

# Lovesickness

## In search of a discarded disease

Janus Oomen & Woet L. Gianotten

*“There is no medicine for lovesickness” is the message of Jan Steen, master of painting and early visual ethnography, in 1666. In lovesickness “an accumulation of peccant humours would render the body economy seriously diseased”. Nowadays the disorder has completely disappeared from the medical textbooks. There are no patients attending Western medical care for a ‘broken heart’ or any such affliction due to an unattainable or unrequited love. Nevertheless, recent biomedical technology, so it seems, offers proof of the ‘peccant humours’, relabelled as (neuro)hormones. Against that evidence, why is the present day victim of lovesickness, from a medical perspective, suffering a non-disease? In this nosological history, are medical doctors fooled or fools? The reasons behind the devolution of lovesickness in Western medicine demonstrate the twists and turns of categorizing disease, illness, and sickness in medical culture, psychology, and psychiatry.*

*[lovesickness, lover’s malady, inordinate love, non-disease, medical nosology]*

How to define lovesickness as a medical entity? Is the term labelling a disorder requiring medical attention? If yes: what suffering is at stake; how is the diagnosis made; who are the sufferers and the caretakers; which treatment should be prescribed; and what outcome should be expected? If no: why is so potent a human agency as love unaccounted for in medical nosology? To answer these questions we will consider explanations by several modern historical, anthropological, and biomedical authors. Our exploration starts around 1665 with Jan Steen, famous for painting love-struck maidens. The concept of lovesickness (in 17th Century Dutch: *minne-pijn*, *-koortz* – pain or fever due to being love-struck – or *liefdesverdriet* – love-sorrow) was a ‘hype’. In the ‘Golden Age’ of Holland, in arts and sciences, the subject attracted authors and artists and was discussed in numerous medical treatises (Van Beverwijck 1992; Dixon 1995). The Hippocratic-Galenic tradition provided a basic humoral explanatory model: if love is unsatisfied, sorrow effectuates melancholy (an excess of black bile). This idiom of suffering visualized an inner fire, being repelled by the cold on the outside, turning onto the victim to consume him or her to ashes. In Steen’s pictorial narratives, the diagnosis is clear to all but

one ever-present hapless doctor. His clothing looks odd: as a physician he seems both out of date and out of touch, befuddled (a fool being fooled). Several attending persons are pictured as knowing more and invite the onlookers to imagine what is at stake. An intriguing portrayal: the painter made eighteen versions, each developing the scene differently (Braun 1983: 134; Petterson 1987, 2000). We will quote from five of Jan Steen's painted narratives. Since the master gave the paintings neither title nor date, we indicate here (and in the Notes with the digital sources) the places where they reside: [1] Amsterdam (Rijksmuseum); [2] London (Apsley House); [3] Munich (Der Alte Pinakothek); [4] Saint Petersburg (Hermitage), and [5] Philadelphia (Museum of Art).

Steen's views are our point of departure for a discourse on lovesickness in the context of time and cultural traditions in Western medicine. Several eminent art historians (Wack 1990; Dixon 1995; Petterson 2000) offer interpretations of and relations to medical cultures of the Ancient, the Arabic, and the Medieval in contrast to the present. For our purpose it is important to exclude the quite different diagnoses in psychiatry of erotomania, and the differential diagnostics of stalking. The reasons are aptly stated by Rosario (1997: 48):

Erotomania is the delusion of being loved by another, usually of higher status. Psychiatrists have tried to legitimize the diagnosis by tracing its supposedly continuous history from Hippocratic cases to medieval *amor insanus* to Esquirol's 19th C. mono-maniacs to Clérambault's Syndrome in the 20th C. In so doing, they often fail to note the dramatic changes in the characteristics. Most significantly, love melancholy was a form of excessive, unrequited love for another, whereas contemporary erotomania is a delusion of being loved. Furthermore 19th C. erotomania is used to describe manic patients, with 'perverse' sexual sensations, obsessions and compulsions, but who confessed no amorous interests at all. In other words, a connotation of deviant sexuality was introduced into the diagnosis of erotomania in the 19th C. and later withdrawn from it in the 20th C.

A lovesickness comeback, as Steen's 'love interrupted', might be near though, as love scientists have reanimated the paradigm of 'unbalanced hormones' (Fisher 2004; Tallis 2004; Wikipedia). Are medical and psychological professionals, historians, and anthropologists ready to accept a revival of this particular disease category? Being physicians and participants in today's culture, we will try to argue and illustrate from medical history that lovesickness is an exemplary theme, inviting consideration of how 'being sick' in this manner is produced, constructed, and interpreted. The construction can be observed to hover between the dictates of the community, the needs craved by individuals, and the internal balance of human beings. As for the distinctive constructs of sickness, illness, and disease, we refer to Kleinman's (1988) formulation: disease as a doctor's perspective, illness as a patient's perception, and sickness encompassing the social implications. The sickness that Steen visualized are images of disturbed affection, to the extent that the suffering disables them to act normally and socially, and instead surrenders them to a yearning, languishing, 'falling in love'. Falling in love, according to Alberoni (1979), is that transient state through which two

individuals have to go to attain a certain mutuality, which produces the formation of a couple in a stable love relationship (Wikipedia).

