

Insane in the Brain, Blood, and Lungs: Gender-Specific Manifestations of Hysteria, Chlorosis, & Consumption in 19th-Century Literature

Anna P. Scanlon
Marquette University

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INSANE IN THE BRAIN, BLOOD, AND LUNGS: GENDER-SPECIFIC
MANIFESTATIONS OF HYSTERIA, CHLOROSIS, &
CONSUMPTION IN 19TH-CENTURY LITERATURE

By

Anna Scanlon

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ABSTRACT

INSANE IN THE BRAIN, BLOOD, AND LUNGS: GENDER-SPECIFIC MANIFESTATIONS OF HYSTERIA, CHLOROSIS, & CONSUMPTION IN 19TH-CENTURY LITERATURE

ANNA SCANLON

MARQUETTE UNIVERSITY, 2019

This dissertation examines literary and medical texts from throughout the nineteenth and early twentieth centuries to better understand prevailing attitudes about gender and disease. The project traces the progression of three diseases – consumption, chlorosis, and hysteria – throughout the long nineteenth century, paying particular attention to the stereotypes and prevailing medical notions of each illness. In general, this work examines the influence of lovesickness, female-patient/male-doctor dynamics, and pathology on the endemic or epidemic nature of each disease. In particular, the first three chapters of this project study tuberculosis – or consumption as it was called in the nineteenth century – and the ways in which society presumed this illness manifested either through the female’s beauty or spirituality. This work also uses nineteenth-century writing from women and men who dispute the notions of the beautiful and spiritual consumptive. The second three chapters of this project examine hypochromic anemia – chlorosis in the nineteenth century – and the prevailing medical notion that its manifestation in younger women could be cured through sex, marriage, and childbearing. In so doing, this dissertation studies its roots in lovesickness, procreation, and the Early Modern era. The final section of three chapters explores the somatic manifestations of hysteria – a disease that appeared endemic to young woman throughout this era – and its comorbid condition of neurasthenia. This project looks at texts written by those so diagnosed as well as by those doing the diagnoses. This work concludes with an afterward focused on how the gender-specific medicine of the past continues to impact racialized medicine of the present.

Keywords: Medical humanities, tuberculosis, consumption, chlorosis, anemia, lovesickness, hysteria, neurasthenia, comorbidities, racialized medicine, gender-specific medicine

DEDICATION

This dissertation is dedicated to the women in my family who have worked to improve not only their own physical, spiritual, mental, and emotional health but that of other women. I also want to dedicate my work to the men in my family who have encouraged, respected, and supported us. God bless and keep you all.

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Chapter One: Introduction

“Miss R— aged eighteen years, of a rather tall, slender form; dark eyes and hair, and fair skin. Her habits were rather sedentary. She was at the time her health failed, pursuing a course of study in a Female Seminary in this city, and applied herself diligently to her studies, continuing them to late hours at night. Her catamenia from their first appearance have been either irregular in time, or deficient in quantity; consequently her health has not been good.¹ The last appearance of her menses was during the time of her examination in July last, prior to graduation. Her lips and cheeks soon became exsanguinous; her eyes lost their lustre; skin became pale, cool and dry; her pulse grew more frequent and feeble; her extremities cool; bowels torpid; appetite defective; she was troubled by a sense of stricture and oppression in the chest, and a pain in the region of the heart, accompanied by frequent attacks of palpitations.”

- Dr. P. S. Shields from “A Case of Chlorosis”
(1852)

The above entry from *The Ohio Medical and Surgical Journal* indicates several interesting points not only about a diagnosis of chlorosis but also about the male doctor’s relationship to his female patient. Ostensibly, this is a case report with the obvious symptoms Dr. Shields presents leading to his unsurprising diagnosis of Miss R as chlorotic. These symptoms—the patient’s gender, age, irregular menstruation, general pallor, disordered eating, and heart palpitations—are all indicative of chlorosis. On the other hand, under the surface, Dr. Shields’s commentary on Miss R’s education—especially her diligent application to her studies—hints at gender biases that are common in the nineteenth century. First, Shields implies that Miss R’s working has made her ill, noting that her last menses took place “prior to graduation,” indicating that her desire to study and achieve a degree—a desire that society deemed outside the female experience—has contributed to her condition. Secondly, he seems to censure Miss R for pursuing this degree in the first place, corroborating her application to her studies following her admittance to the Female Seminary with her diagnosis.

¹ Catamenia is, according to the *OED*, menstrual discharge (“catamenia”).

The above case is also useful for showing the biases of a patriarchal society regarding a woman's health, as embodied in female patient-male doctor relationships. Of particular note in studying these relationships is the work of Dr. S. Weir Mitchell, in his book *Doctor and Patient* (1888). Here, Mitchell echoes an idea shared throughout much of society: "Once in a female college, the woman goes on, and it is my own experience that, on the whole, she exhibits a far larger list of disastrous results from such work than do young men" (149). It is unsurprising, then, that doctors who cared for their female patients in the nineteenth century urged them not to extend their schooling past the socially-acceptable age of eighteen.

The presentation Shields offers also hints at another component of the female patient male doctor relationship we see throughout this century: one that Michel Foucault first introduces in *The Birth of the Clinic: An Archaeology of Medical Perception* (1963) when he explains the medical gaze. Foucault notes: "[i]f one wishes to know the illness from which he is suffering, one must subtract the individual, with his particular qualities" (14). Before we can understand how the medical gaze enacts this subtraction of the individual, however, we must acknowledge the male gaze that informs Foucault's—and many nineteenth-century physicians'—work and the way it silences women. Laura Mulvey's now-famous "Visual Pleasure and Narrative Cinema" (1989) addresses the presence of women in film, a presence that can also be noted in literature, as follows: "Woman then stands in patriarchal culture as signifier for the male other, bound by a symbolic order in which man can live out his phantasies and obsessions through linguistic command by imposing them on the silent image of woman still tied to her place as bearer of meaning, not maker of meaning" (343). The woman is effectively

silenced by the dominant culture so the man can examine her at his leisure and for his pleasure, and assign her meaning without her having any say, as Shields does with Miss R above. While Shields gets publication rights, Miss R gets no such voice. Readers do not learn about Miss R's experiences with her disease firsthand. We receive no information on how she describes her condition or even why she came to Dr. Shields. The only patient history, then, comes not from the patient but from her doctor instead.

To study these manifestations, medicalizations, and gazes, this dissertation examines those texts that represent in some way the expansion of medical and literary thought and the manner in which medical advancements throughout the long nineteenth century influenced the literature from this era and in turn was influenced by that literature. Readers of texts from the long nineteenth-century would have missed an opportunity to discover the interplay among gender, disease, and class. Firstly, this dissertation focuses on gender (exclusively binary due to the understandings presented by the widely-published texts of this era) and the ways in which the female patient is treated within the patriarchal society of nineteenth- and early twentieth-century Britain, Ireland, and the United States.² It explores how she is viewed as an object of sexual desire—her disease in some way makes her stand out as different—or as an object for social censure—such as Miss R who is going to school despite the fact that many young women

² For the purposes of this project, I am looking only at ill characters who are either male or female due to the large representation of the binary genders in popular nineteenth-century literature. However, this is not to say that persons outside these binaries did not exist long before—and continue to exist long after—the nineteenth century. Elizabeth Reis explains in *Bodies in Doubt: An American History of Intersex* (2009) one such point related to non-binary genders and medicine, writing “[i]n the mid-nineteenth century, as doctors became more professionalized, so too did medical assessments of hermaphroditic conditions. Throughout the century and into the twentieth, doctors continued the debate over whether or not true hermaphrodites existed” (24). Therefore, stereotypes about how gendered patients presented to medical professionals was not limited exclusively to females; however, examination of other genders is beyond the scope of this project.

of her era were not encouraged to do so. I then examine how these viewpoints affect the female patient's relationship with the males who attend to her, influencing her diagnosis based on whether or not she follows social strictures. This dissertation also studies the ways in which men contributed to that understanding of gender and the gendered representations that exist in society. By considering the influence of the gender dynamics within nineteenth-century texts, I explore the means through which gender is portrayed in relation to a character's disease, often subverting stereotypes or playing directly into them, sometimes with surprising results.

However, for the purposes of keeping this project focused, I consider the ways in which somatic diseases were viewed similarly in British, Irish, and North American medical and fictional literature throughout the long nineteenth-century. In particular, I examine how these locations in which consumption, hysteria, and chlorosis were endemic or epidemic were further influenced by urbanization, which allowed for an increase in these contagious symptoms as they spread rapidly through highly-populated areas, regardless of social class.

To fully explore the creation of this medical and fictional literature, we must first consider the historical spread of knowledge between these three regions. There are two general reasons that the sharing of ideas reciprocated throughout these places. The first was due to a proliferation of changes in medical practice in Anglo-American culture, and the second came about because of a shared educational and language background among many of the medical practitioners and writers. First, the relatively new career field of the general practitioner (GP) created a medical professional who might appear to be of a higher class than previous iterations of medical practitioners such as surgeons and

apothecaries. Thus, patients who could afford care had medical professionals who came from socially elevated echelons of society. Irvine Loudon, author of *Medical Care and the General Practitioner—1750–1850* (1986) explains, “practitioners advanced from the position of a tradesman of a lowly status, or at best a craftsman, occupying a social world which was totally different from the graduate physician, to a membership of a unified profession in which they were, albeit at a lower level, professional doctors” (4). A career that had previously been looked down upon now became one that second sons of higher social classes could aspire to.

The second reason, a shared educational and language background, was undoubtedly influenced by the first. According to S. E. D. Shortt in “Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century,” medical colleges in the United States, Canada, and Britain increased significantly in number throughout the nineteenth century in part due to governmental acts such as the *Apothecaries Act of 1815* (53-54) and also no doubt in part due to the new appeal of the GP.³ Furthermore, because of a shared print culture, and because most educated British, North American, and Irish people read and spoke English, ideas and knowledge about medicine were exchanged between these locations based on these common characteristics. These exchanges were centuries in the making, so they could not easily be disregarded despite the fact that these regions were all at war with one another at some point during the nineteenth century. Finally, because much of the

³ The *Apothecaries Act of 1815*, according to Loudon (cited above), was fully titled ““An Act for better regulating the Practice of Apothecaries throughout England and Wales”” (qtd. on 167). Implemented so that getting an apothecary license was more difficult and thus more carefully guarded, requirements were passed for candidates who wanted to become apothecaries so that “no one could legally enter on a career as an apothecary without the licence” (Loudon 167) unless they met the age, educational, and apprenticeship requirements.

schooling of doctors in each of these countries was begun or influenced by Scottish and English medical practices, their physicians could be assumed to have had similar educations in medicine (Shryock 279-80).

It is not to say this similar education in medicine did not lead to medical rivalries and competitiveness, particularly as everyone worked to find reasons to explain the various illnesses plaguing the general public. This healthy competition led to a century in which Ignaz Semmelweis determined the cause of Puerperal Sepsis, Louis Pasteur established the field of microbiology, and Robert Koch uncovered the cause of tuberculosis.⁴ In *Germ Theory: Medical Pioneers in Infectious Diseases* (2011), Robert Gaynes explains the progression of these scientific breakthroughs. Of particular use for this dissertation are Pasteur's work and Koch's discovery. Pasteur's establishing the field of microbiology is particularly important to the work this dissertation does with disease as his efforts definitively disproved miasma theory and led to the now-prevailing medical theory of contagion: germ theory (Gaynes 144). Society no longer was convinced diseases occurred due to a miasma that infected specific regions.⁵ Thus, diseases were not seen as exclusively endemic, or confined to a certain area or people for a limited time ("endemic"). Rather, the argument of contamination we today recognize as germ theory emerged, and a better understanding of epidemiology and the pathologies of diseases

⁴ Puerperal Sepsis, also known as childbed fever, is another disease that targeted women exclusively as it came upon them as they delivered children in less-than sanitary situations. According to Gaynes (cited below), this highly contagious disease was not fully treated in patients until humoral theories of medicine were firmly rejected—an occurrence we owe in large part to the discoveries of Pasteur (124). Then “[t]he parts including Fracastoro’s seeds of contagion and van Leeuwenhoek’s animalcules could not be fit together until miasma, the humoral-theory remnant, was disproven and replaced with a specific role for microorganisms in human disease” (Gaynes 124).

⁵ Miasma Theory is also known as Miasma Scheme. It was a theory popular through the eighteenth century and the start of the nineteenth that argued “disease was not spread through personal contact, but rather emanated from appalling environmental conditions that produced bad air, the disease trigger” (Day 130).

developed. By the end of the nineteenth century, medical experts understood that diseases spread through contagion, arising from bacteria and viruses (“epidemic”). We have Louis Pasteur to thank in part for this work.

I would be remiss, however, if I did not also extoll the work of Robert Koch. Koch’s work with TB was groundbreaking for the nineteenth century. His first text’s title, translated from its original German, is *The Aetiology of Tuberculosis* (1890); the book addresses the strides Koch made since first discovering the origins of tuberculosis in 1882 at Charité hospital in Berlin. He mentions that many of the gaps his initial discovery created are now filled by this research. Particularly useful is the section in which Koch describes the process for inoculation as he tested it on rabbits and smaller mammals, articulating that these tests definitively proved “tuberculosis is an infectious disease and that it is conditioned upon tuberculous bacilli” (71). Studies like this one that examined and proved the contagious nature of disease helped lead others to find cures or at least treatments for a whole host of communicable diseases.

In 1891, Koch published a further proceeding titled “Professor Koch’s Remedy for Tuberculosis: A Further Communication on a Remedy for Tuberculosis,” in which he addresses the potential treatment options for TB since the discovery of the tubercle bacillus. Here, the doctor focused primarily on the additional 150 cases he had since treated with some success using his remedy (Koch 21). He remarks that for a patient to be cured, he or she has to have no signs of the tubercle bacillus in their sputum for at least three months (21). Gaynes does caution, however, that while Koch’s initial work was strong and well-researched, his subsequent discoveries regarding TB floundered. He writes that the vaccination, tuberculin, “was not a booming success; less than 20% of all

patients treated were considered to be substantially improved” (198). However, despite Koch’s failures, we must also acknowledge his successes in the field of microbiology.⁶

While men in the nineteenth century were making helpful strides in the diagnosis of diseases, they still left much to be desired in terms of treating each gender equally. Judith Butler explains the motivation behind this the unbalance of gender in *Gender Trouble* (1990), writing that women become “the object, the Other of a (heterosexualized) masculine desire, but also to represent or reflect that desire” (59). Thus, the diseased woman not only becomes an object attracting masculine desire, but also represents and reflects the medical practitioner’s desire to cure her disease. She performs her sexuality in the medical space while under the medical gaze. However, many ill females subvert or reject entirely their illness and subsequent sexualization and reflection of male desire (both for cure and for sex), instead preferring to be perceived in terms unrelated to their illness. Just as the gendered female is the target of a patriarchal society, the ill female is at the mercy of a society that examines disease under the tutelage of that same patriarchy.

Furthermore, since the body is gendered, as Judith Butler argues, the way diseases manifest in these gendered bodies can be articulated as inherently different by the society which negotiates gender norms, regardless of whether or not the diseases actually differ in presentation. Butler writes, “[...] the ‘appearance’ of gender is often mistaken as a sign of its internal or inherent truth; gender is prompted by obligatory norms to be one gender or the other (usually within a strictly binary frame), and the reproduction of gender is thus

⁶ Koch also definitively proved cholera was a waterborne disease after exhaustive study of victims’ intestinal tracts and the bacteria discovered there (Gaynes 201). Further, he is remembered for his postulates, which “still serve as a guide for determining if a microorganism is the cause of a disease” (Gaynes 173-4).

always a negotiation with power” (1). Those with the power in nineteenth-century society—and therefore those who established gender norms—gendered diseases like hysteria, arguing that they affect men and women in different ways. Unfortunately, those not in power are only able to challenge this analysis of gendered illness in their writing, without guaranteeing a shift in public opinion. There is no place the resistance to or acceptance of gendered diagnoses of hysteria becomes more apparent than in the diseased female body, upon which white, wealthy, male medical practitioners enacted their treatments and authors subverted or supported the actions of the practitioners in their stories.

Therefore, the male gaze ends up influenced not only by gendered expectations but also by gendered performances. The male then uses the expectations to silence the woman, exploiting her, subjecting her to his gaze as part of his own gendered performance. “The determining male gaze projects its phantasy on to the female figure,” Mulvey writes, noting that this same figure “is styled accordingly” (346), presumably by the male. We encounter this same phenomenon in literature where male authors create idealized female characters. (We need look no further than George Bernard Shaw’s *Pygmalion* for a simultaneous critique and support of Mulvey’s notion.) Further, the male gaze becomes even more complicated when impacted by Foucault’s medical gaze. When the male objectifies the woman with his gaze but then further compounds this objectification with the medicalization of her person, he treats her not only as an object but also as a diseased object. The woman becomes not only exploited by virtue of her gender but also on account of her illness. Phrased another way, she now embodies the expectations of her gender as well as the manifestations of her illness.

