EDITORIAL

A comparison of 19th century and current attitudes to female sexuality

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(Received 21 June 2007; accepted 26 September 2007)

Abstract

The 19th century medical attitude to normal female sexuality was cruel, with gynecologists and psychiatrists leading the way in designing operations for the cure of the serious contemporary disorders of masturbation and nymphomania. The gynecologist Isaac Baker Brown (1811–1873) and the distinguished endocrinologist Charles Brown-Sequard (1817–1894) advocated clitoridectomy to prevent the progression to masturbatory melancholia, paralysis, blindness and even death. Even after the public disgrace of Baker Brown in 1866–7, the operation remained respectable and widely used in other parts of Europe. This medical contempt for normal female sexual development was reflected in public and literary attitudes. Or perhaps it led and encouraged public opinion. There is virtually no novel or opera in the last half of the 19th century where the heroine with ‘a past’ survives to the end. H. G. Wells’s *Ann Veronica* and Richard Strauss’s *Der Rosenkavalier*, both of which appeared in 1909, broke the mould and are important milestones. In the last 50 years new research into the sociology, psychology and physiology of sexuality has provided an understanding of decreased libido and inadequate sexual response in the form of hypoactive sexual desire disorder. This is now regarded as a disorder worthy of treatment, either by various forms of counseling or by the use of hormones, particularly estrogens and testosterone.

Keywords: Nymphomania, hysteria, clitoris, clitoridectomy, masturbation, orgasm, testosterone, genital mutilation

In medieval times people feared three things: the devil, Jews, and women. Female sexuality was a particular source of anxiety for men, an anxiety which continued until the beginning of the 20th century. Wilmot in 1775 translated from the French the book *Nymphomania, or the Furor Uterinus, clearly and methodically explaining the different causes of that horrible distemper* [1], which outlined the dangers to women and society from this serious medical disease. Details of female anatomy and function seem to be surprisingly well informed for the period, but it is the condemnation of a normal robust sexuality which seems eccentric to us today. We are told that female sexuality is a serpent that is secretly guided into the heart. Goethe, writing about syphilis around the same time, uses similar imagery, demonizing the disease as a beast and warning of ‘a serpent which lurks in the loveliest of gardens and strikes us at our pleasures’. The word ‘garden’, as in the title of Sir Richard Burton’s translation of the Arabic erotic work, *The Perfumed Garden* (1886), was a contemporary euphemism for vulva.

In the last half of the 19th century, the female disorders of nymphomania, masturbation, moral insanity, hysteria and neurasthenia were universally believed to be a serious threat to health and life, and were considered to be the result of reading inappropriate novels or playing romantic music. This was also the case with what was called ‘menstrual madness’ and insanity, the history of which is reported elsewhere [2]. They were diseases which required radical cure. Menstrual madness was dealt with by laparotomy and bilateral ‘normal ovariotomy’ but Charcot, with his public demonstrations of hysteria in women in the 1870s, emphasized his belief that most mental disease in women resulted from abnormalities or excitation of the female external genitalia [3]. These clinical tutorials were very well attended by scores of men, who witnessed in pornographic detail the role of the vulva and clitoris in the causation of hysterical attacks in Charcot’s young and attractive patients. Charcot’s pupil, Sigmund Freud, who attended these demonstrations at La Salpêtrière for 5 months, repeated this...
fashionable view in his writings and lectures while also stressing the effect of the mind on gynecological and mental disease [4]. There is good evidence that Freud even modified his case histories – excluding the realities of deviant sexuality and sexual abuse and replacing them with sexual fantasies [5] which would be much more acceptable to the Viennese upper middle class who were his audience.

There was also the clear belief that masturbation led to a series of disasters progressing through insomnia, exhaustion, neurasthenia, epilepsy, moral insanity, insanity, convulsions, melancholia and paralysis, to eventual coma and death. Charles Brown-Séquard, the founder of modern endocrinology, added blindness to this list of penalties [6]. This clinical entity was known as ‘masturbatory melancholia’ or ‘masturbatory paralysis’. Even the usually sound Lawson Tait stated in 1889 that the evils of masturbation had been greatly exaggerated, although he had seen epidemics of ‘this vice’ in girls’ schools. If it persisted, the child should be taken into care [7].

The irrepressible physician Colombat d’Isere, who had already shocked his contemporaries by suggesting that young women should have a tepid bath at least once a month, confirmed the danger of the child. He published in 1866 a short 90-page book on the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy and Hysteria in Females [12]. This caused one of the biggest medical rows of the century and was perhaps the most famous publication resulting in professional suicide in the history of medicine. Before publication, Baker Brown had been held in high repute, but within a year he was ruined.