### **The doctor's visit**

What is amiss in the individuals so affected by lovesickness, and why and how do they suffer? We need a clarification in order to assess the social connotations. One may think that because the condition is so common, modern medical criteria are unavailable due to the lack of a sense of abnormality. That notion can be dismissed by quoting the vast, varied, and contradictory sources in history, literature, and art which deal with the issue. We offer the pictorial manual by Jan Steen because it is so specific a source of illustration from within the debate. For want of a closer definition, we can treat his art as an allegory of the arrangements which make the disorder knowledgeable. At the heart of the matter there is a doctor visiting a patient. The core subject of the painting is a weak young woman in a bed or chair, head resting on a cushion or table, while a doctor is taking her pulse. She is miserable and at the same time this suffering is precious to her (Fig 1. Detail Rijksmuseum).

Looking at the paintings we can address the peculiar precious agony characterized by Steen. The Rijksmuseum, Amsterdam, offers one basic version [1] (c. 1665) depicting the maiden suffering in her body and the anxious doctor attending her. If the painting is studied in detail, there is a smile on her lips, blush on her cheeks, and glitter in her eyes. All of Steen's compositions focus on the doctor visiting this lovesick maiden. The positioning and characterization of objects (and, in successive paintings, persons) in the enclosure of the room are thick with signs to stimulate the onlookers' imagination. Steen never copies or repeats, but improves and adds, trying to excel over his rivals. His contribution to the Dutch 'genre' – scenic portrayals of what seems ordinary but is not – became known for the mixed narrative, context, and social comment, inviting beholders to see and become aware. This art of the typical in everyday life is an anthropological interpretation 'avant la lettre' and, as a consequence, has occupied many historians with the analysis of the emblematic lovesick patients and the objects surrounding them as iconographic and ethnographic signifiers.

We cannot term Steen's depiction a 'thick description' as in Geertz's definition of anthropological observation (Geertz 1973: 5-6, 9-10). The painter cannot have personally witnessed these scenes, or anything close. He has given an artful construction by including many visual hints on interpretation, without revealing the punch line – as master narrators do (Westermann 1997: 105). An art scientist, for whom Steen is a favourite, considers 'The Doctor's Visit' a seriously puzzling piece of work. Petterson wrote his dissertation on the subject in 2000, emphasizing Steen's particular talent for being witty, intelligent, observant, ingenious, and giving sudden intellectual power by showing. The compositions are delightful in providing a visual texture to rich (even contradictory) emotions; just as much as Steen's brush pleases in the refined rendering of light and colour of expensive satins and furs. He did not need models other than his (extensive) family or helpful passers-by – as brewer and innkeeper in Haarlem



Fig. 1  
Detail of [1] Rijksmuseum



Fig. 2  
[1] Rijksmuseum

(c.1660-1670) he had, at the time of producing these paintings, many visitors. Most of all he collected their countenances, gestures, expressions, and the arrangements of proximity. His wit renders ‘aha-effects’ on how his models looked, when they conveyed their minds. As a result, imagination participates (Pettersen 2000). How do these paintings define the gestures and arrangements of lovesickness? In [1] the Rijksmuseum, Amsterdam, the young woman is alone with her doctor, surrounded by signifiers, repeated and amplified in subsequent paintings. The patient is richly attired and expresses a complete giving in to sorrow: she is swooning, limp with weakness. The doctor, in a serious mood, is taking her pulse, palpating the rate and quality. In the foreground is a ribbon dipped in urine and a smouldering brazier next to a stove with a small bottle on top, and further to the left a candle with chamber pot; in the background a bed, a lute, and a clock on the wall (Fig. 2 [1] Rijksmuseum).

In [2] the Apsley, London, the exposition is up-scaled with household members in attendance and paintings on the wall, but maintains the former elements. Now, the suffering woman is tearful, but her doctor, in mischievous assurance, ‘has solved the problem’ and instructs the concerned lady, who is offering him a bottle of urine for confirmation. That test is unnecessary, because the painter surrounds the personages with clues: her faithful dog has a collar with a little heart dangling, and in the back is a painting of Venus with Adonis taking leave on his way to be killed, adding a second narrative to the one in front. Another feature is a Cupid preparing to shoot a blunt arrow at us. In a room behind them an elderly man is reading; either the sick woman’s husband, no longer able to satisfy her love, or the obstructive father, unknowing of what is going on. Is the paper he is looking at an intercepted love letter? The tragedy-comedy is topped off by another painting on the wall: Frans Hals’ ‘Pickle herring’,



Fig. 3  
[2] Apsley



Fig. 4  
[3] Alte Pinakothek

emphasizing a joke we will understand if we keep the herring in mind. In whatever variation, the theme is present in abundance to tell us that lovesickness is a conundrum (Fig. 3 [2] Apsley).