As a result of the interplay between the male gaze and the medical one, disease becomes a particularly revealing site for the study of gender in literature and the stereotypes and expectations that surround that gender. The connection between disease and gender allows us to explore the impact of epidemiology on these two areas of study. Mary Ann G. Cutter explains gender in *The Ethics of Gender-Specific Disease* (2012) as the result of “embedding a female or male in her or his culture” and sex as based on “the genetic (chromosomal) patterns” (9). However, physicians and other medical authorities of the nineteenth century made no such distinctions. Cutter further explains that very little change regarding the “primacy of the male body” (13) occurred from antiquity through the nineteenth-century in Europe and North America. She writes, “[n]ineteenth-century clinical medicine echoes the view that woman’s bodies were different and difference is deficit” (13). This view is then reflected in much of the literature regarding these bodies—in particular the diseased ones—throughout this era. Cutter further specifies that this perceived difference is due solely to the “female reproductive system” (14), a fact that can seemingly be supported by hysteria, chlorosis, and tuberculosis since these diseases affected many young women at the start of puberty.⁷

Furthermore, this dissertation examines disease within society and how the performance of gender influenced that presence. Therefore, I study the rise and decline in incidences of these three different, gender-biased diagnoses—tuberculosis, chlorosis, and hysteria—throughout the long nineteenth century. First, I examine the exploration of tuberculosis (also known as consumption and commonly referred to as TB). TB was a

⁷ Roberts and Buikstra are careful to note that while we cannot definitively know everything about tuberculosis in the past from the skeletal data we have, scholars of medicine can recognize “that in small groups of people where the disease was endemic in the past, virtually all would have been affected as youths, thus helping us with the consideration of age and its relationship to the infection” (50).

difficult disease to define until Koch's discovery at the end of the nineteenth century. Because of its many symptoms, multiple terms were used to identify, diagnose, and treat the disease we today identify as *pulmonary tuberculosis*.⁸ Chief among these terms during the nineteenth century were *phthisis*, *scrofula*, and (as noted earlier) *consumption*.⁹ Also styled the "White Death" in contradistinction to the famous medieval plague the Black Death, this and the "white plague" were additional well-known terms for TB at a time when the disease reached epidemic proportions with high mortality rates ("white"). However, historical differences did exist among these terms and the conditions to which they refer. *Chapters 2–4* explore the ways in which the experience of consumptive patients and the representation of TB, under its many terms, was influenced by gender biases as well as uncertainties about the diagnosis itself.

⁸ The first medical use of the term *consumption* emerged in 1398 and initially referred to a "humoral" imbalance that led to a wasting of the body ("consumption). Later it came to mean a "n. any disease causing wasting of tissues, especially (formerly) pulmonary tuberculosis" ("consumption"). Further, *phthisis* in a medical context dates back to 1525 and similarly is "[a] wasting disease, esp. one involving the lungs" ("phthisis"). These two terms—*phthisis* and *consumption*—are most likely historic terms today in part because of our emerging understanding of disease and contagion, which has led to replacing the diagnosis of a wasting disease with the identification of pulmonary tuberculosis. The term *tuberculosis* emerged in 1839, to refer to an illness "characterized by the formation of tubercles; spec. that caused in humans by infection with the bacterium *Mycobacterium tuberculosis*" ("tuberculosis"). This term is often used in tandem with a "distinguishing word indicating the site or stage of infection, method of transmission, etc." ("tuberculosis"). This distinguishing word, for the purposes of this project, is *pulmonary* since I focus exclusively on tuberculosis as it occurs in the lungs. Because all three of these terms were used during the era on which this dissertation focuses, I will refer to the disease by all three—*phthisis*, *consumption*, and *tuberculosis*—depending on how the primary and secondary texts I am using refer to the disease.

⁹ Tuberculosis is also sometimes referred to as "scrofula" in older medical texts (and is cited as such by Fergus Shanahan and Eamonn M.M. Quigley in their article "Medicine in the Age of *Ulysses*: James Joyce's Portrait of Life, Medicine, and Disease on a Dublin Day a Century Ago," p. 281.) Scrofula, according to the *OED*, is "[a] constitutional disease characterized mainly by chronic enlargement and degeneration of the lymphatic glands" ("Scrofula"), a definition which seems at once more specific and yet also less connected to the other terms for tuberculosis, which is why it is not being used alongside the others in this dissertation. Additionally, scrofula becomes a hereditary diagnosis of TB according to Gustav Fütterer, who writes in 1895: "Scrofulosis is generally an hereditary condition, which children inherit from parents who were diseased with tuberculosis, scrofulosis or syphilis" (947).

Ultimately, these chapters expand the understanding of tuberculosis beyond the way it was conceived in relation to gender binaries. I thereby expose the way these binaries shaped how doctors thought about and treated TB and, as a result, the way family members understood and patients experienced the illness. To complete this undertaking, these chapters examine the ways in which expectations of the female gender in nineteenth-century U.S. and Britain were subverted or reinforced through textual portrayals of this disease and in medical treatises regarding tuberculosis. I further analyze the ways in which women authors and female characters used tuberculosis as a means of articulating both social and familial expectations regarding their (diseased) bodies. In studying disease as representative of societal and gendered expectancies, this portion of my dissertation focuses on the ways in which consumption shaped social understandings of gender, both supporting and sublimating knowledge and anxieties about the way the experience of disease differed from a male body to a female one.

After focusing on TB in *Chapters 2, 3, and 4*, I then turn to chlorosis as a gender-specific disease that thrives and then nearly disappears under the watchful male, medical gaze. Chlorosis was understood in the nineteenth century to be a disease connected with tuberculosis due to the weaknesses of the patient's heart (Fütterer 948). Further, medical practitioners described it as a disease that predominantly affected young woman. Helen King, author of the most comprehensive text on chlorosis, *On the Disease of Virgins* (2009), explains that "the typical sufferer was still expected to be female and pubertal" by the start of the nineteenth century even though the disease had its roots much earlier (*Disease 8*). The influence of gender impacted understandings of this diagnosis and was further compounded by class and age, a departure from diseases of the past such as

cholera, which could affect any one regardless of class, age, or gender. Because of this gendered and age-related diagnosis, the fictional and real-life figures studied in this section are young women who appear to be exhibiting signs of chlorosis.¹⁰

Interestingly, chlorosis defined in broader terms was a “disorder believed to occur almost exclusively in young, virginal women soon after puberty, characterized by a greenish pallor of the skin, cessation or irregularity of menstruation, and weakness, often accompanied by pica or other disturbance of appetite; an instance or case of this. Also called green sickness” (“chlorosis”). King agrees with this definition, explaining that it was typical of the nineteenth century’s understanding of the disease. However, she further notes that a small proportion of diagnoses of chlorosis “could also appear in young and delicate men” (qtd. in King, *Disease* 8). Thus, while this “disease of virgins” was diagnosed almost entirely in young women, exceptions could be found in the presumably delicate men of the nineteenth century.¹¹ For the purposes of this dissertation, however, my focus is on young women who were either diagnosed with or exhibited

¹⁰ King does note that in some instances, chlorosis was thought to affect older woman. She quotes the midwife Jane Sharp who explains that menstrual suppression is often seen in young women ““whereas women vomit, do not want to eat, or crave unnatural foods”” (qtd. in King, *Disease* 16). Though in general, “chlorosis remained tied, above all, to virgins at menarche” (King, *Disease* 17), thus proving that this disease was most largely experienced by young women.

¹¹ Just as the chlorotic female mimicked patterns similar to those that present in cases of hysteria, the male chlorotic tended towards neurasthenic attitudes. C. F. Martin in “A Note On Chlorosis in the Male” (1894), writes of one of his male patients diagnosed with chlorosis that he had “depression, almost approaching true neurasthenia” in tandem with his chlorotic symptoms (123). One of these attributes might be a propensity to lovesickness or at least general melancholy, as indicated by Martin’s use of the term “depression.” Martin then explains the still-gendered reading of chlorotic males, noting that “[m]any authors, indeed, deny utterly its existence in members of the male sex, while others, though recognising its rare occurrence in men, have regarded it as a condition present only in connection with other feminine attributes, and existing thus only in men whose general characteristics and constitution render them effeminate” (123). He further expands on this reading, noting that many doctors argue that “male chlorotics are always slender individuals, of feminine build, and frequently engaged in effeminate occupations, such as tailoring, etc.” (123). Martin’s case report and analysis prove that though males could contract chlorosis during the nineteenth century, when they did so, it was still coded as a female’s disease, with what they observed as females’ inherent weaknesses, regardless of the biological sex of the patient.

symptoms of chlorosis because these young women were the primary sufferers of this disease and were most often subjected to the medical gaze as a result.

To fully understand chlorosis, one must understand not only who was primarily affected by the disease but also what the disease entailed. According to modern scholar Elizabeth M. E. Poskitt in “Early History of Iron Deficiency” chlorosis was a “hypochromic anemia in adolescent girls associated with gastrointestinal and menstrual disorder” (556-57).¹² These gastrointestinal and menstrual disturbances created a host of other problems in the patient, including “paleness and sallowness of complexion, palpitations of the heart, difficulty breathing on exertion, bloated appearance, loss of appetite, reluctance to exercise and amenorrhea” (Poskitt 557). King’s description of these chlorotic symptoms is even more expansive. She notes that nineteenth-century physician Frederick Hollick identified the sufferers of chlorosis as “the most interesting perhaps of all that come under the physician’s care. Delicate and interesting, stricken by a disease from which they deeply suffer, but which often leaves their beauty untouched, or even heightens their attractions” (qtd. in King, *Disease* 6). Hollick’s description once again articulates the nineteenth-century fascination with feminine beauty in tandem with feminine ailments. As a result of this preoccupation with female beauty and disease, nineteenth-century women were simultaneously warned about the dangers of chlorosis while also being exposed to praise which focused on its symptoms, much like their beautiful, tubercular counterparts.

¹² Hypochromic anemia is often regarded as the modern-day equivalent of chlorosis. The OED defines “hypochromic” as “red blood cells that contain less haemoglobin than normal and show an increased central pallor; esp. in hypochromic anemia” (“hypochromic”). This definition becomes particularly useful as scientific advances allow doctors later in the nineteenth century to study the physical make-up of the chlorotic’s blood under a microscope. For more on the diagnosis of hypochromic anemia—and its still-present relation to the female gender—see *Anemia in Women* (2002) by Joan Gomez.

King explains that chlorosis went by a number of names, some of which continue to the present day. These include the “‘disease of virgins’, or *morbis virgineus*” as well as “white fever, the green sickness, chlorosis [...] and, from the mid-nineteenth century, hypochromic anemia” (King, *Disease 2*). It is in the Greek *chloros* that we find the explanation for the term “green sick,” just as the Greek language provides the root word for hysteria. As King explains, chlorosis arose as “a coined ‘technical’ word based on *chloros*, a Greek term for ‘yellow green’” (*Disease 2*). Thus, the seemingly jaundiced or sallow individual becomes “green sick,” much in the way a plant that does not receive enough chlorophyll turns yellow-green and is therefore also described as having chlorosis. King also offers other possible meanings of “green sick,” noting that it could have to do with another woman’s envy of the green-sick girl, or as a representation of the chlorotic girl’s sexual innocence as “green was also seen as the color of sexuality and nature” (King, *Disease 35*). King also cites Irvine Loudon, a scholar on medical history, who “argued the origin of the label lay instead in the use of ‘green’ to mean youthful, immature, or inexperienced” (34). Furthermore, there are numerous reports of this green skin color occurring, including “eminent US physician W. Crosby’s 1955 case of anemia with green discoloration” (Poskitt 557).¹³ However, the color of the patient’s skin is less important than other symptoms with which a chlorotic girl would present, as mentioned above.

¹³ For more perspectives on green-colored skin in reports of greensickness, see King’s Chapter 1 (particularly the subsection “From green jaundice to green sickness”) in *The Disease of Virgins*. Additionally, a case study was published by Eva Perdahl-Wallace and Richard Schwartz in 2006 titled “A Girl with Green Complexion and Iron Deficiency: Chlorosis Revisited” in which the young female patient was diagnosed as having chlorosis in part due to the green tint to her skin.

A condition sometimes associated with chlorosis is the diagnosis of hysteria and its comorbid condition, neurasthenia. Vandereycken and van Deth explain, “hysteria might lead to cachexia, anorexia, and chlorosis” (126).¹⁴ Therefore, the last area that this dissertation focuses on comprises studies and diagnoses of hysteria and neurasthenia. To study these diagnoses and presentations of the disease, one must first be able to understand the historical contexts of each of these diseases as influenced by gender and/or class. Hoffman explains, “[h]ysteria, while not confined to women, retained the link to femininity that its etymology conveys. Associating femininity and the female body with disease became a commonplace in Britain and the United States toward the end of the nineteenth century, with bed rest and confinement almost a way of life for many women of the middle and upper classes” (7).

Definitions of hysteria as a medical condition emerged in the early nineteenth century.¹⁵ For example, in an 1801 edition of *The Medical and Physical Journal*, one of the doctors—G. McLaren—shares the case of his patient, Mary Aitken, afflicted with violent hysteria, writing: “she was of the sanguine habit, and robust constitution: She had taken a number of medicines commonly used in that disease, but had experienced no relief” (McLaren 235). Here we see not only the difficulty with treating hysteria but the lingering contexts of former medical practices such as humoral medicine as evidenced by McLaren’s use of the term “sanguine” as this term was used in medical contexts to

¹⁴ Comorbid or co-morbid conditions are those which are referred to as “relating to or denoting a medical condition that co-occurs with another” (“co-morbid”).

¹⁵ The Concise Medical Dictionary (2019) defines hysteria as “formerly, a neurosis characterized by emotional instability, repression, dissociation, some physical symptoms (see hysterical), and vulnerability to suggestion. Two types were recognized: conversion hysteria, now known as conversion disorder; and dissociative hysteria, comprising a group of conditions now generally regarded as dissociative disorders. See also neurosis. 2. a state of great emotional excitement” (“hysteria”).

indicate an imbalance of blood in the body.¹⁶ As the century progressed, medical professionals moved away from humoral medicine to studying the nerves, describing hysteria as a pathology “attended with emotional disturbances and enfeeblement or perversion of the moral and intellectual faculties” (“hysteria”). However, their description of hysteria also focused on what medical practitioners saw as somatic manifestations of this disease, including convulsions, hiccups, and disturbances of the womb (“hysteria”), the last—indicating a diseased uterus or atypical menstruation—making it a diagnosis largely associated with the female body.

Sources from the nineteenth century also provide unique perspectives on how hysteria was defined as a disease by the symptoms with which it presented. *A New Medical Dictionary* published in 1890 by George Milbry Gould defines hysteria as “a reflect neurosis; not with certainty known whether it is due to structural alteration of any part of the central nervous system, or to abnormal blood supply, etc. Paralysis, impairment of vision, convulsions, etc. are usually prominent symptoms” (202).¹⁷ This potential structural alteration, an idea echoed by Clarke and Lawlor both, allows readers to not only consider the body of the text but also the body of the patient and how hysteria might change this body, physically as well as mentally through, among other symptoms, incidences of localized paralysis and convulsions. If we take this structural alteration a step further and look at it in relation to the literary texts, we consider how hysteria can pause a text, causing a stop while the hysteric once again gets his or her bearings as we’ll

¹⁶ See William A. Jackson’s “A Short Guide to Humoral Medicine” (2001).

¹⁷ Because of his background in medicine—Gould was a renowned ophthalmologist—and “his interest in medical lexicography,” he published “a number of dictionaries, the first of which was published in 1890; more than a half million copies of his dictionaries were sold” (Alewitz “George Milbry Gould”).

see in the study of Charlotte Brontë's *Jane Eyre* (1847). We can also see hysteria as creating a series of convulsions in a text, when many events are occurring quickly.

Gould's focus on these physical manifestations of hysteria is in keeping with other understandings from the time, including Clarke's knowledge of this illness. In fact, Clarke's text defines hysteria in similar terms. He writes that one "important feature [of hysteria] is the way in which the emotions quickly influence the motor, vasomotor, sensory and secretory functions of the body" (Clarke 11). Here Clarke seems to find a connection between the emotional actions of the body and those which are abnormal, thereby judging those who experience an emotional reaction to an event. It is necessary to note that this misunderstanding is particularly important when we consider instances of traumatic hysteria. Thus, those nineteenth-century women experiencing traumatic and/or emotional events may find themselves facing a diagnosis of hysteria as well, particularly that of traumatic hysteria simply because they are coming to terms with whatever trauma has occurred. Clarke further specifies that the "more permanent hysterical symptoms, such as various paralyses and anaesthesias, frequently appear as the immediate consequence of a fit" (12). So, while these definitions were unclear as to the cause of hysteria, they tended to agree on the physical manifestations of this disease.

As these descriptions indicate, a diagnosis of hysteria focused on more than just a disturbed womb, which means assumptions about the genders it impacted must consider more than female anatomy. In the somatic sense, it was linked with other nineteenth-century diagnoses that encompassed a patient's nervous system. For example, the disorder known as *hyperaesthesia* was considered one of the physical manifestations of hysteria during this era ("hysteria"). Like hysteria, hyperaesthesia was characterized by

both somatic and psychosomatic symptoms, thus reinforcing the need to take both into account when studying this disease and its related ailments. The *OED* defines hyperaesthesia as “[e]xcessive and morbid sensitiveness of the nerves or nerve-centres” (“hyperaesthesia”). This term is further supported by medical dictionaries which describe this condition as “[i]ncreased sensitivity of any of the sense organs, especially touch” (“hyperaesthesia”). However, by the nineteenth century, a strongly gendered component was the focus of studies about hysteria, with experts like Clarke claiming that hysteria “is undoubtedly far more common among women” (6) despite larger numbers of men being treated for similar symptoms. In fact, society looked at sexuality in a woman, particularly sexual excess, as contributing to hysteria. Clarke explains that while at the beginning of the nineteenth century it was understood that sexual organs in some way caused hysteria, by the start of the twentieth century “[s]exual excess and sexual irregularities on account of their exhausting effect, and, in the case of the latter, of its prejudicial action in many ways upon the nervous system, would increase a predisposition to hysteria, and possibly in some cases act more directly” (8). Hysteria, then, became more common due to the fact that “[i]n the nineteenth century, especially young women were expected to be delicate and vulnerable both physically and emotionally, and this image was reflected in their disposition to hysteria and the nature of its symptoms” (209) according to Ilza Veith, author of *Hysteria: The History of a Disease* (1965). Thus, medical practitioners tended to associate exhaustion of the systems particularly influenced by female anatomy with their diagnoses of hysteria.