Because the clitoris was widely understood to be an important source of disease, Baker Brown believed that clitoridectomy was a cure not only for nymphomania and masturbation but also epilepsy, catalepsy, painful periods, heavy periods, depression, insanity, hysteria and dementia. In his book, he did not use the word masturbation, preferring the term ‘peripheral excitement’, the euphemism always used by the experts of on this subject, including Brown-Séquard [6].

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An example of this usage occurs in a case from Baker Brown: ‘there was evidence of peripheral excitement. I performed my usual operation and the patient made a good recovery. She remained quite well and became in every respect a good wife’. Baker Brown’s interpretation of this case is worth noting: ‘the illness’ was her desire to obtain a divorce under the new divorce act of 1857. On another occasion, he performed a clitoridectomy on a 20-year-old woman because she was ‘disobedient to her mother’s wishes, sent visiting cards to men she liked and spent much time in serious reading’.

A typical non-sexual indication was in case XVI [12]:

Has never been strong but 5 years ago had an attack of gastric fever and since then has suffered constantly from great pain during the menstrual period, occasionally loses a great deal and passes large clots of blood. During this time has suffered almost constantly from leucorrhoea, suffers severely from pain over the region of the left ovary and in the spine. Is hardly ever free from headaches, is very restless, never sleeps well, frequent faints, has little or no appetite, all her ills are exaggerated at the menstrual époque. August 7th usual operation performed. September 1st is menstruating without pain. September 30th is...
again menstruating without pain and in normal quantity. Is to be discharged cured.

Readers will note the long period of hospitalization in Baker Brown’s private clinic and a very short duration of follow-up before claiming success for his procedure.

His book produced criticism from the Lancer and the British Medical Journal and unrestrained hostility in the London Times. Within a year Baker Brown was expelled from the London Obstetric Society after a fierce debate led by his professional rivals. This meeting was notable for being fired by commercial jealousy as much as disapproval of his surgery. Baker Brown’s downfall was complete when he resigned in the same year from the London Medical Society where he served as President.

He died in 1873, in penury and suffering from incurable paralysis. The autopsy was allegedly performed by his professional rival, Lawson Tait (although no primary source can be found to substantiate this claim). Lawson Tait pronounced that Baker Brown had the cerebral softening of advanced neurosyphilis. It is tempting believe that this gifted and pioneering surgeon, who is now remembered only because of his advocacy of clitoridectomy, had this aberration later in life because of the behavioral disorder of cerebral syphilis. Or perhaps the temptation to unfairly stigmatize a rival even in death was irresistible to Lawson Tait. This is unlikely, however, as it is clear from a publication 20 years later that Lawson Tait had some respect for the second best ovariologist who, in his view, did not deserve his disgrace [13]. We are told that although semi-demented epileptics were habitual masturbators, the mistake of Baker Brown was ‘jumping over two grave omissions in the syllogism and putting the cart before the horse, he arrived at the conclusion that the removal of the clitoris would stop the pernicious habit and therefore cure the epilepsy’ [13].

But the practice continued in Europe, supported by influential physicians and psychiatrists. Zambaco of Paris reported, in 1882, ‘masturbation and psychological problems in two little girls’, one aged 10 and her sister, aged 6 [14]. He reported that neither corporal punishment such as whipping or restraint with straps helped, nor did the threat that excessive masturbation would damage the elder girl’s health and her reputation. Only cautery without anesthesia helped. This was performed by electrocautery, or more effectively by a red hot iron from the coals. This was applied to the clitoris, the vulvar orifice repeatedly, and on one occasion to the buttocks as ‘punishment’. He concluded that one should not hesitate to have recourse to the red hot iron at a very early stage as a cure for clitoral or vaginal masturbation in little girls. The author enjoyed an illustrious career and became a commander of the Legion of Honour. The article was cited by Krafft-Ebing, Professor of Psychiatry in Vienna, who called it a disgusting story not because of what Zambaco did but because of what Zambaco saw [15].

Although Zambaco’s long paper is so shockingly explicit in its inhumanity and pornographic detail, we should not forget the unheeded silent suffering that is still occurring today in thousands of young girls in parts of Africa and the Middle East. We have a long way to go before female genital mutilation in all its forms is consigned to history.