The [3] Alte Pinakothek, Munich, shows the painter:

... to present misunderstandings, secrets, assumptions and indiscretions. The ‘illness’ is an unforeseen pregnancy? The basin of coal in the foreground with the burning thread is used by quack doctors in diagnosing pregnancy by ‘reading’ the smoke, but, as an alternative, the offensive smell could instigate a wandering uterus (*furor uterinus*) to return to its proper location. The maid with a suitor at the door are further typical features. The patient herself holds a note saying: *Daar baat gen/medesyn/want het is/minepeyn* (No medicine can cure the pain of love) (Walther et al. 1999: 325).

Amor’s statue stands at the left and the Venus and Adonis ‘quote’ is repeated in the upper right corner. The dog turns towards the suitor and sniffs the air (Fig. 4 [3] Alte Pinakothek).

The girl is at her worst in [4] the Hermitage, Saint Petersburg. The accumulating similarities are intriguing: the faces of the patient, maid, and boy we met before (Steen’s household characters). The doctor (detailed in Fig 6) is now impersonated by a character resembling a personage in [5] the Philadelphia Museum of Art, noteworthy because he is known to be Jan Steen himself (Fig. 5 & 6 [4] Hermitage).

In [5] the Museum of Art, Philadelphia, unwatched by the central group, the artist holds a herring and two onions towards us as phallic symbols. The attending doctor is surprised by an improvement of his patient, but we are shown that her maid lets in her





Fig. 5  
Detail of [4] Hermitage



Fig. 6  
[4] Hermitage



Fig. 7  
[5] Philadelphia

lover. The doctor's test for lovesickness – the *pulsus amatorius* attributed to Hippocrates, Galen, and Avicenna amongst others – is to examine her pulse while the agent (the beloved) unexpectedly enters the room: her heart goes racing. Steen demonstrates that the test works, but that the doctor is still not aware (Fig. 7 [5] Philadelphia).

### Under the punch line

In the European scientific literature of the 17th C. *minnepijn* (love pain) was a 'hype' (Dixon 1995, Petterson 2000). Steen visually interprets the public fascination, as did the many dissertations from the medical perspective (Dixon 1995). Petterson (2000) reviewed all the representations by contemporaries in the context of the Golden Age culture. One theory, associated with the lovesickness in these pictures, was summarized by Van Beverwijck (1992), at that time the best-known author of popular Dutch medical texts:

The illness strikes at young women, in particular widowed or childless in marriage. The cause is an intense sexual longing for a man. The signs and symptoms are protracted uterine cramps and dislocations (the *furor uterinus*). The patient is severely distracted, anxious and depressed. On examination she is feverish, with an erratic pulse, and her feelings are hot and cold at the same time. The doctor suspects the diagnosis by observation only and/or by the exclusion of other conditions (such as pregnancy, female disorder or intoxication), but the definite clue is the pulse-test – *pulsus amoris* (Van Beverwijck 1992: 118-121, Petterson 2000: 69).

Jan Steen provides the medically informed with all the idiomatic manifestations: the patient is distracted and suffering; the excessive clothing and stove are to ward against the intense feeling of cold while being in fever. Counter-distraction by music is a consolation (lute, clavichord). Symptomatic treatment is also the enema (*clyster*) or *vrouwenspuit* (syringe for women, another phallic symbol), if there is no prospect of the one and only solution. Sexual intercourse in marriage is the only cure. We find that punch line between these appellations: doctor's visit, sick woman, girl with doctor taking pulse, and in the note held by the *minzieke vrouw* (love-struck woman). The iconic significance is such that the painting has become a stock visual, reproduced over and over to signify medicine-in-history or medical visits, without further reference to the satiric context and the doctor's ambiguity.

If Steen leaves the punch line to onlookers, one has to accept that the narrative will be mis- or multiply-interpreted. At present, the art historians' consensus is that his serial paintings are a parody on *Medicine in Relation to Lovesickness*. The narrator implies, by comic inversion of the heavy-handed dissertations, that falling in love is tricky and the very stuff of in-between-ness. The Golden Age doctor is the first target of artistic wit. His art is to be viewed as a handed down concoction of Greek, Latin, Arabic, and Biblical citations on the amorous misadventures of Venus, Bathsheba, and other legendary 'patients'; hence the furnishings on the wall and the Cupid. Medicine

is visualized as ‘rhetoric based on the academic scripts’; the more ancient, the better. Arrogantly, any honest handiwork was left to non-academicians (the *chirurgijn* i.e. barber-surgeon or the apothecary). The doctor’s fee depended on theatrical performance: private carriage, costume of former days, broad gestures and speeches in dog Latin. In that characterisation, medicine is comedy. Only the best homes are stages and the receipt for the enema is left as comic flourish. Taking a history or background information into account would degrade the performance. Hence the doctor is a fool to be fooled, but in his grandiloquent way he helps to elevate the girl’s disorder to prestige and to transfigure sorrow into esteem: a typical weapon of the weak. If fees are steep, even if the competition is stiff . . . who cares, when taking part in such a splendid and soothing spectacle (cf., Mooij 1999: 57-62)?