It is important to note, however, that some people at this time did believe hysteria could be diagnosed in men. Edmund A. Kirby, in *On the Value of Phosphorus: As a*

Remedy for Loss of Nerve Power and Functional Disorders of the Nervous System

(1881), explains how men who developed hysteria were often afflicted by “worry, anxiety, overwork, late hours, accidental injuries, and dissipation” (52). He distinguishes this diagnosis from females, who often were diagnosed with hysteria due to “vexatious emotions, want of sympathy or success, disappointed or concealed affection, want of occupation, fear, and morbid conditions or supposed morbid conditions of the reproductive system” (52). Thus, despite the fact that the diagnosis would be the same for both men and women, the underlying causes were still being distinguished according to gender even towards the end of the nineteenth century.

According to many American practitioners in the early nineteenth century, men who exhibited some of the same traits were diagnosed with *neurasthenia*, a condition similar to hysteria. Neurasthenia was defined as a “disorder characterized by feelings of fatigue and lassitude” that was accompanied by “vague physical symptoms such as headache, muscle pain, and subjective sensory disturbances” (“neurasthenia”).¹⁸ Further, neurasthenia was “originally attributed to a weakness or exhaustion of the nerves” and only later was “considered a form of neurotic disorder” (“neurasthenia”). Gould defines neurasthenia as a “deficiency or exhaustion of nervous force. Debility of the nervous centers” (305). It is important to note, too, that Clarke carried on this idea that neurasthenia was due to a depletion of the body—mostly in men due to overwork and the

¹⁸ Per Fink, author of “From Hysteria to Somatization” argues that there is in fact a similarity between this presentation of hysteria and our modern diagnosis of fibromyalgia. He writes, “[a] local irritation of the spinal marrow (spinal irritation) would cause symptoms from the reflex arcs. [...] To diagnose a patient, they looked for signs of irritation—the so-called ‘tender points’ in the musculature, tenderness between the shoulders, and so forth. The concept was later used by Charcot, who described the so-called hysteriogenic zones. Today similar ‘tender points’ are used in diagnosing fibromyalgia. When the centre of irritation was found, certain things were applied locally to the skin, or the patient was blistered or cupped, and so forth” (355).

other strictures of nineteenth-century industrial life. He writes that while neurasthenia is not a terminal disease, it does sometimes take the “best years of a man’s life,” which are then “passed in a carefully restricted activity” (261) due to the constraints of modern living. Thus, it is not a surprise that for nineteenth-century practitioners neurasthenia—associated so much with work and energy—was more closely linked to men whereas hysteria—commonly associated with nerves and emotions—was seen as a woman’s disease.

These diseases were not always separated on gendered lines, however. Because both neurasthenia and hysteria focused on nervous complaints and physical symptoms, an overlap between these two diagnoses was not uncommon, especially if one went abroad, where the gendered distinctions were not prevalent. In “Writing Siblings: Alice James and Her Brothers,” Anne Golomb Hoffman explains that in the United States the difference in gender as it related to a diagnosis of hysteria or neurasthenia was most pronounced.¹⁹ She writes, “[i]n its American context, the connotations of neurasthenia were masculine, although it was not restricted to men, and indicated the depletion of energies that had been employed in productive work” (7). This gender distinction may explain why the expatriate James first received a diagnosis of hysteria in the United States and only later was diagnosed as having neurasthenia while she was abroad in Europe. Although some experts, like Clarke, considered hysteria an umbrella term under which nervous diseases like neurasthenia fell, others argued that neurasthenia and hysteria were two distinct diagnoses.

¹⁹ It is important to note, for example, that Alice James herself was diagnosed with both hysteria and neurasthenia at different points in her life and by different practitioners, thus indicating that gender biases only marginally separated these two diagnoses.

Furthermore, authoritative dictionaries make no mention of gender in regard to this diagnosis, thus suggesting that there is only some historical grounding—mentioned in the work of scholars like Hoffman—to separate hysteria and neurasthenia along gendered lines. The cases of several well-known hysterics, including Alice James, and neurasthenics, including Charlotte Perkins Gilman, support this point. In fact, many sources providing a historical perspective on these diagnoses argue that throughout the nineteenth century there was much uncertainty about how to diagnose patients. For example, in *Cultures of Neurasthenia from Beard to the First World War* (2001), the editors acknowledge that “confusion reigns over gender: some doctors, and later historians, may have presented neurasthenia as a primarily male affair—the counterpart of female hysteria—but others disagreed, and the known examples of British diagnostic practice and treatment indeed show a fairly mixed picture” (Gijswijt-Hofstra & Porter 7). This mixed picture prevailed throughout the nineteenth and into the twentieth century and impacted treatments and literary representations of these illnesses.

A comorbid condition that all three of these diseases have in common is the diagnosis of lovesickness or love melancholy. Problematic in its very nature as it is an archaic and gendered diagnosis that focused on the impact thwarted love has on a woman, lovesickness is often described as both a symptom and a cause of tuberculosis, chlorosis, and hysteria. On the one hand, as a symptom, lovesickness indicates that something is wrong with the diseased female and allows her doctors to explore possible reasons for this abnormality; on the other, it is a cause for other illnesses as this type of sickness increases her susceptibility to getting other diseases as it physically and emotionally weakens her. Lovesickness exacerbates the sexualization of the tubercular

woman as it indicates her desiring nature, the repression of the hysterical one as it shares her thwarted love, and the stunted development of the chlorotic as it intensifies her aversion to love.

There are two specific definitions for lovesick. First, the *OED* defines the condition as “[o]verwhelmed by (esp. unrequited or unfulfilled) love; languishing for or with love” (“lovesick,” n.1). Secondly, the *OED* describes it as “[r]esulting from or displaying evidence of lovesickness” (“lovesick,” n.2). The first definition privileges the idea of the invalid languishing from love, equating the condition with a wasting illness such as consumption. The second relies on the idea of performance. To the first, I simply offer that it places the blame of illness on something which the patient has failed to do. Chiefly, they have been unable to fulfil their love *or*, worse, have been found lacking by the object of their affections; they have begun then to languish. In response to the second definition, I offer part of Butler’s description on performance:

[...] acts, gestures, and desire produce the effect of an internal core or substance, but produce this *on the surface* of the body, through the play of signifying absences that suggest, but never reveal, the organizing principle of identity as a cause. Such acts, gestures, enactments, generally construed, are *performative* in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained through corporeal signs and other discursive means. (185)

Thus, the lovesick person’s body becomes the stage on which the corporeal signs of her condition are acted out. We see her languishing, we discover that others are now attracted to her because she performs through her identity those things which signify her

attractiveness—she is the object on which their desires can both be played out and towards which they can direct their (male, medical) gaze—and we recognize that all of this action and reaction occurs as a result of illness and the manufacturing of disease as something desirable rather than something deadly.

Art from the nineteenth century illustrates vividly the objectification of and desire for the languishing, lovesick woman as a result of the male and medical gazes. The artwork included below by John Opie (tint by William Walker) provides one example of many. Opie has titled his painting either the *Doctor Fooled* or *Lovesick Maid* (1802) indicating the troubling take on lovesick women as opportunistic



Figure 1: Taken from the Wellcome Collection.

when they rely on their physician's sympathies. However, more than simply playing on the doctor's sympathies—despite his clearly grave face as he considers her pulse and is displeased with what he finds—the idea of the lovesick maid as attractive comes across clearly here. Note her fawning audience (including a capped figure at her side representing either her mother or a devoted servant in addition to the smiling Cupid hovering over her chair) as they give her their undivided attention; the capped woman's

no doubt is borne out of fear, while Cupid's clearly arises from his delight in causing mischief. Here, too, is a commentary on lovesickness as outside the female's culpability as seen in the second definition mentioned above. The fault for her disease lies with Cupid, not herself, and therefore she is a passive sufferer worthy of our sympathy.

It is not the maiden's audience that captures our attention for long, however. Just as her attendants focus on her, viewers outside the artwork are drawn towards studying the lovesick maiden almost exclusively after a cursory glance at the others (in which we note where their attention is as well). Only the two men look directly at the audience viewing the painting; however, the women are the two on whom our attention, our gaze, rests. The maiden's white dress—an obvious symbol of her purity—elicits a more detailed focus than the dark coverings of the other figures. Further, her languishing pose works at drawing our sympathies as we consider how tragic lovesickness truly is. She seems nearly incapable of holding herself up; her hand lies at her side, her body reclines in a half-supine position, and her facial expression is blank, as if she is past caring about the state of her health.

As the brief analysis proves, in looking at artwork, we can visualize aspects of the diseases mentioned in literature, using, as is hinted above, our own medical gaze. In fact, the painting illustrates many of the themes that this dissertation considers. For example, we are able to see the connection or lack thereof between the patient and her doctor, which becomes so important in studies of hysteria, tuberculosis, and chlorosis. We are able to make the connection between the young girl and her support system as she leans on them—at times quite literally like in the artwork—just as she would with her chaperones, family, or friends as she does when diagnosed with consumption, hysteria, or

chlorosis. Finally, we notice what is absent—there is no lover, for example, nor any signs of the woman’s interests besides the lover—and so her heart has weakened, as do so many of the women studied in the following chapters, from the absence of stimulating (sexually or otherwise) persons and materials. The visual depiction clearly encapsulates the same message this dissertation does in its following chapters: illness—and writing about disease—is about far more than the diagnosis.

The question of this dissertation’s purpose, then, comes down to not why write about disease but rather why write about these diseases during this time and in connection with gender and literature? The answer to this question is two-fold. These diseases rose in incidence during the nineteenth century as did new medical practices and emerging understandings of epidemiology as mentioned above with the work of Pasteur and Koch. Further, because tuberculosis was a bacterial disease, incidences of it arose as a result of the urbanization of industrial centers, in which people were crowded into often unhygienic environments. Hysteria and chlorosis, while not bacterial illnesses, also rose in occurrences due to shifting understandings of women’s places inside and outside the home. These increases and then subsequent decreases of each disease are explained in more detail in *Chapter 2* (tuberculosis), *Chapter 5* (chlorosis), and *Chapter 9* (hysteria). As the chapters that follow illustrate, the sexual nature of nineteenth-century female-associated illness captivated contemporary male authors, medical practitioners, and audiences. Each chapter of this dissertation considers precisely why female-associated illness was in fact so captivating—and why it remains captivating, in many ways, today.

To begin, *Chapter 2* provides a more detailed background of consumption or tuberculosis and the context in which the nineteenth century places it in regard to gender

and medical dynamics. I use the work of Clark Lawlor here, in particular his studies of tubercular women and the myths that surrounded these women in the nineteenth century. I begin by examining Lawlor's notions of the spiritual and beautiful consumptives during the Romantic era. I then study these notions alongside transatlantic texts. *Chapter 3* investigates the ways in which tuberculosis was first viewed as a disease that made its female sufferer beautiful and its male sufferer creative. I then add my own take, disputing parts of Lawlor's myths to dig deeper into representations of the creative female consumptive. The texts that assist in my study are the poetry of Keats—after all, Lawlor articulates that “[p]oets were influenced by physicians—and vice versa—in a process of cultural feedback” (16)—“The Masque of the Red Death” by Poe, and *Wuthering Heights* by Emily Brontë. Moving towards the middle of the century, *Chapter 4* expands upon Lawlor's concept of the beautiful consumptive patient and looks at the ways in which she was also a spiritual sufferer by examining the novel *Uncle Tom's Cabin* by Harriet Beecher Stowe. Then, using the poetry of Emily Dickinson, I explore the problematic nature of beautiful suffering. Finally, to conclude this chapter, I examine James Joyce's “The Dead” to consider how this male writer perceived female consumptives as striving to move away from these distinct myths by the start of the twentieth century.

Turning from TB, *Chapter 5* moves the focus to chlorosis because of its connection to tuberculosis (outlined above), a connection that arises from the weak state of the chlorotic's heart. In particular, I introduce the ways in which it has its roots in an Early Modern setting and why those early ideas were still applicable by the 1800s. *Chapter 6* then examines the ways in which these understandings influenced parent-child dynamics (and vice versa) as well as doctor-patient ones when the female patient was

experiencing symptoms of chlorosis. To this end, I analyze the short story “Rappaccini’s Daughter” by Nathaniel Hawthorne. I then juxtapose the Rappaccinis’ father-daughter relationship with the mother-daughter dynamic of Catherine and Anne de Bourgh in Austen’s *Pride and Prejudice*. *Chapter 7* rounds out the study of chlorosis with an exploration of how understandings of the disease had changed by the end of the century even as the number of cases declined. I compare the novels *Dracula* by Bram Stoker and *Wings of the Dove* by Henry James to explore the intersections of gendered disease, lovesickness, and social change around the turn of the twentieth century.

Then, due to the link between chlorosis and hysteria, *Chapter 8* introduces hysteria and its comorbid condition neurasthenia in a nineteenth-century context, using a medical source from that time to study the ways in which the diseases were understood as separate and yet also correlated. *Chapter 9* then moves to focus on the way hysteria was either resisted or succumbed to in early- and mid-nineteenth-century texts such as Charlotte Brontë’s *Jane Eyre* and the autobiographical *Diary of Alice James*. Finally, *Chapter 10* studies shifting ideas about this disease and treatments by the end of the century by examining “The Yellow Wall-Paper” by Charlotte Perkins Gilman and a short story, “The Autobiography of a Quack,” by her infamous doctor, Silas Weir Mitchell. To conclude this project, the afterword offers a look forward at the ways in which biases continue to impact gender-specific medicine today and how those biases have been impacted by the determinantal mal(e)practice of racialized medicine. Ultimately, the goal of this project from *Chapter 1* through the afterword is to inspire readers to engage with texts in ways they have not previously. In reaching this goal, I hope to encourage scholars

to not only consider the placement of the disease within the text but also what it accomplished in and from that place.

Chapter Two: The Ideal Tubercular (Woman) in Nineteenth-Century Literature

“This patient consulted me Feb. 7, 1872. Her medical history was very discouraging, her mother having died of Consumption many years ago. She complained of severe cough, with copious mucopurulent expectoration, and distressing want of breath.¹ She was also very bloodless, her lips, tongue, and inside of eyelids being unnaturally pale.”

– Dr. E. H. Ruddock from *On Consumption, and Tuberculosis of the Lungs: Their Diagnosis, Causes, and Preventive and General Treatment* (1873)

The above vignette is representative of perceptions about consumption in the nineteenth century.² The medical community understood this illness to be a hereditary disease that included symptoms of breathlessness, paleness, and a productive cough, among other symptoms, as presented in the above entry (Fütterer 944).³ Because tuberculosis reached epidemic proportions by the start of the nineteenth century, creative writers were quick to explore the disease in their work, likely knowing they would attract audiences. For that reason, this dissertation first turns to consumption, which E. H. Ruddock showcases so clearly above in his female patient’s symptoms of coughing, breathlessness, and pallor among others.⁴ The TB portion of this dissertation opens with a study of how consumption became an epidemic during this era and how society reacted as the disease manifested throughout the populations of Britain, Ireland, and the United

¹ The OED defines mucopurulent as “consisting of mucus and pus” (“mucopurulent”). Thus, Ruddock’s patient was coughing painfully and her expectoration was full of pus, indicating infection in the lungs or other respiratory passageways.

² Throughout this chapter, the term *tuberculosis* will be used to refer exclusively to the pulmonary tuberculosis diagnosis. According to *The Bioarcheology of Tuberculosis*, this would be the form of tuberculosis “transmitted by infected droplets into the lungs from an infected person to a non-infected person; this is termed the respiratory route and occurs through coughing, sneezing, and even speaking and singing” (Roberts & Buikstra 5).

³ Gusta Fütterer, a professor of physical diagnosis and a consulting physician in 1895, presents an interesting text on the relationships between TB, chlorosis, and scrofula. For more on his understanding of the relationships between these diseases see *Chapter 1*.

⁴ E.H. (Edward Harris) Ruddock was a member of England’s royal college of surgeons who believed in homeopathic care for patients and practiced from the mid-nineteenth-century onwards (Young “Ruddock”).

States. Next, I shed light on the ways in which presentations of TB were thought to differ in men and women and how treatments for each gender surfaced separately as a result.

Social understandings of TB were influenced to a large degree by the ways in which this disease spread. Because of its wide-reaching contagion, tuberculosis infected many populations during the nineteenth century. Therefore, I study the common expressions of the disease in the United States of America, Ireland, and England, including the way this wasting illness impacted the lungs and led to recorded symptoms such as “progressive emaciation, coughing, languidness, fever” and eventually to hemoptysis, or the coughing up of blood (Sontag 12). Further, because this illness began to spread throughout both continents, quickly reaching an epidemic level of contagion with similar expressions of symptoms in the patients’ bodies, it is necessary to study what medical minds and literary ones were expressing about consumption.

