus going rogue and roaming at large through the system in search of satisfaction: “The animal within [women] is desirous of procreating children, and when remaining unfruitful...gets discontented and angry, and wandering in every direction through the body drives them to extremity, causing all varieties of disease.” Galen, the great 2nd century physician, rejected the idea of the wandering womb, but observed that hysterical symptoms appeared more often among virgins, nuns, widows, and unmarried or unhappily married women, concluding that the condition was a result of sexual deprivation; abstinence or frustration, he theorized, led to a toxic accumulation of vapors in the uterus that affected physical and mental well-being.

All the ancients agreed that the most effective treatment was external pelvic massage to lure the vagabond womb back to its proper place or to encourage the congesting vapors downward and clear the system. The prescription in medieval and renaissance medicine was intercourse for married women, marriage (and intercourse) for unmarried women, or as a last resort, massage by a midwife. Sneezing, vigorous outings on horseback, and prolonged sessions in a rocking chair were also considered viable alternatives.

Over the ensuing centuries, the clinical definition of hysteria expanded to include an ever-lengthening list of female complaints and behaviors: anxiety, surliness, faintness, nervousness, insomnia, fluid retention, restlessness, heaviness in the abdomen, muscle spasms, shortness of breath, irritability, loss of appetite, inability to climax during intercourse, erotic fantasies, an urge to

masturbate, depression, heart palpitations, headaches, weepiness, confusion and a general “tendency to cause trouble” – in short, almost any female behavior that

men found bewildering or irritating.

To a modern understanding, the “symptomology” clearly describes various physical and psychological conditions occurring in a healthily sexualized woman, including the normal hormonal cycle, PMS, post-partum depression, and sexual frustration. But by the late 1800s, when Sarah Ruhl’s *In the Next Room, or the vibrator play* takes place, the catalogue of “hysterical symptoms” was 75 pages long and still growing: normal female sexuality transformed into a pathology by a social context in England and America that was in every respect, including in the bedroom, based on the superiority of the male.

In the latter half of the 18th century and the early years of the 19th, things had been very different. While they had never enjoyed social or political parity with men, there had been an acknowledgement of equality for middle and upper class women in certain

respects. A lively wit and nimble intellect were admired and appreciated in a woman. Depending on her social status, a woman could, in fact, become a significant offstage political force as a hostess and as an influence on her husband and the powerful men in his circle; and she was welcomed as a full and enthusiastic participant in sexual relations, which were viewed as a healthy and natural activity among consenting partners. So-called “marriage manuals” of the time display an exuberant relish for the erotic pleasures a man and woman might enjoy together. This was the era of Henry Fielding’s rowdy, romping *Tom Jones* (1749), Lawrence Sterne’s ribald *Tristram Shandy* (1765), and the extraordinary correspondence between a husband and wife who clearly shared a full and equal partnership in every sense, John and Abigail Adams.

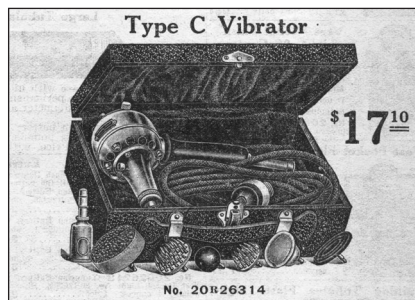
But the pendulum swings to the left, the pendulum swings to the right, and the late 1820s saw the beginning of a shift in the socio-sexual paradigm towards what Dr. Rachel Maines, in her fascinating book *The Technology of Orgasm*, calls “an androcentric model”: an institutionalization



BY MARGARET LAYNE

of the centrality and superiority of the male physically, mentally, politically, socially, and of course, sexually. In this androcentric world, where women had been recast as pure and passive domestic helpmeets – “The Angel in the House,” as one popular poem had it – the deck was stacked against their sexual self-realization in almost every way. “Real Sex” was defined solely as the act of male penetration and orgasm. Women were not thought to possess sexual desire or to experience sexual pleasure; innocent of the primitive urges that drove the male, they nobly endured the animal attentions inflicted on them by their husbands in order to achieve the one thing they did desire above all else: motherhood.

“I should say that the majority of women...are not very much troubled with sexual feeling of any kind,” wrote the distinguished physician William Acton in 1857. “What men are habitually, women are only exceptionally...There can be no doubt that sexual feeling in the female is in the majority of cases in abeyance, and that it requires positive and



knowledgeable and risk her reputation as a “nice woman.” Men, for their part, were taught to respect their wives and show sexual restraint towards them, discharging their husbandly duties as quickly and efficiently as possible, preferably in under five minutes, in order to spare their spouse’s tender sensibilities and not expend too much valuable male life force. (There was a prevailing belief that an ounce of semen equaled more than a quart of blood; too much marital sex could lower a man’s life force to dangerous levels and expose him to weakness of the brain, disease and premature death.)

Add to this discouraging scenario the statistics compiled later in the 20th century by sexual researchers like Alfred

Kinsey and Shere Hite indicating that at least 50% of women, and possibly as many as 70%, require some value-added activity in order to reach orgasm. Add as well the fact that Victorian women were discouraged from taking matters into their own hands, so to speak, both for religious reasons (onanism, as it was called, was considered a sin) and for medical

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considerable excitement to be roused at all; and even if roused (which in many instances it never can be) it is very moderate compared with that of the male.” In other words, a free pass for the male partner to not expend energy on a futile task. The female’s alleged indifference to sex was, the argument went, naturally ordained to preserve the male’s vital energies.

It had, of course, been observed that some women did experience both pleasure and release during intercourse, which presented a challenge to the notion that they were without the capacity for sexual pleasure, but the medical establishment was ready with an explanation: a wife who appeared to be enjoying sex was not showing pleasure in the act, but in the anticipation of pregnancy and motherhood that would result.