In a more sober interpretation of the scene we can imagine further facets of the illness: not only is the sickness excessive, but also lustful, due to an irresistible inner force beyond reason – a consumption both painful and precious, intensely perceived by body and mind, at once genuine, exciting, and delectable. The resulting contradictory emotional disorder requires, for solution, the beloved to become a victim too; but mating, the matrimonial remedy, in the human context is for the lesser part nature, and mostly culture. More precisely, the remedy requires the short-term response of the beloved and the permanent cultural permission of significant others. If the natural-cultural match fails, the amorous turns into illness. In Steen’s depiction all these problems are kept in the balance by benevolent parody. Was there no commiseration at all on the painter’s part for the disordered woman? Not a bit: in Steen’s view ‘lives were not at stake’. The suffering, also target of the wit, would have to be borne, or deteriorate into the silliness of pining or being struck with blindness. The erotomelancholia is, in Steen’s image, despair, eyes staring without seeing. Without solution, ill will transform to madness. The sickness of an unrequited love makes sense – whether in deceit or honesty – by acting towards the solution of mandatory marriage: ‘the remedy is found in uniting with the one by whom harm is wrought’. One plot enacted is widely known as ‘*Amans Amanti Medicus*’ – the one who causes also cures love (Pettersen 2000: 128):

The girl is in love with a man and her father does not want to hear of it. She suffers and her maid orchestrates the lovesickness performance with the lover attired as the doctor. The father is pressed to admit this pseudo-physician, who imitates the examinations on his daughter and afterwards reveals his true identity to force the father into acceptance. A crude doctor novella, but certainly frontal in the minds of the golden age onlookers.

The attending doctor is not in every case also the suitor in Steen’s staging of love-sickness, but always sincerely involved. The feminist historian, in our times, has no doubts about doctors and painters being ‘misogynist participants’ in the construction. Both Wack and Dixon stated that medical science was a factory for *furor uterinus*. Wack (1990: 166) argues that the aristocratic and male predominance of the disorder resulted from the psychic tension between men’s inordinate power over women versus men’s ideal courtly subservience to their beloved. She further suggests that the



medical discourse on lovesickness allowed medical students, faculty, and literate male readers to master their anxieties over these conflicting cultural amorous conventions. She proposes that the subsequent feminization of heroic love in the Renaissance may have been due to the availability of new 'classical' medical texts depicting lovesick women.

Dixon (1995: 11) agrees that women were under the relentless scrutiny of the male medical establishment, a scrutiny borne out by the unprecedented increase in the number of medical treatises devoted to uterine disorders, and paralleled in the popularity of the female sickroom as a subject for artists. Through the ages, males have re-enacted this ploy of shaping female diseases (from hysteria to any other 'desire disorder') for 'a doctor's visit'. So, Wack and Dixon's comments can effortlessly be applied to aspects other than the tenderness of gender. Important to the search for the agency behind is the recognition of the cultural power shaping lovesickness. In matters of the heart cultures go far. What purpose makes doctors perform as they do? Were they, in the 'Enlightenment era', more understanding to feelings and, in this respect, better comparable to modern authors of romance? Medical treatises cannot completely capture the essence of lovesickness and need more historical context. Steen's patients' intense self-involvement characterizes suffering, but is the pain due to love and love only? The painter personally joins the attending doctor in the scene and partakes in his characters, assisting with interpretation. Why are 17th C. painters and doctors so secondarily enamoured?

Love is a mighty mental incentive and lust a powerful physical stimulus: love, power, and sex together make a strong elixir. The medical version of the damsel in distress: sprinkle that mixture over a scene offering a rich and beautiful girl, weak and desperately needing help – who will resist? To tie the knot of love, the sufferer's performance gives the agency required in getting her beloved in a position where he cannot refuse. Isn't it in love that all is well and endurable if only it ends well? How about the aspect of parody in Steen's art? These paintings conform to the theory on *parodia* (Greek: counter song) as witty comment on the world (Hutcheon 1985: 32). The paintings emulate a critical distance and ironic ambivalence, implicitly reinforcing even when debunking at the same time. Authorized crudeness embodies, denudes, lays bare, and brings to life the actual historical tensions. Steen's parody visualizes insight, a coming to terms, while activating the onlookers' awareness. *Steen pictured the moment when instinct meets culture.*