In addition to studying broadly the way the disease manifested in those it affected, medical practitioners specifically examined how TB appeared in female members at different levels of society.⁵ To better understand the shift in ideals regarding consumption, some cultural knowledge is necessary. By the end of the 1800’s, the idea of germ theory was largely accepted by scientists and medical practitioners as a replacement theory for the idea that miasmas of diseases allowed the progress of assorted illnesses throughout populations. In fact, eighteenth- and nineteenth-century proponents of the

⁵ Historical research into the pandemic of tuberculosis is not a new field; rather, this study is an undertaking that spans genres, centuries, and continents. Many works address the ways in which TB symptoms presented in those the disease infected throughout the long nineteenth century. Of paramount importance for understanding emerging developments regarding consumption in the nineteenth century is Dr. Robert Koch’s report on the etiology of the disease addressed in the introduction to this project. Furthermore, without the work of Louis Pasteur on the germ theory of disease and Koch’s subsequent discovery, we would not have any understanding of precisely why TB was contagious and of how it presented in those infected. For more on the work of Koch and Pasteur, see *Chapter 1*.

Miasma Theory of Disease “believed that disease was created and carried by foul air emanating from sewage, polluted waters, and putrefying organic matter. Air, not water, was seen as the primary threat to health in the first two-thirds of the century” (Smeele 17). However, by the end of the nineteenth century, scientific discoveries led to a shift in beliefs about the way diseases spread. Specifically, the work of Robert Koch in isolating the *Mycobacterium tuberculosis* definitively proved that tuberculosis “was due to an external cause, an ‘infectious agent’” (Cambau & Drancourt 199).⁶ Thus, society could no longer blame the patient’s hereditary dispositions, location, gender, age, or status for contracting consumption; there was a medically-proven external cause.

Sir James Clark’s *A Treatise on Pulmonary Consumption* (1835) explains some of the purportedly female-specific manifestations of this disease, and rejects those that are inaccurate.^{6 7} First, Clark notes, females are understood to show the symptom of hemoptysis slightly more often—“in the proportion of three to two” as compared to males—which he links to either amenorrhea or the cessation of menstruation due to age (94-95), seeming to harken back at least somewhat to humoral medicine and the balance of blood in the body. In addition to explaining to a largely ignorant society reasons why

⁶ For more on Koch’s work in his own words, see *The Aetiology of Tuberculosis* (1980) as translated from the original German by T. Saure.

⁷ Sir James Clark was the British physician to Leopold I of Belgium before Leopold was crowned king, a fact Clark mentions in the introduction to his text, which he dedicated to Leopold (n.p.). Leopold I recommended Clark to then Princess Victoria (n.p.). When Princess Victoria became Queen of England, Clark remained her physician and was given the title of first baronet. He published two other works on consumption: *Medical Notes on Climate, Diseases, Hospitals, and Medical Schools in France, Italy, and Switzerland, comprising an Inquiry into the effects of a residence in the South of Europe in cases of Pulmonary Consumption* (1822) and *The Influence of Climate in the Prevention and Cure of Chronic Diseases, more particularly of the Chest and Digestive Organs* (1829) (n.p.). Further, Clark was also Keats’s physician through the poet’s TB diagnosis and death, a fact mentioned in one the letters his friend, Joseph Severn, wrote home: “When Dr Clark came on the 2nd day Keats demanded ‘How long is this posthumous life of mine to last?’ The Doctor was unable to answer & afterwards he assured me that he was unable to stand the intense expression of Keats's eyes” (648-49).

women may get certain symptoms to a larger extent, Clark also details how societal customs might further negatively impact women's health. He, like medical practitioners and modern historians after him, also blames stays and tight lacings for female contraction of TB, noting that while society may encourage the use of corsets, "[t]he idea that young females require stays as a means of support is admitted by all medical men to be most erroneous; such mechanical restraint to the free motions of the trunk of the growing female is productive of much evil and frequent deformity" (294). Thus, a heavy corset compromised a tubercular girl's trunk—or torso—as it repressed her breathing and caused her body to deform from its natural shape, further inhibiting her ability to breathe fully and deeply. Carolyn Day, author of *Consumptive Chic: A History of Fashion, Beauty and Disease* (2017), also addresses how dangerous medical professionals considered the practice of corseting. Wearing a corset "was believed to create a tubercular diathesis by applying injurious pressure to the pulmonary system" (110). Day further explains, "[u]ndue pressure upon the organs of respiration was thought to result in phthisis, and the new style of corset, along with the practice of tight lacing, became one of the major causes articulated to explain the incidence of consumption in women" (115). As we'll see, then, throughout this chapter, social constraints were responsible for tuberculosis in woman in more ways than one.

One of the more common claims regarding TB and gender that Clark supports is that higher-class females are more predisposed to consumption because of social expectations, explaining that "sedentary habits are among the most powerful causes of tuberculosis disease," which "operate in the higher classes as the principal cause of its greater frequency among females" (201). However, he also specifies that while society

in the past generally “believed consumption is more prevalent among females than among males” there are a lot of variables to consider before making such a generalization, including “the relative number of sexes alive in each place, their relative deaths from other diseases” and also, “their relative admissions into the hospitals referred to” in each study (183-84). Clark’s treatise shows that at least some medical texts were slowly working to counteract gender biases about tuberculosis, though unfortunately the medical institutions were slower to adapt.

The question we must ask, then, is why women were depicted and treated differently from their male counterparts. In part, the limited understanding of physiology throughout the eighteenth and nineteenth centuries is one reason for the dramatic portrayal of the female consumptive as a passive sufferer when contrasted with her male contemporaries. In fact, women were denied not only the power of their physical strength but of their mental capabilities as well. Clark explains the presumed connection between physical weakness and mental debility, writing “[w]ith the loss of physical strength, the energy of the mind generally undergoes a corresponding diminution; the reasoning faculty remains, but its powers are evidently enfeebled” (34). While Clark does not relate this notion to a specific gender, but rather associates it with the tubercular sufferer in general, the feminine tubercular patient, perceived as weaker, still becomes a mainstay of literature in the nineteenth century, revealing the biases of the writers—and the larger nineteenth-century society—if not the biases of medical minds.

This suffering the consumptive patient underwent became a metaphor in nineteenth-century society. The tubercular look turns into one which, according to Susan Sontag, “symbolized an appealing vulnerability, a superior sensitivity” and “became

more and more the ideal look for women—while great men of the mid- and late nineteenth century grew fat, founded industrial empires, wrote hundreds of novels, made wars, and plundered continents” (30). Ultimately, the sexualization of female-associated illness emerges as one of these issues over which men could indeed make war: a war over the female body that continues today in various forms, including sexualizing breast cancer, idealizing the effects of eating disorders, and promoting costly, oftentimes unnecessary, cosmetic surgeries.

According to Thomas Dormandy in *The White Death: A History of Tuberculosis* (2000), “[t]he fact that tuberculosis transcended barriers of class and rank did not mean that it ignored social divisions” (76). TB did not only impact high-class women who were able to stay home, confined by gender expectations, in the overcrowded cities, but also those lower-class women forced to make a living in those same dwellings. As we read nineteenth-century texts in which authors address TB, we can see that upper-class women experience both consumption and treatment differently from their less-wealthy counterparts. These differing experiences between consumptives of separate classes were modeled on real life, where a poor woman like Virginia Poe (discussed in *Chapter 3*) had a drastically different treatment regimen than that of wealthier women such as Deborah Fiske and Mary Graham, whom I discuss later in this chapter.

In fact, it wasn’t until the end of the nineteenth century that many texts even acknowledged the poorer consumptives. In the May 12th, 1900 issue of *The Journal of the American Medical Association*, Dr. S. A. Knopf writes of New York City in particular:

In these tenements there are not only a far greater number of consumptives than in the same area elsewhere, but the proportion is actually greater per

number of inhabitants. Thus they not only contain countless centers of infection for old and young, and multiple foci of reinfection for those already afflicted, but these dwellings, with their bad air, darkness and filth, make a cure of the disease impossible, and a lingering death for all those infected by the germ of tuberculosis a certainty. If any one thinks me an alarmist, let him glance at the charts exhibited in this building. There he will see that there are houses in which can be counted as many as twenty consecutive cases of tuberculosis during the last four years. This number represents, however, only the cases reported to the Board of Health.

(1151)

Knopf is writing as the twentieth century begins to unfold in order to document the previously disregarded or underreported cases of TB in poorer areas of the city, acknowledging what was previously understood but not mentioned.

The influence of treatises like Knopf's impacted the conversation about tuberculosis as a disease that spread through large parts of the English-speaking world. This discussion, then, also merged with commentary on how the disease affected, or was perceived to affect, white women of all social classes. A large part of the scientific research about pulmonary tuberculosis traces the spread, symptoms, and infected bodies of the pandemic throughout the centuries. One such study that tracks the progress of TB over time is *The Bioarcheology of Tuberculosis: A Global View on a Reemerging Disease* (2003). In this study, Charlotte A. Roberts and Jane E. Buikstra present information about the patterns of TB from its earliest emergence as a phthisis or consumption to its closest modern equivalent of pulmonary TB. Roberts and Buikstra

explain that medical experts assumed nineteenth-century women had worse experiences with consumption as compared to their male counterparts due to their “having an inherent weakness,” which was augmented by wearing “tight corsets which inhibited the movement of the chest and predisposed them to tuberculosis” (46), as mentioned earlier by both Clark and Day. Aside from the problematic generalizations regarding women’s strength, as well as the underlying social—and quite literally physical—constraints, these facets of a nineteenth-century woman’s experience provide an interesting viewpoint. That is, from a medical perspective, women’s biological differences were perceived to negatively impact their physical and emotional well-being, and were further augmented by societal pressures.

Further, society considered female experiences of consumption divergent from those of men based on misconceptions regarding the body’s nervous system and a misunderstanding of the specific characteristics of the sexes and the effects of diseases on those characteristics. Because women were seen as having finer, thinner, and more fragile nerves than men’s, they were considered “more susceptible to the ill-effects of their passions” (Lawlor, *Romantic Disease* 560). At the same time, according to Roberts and Buikstra, the social hierarchy that privileged men’s perceived constitutions over those of women led to tuberculosis in women being viewed as inherently different from the disease men experienced despite the similarities in symptoms (45). Furthermore, whatever this societal stricture was, it also led to the fetishizing of female consumption “thought to make the sufferer sexy” (Sontag 25), thereby setting it apart from the experience of the disease that consumed men. Another reason men appeared to be infected to a lesser extent and were considered stronger than their female counterparts

was because the data on men with tuberculosis was more complete by the end of the nineteenth century than the data on women's tuberculosis. Therefore, the numbers for male cases were more accurate and thus trusted more as compared to women's.

Consumptive women may not have always reported their disease, as Clark mentions above and other medical practitioners presumed. Many of the medical texts from this era privilege statistics about tuberculosis in men, going so far as to include charts—which at first glance seem to be comprehensive but in fact only address statistics of consumptive males.⁸

While modern understandings of disease and the body have begun to enlarge in order to encompass both gender and sex, Roberts and Buikstra write that even today tuberculosis continues to cause “more deaths in women of reproductive age,” citing “the onset of menses” (46) as a potential reason for these mortality rates, echoing the sentiments of Clark from over a century ago.⁹ Though several sources agree on the fact that “[o]nce infected, women of reproductive age are more susceptible to developing TB than men of the same age” (Casali & Crapa 398), none conclusively states why this susceptibility exists.¹⁰ Kenneth Silverman, in *Edgar Allan Poe: Mournful and Never-*

⁸ To clarify, today's medical texts also generally preference men's medical statistics over those of women. See the text *Ethics of Gender Specific Disease* (2012) by Mary Ann G. Cutter for more information on biases in disease diagnosis and treatment.

⁹ As of 2018, the World Health Organization (WHO), estimated that one billion children are still infected annually with TB. The website further explains, “Children represent about 10% of all TB cases” (WHO).

¹⁰ The WHO also articulates in their 2018 fact sheet “Tuberculosis in Women” that “TB mainly affects women when they are economically and reproductively active, the impact of the disease is also strongly felt by their children and families” (WHO “TB in Women”). The website TB Alert also explains “Women of reproductive age are more likely to develop active TB if they encounter TB bacteria, yet they are less likely to seek help for TB symptoms than men” (TB Alert “TB and Women”). However, none of these sources, or any further research I did, clarify why this situation is the case. In fact, the WHO explains one of their initiatives is to investigate “the specific ways in which tuberculosis affects women of reproductive age, and especially their reproductive health, including the consequences for foetal and neonatal health” (WHO “Gender and Tuberculosis”).

ending Remembrance (1991), explains that at the start of the nineteenth century, tuberculosis not only “accounted for up to a fourth of all deaths” but also “seized the young,” leaving them with “rouged-looking cheeks” (182). TB was therefore dissimilar to many other diseases that nineteenth-century society would have been familiar with in terms of those whom it was assumed to target—those young men and women in the prime of their lives. Roberts and Buikstra explain that in places and among groups “where the disease was endemic in the past, virtually all would have been effected as youths” (50). Furthermore, as this disease continues to affect women of childbearing years—as mentioned earlier—it is not a surprise that nineteenth-century medical practitioners saw consumption as linked clearly to a woman’s reproductive system developing at puberty.

Thus, (mis)understandings of the female body’s physiology led to gendered assumptions and expectations regarding female consumptives’ behavior and attitudes. These assumptions and expectations, in turn, left women with far fewer chances to step out into fresh—or even simply open—air, aside from their domestic opportunities or conditions of employment. Ruddock shares a story that highlights clearly the ways in which women’s minimal prospects influenced their contracting tuberculosis based on confinement, a situation that contrasts with their male counterparts:

In the true Alpine region, Tubercular Consumption is almost absent [...] Still, even there, especially in the lower heights, women suffer greatly in consequence of setting at defiance the principle we have so much insisted on. The women employed in making embroidery congregate all day in small, ill-ventilated, low rooms, where they are often obliged to be in a

constrained posture. Their food is poor in quality. Scrofula is very common. The men, who live an open-air life, are exempt. (qtd. on 93)

In descriptions like the one above, we see women emerging clearly as victims not only of TB but also of societal norms. These expectations hold that woman should remain at home, relegated to domestic duties instead of being employed outside the home. Thus, society holds woman responsible for their “setting at defiance” the principles of that same society if they do obtain an occupation, even if it is in the domestic arts. Society further victimizes the women if their social position is such that they *must* work, or choose to work to gain independence. Their dual victimization plays out as well in the literature, where, by virtue of the restraints placed on their gender, women run the risk of becoming ill.

As this excerpt suggests, women’s domestic and workplace situations were viewed as detrimental to their health because of the close proximity to other people and the limited range of motion their jobs provided—as above, they remain in a “constrained posture” compared to those of men at this time (see also Roberts & Buikstra 46-47). The assumptions regarding a woman’s predisposition to contract TB were further influenced by their frequent confinement to domestic situations, either as hired help or as the mistress of the home. Even if members of the large, city-dwelling population of tubercular women were not working in unsuitable conditions, they were likely living in them: “TB was a wet disease, a disease of humid and dank cities” (15), Sontag writes, showing how dangerous overcrowding was becoming due to the rapid urbanization taking place throughout Europe and the United States. In fact, according to London bills of health, “tuberculosis was classed as one of the main causes of death at the end of the

Victorian era,” partly due to the “rapid urbanization of populations” during the Industrial Revolution, “which favored the spread of tuberculosis” (Roberts & Buikstra 216). Ruddock, too, blamed cities for the fast spread of TB, writing of treatments such as calcarean phosphate that “[i]t is especially valuable for patients who have grown too rapidly, or suffered from exhausting discharges, excessive menstruation, prolonged nursing, the bad effects of town life, worry, or any other causes of debility” (102).^{11,12} Ruddock’s text provides evidence that nineteenth-century medical professionals, like later historians of the disease, understood TB to be a disease of cities. Furthermore, Ruddock’s claim reinforces the view that consumption was thought to be often caused by women’s reproductive processes, such as menstruating and nursing.

It is important to note, too, that in Ruddock’s analysis several physiological events as well as occupational activities specific to women negatively impacted their experiences with TB. He explains that a cessation of the menses was found to be commonly linked to tuberculosis, writing of a patient that “the Menses became suppressed, and in a month or two afterwards symptoms of Phthisis appeared” (43). This observation ties to his one in the vignette that opens this chapter as the unusual flow of blood—suppressed menses—is again connected to the tubercular woman. He further specifies that breastfeeding and childbearing exacerbate the presence of TB: “labour, and nursing are serious drains on such constitutions, and are almost certain to rekindle the disease if not thoroughly cured. Even after marriage, if consumptive symptoms reappear,

¹¹ Calcarean phosphate was a cure for tuberculosis recommended by homeopaths like Ruddock. It was often prescribed during this era to young women “who are maturing and are nervous and restless” as well as a tonic against headaches, head colds, as well as “in tuberculosis when there is great emaciation” (Fyfe 438-39).