It is interesting to note how literature followed the contemporary prudish and censorious views prevalent in medicine – or perhaps it led the way. Mark Twain, in his A Tramp Abroad (1889) [16], wrote about the exquisite Titian portrait, Venus of Urbino (1538) (Figure 1). She famously adorns the Uffizi Gallery, lying naked with her left hand over her pubic hair. At first sight it may be unclear whether she is being modest or having fun. But to judge from her fingers, curled into her pubis, and the look on her beautiful face, she is clearly teasing her lover, the Duke of Urbino. The erotic nature of this picture has always been clear to art historians. Mark Twain wrote about the foulest, the vilest, the obscene picture the world possesses. It isn’t that she is naked and stretched out on the bed – no, it is the position of her hand. I saw a young girl stealing furtive glances at her, I saw young men gazing long and absorbedly at her, I saw aged infirm men hanging upon her charms with a pathetic interest. How I should like to describe her . . . yet the world is willing to let its sons and its daughters and itself look at Titian’s beast but won’t stand a description of it in words.

Of course Mark Twain loved the picture. His protest was about the limitation imposed on the written word by censorship from publishers and the powerful lending libraries.

In 19th century European literature there is a hardly an example of a female character who has what is called ‘a past’, or who has had an adulterous relationship, who survives to the end of the novel, regardless of the country of origin. The fate of the fallen woman was suicide, murder, or deportation to Australia. It would be reassuring if redemption was one of the options, but no examples come to mind. David Copperfield’s childhood sweetheart, little Emily, is deported to Australia as the result of having been seduced by David’s best friend. In Oliver Twist, the prostitute Nancy dies horribly at the hands of her lover, Bill Sykes, and in another Dickens’ novel, Bleak House, Lady Deadlock – who had a lover and an illegitimate child years before marrying her husband – dies after a 12 hour walk through the
night in the snow. Tolstoy’s Anna Karenina expiates her sins by jumping under a train. And Flaubert’s Emma Bovary dies of arsenic poisoning, as described in horrific detail over many pages. It is said that Tolstoy and Flaubert loved their heroines but were forced by public expectation to end their characters’ lives by such shocking and ghastly deaths.

Similarly, in 19th century opera, all of the heroines with a sexual past die. The most famous and perhaps the first musical description of sexual intercourse occurs in Act II of Tristan and Isolde, which leaves nothing to the imagination. But in this opera, both lovers have to die in the end – like most of Wagner’s wonderful heroines. Wagner the man allowed himself much sexual license – a freedom he does not allow his Brunnhilde, Seiglinde, Kundry and even the Dutchman’s poor Senta, who only makes such a promise. All these heroines succumb to the contemporary need for punishment of female sexuality. The virtuous women like Eva, Elizabeth, Gutrune and the Rhinemaidens live another day. Most of Verdi’s heroines with a sexual history – Aida, Violetta and Gilda – die; although mezzos, who are usually more sinister characters, seem to have a better survival rate than sopranos. Similarly, all Puccini’s heroines with a sexual past – such as Mimi and Tosca – succumb before the final curtain. In contrast, Turandot’s virginity guarantees her survival in spite of her appalling murderous behavior.

Richard Strauss’s Salome (1905) – using Oscar Wilde’s play as libretto – could have been a turning point, as the play is unashamedly sexual. It was banned in the UK until 1908 and was banned in New York for 27 years after a mere two performances. However, the libidinous Salome also meets her end in the final minutes of the opera. Eighteenth century composers were more forgiving. Poppea, one of the most promiscuous women in opera, survived to marry the emperor in both the Handel and Monteverdi account. Agrappina and Calisto thrive, and Don Giovanni’s seduced women survive to witness his descent into hell.

The prudery and hypocrisy of the last half of the 19th century was challenged by artists. Manet’s Déjeuner sur l’Herbe (Figure 2), refused for exhibition in 1863, is now recognized as a masterpiece. Courbet’s graphically gynecological L’Origine du Monde (Figure 3) in the Musee d’Orsay, and the erotic lesbianism of The Sleepers (Figure 4), were both painted in 1866 and probably appear less shocking in these enlightened days than in the artistic world of contemporary Paris. Even the half-naked Salome of Lovis Corinth (1900) (Figure 5) is now allowed to be given a sexual interpretation – inspecting the head of her would-be lover in anything but a biblical pose.

What happened at the end of the 19th century? When did literature, society and indeed medicine catch up with the artists and accept that sex was fun and that fallen women did not have to end up dead or transported? And in the real world, when did enthusiastic female sexuality cease to be a target for demented doctors? Literary colleagues have informed me that the novel Ann Veronica (1909), by H. G. Wells, was such a turning point. Wells was a feminist as well as a futurist, and his headstrong heroine leaves home after her father forbids her to
Masters and Johnson’s four phases of human sexual response in the music. The quotes are not mine or invented but belong to Mann from his classic reference work, *The Operas of Richard Strauss* [17]:

1. **Excitation** – ‘nobody who understands the language of music can misunderstand the meaning of the initial rising horn call’.
2. **Plateau** – ‘the piercing and rising arpeggios that rise higher than expected’.
3. **Climax** – ‘whooping horns rather too soon’.
4. **Resolution** – ‘dawn and birdsong and music of loving contentment and a theme of aching passion’.