### **History and culture of lovesickness in the West**

If lovesickness strikes, call the doctor to visit you at your home. Probably the very same doctors, who were Steen's models, commissioned and bought his admonitions. The punch is in his scepticism about the truth, and his emphasis on the inevitable dishonesty of lovesickness: suffering should not be double-dealing, but in lovesickness it is. The diagnosis sets a trap to get the actors in the mood for marriage. With the high and mighty, he used wit because:

Courtship was experienced as a perilous activity, in which the possibility of sin lurked beneath the surface of seemingly polite activities: the stage of life in which one is most easily led astray by sensual temptations. Along with that went the usual emotional chaos and subterfuges of love, a condition in which men and women tended to hide their feelings even as they sought to discern those of others. Testing the limitations. Desire is always liminal, of course? (Nevitt 2003: 4).

Nevitt's comment connects the conditions of Steen's era with those of all times. Why was this peculiar form of desire discarded from the medical mind? The doctor's mind too, while dealing with natural events, exists as a creation of culture. A historical-cultural comparison enables us to grasp the perceived nature of lovesickness in former ages and widens the scope of discourse. It is a big task because the 'informing' is stored by culture, acting in novels, poetry, songs, proverbs, and visual arts. What else, by and large, is love other than a human narrative? To avoid truism, we must keep to 'sickness due to unrequited love', and 'physicians who attend sufferers, failing in love's fulfilment'. Love, lust, and suffering – how to construct these into one medical entity? Wack clarifies that the perception of a causal connection has a long history. She gives a medical textbook outline of the medieval patients who were, prior to Steen's generation, predominantly male:

- Definition & causes: principal/extrinsic apprehension; adjuvant/ beauty; need to expel excess seed.
- Symptoms & signals of disease: physical, behavioural, and involuntary (pulse, breathing); signifying the person provoking the disease: pulse test.
- Cures: physical/ restore the body's composition and balance of humours; psychological (to be adapted to patients without and with discretion); universal cures/ travel, business, litigation, intercourse and additional helps (Wack 1990: 132).

Medieval lovesickness shares features with depression, melancholia, addictive love, infatuation, romantic love, empty love without prospects (Wack 1990: xii).

[Questions were:] what is the dividing line between a somatic disease and an illness of the soul. And where on that axis is the disease of love located? Love is not actually a disease except by virtue of its consequences and these affect the brain. The subject of *amor hereos* was used to probe the psychosomatic unity of the human subject (Wack 1990: 79).

Society and Church, at the time, had no qualms about the claim that the lovesick are cured by sex. Medicine and theology were far from irreconcilable and slept in the same bed when the lovesickness enigma was taken on by Petrus Hispanus, clerical physician, who became Pope John XXI in 1276 (Wack 1990: 84). Ferrand (1623), a physician who travelled the same territory 350 years later, shows the mood had much changed already:

It is earthly Venus leading both men and women into fixations that offer no promise of joy or mutuality. Western physicians, following the Arab founders of the tradition of *amor hereos*, perpetuated the definition of love as a form of insanity arising from an

inordinate desire to enjoy an object of beauty, an insanity accompanied by intense fear and sadness. Such a definition allowed for a complex interplay between physiological – psychological causes, between love as endogenous (by inner cause) disease conditioned by complexions of the body, and love as a passion of the soul, that begins in an act of misguided volition. But Ferrand states: “Only when love is defined in material terms it can be effectively treated by altering the conditions within the body: drawing off the polluted blood, purging of adustion (parchedness), humidifying dryness and enforcing repose through narcotics and soporifics” (Beecher & Ciavolella 1990: 4-5).

Here are reasons for doctors to picture themselves as less befuddled than Steen pictured them. They attempted, for a long time, at once to define and treat love as both spiritual and material agency. Descartes’ *Traité des Passions* (1649) defines lovesickness as a melting process, an embodiment in which love (*l’amour de bienveillance*) and lust (concupiscence) dissolve. He describes the causal pathway thus:

The mixture of love with lust is the cause. If a love links up with a lust for the beloved, which cannot be satisfied, then the mixture causes such intense contemplation of the beloved, that all lustful activities become enclosed within the brain, so that the remaining body drops into torpor. During this sorrowful state the pulse is weak and torpid, because a band of ice constricts the heart, slowing down the blood, as manifested by the pale countenance and the calling forth of tears and moaning. When awake the love struck dreams of the beloved, and, commensurate to the inability to satisfy the desire, a profound frustration is perceived as an illness. While love (*bienveillance*) is laudable, lust (concupiscence) makes ill, because it is founded on false, unrealistic premises. The patient can be redeemed by virtuous love: the patient should only desire, what is allowed and can be fulfilled (Pettersen 2000: 266-75).