¹² Clark goes a step further, linking gender to the spread of TB, noting that this illness can propagate in boarding schools, explaining, “almost all the requisites for the production of scrofula may be found in female boarding-schools” (292).

the process of child-bearing should cease” (32-33). In numerous literary texts, as subsequent chapters illustrate, the danger of consumption concurrent with pregnancy reveals itself, tending to echo with Ruddock in his concerns about childbearing and phthisis.

Yet nineteenth-century medical works such as Clark’s and Ruddock’s also offer further insights into the manifestation of TB. These treatises present tuberculosis as an illness resulting from, among other conditions, melancholy or a depression of spirits. Ruddock focuses on this nineteenth-century form of depression and its correlation to consumption when he writes that there are “[i]nstances of very rapid cases of Consumption” in which the patients appear to be affected by a “mental anxiety” that leaves them predisposed to TB (42-43); he then quotes another physician, who explains that some of his tubercular patients are strikingly affected by “melancholy in the production of Phthisis” (qtd. in Ruddock 43). Clark, on the other hand, attributes TB to several causes, including “intense application to study”—a cause many connect specifically to women—while also noting that “[d]isappointment of long-cherished hopes, slighted affections, loss of dear relations, and reverse of fortune, often exert a powerful influence on persons predisposed to consumption, more particularly in the female sex” (180).

Lawlor gives further justifications for why the experience of consumption differed between men and women, pointing not to general melancholy, as Ruddock does, but to melancholy caused by unsuccessful romantic entanglements. He notes that from the Early Modern era onwards, consumption was associated with wasting away as a result of unsuccessful love (*Romantic Disease* 15). Lawlor further writes that “in all forms of

literature was the assumption that consumption is the physical disease of love, a flexible and gendered discourse that was to become important in the formation of the glamorous consumption myth in the eighteenth and nineteenth centuries” (*Romantic Disease* 27). As the nineteenth century progressed, basing a woman’s consumption in lovesickness rapidly became the way for mothers to marry off their diseased daughters, for women to achieve an idealized form, and for men to lust after women who had ““embraced sickliness instead of delicacy”” (qtd. in Lawlor, *Romantic Disease* 43). Thwarted desire further impacted the social and medical perceptions of TB: “Consumption was a disease of love, desire, and—regrettably, death” (Lawlor, *Romantic Disease* 15). Male desire for the consumptive beauty begins to inform imaginative literature, which by the turn of the eighteenth century shaped the social constructions of this disease for a general reading audience.

To appeal to the female and catch the eye of the male, nineteenth-century women’s fashion attempted to attract their high-class clientele. For the consumptive woman who could afford to keep up with the latest styles, fashion trends throughout the nineteenth century continued to accentuate the wan, tubercular look. A recent take on the fashionable trends associated with consumption appeared on *Smithsonian Magazine’s* website, where Day explains that ““tuberculosis enhances those things that are already established as beautiful in women’ [...] such as the thinness and pale skin that result from weight loss and the lack of appetite caused by the disease” (Mullin “How”). In an interview about her book, Day further explains that as the century progressed, so did fashion. She elaborates, “[t]he height of this so-called consumptive chic came in the mid-1800s, when fashionable pointed corsets showed off low, waifish waists and voluminous

skirts further emphasized women's narrow middles" (Mullin "How"). This popularity wasn't confined to one social class, either, as Day clarifies, noting that middle-class women "also attempted to emulate the consumptive appearance by using makeup to lighten their skin, redden their lips and color their cheeks pink" (Mullin "How"). Many women who could afford to appear consumptive did so, confident in the knowledge that if they contracted the disease, they could afford treatments, unlike the poorer classes. This recognition of TB and the way it influenced the lives of nineteenth-century women encouraged writers to pull tubercular (or seemingly tubercular) women into the spotlight alongside their fashion-designing counterparts.

For the wealthy tubercular woman, it wasn't enough to have clothing that enhanced her beauty. She also needed to be seen getting the most up-to-date treatments from her doctor. Thus, the consumptive's reliance on her physician is also an important factor to consider in the cultural production of the disease. Still, it is easy to see why society assumed women could be infected for a longer period of time, as Clark mentions. One point explaining men's less frequent, shorter-term duration TB over that of women's was the fact that men could undergo treatments that women were not allowed to attempt due to the aforementioned biological misunderstandings about gender. Ruddock explained that certain treatments for the disease, such as lycopodium, were "more useful in young men than in young women."¹³ He doesn't explain why, however, leaving modern readers to conclude this idea of gendered treatments was inherently flawed (104).

¹³ According to Joseph Laurie's *Homeopathic Domestic Medicine* (1854), lycopodium was prescribed for the those who were scrofulous, those with a melancholic or lymphatic temperament, and for those with a mild disposition (xvi). He further explains "lycopodium is one of those medicines, which, by operating doubly upon the nervous system and more locally, though diffusedly, upon the absorbent and exhalant vessels, embraces a very wide range of usefulness" (Laurie 797) as evidenced above by the conditions it was prescribed—and in some cases still is—to treat.

Treatment practices were further impacted by the rise of the general practitioner (GP) in both Britain and the United States during the nineteenth century. The advent of the GP was largely responsible for the development of more medically precise treatments, according to Irvine Loudon in *General Care and the Medical Practitioner, 1750-1850* (191); thus doctor-patient relationships began to develop differently as a result. Sontag provides insight as to how understanding the figure of the doctor allows readers to make additional inferences about the way consumptive patients were perceived. She writes, “[n]ineteenth- and early twentieth-century physicians addressed themselves to coaxing their tubercular patients back to health” because they saw them as “quintessentially vulnerable, and full of self-destructive whims” (63-64), presumably related to lovesickness and an unwomanly desire for employment. The doctor made assumptions about his patient’s mental or emotional predisposition simply based on the fact that he or she was physically ill. Just as society was attempting to understand this disease (albeit not with much success) that devastated populations regardless of gender, so, too, were doctors attempting to understand this illness that ravaged their patients; however, their own set of gendered assumptions hindered their ability to provide the best care.

Some of the most interesting accounts of doctor-patient relationships come from the records of the real-life doctors. For a case involving a diagnosis of tuberculosis, we need look no further than Ruddock, who compares the treatment of his female patients with that of their male tubercular counterparts. Ruddock writes about Anna W, a thirty-year-old woman who came to him in her “first stage of phthisis,” noting that her seeking a remedy at this early stage allowed her treatment to produce “speedy results” (110). He

specifies that in the course of her care, “little or no change in the hygienic surroundings of the patient were practicable” (111). However, in the contrasting case of the previous patient Ruddock had mentioned, a male abbreviated as J.T., aged 21, the doctor sent him to “a sea-coast residence” in Yarmouth, so that the tubercular man might resume his work as a tailor (109). Ruddock does acknowledge that the change in venue might have benefited Anna W. as well, remarking, “could the advantages of a dry climate, a sheltered house, and other favorable hygienic conditions have been superadded to the medical treatment, the tubercles present could no doubt have been reduced to so latent a state that she might almost literally have been said to be cured, and years added to her span of life” (111). Yet in describing Anna’s case, he gives no reason why this course of treatment was not prescribed to her.

To see how the doctor may have cared for his female patient differently from his male one, we need to consider the examples provided by Ruddock. Interestingly, not long after he addresses Anna W's state, he moves on to his treatment of another male consumptive, J.J.H., who was 17 at the time he entered Ruddock’s care in 1871 (116). Ruddock recommends to the young man that he move back to his native Ireland, where J.J.H. “rapidly regained health” once he followed Ruddock's orders (116). Ruddock hypothesizes that J.J.H.'s health improved because he was no longer working indoors. He further speculates “that patients with consumptive symptoms more frequently recover or improve under medical treatment when they can pursue out-of-door occupations” (117). However, in addition to sending only his male patients to other locales for cures, Ruddock also does not prescribe out-of-doors pursuits to his female patients, despite actively recommending them for male consumptives. As Ruddock’s account

demonstrates, nineteenth-century remedies for TB varied significantly according to the gender of the patient.

On the other hand, it is important to note that some doctors did recommend sending female patients to milder climates. Day studies the life of the consumptive Mary Graham (1757- 1792). Mary's devoted husband, Thomas, agreed to pay for a trip and travel to move his ailing wife from Scotland to the "milder climate of England to avoid stressing her delicate constitution" (Day 1). Husband and wife also went to health resorts and adhered to "a regimen of sea-bathing at Brighton, and visiting Clifton, a popular option for consumptives" (Day 1). Ultimately, however, despite the fact that Mary's "physician prescribed a sea voyage" for her condition, she died of consumption in France (Day 1-2). But Mary Graham's case was one of the few recorded in which a devoted husband and a practicing physician collaborated to maintain the health of a woman suffering from TB despite her prognosis. Many other women of the long nineteenth century were not so fortunate.

Rothman provides an alternative to the account of Mary Graham's wealthy and cared-for person in the figure of another female tubercular patient from the nineteenth century, Deborah Fiske.¹⁴ Fiske left an account of her illness with her family much like the narrative of gender-related illness in *The Diary of Alice James*.¹⁵ By exploring Fiske's life, Rothman finds commonalities among female consumptives' experiences, including the doctor-patient connection, as well as differences, such as the extent to which the

¹⁴ An interesting historical side note: Deborah Fiske lived in the same town in which Emily Dickinson grew up, Amherst, Massachusetts (Mamunes 11). Further, her daughter, Helen Hunt Jackson—a famous writer herself—was a childhood friend of Dickinson's who regularly encouraged Dickinson to publish her own poetry (Mamunes 11).

¹⁵ *The Diary of Alice James* is explored in *Chapter 7* on hysteria and the author is mentioned again briefly in *Chapter 10* on chlorosis.

consumptive woman could or would travel. In regard to the female patient–male doctor dynamic, Rothman explains, “[t]he relationship between women invalids with consumption and their physicians, as they described it in their letters, was a fluid and negotiated one” (105). She then moves on to treatment plans, noting that these could differ among tubercular woman so as not to allow medicine to “override social and religious values,” but rather to keep “their prescriptions [...] fit with and reinforce women’s social and domestic duties” (105). Fiske’s doctor “scheduled her outdoor exercise around her domestic chores and joined it whenever possible to other social and religious duties,” for example; “thus, she rode on horseback to visit friends or make calls” (107). As Fiske’s story shows, society required women to continue meeting their domestic obligations despite their dread diagnosis while their male counterparts of the same class were offered more leisure time. This concept of prescriptive care connects to the earlier idea, mentioned by Lawlor, that women consumptives, while beautiful to some, were still feeble and thus in need of careful observation to avoid succumbing to their “weaker passions” and corroborates Sontag’s point that doctors saw their female consumptive patients as vulnerable. As in so much else, the woman invalid was subject to the men in charge of her well-being who sought to protect her from herself in addition to safeguarding her from disease.

Fiske’s experiences with her doctor reflect another difference between an upper-class male consumptive and a female one. Rothman writes, “[u]nlike male invalids of her social class and background, Deborah did not undertake a long voyage for her health; instead, throughout her adult life she took her cure at home” (107). While Graham was able to travel, she did so in the presence of her husband. She was thus not an exception to

the rule but rather still beholden to the men in her life for her cure. In general, ill women of the U.S., Britain, and Ireland continued to reside in closely-confined areas, where the cough of one's neighbor could easily spread to infect an entire block.¹⁶ The fear of allowing these arguably fragile women to leave their domestic duties, even to receive care, loomed large in nineteenth-century medicine. Indeed, when we encounter female consumptives in literature and society leaving their homes for cures, appropriate male chaperones accompany them just as Graham's husband accompanied her. In Fiske's case, this inability to leave the home was due to her doctor's discretion. Rothman explains that "[I]ike other physicians, [Fiske's doctor] too reserved the prescription of travel for male patients. 'He thinks going to a warmer climate [...] would be of no service and says I must accustom myself to a variety of temperatures,'" Fiske informed her husband (113). It is no surprise, then, in a society that had conflicting interpretations of an illness based solely on biological sex that while women were considered to be too ill and weak for travel, the rigors of giving birth to children, keeping house, and performing other domestic duties were perceived as not only necessary but easily accomplished, provided the ill women were kept within their domestic domain.

As the century progressed, treatments for women still had significant distance to travel in order to close the gap between the experiences of men and women afflicted by the same disease. A male contemporary of Fiske's wrote in his diary, "[f]emales, from their nature, as well as the customs of society, are far more dependent beings than

¹⁶ As explained by Roberts and Buikstra, the probability of tubercular infection depends "on the number of cases of pulmonary tuberculosis in the community, the density of bacteria in expectorated sputum, the density of bacteria in air surrounding the person (related to ventilation and size of habitation space), the number of people present, and the duration of contact with the person with disease" (11-12). However, it is important to acknowledge this understanding of tuberculosis is based on our modern knowledge of epidemiology, something that, for most of the nineteenth century, medical practitioners did not grasp.

ourselves. Man may roam the seas and the earth at his pleasure, hardship and change are his enjoyment, and the world his home. But woman is more the creature of domestic life” (qtd. in Rothman 23). Here we see the idea that women’s duties are without hardship—again seeming to support the outdated idea that childbearing and childrearing are easy and that women not of the leisure class do not cope with difficulties; at the same time, we are reminded how much more freedom nineteenth-century men enjoyed than their female contemporaries. In subsequent chapters, I examine this imbalance in understanding the sexes while dismantling its enabling assumptions and exploring its impact in literature and on life. Cutter’s book moves in this direction as she writes, “[g]ender serves to draw attention to how social systems support and maintain gender performative roles and to the problem of stereotyping of certain genders” (40). Tuberculosis was no exception to this biased maintenance of gendered roles in the nineteenth century, as Fiske’s story shows. Her disease and treatments required that she continue performing the duties expected of her gender while neglecting to offer her any new opportunity. Furthermore, as Cutter’s work on gender-specific disease articulates, Fiske is far from the only female patient to suffer gender-differentiated treatment.

Interestingly, wealthy female invalids in Europe had a few more options than their American counterparts for treating their tuberculosis. In *The Art and Practice of Western Medicine in the Early Nineteenth Century* (2013), Carl J. Pfeiffer explains that “it was the practice to send those few who could afford it, to other European regions for recovery” (159), as we saw in the case of Graham, in contrast to her American counterpart, Fiske. Pfeiffer explains that this convention was based on evidence showing that “moist seasons were the healthiest and most free of epidemics” (159) and the resulting belief that sending

people to locations with humid climates could help them heal. However, the doctors from this era also specified that this treatment was only available to patients in the early stages of pulmonary tuberculosis, and, I would add, those that could afford to travel. In actuality, these practitioners were against “sending abroad patients in a late stage of consumption” (Pfeiffer 160), which might explain in at least some instances whether or not a female patient was sent abroad for recovery.

By the second half of the nineteenth century, an additional method for treating both male and female consumptives had emerged: the sanatorium. Roberts and Buikstra write about these health institutions, explaining that they “gave hope (if nothing else) to many with tuberculosis and indicated the growing concern in countries around the world for the problem” of consumption (227).¹⁷ As with the treatment of tuberculosis elsewhere, women patients in sanatoria followed specific treatment regimens. By the second half of the nineteenth century, sanatoria were gaining in popularity wherein, women and men had a strict code of rules to which they had to adhere (Roberts & Buikstra 228-29). Men were sometimes made to “shave their beards to prevent phlegm being caught in them,” and women were expected to “shorten the hems of their dresses to avoid gathering dust which could harbor tubercle bacilli or be irritating to the lungs” (Roberts & Buikstra 229). Furthermore, “males and females were also kept separate except at meal times,” and patients could be expelled for breaking these as well as other rules (Roberts & Buikstra 229, 232). Despite the strict rules of the sanatoria, however, or

¹⁷ It is important to note that these institutions predominantly only gave hope to white people. Consider, for example, the life of Paul Lawrence Dunbar, addressed in *Chapter 11* of this dissertation. Dunbar, as explained in *The Invincible Microbe* (2012) by Jim Murphy and Alison Blank, was a poet born in the nineteenth century who was barred from receiving TB treatment because he was African American (67). He ultimately died of the disease at the start of the twentieth century (Murphy & Blank 67).

perhaps because of them, “there is no clear association between sanatoria treatments and a tuberculosis decline” throughout the Western world (Roberts & Buikstra 227).

Ultimately, a decrease in diagnoses of TB came slowly and not through treatment alone. It wasn't until Robert Koch identified the *tubercle bacillus* in 1882 that tuberculosis began to take on an identity that modern medicine can recognize (Lawlor, *Romantic Disease* 186). With the rise of germ theory as well, people began to understand how tuberculosis was contracted and what they could do to prevent it. In “James Joyce and Germ Theory: The Skeleton at the Feast,” Martin Bock expands on this notion, explaining—as mentioned in this project's introduction—that the pervading idea about illness during the first part of the nineteenth century suggested that disease was “miasmatic, that is, caused by a poison that lurks in the environment: in the water, air or soil” (23). This notion was gradually developed further to include the idea that “[t]he transmission of disease, especially tuberculosis, was generally thought to be through human secretions (usually sputum), contaminated air, particulate air-borne matter (especially dust), sawdust, and clothing” (Bock 24). Even once scientists proposed germ theory as the cause of contagion, many in society remained skeptical regarding the transmission of illnesses (Bock 23). As a result, it would take nearly until the end of World War II and the discovery of streptomycin before developed nations saw any wholly effective cure for TB (Lawlor, *Romantic Disease* 187). In the meantime, this disease continued to capture the minds of artists, medical doctors, and authors even as it grabbed the attention of the audiences these professionals sought to address.