Then the curtain is raised to reveal a scene with two scantily clad women in bed. There is no ambiguity here: the young boy Octavian, mezzo soprano, and the older, but very beautiful, Field Marshall’s wife, Marie Therese, the soprano. Sadly, the music tells us that Octavian, in his youthful inexperience, reaches his climax too soon, with the whole sexual episode in the Prelude lasting no more than 53 seconds, in what is a clear musical account of premature ejaculation.

Strauss wrote similar erotic descriptions in *Symphony Domestica* and the Prelude to Act 3 of *Arabella* – but nothing to match the prelude to *Der Rosenkavalier*. It is hoped that the reader will never again listen to this piece without understanding, a smile on the face, and satisfaction in the soul.

In the real world, however, acceptance of the importance of satisfactory orgasmic sexual...
intercourse was slow. Marie Stopes’s *Married Love* (1918) [18] has been listed by Bragg [19] as one of the twelve books that ‘changed the world’. Written by a female doctor falling back on her own painful sexual failures before and after her marriage, it movingly relates the dangers of ignorance, and the
no longer forbidden pleasures that can be achieved with sexual intercourse within marriage. Most publishers turned down the manuscript but eventually it was accepted by a small publisher and became an immediate best-seller. However it was banned in America, where it was first published in 1931. Marie Stopes wrote about the ‘virgin sweetness of women shut in ignorance and these in the pristine purity of an educated girl of the northern race’. She accepts that men are often bewildered by causing pain with intercourse ‘...as he finds restraint and self-control urged on him by books he compensates by working hard and arriving home late in the evening’. She believed that such was the fear of sexuality that several brides resorted to suicide or insanity rather than accept the horrors of the first night. She regretted the notion deeply rooted in society that a woman is lowered by sexual intercourse. Married Love achieved a realization in the community that sex was good, but Stopes deliberately only discussed sexual intercourse within marriage and in early editions did not speak about contraception, miscarriage or even achieving an orgasm without the husband. However, she does seem a little out of date, informing us that even when the woman is ‘strongly sexed with a well marked recurrence of desire it is generally satisfied by fortnightly unions’. She states that the supreme law for husbands is to remember that each active union must be tenderly wooed for and won, and that no union should ever take place unless the woman also desires and it is made physically ready for it.

Kinsey and colleagues in 1953 [20] broke the scientific silence by publishing the controversial Sexual Behaviour in the Human Female, which reported on taboo subjects such as orgasm, masturbation, premarital sex and infidelity within marriage. The public reaction ranged from disbelief and disgust to admiration and gratitude. But at last people were armed with the facts of female sexuality and the work remains the standard text on the subject.

Twenty years later Seymour Fisher [21] devoted a whole book to the female orgasm, discussing the psychology, physiology and fantasy of the event. In his study of 300 women only 39% claimed to always or nearly always orgasm during intercourse, with only 20% stating that they did not need ‘a final push’ for orgasm by manual stimulation. If given the choice, 64% would chose clitoral stimulation rather than vaginal. The Victorians would never have believed it. Not to be outdone, Shere Hite [22], in her extensive use of questionnaires from women, describes six basic types of masturbation in women, each subdivided into five variations. It is unscientific but a fascinating read.

Masters and Johnson’s [23] work on the physiology of Sexual Intercourse in the Normal Female Social Response was a landmark piece of research which has helped women, their partners and medical advisers understand the events of sexual excitement. They brought discussion rather than an embarrassed, silent dismissal of the subject. The researchers initially used prostitutes for the laboratory studies of coitus but had to change to other volunteers as the sex workers were habituated to intercourse without orgasm.

They were able to show the hyperemia of the vulva, the enlargement and erection of the clitoris and the transudation of fluids from the perivaginal vasculature during the excitation phase. This was followed in the plateau stage by dilatation of the upper third of the vagina and the formation of the orgasmic platform in the outer third of the vagina. Orgasm consisted of involuntary contractions of the pelvic and uterine musculature, often accompanied by uncontrolled physical and verbal responses. Resolution was essentially the reversal of these hyperemic changes back to the normal unstimulated state.