Do Steen’s pictorials visualize the domestication of lust? Steen and Descartes were contemporary Roman Catholics in Leiden, where in 1575 an academic centre of the Protestant rebellion was founded. In the burgher republic’s fierce battle against the Spanish king and Roman Catholic pope, ideas of virtue went adrift. The earlier concepts of carnal love were overruled: for instance celibacy was seen as a popish calumny of the apostolic instructions. Luther (1523) prescribed marital intercourse as both the remedial cultural virtue and the cure in the flesh. The mutuality between men and women became respected as domestic virtue. Such theology and philosophy, at that time, was not a matter of quiet conviction as it is now, but part of warfare in the liberation of the mind from a religion experienced as oppressive. If physicians in this battlefield differed, they suffered more than parody. The 17th C. Italian physician Vanini, who arrogantly continued to advocate the sexual remedy as cure for lovesickness in a Roman Catholic stronghold, was burned at the stake for atheism by the inquisition (Allen 2000: 23). Is this one reason, in hindsight, for understanding the doctor’s role in Steen’s era as less than befuddled? It can be that the doctors tried to neutralize the inquisition by being comical, and this is in line with today’s appreciation of the medicine of that era as poor on seeking scientific evidence independent of

the social dictates (Mooij 1999: 123). When medicine became inspired by the body as the exclusive focus (Ferrand's directive to search for love in material terms) and followed Descartes' proposition to distinguish between the mind and the body, lovesickness was simply extinguished as a disease concept.

### **Discarding a diagnosis, recovering a disease**

For lovesickness there is no medicine, is the message of Steen. Nowadays there is not even a diagnosis. Have the medical professionals forgotten, lost interest, or do they consider the qualification as disease a mistake of their 17th C. namesakes? Allen (2000) states that lovesickness was discarded as a "hodgepodge of emotionality, insomnia, arrhythmias, culminating unless cured by sexual intercourse". Bynum (2001: 403) implies, in a semi-serious Valentine mood in *The Lancet*, that the diagnosis must be discarded:

As accumulation of peccant humours, rendering the body economy seriously diseased, for doctors since Hippocratic times lovesickness is not so much about love as about what we would call fixation. For the cure is sex. "Shame on a malady which requires sensuality for its cure" (Thomas Archbishop of York, in 1114). The dilemma is formidable, but sex cannot be admitted for curing the suffering.

How then to define the lovesick in the context of the next era? Physicians (a professional term we will from here onwards use to distinguish from Steen's doctors) were, in the 18th and 19th Centuries, still observing the same signs – descriptions are not different – but they came to qualify these under another diagnosis (Lahtinen 2007: 44, Dzaja 2005: 284). Revealing is the fact that a somatic origin of the complaints is now being looked for with vigour, both by the patient and the physician, and love becomes a coincidence, reluctantly admitted to in the explanation. One such description is by Diderot (1775: XVII) and an almost identical one is by 19th C. physician-psychiatrist Griesinger (1845: 39):

[In Diderot's case:] ... the persevering attentions of a visiting acquaintance completely gained her affections. Filled with ideas of her duty, she resisted the seducing influence and kept the secret of violent passion buried in her heart. This constraint gradually affected her health; she began to suffer from palpitations, sensation of fullness at the chest, and indescribable morbid symptoms. The appetite failed, the gastric region felt painful and stitches were felt in the side. These actual sensations were associated with the most peculiar and sad ideas concerning her health. She believed sometimes that she suffered from aneurysm, sometimes from cancer of the stomach, sometimes and most frequently from consumption. Indeed, a feeling of tenseness, cough and abundant expectoration, feverishness and nocturnal perspirations, had established themselves... [When] she again saw the object of her passion, [she] succumbed, abandoned her husband and family and fled with her seducer. Six months afterwards I saw her again. I could scarcely

recognize her. Beauty, freshness, and fullness were in the place of a condition bordering on marasmus. There was no longer cough, expectoration, palpitation, gastric affection, pain or any disease. The gratification of her passion had re-established her health and dissipated the dark ideas.

[In Griesinger's case:] The patient experienced vague symptoms, including heart palpitations, abdominal pains and failing appetite. She felt that scorching red irons were being forced through her body. She was convinced that she had major health problems such as an aneurysm, cancer of the stomach, or tuberculosis. Another physician actually diagnosed her with tuberculosis, but Griesinger discovered that the true cause of her illness was not being able to be with the man she desired. Indeed, when she ran away with him, her health was completely restored and her preoccupation with illness disappeared. It is clear that although the major symptoms of lovesickness are fairly consistent, the disease also had a lot of variability in its presentations.