Further, because of its preponderance in the nineteenth century, and because of its intersection with representations of gender, tuberculosis soon came to influence many

aspects of cultural production, which, in turn, informed the experience of real-life consumptives. Everything from the architecture of homes to the length of women's skirts was affected by the white plague, as Sheila M. Rothman explains in *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (1994). One of these cultural productions was literature. According to Dormandy, “[b]y the mid nineteenth century tuberculosis had pervaded literature even in far-off China” (92). He further argues that “tuberculosis became the natural manner in which to dispose of youthful lovers and characters without the horrors of disfigurement or character-destroying physical pain” (92). The cultural influence of TB in turn circled back to medical writing, appearing in case studies in ways that linked the disease to fashion, as mentioned earlier. Ruddock shares the patient history of M.A.S., who at the age of 21 started complaining of symptoms of tuberculosis and lost so much weight that “her dresses had to be taken in” (117). Such accounts once again anticipate the heightened appeal of a consumptive beauty with a small waist.

The sharing of medical and other scientific knowledge allowed for an increase in previously limited understandings of contagion as the nineteenth century progressed. Works of fiction provided information about diseases for an uncertain public that might not have had access to or been capable of understanding medical treatises on the subject. Lawlor introduces several forms of TB that nineteenth-century people would have read about. As others have, he first explains love melancholy (also often referred to as lovesickness) and its relationship with consumption, arguing that those afflicted experienced a disease in their “youth, according to medical and popular lore” and thus

suffered from TB as a result of that earlier lovesickness (22).¹⁸ Lawlor then moves on to the understanding of consumption as a worthy death—almost a holy death—for those who have lived “an exemplary life” (31), an understanding that gained a strong hold in mid-eighteenth-century literature. Next, he articulates that by the end of the eighteenth century, consumption was associated with female beauty and male creativity (43). Later, he expands on his last two points: first drawing connections between consumption and female creativity, as in the case of the Brontës, and also developing further his idea of spiritual consumption and a good death (167). I expand on each of these concepts in turn throughout the following chapters. To do so, I comprehensively study authors and their works of fiction throughout the long nineteenth century, several of whom Lawlor has not explored (such as James Joyce and Emily Dickinson) as well as many of whom he has not devoted as much space to (including Edgar Allan Poe, Emily Brontë, and her sister, Charlotte).

As indicated by this brief history of consumption, men and women's experiences of tuberculosis in the nineteenth century varied drastically from one another with regard to everything from the fashions they wore to the treatments they received and the places they lived and worked. Writers could not help but be intrigued and influenced by these distinctions, and so the gendered implications surrounding consumption found their way into literature throughout the nineteenth century. Because the differences proved so intriguing, the characters portrayed in these stories and the authors of these texts articulate clearly nineteenth-century ideas regarding disease and the impact gender had on the experience of tuberculosis and other illnesses. By reading these medical, literary,

¹⁸ The introduction to this project explains in more detail what love melancholy was understood to be and how this understanding in turn influenced the dynamics between male doctor and female patient.

and historical pieces, we not only gain insight into the ways in which society dictated treatments of consumption based on gender, but we also see the reactions of the members of that society and the ways in which they either submitted to or circumvented those principles.

These principles and the resistance to or acceptance of them are the focus of my next two chapters. While Lawlor focuses on the female consumptive as a love-sick, sexualized beauty throughout the eighteenth century, I argue that that figure persisted in American and British society for far longer, well into the nineteenth century and beyond into the twentieth. In fact, the craze for this type of pale beauty became so pervasive that even healthy young women attempted to emulate it, as mentioned by Day. Dormandy expands on this desire to look like a lovely consumptive, writing, “[b]ecause young men of fashion had developed or professed to have developed a passion for pale young women apparently dying of consumption, young women took to drinking lemon juice and vinegar to kill their appetites and make themselves look more alluring” (91). *Chapter 3* begins the discussion of the alluring consumptive by exploring this idea as a literary trope in Poe’s “The Masque of the Red Death” (1842) and Emily Brontë’s *Wuthering Heights* (1847). Specifically, I study the myth of the beautiful consumptive seen in the literary figure of Catherine Linton Earnshaw and the historical presence of Virginia Poe, who inspired many of Poe’s female characters.¹⁹ In these two figures—and in others like

¹⁹ Poe’s representation of women often pulls examples from his real life, including those of his wife and mother, discussed in the next chapter. Perhaps one of the best examples of a diseased, beautiful young woman created by Poe is Annabel Lee from the poem of the same name. Adam Bradford explains that Poe’s work, including “Annabel Lee” and “The Fall of the House of Usher” “comprises a critique of the nineteenth-century’s wide-spread rituals, practices, and conventions of mourning and memorializing” (73). Thus, Poe seems to be immortalizing even as he’s critiquing the methods by which others do so. For more on the ways in which Poe would have realized how to grieve for Virginia through his writing, consult Adam Bradford’s article “Inspiring Death: Poe’s Poetic Aesthetics, ‘Annabel Lee,’ and the Communities of Mourning in Nineteenth-Century America”

them—we encounter clear descriptions that focus nearly exclusively on the attractive female consumptive both from fictional and nonfictional perspectives. I then consider the representation of these women in relation to the myths and stereotypes perpetuated through nineteenth-century medical discourse.

Finally, in these chapters, I examine how the literature was not only influenced by the figure of the invalided consumptive but also how this consumptive developed a new identity by the end of the century as a creative female. In *Chapter 3*, I explore Keats's poetry and Poe's "The Masque of the Red Death." I study these texts in connection with their authors' interactions with consumptive people as well as their diagnoses. Here, I pay particular attention to the ways in which gender influenced these diagnoses and representations in literature, a topic Lawlor begins to explore in *Consumption and Literature: The Making of a Romantic Disease* (2006). Lawlor writes about tubercular suffering from a Romantic standpoint, making useful points about the (often gendered) portrayal of this disease. He argues that "women were increasingly conceptualised in terms of a model of feminine beauty based on disease" (*Romantic* 57). However, Lawlor does not provide close readings regarding the literature from this era, nor does he focus in detail on the female authors' lives. Further, in *Chapter 4*, I debate Lawlor's notion of the spiritual consumptive, examining how fictional and real females either uphold or subvert this stereotype. To that end, I develop a study of the child-like, spiritual consumptive in Harriet Beecher Stowe's *Uncle Tom's Cabin* (1852) and subsequently explore how other women writers, such as Emily Dickinson, reject this representation of suffering. I also examine how authors create female characters, for example, Gretta Conroy in Joyce's "The Dead" (1914), who are portrayed in an entirely different manner from the

representation Stowe provides, deromanticizing once and for all the disease which held this century in such thrall.

Nineteenth-century literature does not focus solely on the beautiful consumptive without considering her other attributes, however. As Lawlor argues, a new myth of the spiritual tubercular woman grew in popularity by the middle of the century. This ideal of spiritual beauty often coincided with a positive physical appearance. In *Pulmonary Tuberculosis: Its Pathology, Nature, Symptoms, Diagnosis, Prognosis, Causes, Hygiene, and Medical Treatment* (1875), Addison Porter Dutcher notes, “[s]ome tell us that [TB] improves the human form,—that it adds to its beauty. Nothing can be more absurd than this” (328). Instead, Dutcher argues that there is a sort of spirituality in consumption. He describes this type of consumptive as having developed “this spiritual beauty as the outward graces disappeared! As the countenance grows paler and the frame becomes more attenuated, the soul appears to shine through them. The eye grows more spiritually bright, and the wasted cheek puts on a beauty which it had not in its bloom” (96).

Chapter 4 explores the spiritual consumptive that was gaining the public’s interest by the middle of the nineteenth century and building through the start of the twentieth. Here, I turn to Harriet Beecher Stowe’s *Uncle Tom’s Cabin* (1852) and the poetry of Emily Dickinson. In these works, we see this spiritual consumptive become fully developed and the stereotypes about her beauty and pain surrounding her dismissed.

Finally, I cannot ignore how the consumptive moved forward into the twentieth century. Thus, I close with a study of the myth of the male consumptive and his artistic abilities and how this was upset by creative female consumptives of the era—both fictional and real-life—to close *Chapter 4*. There, I examine the figure of the male

consumptive as artist portrayed very clearly in Joyce's "The Dead" (1914). However, we also see the creative consumptive beauty finally begin to be recognized for her worth with the deaths of the Brontë sisters (and their brother).

Coinciding with the literal, medical interpretations of TB, literature about this disease also focuses on figurative renderings of the consumptive. Sontag provides one such examination of these portrayals using a historic lens. Here, readers encounter a concise description of eighteenth- and nineteenth-century understandings of the symptoms of tuberculosis and gain knowledge of the epidemic proportions of this illness. To help readers grasp the danger of TB in the eighteenth and nineteenth centuries, Sontag likens our modern experiences with cancer to the suffering of TB patients of the past. She further articulates that pulmonary tuberculosis was "a disease thought to be intractable and capricious [...] a disease not understood" by many throughout the long nineteenth-century, just as many cancer diagnoses perplex us today (5). She then explains how TB was "understood as a disease of extreme contrasts: white pallor and red flush, hyperactivity alternating with languidness" and a consumptive "wracked by coughs" (11). In reading Sontag's work, written while she herself was suffering following a serious cancer diagnosis, we recognize the importance of her contribution, summed up in *Chapter 1* of this dissertation. Sontag writes that she wants her work to explain "the punitive or sentimental fantasies concocted about that situation: not real geography, but stereotypes of national character" in the world of invalids (3). By providing an examination of the figurative portrayals of the consumptive in her text, Sontag also gives readers perspective on the fantasies surrounding an invalid. She further offers us a

historical lens by relating TB to our current understandings of contagion and epidemiology, and our modern stereotypes of the invalid.

Sontag explains that while “the poor and the rich both get TB” certain mythologies about the disease persist (17). I argue that in order to better understand these mythologies, we must explore the class biases, gendered stereotypes, and medical misunderstandings surrounding tuberculosis in literature from the nineteenth century. First, we must acknowledge most simply that TB was often treated more easily in higher classes because the wealthy could afford medical care, regardless of society’s idea that because forty percent of tubercular patients were poor, many wealthy did not succumb to the illness (Brown 28). Further, they had greater access and time to undergo treatment as compared to their working-class counterparts. Thus, since the wealthy were the ones getting treatment, they were also the ones medical and literary works were predominantly addressing both as readers and as subjects. Even in earlier works that did acknowledge lower-class consumptives, such as Dr. Ruddock’s medical text, societal biases were apparent. Ruddock writes, “[a]s before remarked, no one but a physician can fully appreciate this evil, or accurately trace its workings in society. Consumptive parents become the propagators and transmitters of a grave constitutional disorder, and with it misery, pain, and often poverty” (30). In Ruddock’s view, poverty only results from consumption; it is not truly considered a cause. This point indicates that Ruddock’s audience was more concerned about their social status than the spread of disease among every echelon of society.

Throughout *Chapters 3 and 4*, I have selected specific literary texts for analysis based on how consumption—or an unspecified pestilence described in terms consistent

with it— emerges in at least one of the text's characters. I then investigate the tubercular figure informing the text, whether a character, the writer, or a person who influenced the author of the text. In some instances, all three impact the work. Most importantly, the sources for this project focus on how representations of tuberculosis assisted in defining gender. Because my primary sources are arranged chronologically, they provide a timeline of the way this disease is reflected in and influences British and American literature of the long nineteenth century.

Chapter Three: The Lovely and the Lovesick Consumptive:

Early to Mid-Nineteenth-Century Gendered Representations of Pulmonary Tuberculosis

Her family were of a delicate constitution: she and Edgar both lacked the ruddy health that you will generally meet in these parts. What her last illness was, I am not certain; I conjecture they died of the same thing, a kind of fever, slow at its commencement, but incurable and rapidly consuming life towards the close.

—Emily Brontë, *Wuthering Heights* (146-47)

In the above vignette, fiction echoes real life as tuberculosis consumes the wealthy Linton family in much the same way that it decimated Emily Brontë's own poor but genteel family. Here, Brontë makes it clear that the disease affected male and female Linton family members in a similar fashion, mirroring the way consumption impacted her own sisters and brother. The idea that male and female people contracted TB in a similar manner is not reflected in the larger canon of nineteenth-century disease fiction, however. This divergence marks Brontë's personal and literary experiences as an apt starting point for discussing the shaping of female invalidism and illness in literary texts in relation to consumption in the nineteenth century. By analyzing these texts, we can learn about the influence of TB on literature and the populace it infected, regardless of class. Further, by examining gender in these texts, we can expose the myths and misconceptions of the larger nineteenth-century society towards the female invalid.

The question we must answer before we turn our attention to Brontë's fiction—and that of other nineteenth-century authors—is why women were depicted as beautiful tubercular patients when their male counterparts were given more depth as not only attractive but also creative, as mentioned in *Chapter 2*. Therefore, we need to explore and understand the myth of the beautiful, consumptive woman and the creative consumptive male while also considering those authors like Brontë who dismantle those myths. To that

end, this chapter considers the personification of beauty in texts about consumption while also studying the place that this personification has in the stereotypes surrounding the tubercular female and male. Then, the research in this chapter illuminates the contrast between the male consumptive and the female consumptive, considering how notions of class play into these depictions and contrasts. Finally, this chapter rejects the notion that creation is limited to the male consumptive, examining the work of Emily Brontë in particular to prove creativity in consumptives is not based along gendered lines.

I begin this chapter by showing the relationship between literary representations of TB and the lived experiences of a purported “creative male consumptive” and author. Thus, I start with an exploration of John Keats, focusing on his own experience with consumption and his poem “Ode to a Nightingale” (1820). I look at how the myth of the creative male consumptive is supported by events from Keats’s own diagnosis. I then turn to the myth of the beautiful female consumptive, as I study the life of Edgar Allan Poe’s wife, Virginia, and examine how her disease influenced his work, particularly the masculinized, consuming personification of a TB-like disease in “The Masque of the Red Death” (1842) and its relation to Poe’s personification of Beauty. Finally, I end with an exploration of Emily Brontë’s life and its relation to her depiction of consumption in *Wuthering Heights* (1847). I focus on how Brontë’s own creativity, her irreverence regarding the myth of the beautiful female consumptive, and her own family history of TB complicate the myth that only male consumptives were creative. I then study the portrait of male consumption that Brontë presents in the form of Linton Heathcliff as the effeminized male consumptive, one that counters the prevailing social attitudes of the creative male consumptive and the strictly beautiful female consumptive.

To truly begin with Keats, we must investigate his own reactions to his tuberculosis diagnosis. In particular, the wasting nature of his disease marked it as particularly troubling once the symptoms began to manifest. Lawlor expands on this well-known epidemiology:

There was no cure: the dread diagnosis of "consumption" was often thought of as a death sentence, as Keats's famous pronouncement on coughing up a drop of blood on a white handkerchief affirmed. Its symptoms were paradoxical because, on the one hand, the lungs' disintegration caused choking on the often putrid matter the consumptive expectorated, foul-smelling breath, fevered nights [...] On the other hand, because the lungs are not greatly supplied with nerves, the patients often felt little pain as they wasted away, remained *compos mentis*, and frequently took a long time before the final "decline." ("Consumption" 3)

Keats was one of many early nineteenth-century males who contracted TB and ultimately died of his illness. The "pronouncement" to which Lawlor refers is described by Hillas Smith in "The Strange Case of Mr. Keats's Tuberculosis." Smith writes that after Keats coughed blood into a handkerchief, a sure sign that hemoptysis had appeared, Keats demanded of his friend, "'Brown, let me see this blood.' And then, looking up at Brown, he said, 'I know the colour of that blood; it is arterial blood. I cannot be deceived in that colour. That drop of blood is my death warrant. I must die'" (qtd. in Smith 993).¹ Keats's own medical knowledge informed his understanding of how truly horrifying TB was, and

¹ Hemoptysis is the coughing up of blood, often considered a definite sign of tuberculosis in the nineteenth century. The *OED* defines this action as the "[s]pitting of blood; expectoration of blood, or of bloody mucus, etc., from the lungs or bronchi" ("hemoptysis").

this knowledge was further expanded by the deaths of his mother and one of his brothers. In fact, their deaths first encouraged and then discouraged Keats's medical studies, though he remained for his short life "a qualified doctor" despite turning to poetry as a creative outlet for coping with his disease (Dormandy 13). As symptoms of TB continued to appear in the poet, Keats suffered his first hemorrhages before spending "long hours in bed or on the sofa [...]. He was greatly weakened, sometimes it seems nearly delirious, from what must have been partly at least hunger as well as regular bleedings (every time he coughed up blood)" (Dormandy 14). Further, his disease hindered his ability to see the woman he loved most, Fanny Brawne, "who obsessed his mind and whom he both longed for and feared to see" as he was ailing following several hemorrhages prior to his TB diagnosis (Dormandy 14-15). It is no surprise, then, with the influence TB had on his life and his loved ones, that the disease found its way into Keats's work as well.