So let us consider the sexual situation of middle and upper class women in the U.K. and the U.S. at this time. Most came to their wedding night entirely unaware of the mechanics and potentialities of their own bodies and with virtually no idea of what was about to happen, which meant that unless they were very lucky in their new husband, what did happen would not have been very far from rape - hardly a felicitous introduction to the joy of sex. Even a woman who was fortunate enough to share a physical attraction with her husband still had to tread very carefully into the arena of sexual pleasure lest she appear to be improperly

ones: it could lead to sexual mania and cause them to make unreasonable sexual demands on their husbands. Small wonder, then, that by the early 1900s almost three-quarters of the female population in Britain and America was thought to be suffering from some form of “hysteria” – or, as we might describe it now, profound orgasm deficit.

In a male-dominated sexual world, the female orgasm was considered incidental to successful male climax and not as a thing unto itself which could in fact be achieved *without* penetration, or indeed the participation of a man at all. Husbands by and large felt no interest in or responsibility for their wives’ sexual satisfaction, and so the task of relieving women’s frustrations fell to doctors. Such treatment was not perceived as sexual, suspect, or perverse: it was a medical therapy, performed in a doctor’s office by medical personnel, to treat a medical condition. And, since sex meant penetration, and only penetration could create sexual gratification in women, where no penetration occurred there was no sexual component and, *voilà!*, the resulting paroxysm was not an orgasm.

It is important to note that most Victorian doctors treating women’s complaints were not charlatans; they genuinely wanted to relieve the obvious distress of their patients. Some even suspected that women might experience sexual pleasure differently and on a different timeline than men. However, the understanding of what

caused “hysteria” had not advanced much beyond Galen’s congestive theory of 2000 years earlier – and the most effective treatment remained external pelvic massage to create an “hysterical paroxysm.” Fortunately for the doctors’ income, this was only a temporary fix and required repeated office visits to maintain its positive health benefits.

The problem with this was that it was tedious, tiring and time-consuming; many doctors delegated the task to their nurses, or to midwives. Rachel Maines suggests that the universal complaints about the time issue, coupled with the uniform failure of these doctors to identify the resulting restorative paroxysm as what it so patently was, implies that they had never actually induced or observed an orgasm in their own sexual partners. More probably the difficulty was that there was so little detailed understanding of the female anatomy, or of where the true seat of the female orgasm was located; successful “treatments” were likely achieved more often by accident than by design.

At this challenging juncture, enter Dr. Joseph Mortimer Granville, a British physician who invented the first electrical massage device for the treatment of joint and muscular ailments. Granville did not intend his invention for the treatment of hysteria, and in fact advised against it for fear of its creating onanistic tendencies in female patients, but gynecological doctors immediately saw its potential: it required no physical effort to use, offered more targeted treatment, and got much quicker results, so that more patients could be treated (and charged for it) in a day’s work. Within 15 years of Granville’s innovation, more than a dozen manufacturers were producing electrical and battery-operated vibrators in all shapes and sizes for professional use: vibrators that hung from the ceiling, foot-pedal vibrators, oscillating vibrators, counterweighted vibrators, table-top vibrators, floor models on rollers, portable devices that fit in the palm of the hand, and, in a particular burst of whimsy, vibrators that played music.

As the technology advanced, smaller and smaller vibrators were invented that could be used for less expensive self-treatment in the home. In 1902, Hamilton Beach patented the first electrical vibrator for retail sale. Only the fifth domestic electrical appliance on the market, it arrived, in an interesting commentary on consumer priorities, just behind the sewing machine, the fan, the tea kettle and the toaster, and about ten years ahead of the vacuum cleaner and electric iron.

For the next two decades, personal vibrators were marketed freely as health and relaxation aids in such

respectable periodicals as *Needlecraft*, *Home Needlework Journal*, *Modern Women*, and *Woman’s Home Companion*.

The ads usually featured a young woman seated at her vanity, with the tip of her vibrating device placed coyly against her chin or her cheek. Accompanying copy was similarly ambiguous, but everyone knew what was really being advertised: “All the pleasures of youth will throb within you!;” “For the good of your family!;” “Makes you fairly tingle with the joy of living!;” and, in a rather more direct pitch from *La Vida*, “It is the rapidity of the action, not the force of the blow, that produces the

most successful results.” Even the hardy Sears & Roebuck Catalogue of Electrical Goods for 1918 had a versatile model on offer designed for the post-war multi-tasker: it came as part of a set of attachments for a home motor that also operated an electric mixer, an egg beater, a grinder, a buffer, an electric fan, and in a piece of subliminal advertising that should win some kind of retroactive prize, a butter churn.

By the 1920s the careful and tacitly understood social camouflage of the vibrator began to fall apart as physicians’ understanding of women’s sexuality evolved and as the devices began to appear in a purely sexual context in “stag films” which made their identity as sex toys explicit and associated them with the loose moral fiber that would shortly be

giving the Hayes Office fits. For almost four decades they went “underground,” only reemerging in the 1960s, freed of any association with medical treatment and coming into their own as sex aids. In 1976, sexual counselor Joani Blank published *Good Vibrations: The Complete Guide to Vibrators*, and the following year opened her San Francisco store of the same name devoted to the vibrator, now in several locations. Blank’s substantial collection of antique vibrators is often on display. Blank acknowledges that she has tried most of them out, and all of them still provide the same satisfaction as their contemporary descendants, although “some of them are noisier and shoot off sparks and stuff. So you have to be careful with them.”

Note: The American Psychological Association officially deleted Hysteria from its list of psychological diseases in 1952. As of 2007 there were still seven states where it was illegal to buy or sell vibrators. It is still illegal in Alabama.


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