The physicians are at loss in the emotional matters of the heart, by virtue of the fact that they discovered the heart is a pump. Due to the change of bias to provide rationality, the basing of paradigms on human automatism, and the use of the tools of anatomy, chemistry, quantification, physiology, and mechanics, love is lost as an agent of disease in the post-Cartesian medical perspective. Thus, one reason why the lovesickness entity was discarded is the way medical nosology perceives rationality. Throughout medical history two attitudes, observational-empirical versus rationalist, have continued side by side. One approach is preferred for a period of time, only to give way to the other bias. The empirical approach led descriptors to group disorders on their similarity of observations, making minimal assumptions about the aetiology. In contrast, the rational approach tended to group disorders based on current understanding of their underlying nature (First 2004: 4). Love, perceived by physicians as immaterial and irrational, went out of the somatic medical textbooks as an agent, in striking contradiction to a concurrent observational development as an emotional perception. The romantic era produced suffering due to unrequited and unobtainable love in excess: almost no opera, song, theatre play, ballet, novel or poem is without. The 'romantic' unsatisfied love moved away from sickness towards distinction. The excess of love, being interrupted and enjoyed at the same time, convinced physicians that the term was a meaningless cliché for their scientific discourse. Instead, physicians developed the concept of lust for human automata, featuring clearly discernible material mechanics in their coupling of genitals, exchanging of fluids and corpuscles (eggs, sperm). Love and lovesickness were redefined and relabelled as sex life and libido, with physical connotations and complications, to be taken care of by the new medical speciality of sexology. In the interface of individualism-collectivism, and at societal-psychological levels, new visions on the nature of sexual intimacy, now called romantic, passionate, or companionate, were constructed and categorized. In recent medical literature, for instance Money's textbook, lovesickness is in the title, but merits few pages and no disease definition:



No prescription except either to relinquish the paramour, or to divorce the spouse, or to be killed in a crime passionnel, no alternative does justice to one of the primary realities of pair-bonding, namely that each partner becomes the psychic property of the other. Dis-possession by a lover is to have a broken heart. Despair and rage, when a love relationship is unilateral, are intensifications of similar reactions experienced when one partner has a complete falling in love. The kind of disequilibrium that ensues leads to the possibility of self-injurious sabotaging manoeuvres aimed at the partner, or sometimes another. It is much the same as when a lover or spouse is lost by death or divorce. People do not have voluntary control over whether they will become love-smitten or not. Neither science nor society have, as yet, a coherent tradition to help them spare themselves the lovelorn agony of love unrequited or love dispossessed. In particular, there is no tradition of how to fight fair (Money 1980: 70-71).

Is Money unaware of the duplicities parodied by Steen, whose love-struck girl tried to get what mattered most as a cure for lovesickness? Founder of sexosophy, Money appears intent to match sexual hardware (love physiology) and chemistry (cascade of genes / genotypes, hormones / phenotypes) with the social implications of love and sickness. His views do not yet provide a sightline to establish the continuity between individual complaints, professional data on pathophysiology, and clinical insights on the suffering of populations affected. Dejected, he states that:

Sexology is the science that until the 1970's dared not, in respectable company, speak its name. By other scientists it was ridiculed as pornographic (Money 1980: 187).

More recently the scientific mood is again in for love. Healthy volunteers serve as living laboratories for sexology and lovers have their sexual performance and complaints inventoried, explored, and analyzed in respected scientific surroundings. In the past twenty-five years, in a recovery of the historical humoral model, scientists have restated love as an agency in health, and lovesickness as meriting positioning in medical diagnostics (Gianotten 2003). In particular, Fisher (2004) and Tallis (2004) try to link neuroscience to lovesickness as an act of mental derangement. Tallis (2004: 30) asks us to 'suspend disbelief and provisionally define love as a mental illness'. Fisher (2004) grounds the argument on functional magnetic resonance images (fMRI) of the brain at work. As a research anthropologist she scanned the brains of volunteers, madly in love, obsessed about their beloved almost every waking moment. Then she scanned the brains of the newly dumped, love-scorned subjects throbbing with rage. Specific areas of the brains lit up with increased blood flow, elevating the levels of the chemicals dopamine or norepinephrine or both. These chemicals cause ecstasy, hyperactivity, loss of appetite, and sleeplessness. The systems are expertly choreographed at the neuro-chemical level, each with attendant neuro-hormones, she contends. The dopamine in particular allows us to maintain romantic love's unique, intoxicating properties, even in long-term attachments. However, arguments between lovers trigger a rush of adrenaline, which kicks in during risky, dangerous, or new situations. This may explain the high-voltage couple, who dramatically splits only to reconcile

with still more gusto. Separation from a beloved moves dopamine and norepinephrine production into high gear by activating goal-driven pathways associated with these neurotransmitters. When a reward is delayed, these brain circuits sustain their activity, which is probably what gives the feeling of frustrated attraction – wanting the person more when barriers are increased (as in addictions). Summing up: romantic love is primarily a reward system, which leads to various emotions rather than one specific emotion.