One of the poems most often associated with Keats's tuberculosis diagnosis is "Ode to a Nightingale." As we read Keats's poem, we recognize that while he is ostensibly writing about the nightingale, he is also coming to terms with his own imminent demise. Kevin Patrick Milewski notes that "Ode to a Nightingale" "was written after [Keats's] diagnosis of tuberculosis and explores his personal development as a poet through this affliction" (6). This thematic content carries throughout the poem, marking Keats's work not only as indicative of consumption but also of creation. His poem opens with the lines "My heart aches, and a drowsy numbness pains/ My sense, as though of hemlock I had drunk" (ll. 1-2). Here, we read the suffering of a person with a weak heart, which nineteenth-century physician Edward Ruddock indicated is a symptom of TB. As Ruddock explained, the heart was believed to share "in the general waste of tissue" (56),

which those who had consumption experienced. We can further read in these lines the typical link between TB and the ways in which it lays waste to the body, making one feel as if he or she has been poisoned by their disease as it dulls their senses and their notion of pain due to the lack of nerves. It is not a surprise, then, that the speaker in Keats's poem—often identified with Keats himself²—keenly feels this decline not only of his heart but his connection to the larger world, as his senses dull. He is now pained by the realization that his time is near, that he has in fact been issued a death sentence.

Keats explores his disease in a way that many other consumptives were not known to, and this exploration allows readers to understand his place in the literary canon as a creative consumptive. For an example of his unique style in addressing the dread diagnosis, consider the line: “O for a beaker of the warm South” (ll. 15). Here, Keats makes a unique choice in using the word “beaker.” Inexorably linked to medicine and scientific pursuits, measuring anything in a beaker connotes a clinical precision. Further, by coupling the beaker with the warm Southern climate, Keats's speaker calls to mind the warm weather cures prescribed to many eighteenth- and nineteenth-century tubercular patients; here, his longing for better climates and his way of expressing that longing catch audiences' attention and gain their empathy. Further, Keats uses the gendered and classist treatments for TB to make it clear that his speaker is able to afford a trip to a warmer climate and is further capable of traveling there. Thus, it is likely that the speaker is a

² Milewski argues in “The Flight of the Nightingale: From Romans to Romantics” (2013): “John Keats experiences a poetic connection with the nightingale in the midst of his own emotional turmoil,” marking him as not only the author but also the subject of his own poem (6). This point is also made in *Consumptive Chic* when Day writes that “Ode to a Nightingale” was “likely an attempt to make sense of the tragedy not only of his brother's illness but also of his own, which by then was already evident” (49).

upper-class male either traveling alone or accompanying his consumptive (female) loved one as she cannot travel alone.

The poem continues, “And purple-stained mouth;/ That I might drink, and leave the world unseen,/ And with thee fade away into the forest dim” (ll. 18-20). While Keats is writing about the purple color hemlock poisoning leaves around the mouth, we can also see here echoes of the poisonous nature of the disease and the way it lays waste to the body much as a toxin would. Additionally, we see further allusions to hemoptysis and how it stains the mouth a dark red—perhaps appearing to some as purple—as the body wastes, or fades away. Further, his longing to leave the world unseen can be understood as hope for a peaceful death, which reinforces the idea of the human body wasting away and returning to nature, fading “into the forest dim,” showing that Keats’s speaker looks for another typical treatment, an escape from crowded areas to the expanse of nature. The body desires the fresh air and so escapes the dank, diseased, and crowded cities that, as *Chapters 1 and 2* established, were breeding grounds for TB.

The first lines of the third stanza bring consumption clearly into focus, centering on the speaker’s desire to fade away from society:

Fade far away, dissolve, and quite forget

What thou among the leaves hast never known

The weariness, the fever, and the fret. (ll. 21-23)

On the one hand, this idea of fading away might first bring to mind the wasted figure of the consumptive, lost to his or her fever, exhausted by this wasting disease. However, upon closer inspection, we look at the way Keats’s speaker proclaims that “what thou among the leaves hast never known” is the weariness, fever, and anxiety of the diagnosis.

Thus, returning to nature is a positive experience here, where the speaker can encounter cleaner air. The stanza continues a little later with one of the most famous lines in consumptive literature:

Where youth grows pale, and spectre-thin, and dies;
 Where but to think is to be full of sorrow
 And leaden-eyed despairs,
 Where Beauty cannot keep her lustrous eyes,
 Or new Love pine at them beyond to-morrow. (ll. 26-30)

Here, this depiction of pale, emaciated youths soon to die conjures the image of a young consumptive and allows us to examine for the first time the personification of their female Beauty that will fade in the grave. Keats's reminder is timely, calling to mind that consumption "seized the young" (Silverman). Not only does this line reference the way the disease took the young, however. Keats's use of the word "Beauty" coupled with his use of "her" shifts the focus to the large population of young *and* beautiful woman consumed by the disease. Then, the speaker returns to the other gendered notions of consumption as afflicting the creative male with the line "to think is to be full of sorrow." This line correlates with Keats's own experience with his disease: as he considers his diagnosis, he grieves for what he knows he will lose. We clearly see the fear of thinking about disease and how that thinking can contribute to the more rapid decline of the diseased as one acknowledges it.

In the next stanza, the speaker begins to dream of alternatives, of sending this illness "Away! away" (ll. 31). However, he abruptly shifts in the fifth stanza to the idea of being stalked by death because he "cannot see what flowers are at my feet,/ Nor what

soft incense hangs upon the boughs, / But, in embalmed darkness, guess each sweet” (ll. 41-43).³ The flowers laid at the speaker’s feet, combined with the incense and his use of the word “embalmed,” forces Keats’s audience—and the speaker—to confront the implications of death as they are associated with TB. We can imagine the flowers laid at the feet of a corpse lying in its coffin during a wake or laid by the graveside following a funeral service. Further, we can smell the incense being burned either to cover up the smell of decay as a consumptive patient wastes away or as part of the last rites or burial service. Finally, as Keats and others from his era saw death inevitably following a consumption diagnosis, Keats’s use of the phrase “embalmed darkness” suggests the blackness of a crypt or burial plot.

In the sixth stanza, we realize quite clearly the fears a nineteenth-century tubercular patient operated under. While much of the other literature from this era focuses on the pain and suffering of those who love consumptives, Keats offers the perspective of the stereotypically creative male TB patient himself. He writes, “I have been half in love with easeful Death, / Call’d him soft names in many a mused rhyme, / To take into the air my quiet breath” (ll. 52-54). We encounter in these lines the suffering a consumptive undergoes and the ways in which he or she may hope or even beg for death, cajoling it to come and end their suffering. Here Keats also touches on how his consumption has fed into his creativity, as he muses through rhyme. Additionally, the last line clearly focuses on the struggle the TB patient faces as he tries to speak; his ragged breath affects his ability, ultimately making him “quiet,” as his speech—if not his breathing—is constricted

³ The process of embalming is one with which nineteenth-century readers would have been familiar. The *OED* defines it as “[t]o impregnate (a dead body) with spices, to preserve it from decay” (“embalm”). Further, as it is a word exclusively connected with the preservation of a dead body, readers can clearly understand Keats’s focus on death here.

by his wasted lungs. Joseph Severn, longtime friend of Keats, comments on this wasted breath in his letters home during Keats's last days: "The poor fellow bade me lift him up in bed—he breathed with great difficulty—and seemd to lose the power of coughing up the phlegm—an immense sweat came over him so that my breath felt cold to him—"dont breath on me—it comes like Ice" (138). In this depiction, we see the unvarnished difficulties of TB as opposed to the romanticized ones readily available in fictionalized accounts. Ultimately, the TB patient who has not previously written much about their own condition is given a voice in Keats's poetry, albeit a "quiet" one.

In the second-to-last stanza, Keats addresses the nightingale for whom the poem is named. He writes, "Thou wast not born for death, Immortal Bird! / No hungry generations tread thee down!" (ll. 61-62). Most apparent here is this speaker's envy of the immortal nightingale. He converses longingly with the bird, who is free from death in a way Keats himself was not. The bird has successfully escaped consumption for generations in a way Keats, his family, and others experiencing the influence of the crowded living and working conditions, regardless of class, are unable to.⁴ Sadly, Keats—a doctor and writer—was one of the few to acknowledge the influence of poverty on tubercular patients whereas much of the popular literature of the time focused steadfastly on the wealthy, languishing tubercular ideal.

Finally, in the eighth and last stanza, the speaker connects very clearly with the nightingale as a symbol of sorrow, perhaps even death. He writes, "Adieu! The fancy cannot cheat so well / As she is fam'd to do, deceiving elf" (Keats ll. 73-74). We realize

⁴ Lawlor further argues that this envy of the nightingale fleeing may also reflect Keats's very specific attempts to escape "from early death to the Piazza di Spagna in Rome" (*Romantic* 113) where the climate was better for a tubercular patient.

here that Keats is focused on how he is unable to escape sorrow, even though the nightingale seems to be able to, or rather is “fam’d to do.” While Keats never explicitly connects the nightingale to death in such moments, allusions to the nightingale as a harbinger of death are not unheard of in literature. In fact, since the *Odyssey*, Milewski writes, the nightingale’s song has been associated with sorrow (2). However, Milewski does not associate this sorrow with the nightingale in Keats’s poem. Instead, he argues that Keats “idolizes the nightingale’s effortless song and longs for such ease in his own poetic lyrics” (6). But the speaker is doing much more than longing for stronger poetry—he is hoping for the freedom of the nightingale. Keats expresses sorrow that while the bird is immortal, the poet is not. Further, the bird goes where he cannot because of his impending death: “Adieu! adieu! thy plaintive anthem fades / [...] / Fled is that music—Do I wake or sleep?” (ll. 75 & 80). Keats’s fear is clearly expressed here: he may soon be sleeping eternally. His tuberculosis is a death sentence that will inevitably be carried out as it has been for many before him.

Because, as Lawlor argues, poets like Keats “were subject to consumption,” medical practitioners fell into “the broad pattern of labelling male illness as creative and female disease as debilitating but beautiful” (*Romantic* 56). Thus, Keats’s approach to his disease allows us to consider the myth of the creative male literary consumptive living at the start of the nineteenth century. He embodies the Romantic poet whom Lawlor describes as passionate and in love with the world who “was likely to result in early death or painful old age.” Lawlor continues, sharing the perception that: “Poets too were subject to consumption, although the effects were accelerated” (*Romantic* 55) due to their more creative, sensitive approaches to life and literature. Thus, as a result of writers like

Keats, the myth of the male consumptive became entrenched as the disease took its toll on nineteenth-century populations.

Even as Keats reflected on his own experience with TB, many white, male writers of the nineteenth century developed literary representations of the female tubercular patient, or the ways in which consumption influenced feminized Beauty, as Keats did. Perhaps the best-known of these writers is Edgar Allan Poe, a man who had close relationships with many women infected with consumption. These women included his wife and cousin, Virginia, and his biological mother, Elizabeth. Poe's mother died soon after contracting pneumonia, which alongside her tuberculosis, ended her life quickly.⁵ Later, Poe would also lose Virginia to consumption. For a time, Virginia suffered like Keats from hemoptysis. During this period Poe attempted to nurse his ill wife with little success (Patterson 1246). Thus, Poe's experiences with loss as a result of consumption had a profound influence on his life. In his "Philosophy of Composition" (1846)—published a year before his wife's death—he alludes to his mother's and Virginia's suffering:

I asked myself —“Of all melancholy topics, what, according to the universal understanding of mankind, is the most melancholy?” Death—was the obvious reply. “And when,” I said, “is this most melancholy of topics most poetical?” From what I have already explained at some length, the answer, here also, is obvious—“When it most closely allies itself to Beauty: the death, then, of a beautiful woman is, unquestionably, the most

⁵ Furthermore, Poe's father abandoned his family when Poe was an infant but then died not long after due to tuberculosis.

poetical topic in the world—and equally is it beyond doubt that the lips best suited for such a topic are those of a bereaved lover.” (265)

The passing of Poe’s mother began his now-famous exploration of the deaths of beautiful women in Poe’s work, a theme that was exacerbated by his wife’s experience with and death due to consumption.⁶ Even as Poe grieved the losses he suffered, however, he used his writing to examine these deaths. And, in much the same way Keats created an extended means of examining the destruction of consumption, so, too did Poe, as will be shown shortly with reference to “The Masque of the Red Death” (1842).

First, however, a few biographical explanations of Poe’s life and experiences must be noted. According to Kenneth Silverman, author of *Edgar A. Poe: Mournful and Never-Ending Remembrance* (1991), Virginia Poe’s death in 1847 called to mind Poe’s other experiences with the deaths of important young females in his life (326), thus inspiring him to expand on the gothic literature for which he is so well-known. His thematic focus on the suffering of beautiful women and their creative male counterparts may exacerbate his modern readers’ horror while it may have alleviated his own. The purportedly poetical nature of these deaths inspired him, creating a narrative of death as generative for his work (Poe, “Philosophy” 266). In fact, Poe’s literary texts became

⁶ It is important to note that Poe struggled throughout his life as a result of these deaths and so much psychological study was devoted to his struggles. Henry Maudsley—a medical doctor and superintendent of the Manchester Royal Lunatic Hospital—wrote a psychological evaluation of Poe approximately a decade after the author’s death. This evaluation provides interesting clues as to the medical practitioner’s regard for and understanding of Poe. He notes early on in his evaluation (admittedly never having met Poe face-to-face) that while Poe was a “warped slip of wilderness” (qtd. Maudsley 337) readers should not look at his life and work and presume to know him. Maudsley argues, “black as his character seems, yet may there be, in an examination of circumstances, some explanation” (337). He then goes on to specify which circumstances these are, including the loss of Poe’s mother and most of his family at a young age. It was Virginia’s death and Poe’s subsequent search for happiness, however, that delivered the crushing blow. Maudsley writes of Poe again taking “refuge from the anguish of his crushed feelings in alcohol, and sought consolation there” (361). While physical disease brought death and peace for many of Poe’s characters and family, it was ultimately his own mental anguish and subsequent alcoholism that served to end Poe’s own revelry.

important to readers who wanted to explore their own losses or escape from their suffering for a time, just as he must have done while creating these stories.

One literary text that allows us to experience the mourning that follows disease is Poe's "The Masque of the Red Death." From the first lines of this tale, we understand the impact disease has on a society. Poe opens his story with the line "The 'Red Death' had long devastated the country. No pestilence had ever been so fatal, or so hideous" (251). This line shows not only how a disease could maim and kill an individual, but also how it could lay ruin to an entire region. The terms Poe uses here to describe this disease place it at an epidemic level, not unlike nineteenth-century TB. A nineteenth-century British journal aimed at garnering middle-class readership, *The Cornhill Magazine*, explained in its May 1865 issue that "[t]o be entitled to the name of pestilence, a disease must be unusually fatal, very rapid in its operation, and must destroy great numbers of victims" ("pestilence").⁷ By making the idea of pestilence in relation to diseases more approachable to a larger readership (among whom doctors as solid middle-class members would have numbered), the classist commentary in Poe's short story, particularly the way the wealthy left their poorer neighbors to die, would be more apparent to nineteenth-century readers. Further, Poe's particular focus on the way the Red Death makes its victims "hideous" clearly calls to mind the ways in which TB lays waste to a body, a theme that carries throughout his tale.

⁷ The *Cornhill Magazine* "revolutionized magazines in 1860 by providing a monthly miscellany of 128 pages aimed through its shilling price at the expanding number of middle-class leisure readers" (Schmidt 202). See Barbara Quinn Schmidt's "Introduction: 'The Cornhill Magazine': Celebrating Success" for more about this publication. This definition of pestilence appeared in the article "Plague and Pestilence" (*The Cornhill Magazine*, vol. 11, no. 65 [1865]: 591-603).

An aspect of Poe's Red Death that would at first seem to set it apart from TB is its rapid progression. Poe writes in his opening paragraph that "the whole seizure, progress, and termination of the disease, were the incidents of half an hour" (Poe, "Red Death" 251). As a result, modern readers may wonder what similarity the Red Death had to TB, a disease that from all current medical accounts is slow-moving. On the other hand, if we consider nineteenth-century understandings of the disease, we will have our answer regarding the similarities in progression of these two diseases. While TB's infection rate may appear slow-moving according to current understandings of this disease, in the nineteenth century, it often caught its victims unaware. In fact, it quickly overwhelmed a patient at the end of its manifestation, following months or even years of dormancy. Day writes, "consumption's slow, creeping nature meant it often remained unnoticed until the latter stages" (8). In other words, because of the ways in which its symptoms manifested slowly but then progressed rapidly at the end, tuberculosis was a diagnosis people could be certain of only when there was little time left for the patient to try one of the many "cures" available, thus making the conclusion of the disease rapid.

Poe was well acquainted with the rapidness of tuberculosis due to his wife's battle with the disease. Paul Collins expands upon Virginia's illness, noting that her disease began as a cough during an evening at home but ultimately worsened to "the dramatic, frightening onset of tuberculosis" (51). Thus, Poe's writing shares the terror of those who lose someone afflicted with—or themselves are diagnosed with—tuberculosis as their disease swiftly reaches its end. In "The Masque of the Red Death," Poe describes the disease's manifestations as "scarlet stains upon the body and especially upon the face of the victim" (251). This description aligns with what was known about tuberculosis during

this period in terms of the physical presentation of the disease.⁸ Therefore, readers of “The Masque of the Red Death” who have knowledge of Poe’s life encounter an author not only grieving as a result of consumption but also publicly commenting on the destruction caused by this disease and the helplessness of those who can only watch as they or their loved ones are consumed.