Attitudes to the female orgasm have undergone a revolution. The front covers of monthly magazines for women blatantly advertise ‘40 ways to Orgasm this Weekend – How to Achieve an Orgasm Every Time – Would you dare Hire a Male Escort – How to Effectively Perform Oral Sex, With or Without a Condom’. We now recognize the problems of loss of libido produced in relationships and even have a syndrome of hypoactive sexual desire disorder (HSDD) [24]. Sexual satisfaction has now become virtually compulsory, with treatments ranging from psychosexual counseling to hormone therapy with estrogens or androgens.

HSDD is a complex issue, probably made more complex by investigators who subdivide it into sexual desire disorder, sexual arousal disorder, sexual aversion and many other subgroups. The different factors which play a part in female sexual response are physiological, psychological, interpersonal relationships and socio-cultural influences. These are perhaps expressed more simply as Heart, Head and Hormones. Patients understand this.

Finally, there must be a brief comment on the 21st century to see how attitudes to female sexuality have been modified with acceptance of the concept of androgen deficiency [25]. For about 30 years now, there have been a few eccentrics like Greenblatt [26] and Studd [27] who gave testosterone to women for various psychosexual and mood problems. This was in the form of testosterone implants because that was the only preparation licensed for use in women. The clinical response has been impressive, but the treatment for loss of libido did lack scientific confirmation until very recently.

Testosterone is a normal female hormone present at ten times the level of estradiol in young women, but levels begin to decline at the age of 20 years: by the time of the natural menopause there is also a 50%
fall, and a 75% fall after bilateral oophorectomy [28].

The decline in androgen levels contributes to the
decline in sexual desire, arousal and orgasm, and also
has effects on general well-being, energy, mood,
bone physiology and decreased muscle mass, as well
as hot flushes. This is now regarded as female
androgen deficiency syndrome (FADS) [25]. It is no
surprise that FADS occurs commonly after bilateral
salpingo-oophorectomy, but we do not know its
incidence after hysterectomy with ovarian conserva-

It is not rare. Nor is it rare in intact
postmenopausal women, perimenopausal women or
even younger women who have an impaired sexual
response.

There are now gels licensed for men which are
often used off-license in a smaller dose for women,
and at last a testosterone patch has recently received
a license specifically for use in women who have had
a hysterectomy and bilateral salpingo-oophorectomy.

The studies have demonstrated positive effects of the
transdermal testosterone patch on sexual desire,
sexual activity, orgasm, pleasure, responsiveness
and self-image, with a corresponding decrease in
sexual distress [29]. Although there is a tendency to
equate testosterone therapy with a sexual response
measured by increased sexual episodes, libido and
easier orgasms, it is important to realize that there is a
non-sexual component in these benefits. Women
speak of greater self-confidence, greater mental
acuity and less depression, and they even speak
about greater efficiency and communication in
their work. They are also aware of increased self-
worth and state that they behave like wanted women
rather than neglected ones. These non-sexual com-
ponents, although important, are more difficult to
assess in trials and therefore, alas, have not been
evaluated.

This information does leave the question about
who should be treated. Clearly, nearly all women
who have had a bilateral oophorectomy should have
appropriate replacement therapy, which should con-
sist of testosterone as well as the more obvious
estrogen. Now that testosterone is available on-
license for women, it is hard to justify oophorectomy
in premenopausal women without replacement of
testosterone [30]. Although there is no license for
non-hysterectomized women to receive testosterone,
there is no doubt that good, well-experienced doctors
will prescribe testosterone to such women and even
to those who are premenopausal with the appropriate
symptoms. Prescribing ‘off-license’ is controversial,
but it happens.

Testosterone treatment is very effective, with the
potential complications of acne and hirsutism rare if
levels are kept within normal values. After many
years of therapy women often experience a slight
enlargement and increased sensitivity of the clitoris,
but they never complain about it as an adverse effect!

They are happy with the change, or perhaps they wish
to avoid the 19th century attack on the clitoris.

We have come a long way from Baker Brown’s
clitoridectomy as a cure for a young woman’s normal
sexual behavior, but the revolting practice of female
circumcision remains a commonplace cultural re-

requirement in many parts of the world. Even the new
Western vogue of vulvovaginal rejuvenation and
labial trimming – performed in order to look like an
airbrushed porn star, as advertised on more dis-

reputable medical websites – looks backwards to
these customs of female genital mutilation.

In general, we still have a great deal to learn, with
medical history teaching us that many of our beliefs
today will be regarded as eccentric at least, or
perhaps clearly dangerous, in years to come. We
must never forget that we used to bleed for anemia.

Acknowledgement

This paper was originally given as a lecture to The
London Medical Society in 2006.

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