These new angles in love science allow the onlookers to envisage another '*mise en scène*', different metaphors, and new signifiers. Hormones (neurotransmitters) and love scents (pheromones) are Cupid's chemistry for preparing the brain for love, to digest the lover's messages, to attract mating candidates through the air. Taking brain scans for signifiers, researchers find that women, when their monthly cycle is appropriate, register the male pheromone in the smell-processing parts and their hypothalamus lights up (Savic 2002). Tallis adds post-Darwinian theory (what evolutionary function is served?) to construct the purpose of lovesickness:

At first sight, it seems extraordinary that evolutionary forces might conspire something that looks like a mental illness to ensure reproductive success. Yet there are many reasons why love should have evolved to share with madness several features – the most notable of which is the loss of reason. Like the ancient humoral model of love sickness, evolutionary principles seem to have necessitated a blurring of the distinction between normal and abnormal states... Sexual intimacy engenders, by chemical changes, perceptual distortions. Evolution expects us to love madly, lest we fail to love at all...and to reproduce (Tallis 2004: 287).

Love may be in the air, in the brain, and everywhere, but physicians have not yet succumbed and restored lovesickness as a textbook entity. For illnesses to be promoted as disease, categorization has to have sufficient qualitative criteria and a quantitative basis, requiring transversal and longitudinal epidemiology in populations affected. In addition, a clinical consensus requires the medical evidence to be widely accepted in specialist research and supported by a broad debate, framed in conferences, journals, and organized platforms with patients and other interested delegates taking part (government, industry, media), all demanding the issue to be solved. Only once this unpredictable medical cultural process is completed will lovesickness be recognized as a disease again. Until that time clinicians will invent reasons to be unconvinced:

We continue to invent illnesses. An 'illness of the week', if you like medicalizations of normal occurrences. Those little actions, which are normally seen as the symptoms of the first flush of love – buying presents, waiting by the phone or making an effort before a date – would be the prodromal signs of a deep-rooted problem to come? Maybe some people cannot cope with the intensity of love and are destabilized or even feel that they suffer on account of their love being unrequited, but would they ask a physician for a diagnosis? When even love can be seen as the harbinger of illness, what aspect of our lives cannot be called illness? (Furedi 2005: 23)

The symptoms of lovesickness differed sufficiently from those of present-day illnesses, and the possible uses of those symptoms are sufficiently obvious, that many such patients must have been acting out illness roles. (Wenegrat 2001: 54)

How to argue against this aversion of the ‘acting out’, which, for all practical purposes, seems close to ‘using agency’. Without a diagnostic peg to hang it on, how can the medical professional of the present have an empathic look? Not all is allowed nor accepted, even in love, as our résumé on Western medical history shows. Lovesickness, a borderline concept, highlights how important a role temporary medical culture plays in the definition of a disease.

## Notes

Janus Oomen, MD PhD MA, is a physician (non-practicing internist), medical anthropologist and volunteer-researcher for the University of Amsterdam Master’s of Medical Anthropology (AMMA), oomen@xs4all.nl.

Woet L. Gianotten, MD, is a psychotherapist, formerly in the Department of Medical Sexology, University Medical Centre Utrecht and Department of Reproductive Health, Erasmus Medical Centre Rotterdam Presently he is working as a rehabilitation sexologist in De Trapenberg, Huizen, The Netherlands, woet@gianotten.com. The authors thank the peer reviewers for their constructive comments and Trudy Kanis-Scholts and Zoe Goldstein for editing the manuscript.

The five Jan Steen’s paintings, their residences, titles, dates (annotations on the web) are: [1] RIJKSMUSEUM, Amsterdam: ‘The Sick Woman’ (c. 1665) [www.rijksmuseum.nl/images/aria/sk/z/sk-c-230.z](http://www.rijksmuseum.nl/images/aria/sk/z/sk-c-230.z) [2] APSLEY HOUSE, London: ‘The Physician’s Visit’ (1658-1662) [www.englishheritageprints.com/image/Steen-The-Physicians-Visit-J040066\\_628125.jpg](http://www.englishheritageprints.com/image/Steen-The-Physicians-Visit-J040066_628125.jpg) [3] ALTE PINAKOTHEK, Munich: ‘The Lovesick Woman’ (1660-1668) [www.abcgallery.com/S/steen/steen19.JPG](http://www.abcgallery.com/S/steen/steen19.JPG) [4] THE HERMITAGE, St Petersburg. ‘Sick Woman and a Doctor’ (c. 1660) [www.hermitagemuseum.org/tmplobs/VE6XEYHLJ3N4Y1S36.jpg](http://www.hermitagemuseum.org/tmplobs/VE6XEYHLJ3N4Y1S36.jpg) [5] MUSEUM OF ART, Philadelphia: ‘The Doctor’s Visit’ (c. 1663-1665) [witcombe.sbc.edu/baroque-art-theory/images/steendoctorsvisit2.jpg](http://witcombe.sbc.edu/baroque-art-theory/images/steendoctorsvisit2.jpg)

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