The similarities between Virginia’s illness and pestilence in Poe’s gothic tale do not end with the symptoms of this disease. Poe writes about the court of Prince Prospero and their many attempts to outsmart the death, noting that only at midnight was there “an uneasy cessation of all things as before” including the revelry (“Red Death” 253). In much the same way, Virginia and her family regularly attempted to escape consumption and enjoy life by traveling to Saratoga, “presumably to see whether the mineral springs might provide long term relief” (Silverman 183).⁹ Ultimately, when relief was not found, Poe took Prospero-like desperate measures: “It may have been hope of finding a more healthful environment for Virginia that also prompted Poe to leave his cramped portion of a house” sometime in 1842 (Silverman 183). Collins explains that this move seemed to come at a good time for the Poe family because Virginia had “‘coughed hardly any and had no night sweat’” (qtd. in Collins 62). However, just as the “Red Death held illimitable dominion over all” (Poe, “Red Death” 255), so too, did tuberculosis. About four years after this move, and many intervening attempts to revive his wife’s health—

⁸ Furthermore, this claim is supported by Patterson’s argument that “TB provided the model for the scourge in *The Masque of the Red Death*” (1247).

⁹ Saratoga Springs, as described by Charles Dawson in *Saratoga: Its Mineral Waters and Their Use in Preventing and Eradicating Disease and as a Refreshing Beverage* (1868), is located in Saratoga, NY. He explains that its water has effects that “are peculiarly grateful to persons having weak or diseased lungs, and to all who are suffering in any way from the influences of a miasmatic climate, or the damp, chilling winds common to the sea-coast” (8).

which were always only successful for a brief time—Virginia died “of pulmonary consumption” (Silverman 326) at only twenty-five years of age.

Because the Red Death was an epidemic pestilence that ended in the deaths of its victims, it is easy to see why Poe’s story is engrossing, particularly as it relates to many nineteenth-century portrayals of epidemic disease. Prince Prospero, in particular, is a fascinating character, described when we first encounter him as “happy and dauntless and sagacious” (Poe, “Red Death” 251). Here, Poe describes Prospero as cheerful, but readers of the time would wonder how one facing such a terrible disease could be so content. Are they supposed to take a page out of Prospero’s book and live while they still can? It would seem so, as Poe also describes the prince as wise. We can only interpret this point as either completely true—Prospero is wise to live while he still can—or completely facetious—his blissful ignoring of the pestilence will only end in renewed devastation. On the one hand, if we consider the fact that either way Prospero and his courtiers are likely to die based on the rapid spread of the illness, it seems we are supposed to read him as wise to seize what life is left and enjoy it, to remain undaunted by the terrible future that awaits all of them. On the other hand, closer inspection causes audiences to realize that Prospero is undoubtedly a selfish man, protecting only those people and things that he values while the “[t]he external world could take care of itself” (“Red Death” 251). Far from being a leader that his subjects can look to in times of crisis, he builds a wall between himself and those who most need his help, ignorantly assuming that with this edifice, his problems will cease. Poe’s commentary on the selfish and obstinate nature of the higher classes cannot be missed here as it underscores one of the most dramatic points

about TB: it is a disease that, despite evidence to the contrary and societal misunderstandings, does not distinguish between gender *or* classes.

In fact, the very clear *carpe diem* attitudes of Prince Prospero and his court gave nineteenth-century TB sufferers another option besides succumbing to their fainting couches and waiting for death. They, too, were already infected—or likely to be—so they also “might bid defiance to contagion” (Poe, “Red Death” 251) just as Prospero and his court have. For those facing what was certain death, acts of defiance gave them something on which to focus besides their disease. For them, it might be “folly to grieve, or to think” (Poe. “Red Death” 251), thus by distancing themselves from their diagnoses and their infected situations, whether literally by building walls as Prospero’s court does or figuratively in escaping to fiction such as Poe’s short stories, both the fictitious revelers and real patients were able to defy the situations in which disease placed them, if only for a short while.

In bidding defiance to these experiences of death, both real and fictitious individuals were able to seize the moment and enjoy the opportunities they still had left to them. We encounter this enjoyment when consumptives decide to write about their experiences—as Keats and the Brontës do. We also see this attitude of *carpe diem* in the revelers in Poe’s tale. Poe writes, “[i]t was towards the close of the fifth or sixth month of his seclusion, and while the pestilence raged most furiously abroad, that the Prince Prospero entertained his thousand friends at a masked ball of the most unusual magnificence” (“Red Death” 251). Despite knowing that the world is succumbing to a terrible disease around them, Prince Prospero determines the best course of action would be to celebrate what time they do have left with a sumptuous ball. However, even hiding

in their secluded magnificence, these courtiers and their prince will not be safe forever, and they all seem to acknowledge that fact at least tacitly by devoting themselves to the hedonistic opportunities around them.

The revelers' defiance and subsequent devotion to pleasure is a seeming departure at first from other tubercular tales that focus exclusively on the languishing, painful nature of the disease. However, as Silverman argues, the story is focused on "the attempt to defend oneself against what is most feared and unwanted" (181). I would add to this point, noting that just as the revelers' flee the Red Death by retreating to the countryside, so, too, did those who could afford to leave the cities in order to escape the overcrowding that allowed TB to breed. Poe writes of one of the performers: "Then, summoning the wild courage of despair, a throng of the revellers at once threw themselves into the black apartment and, seizing the mummer, whose tall figure stood erect and motionless within the shadow of the ebony clock, gasped in unutterable horror" (Poe, "Red Death" 254). Quite clearly articulated in this passage is the last valiant attempt by the revelers to stave off the Red Death as they confront it, only to be horrified once again by its presence. The wild courage they show comes not because they have nothing left to lose but because they still have *everything* to lose. This disease hasn't yet touched them; they are reveling in their escape thus far from death and have not begun to despair.

Another message can be read here as well—the revelers *can* escape to the countryside; not only do they have the ability, but also the means to do so. First, as previously mentioned, because Prince Prospero has the resources available to go to the country, he does so, taking his courtiers with him. He can afford to hide in his castle with his friends and all the entertainments available for their pleasure. On the other hand, those

without his means cannot and thus are that much more susceptible to the Red Death. Furthermore, there is a gendered component to Prospero's fleeing to the country. He has the freedom to escape to the country and not only because he can afford it but also because he is not tied to the domestic sphere in the way a female counterpart would be; in fact, presumably all the females taking part in his revels are only there because they are accompanied by men. As mentioned in *Chapter 2*, women were generally prescribed country air for their illnesses only if a male counterpart could be found to go with them, as evidenced by the tubercular Mary Graham. Otherwise, like Deborah Fiske—who also suffered from consumption—these women took their treatment at home. Thus, Prospero's leaving the crowded, diseased city for the country air indicates not only a freedom available to the upper classes but also a freedom nearly exclusive to men, whether as escorts to consumptives or as consumptives themselves.

Despite their ability seemingly to escape, however, the Red Death arrives among the revelers, a figure “dabbed in blood,” in such a way that we cannot but assume the worst is soon to come (254). Once this grotesque figure breaches the castle walls, the court becomes afraid, knowing that now the Red Death will seize its own moment: “And the rumour of this new presence having spread itself whisperingly around, there arose at length from the whole company a buzz, or murmur, expressive of disapprobation and surprise—then, finally, of terror, of horror, and of disgust” (253). As their defiance is replaced by horror, the Red Death strikes these men and women down quickly, beginning with their prince. Prospero rushes towards death in what seems at first to be one final act of defiance: “He bore aloft a drawn dagger, and had approached, in rapid impetuosity, to within three or four feet of the retreating figure [...] There was a sharp cry—and the

dagger dropped gleaming upon the sable carpet, upon which, instantly afterward, fell prostrate in death the Prince Prospero” (254). However, if we consider Poe’s use of the word “impetuosity” we recognize that he is actually condemning Prospero for seeking out death when someone else was in its sights. By attacking the Red Death, Prospero turned its attention back to him and was killed. Soon after, the Red Death has similarly dispatched the rest of the castle’s inhabitants, spreading rapidly, in much the way TB spread throughout other closely-packed populations. Poe’s judgment on those seeking death when it will soon come anyway is clear here. In the similarities between what Virginia experienced and what the Red Death caused, unchecked, we cannot help but see Poe as writing about his own inability to protect his wife. Prince Prospero mirrors Poe’s inability to save his wife in Prospero’s failure to guard his subjects, most specifically his high-class courtiers. Ultimately, the Red Death is as inescapable as TB, a fact Poe proves when he concludes his story with the line “[a]nd Darkness and Decay and the Red Death held illimitable dominion over all” (255).

While we’ve already established that TB is not a disease that kills as quickly as the Red Death, it does produce reverberations of suffering in much the same way. In fact, this project is not the only one to call upon the connection between Virginia’s prolonged suffering—occurring even as Poe was publishing his work for money with which to care for her—and this fictional disease. Silverman focuses on this connection when he describes the Red Death as a devastating “Virginia-like pestilence” that rages through the countryside (180), reintroducing the theme of gender that may not at first be visible in Poe’s story due to the strong classist focus. First, both the color of the cheeks and the hemorrhaging are among the classic signs of consumption, such as those Virginia

experienced, and they indicate a distinct relationship to Poe's Red Death, which brought "sharp pains, and sudden dizziness, and then profuse bleeding at the pores" ("Red Death" 251) in addition to the red tint it left upon the victims' faces.¹⁰ This description is the first indication readers have that Poe's writing has been influenced by his wife's condition and the ways in which her disease consumed her despite his best efforts. Further, we recognize that Poe personifies the Red Death as a bloodthirsty male: "His vesture was dabbled in *blood*—and his broad brow, with all the features of the face, was besprinkled with the scarlet horror" (254). Based on this horrifying embodiment of disease, readers are able to empathize with some of the dismay Poe must have felt as the disease consumed Virginia's beautiful body and spirit. We also encounter a sort of mimetic rivalry—or a rivalry of mirrored desires—as Poe loses his wife to a figure he later personifies as male.¹¹ Rene Girard unwittingly creates a comparison for this rivalry to the Red Death when he describes the mimetic rival as "the uninvited guest" (14) in *Anorexia and Mimetic Desire* (2013). In the "Masque of the Red Death," we see the

¹⁰ Other scholars support the idea that Poe was fixated on TB to the point that it could make its way into his work. In "Poe's Pandemics: Mass Death in Gothic America," Alan Brown argues that "Poe's emphasis is on the heartache brought on by [Virginia and his mothers'] untimely deaths. For years, most critics, teachers, and professors have assumed that the women [and men in "The Masque of the Red Death"] died from the same disease that took his mother and his young wife," a disease we now understand is tuberculosis (28). He further expands on his argument, explaining that "Poe's intent in these works is clear: to work through his grief poetically and thereby elevate his beloved's suffering to high art. However, when a specific disease is identified by Poe, it almost always takes the form of an epidemic that claims thousands of lives" (Brown 28). His public acknowledgement of his private loss in "The Masque of the Red Death" and his justification for the continued exploration of that theme in his writing are impacted by disease and in turn create a record of that impression.

¹¹ Girard explains the motivations that influence mimetic rivalry in his interview with the journal *Diacritics* in 1978. He states, "one must realize that mimetic rivalry is not even specifically human. There must be a mimetic element in the intra-specific fighting of many animals since the absence of an object—the flight of the disputed female, for instance—does not always put an immediate end to the fighting" (32). He further explains that "the fighting comes to an end with a kind of submission of the vanquished to the victor" (32). The Red Death is clearly in this moment the victor, and the submission it receives is Prince Prospero's. We could take this argument further, too, and note that real-life mirrors Poe's work in that the vanquished here is the consumptive and the victor, at least through the middle of the century, is tuberculosis. *Chapter 7* (on chlorosis) focuses on mimetic rivalry as it relates to the "love" triangle of Lucy Westenra, Arthur Holmwood, and Dracula.

uninvited, masculine Red Death consuming the body, though of course the figure Poe is most concerned with is that of a beautiful woman. The Red Death wants this same woman: she appeals to him simply because she appeals to others. He might not find her as attractive if she weren't defined already by others as the personification of Beauty. In this moment, then, the tubercular woman becomes the personification of Beauty simply because she is desired.

In neglecting to consider the disease might have followed them into his palace, Prospero's courtiers are caught unaware at the end of the story, just as a nineteenth-century victim of TB might have been. Poe writes, "[a]nd now was acknowledged the presence of the Red Death. He had come like a thief in the night. And one by one dropped the revellers in the blood-dewed halls of their revel, and died each in the despairing posture of his fall" (254-55). The sudden deaths caused by Red Death, again despite TB's more languid march towards eternity, horrified the revelers as it crept upon them while they were enjoying the prime of their lives, much as TB did to its victims. Further, this masculine personification of the Red Death appears again here as he comes sneaking in, stealing the lives of the revelers. After all, the courtiers were aware of the Red Death or they would not have felt the need to "bid defiance to contagion." However, they had denied so long the presence of the Red Death in the palace in order to instead celebrate and revel that they have neglected to consider the implications of such a widespread contagion. This thoughtlessness—recall that for the revelers to think was folly—is something nineteenth-century readers would have understood, even if they did

not necessarily approve.¹² Thus, the Red Death's ability to shock its victims, catching them unaware despite their knowledge that it prowled about the countryside, indicates that even if one was aware of a dread diagnosis or epidemic, the loss of life that resulted could still astonish and horrify.

Toward the middle of his short story, Poe begins to explore multiple concerns about disease—concerns Poe himself no doubt had—that arise as a result of differences in class. First, Prince Prospero's erratic behavior mirrors nineteenth-century fears of the high probability of contracting an epidemic disease, regardless of class. Ruddock explains precisely where these fears arise when he states that he is writing on a subject “in which, unfortunately, most persons are deeply interested, there being few families of which some member near or remote, has not fallen a victim to Consumption, or Tuberculosis.” He explains how readers can avoid this disease if they follow the treatments and recommendations outlined in his text (5).¹³ Lawlor provides modern readers with additional historical context, explaining that as the century progressed “consumption was thought to kill almost one in four people: almost everyone was touched—if not one of their immediate family, then one friend or another would invariably be affected by this ‘White Plague’ of the eighteenth, nineteenth, and early twentieth centuries” (“Consumption” 3). Then, as a result of TB's highly infectious

¹² This intentional ignorance is mirrored, as already mentioned, in other works on consumption, including Keats's “Ode to a Nightingale,” though Poe's motivations are different from Keats as the latter watched his wife die of consumption while the former himself died of the disease.

¹³ Here we get a glimpse of the sometimes-opportunistic nature of nineteenth-century medicine when we realize that while as a first-person observer of the spread of TB throughout his time, Ruddock can be trustworthy, the same is not necessarily true of his cures as he has invested an interest in having people seek his treatment as any pharmacological representative does today.

nature, readers could well understand the fear of “The Red Death” that had Prince Prospero locking his friends and loved ones into his castle to escape its spread:

The external world could take care of itself. In the meantime it was folly to grieve, or to think. The prince had provided all the appliances of pleasure. There were buffoons, there were improvisatori, there were ballet-dancers, there were musicians, there was Beauty, there was wine. All these and security were within. Without was the ‘Red Death.’ (251)¹⁴

The Prince has used his money and resources to provide entertainment for his courtiers so that they all can avoid thinking about the inevitability of death. While their wealth may not save them, it will at least assuage their fears somewhat by allowing for distractions.

From the first line of the above quote, we can see the centrality of class and money to Prince Prospero and his court. Poe is clearly looking at the idea of those with wealth escaping the external world because they have the money and power to do so. They neglect those without and allow the impoverished world to “take care of itself” while the wealthy exclusively take care of themselves. The third line returns to the *carpe diem* mindset seen elsewhere in this story. Chiefly, here, the wealthy can enjoy their exclusivity while the poor struggle with fear due to the Red Death. Part of the wealthy’s problem here becomes apparent in the next line—they have been distracted by Beauty, by wine, by life’s pleasures, while those outside their walls have no pleasures left to enjoy.

¹⁴ These moments of captivity within the castle call to mind later quarantining practices in the latter half of the nineteenth century wherein people “had to leave family, friends, and home—everything that was familiar—and face an unknown future alone” (Murphy & Blank 40). However, people were willing to go to these places, to accept the new experience, because “These institutions created a unique lifestyle that many patients hated, some tolerated, a few even enjoyed, and all endured because it offered something no hospital could—the hope of a cure” (Murphy & Blank 39). For more on these practices, consult *Chapter 4* of Jim Murphy and Alison Blank’s *The Invincible Microbe* (2012) and Charlotte Roberts & Jane E. Buikstra’s *The Bioarcheology of Tuberculosis: A Global View on a Reemerging Disease* (2003), which is cited in *Chapter 2*.

However, here, we also see them lulled into a false sense of security and wonder what is on the horizon for Prince Prospero's court. They may contrast themselves with those left "Without," but as Poe and his audience undoubtedly already knew, disease could come for anyone, regardless of the defenses built up against it.

One family intimately acquainted with how TB could come for anyone was the nineteenth-century literary family, the Brontës. Scholars understand that Emily Brontë and each of her siblings in turn fell victim to tuberculosis; however, there were distinct differences in why the disease manifested in her sisters and her—mostly because of overcrowding in boarding schools—and how it came to infect her brother. John Ross, author of *Orwell's Cough* (2012), notes that Branwell, as was well known in Brontë's time, was an inveterate drinker; he was self-described as someone who had "strong passions and weak principles"¹⁵ (qtd. 86). Ultimately, as he deteriorated due to his comorbid conditions of tuberculosis and alcohol dependence, he visited several horrors upon his family and himself, including setting his bedroom—and nearly the entire house—on fire (Ross 87).¹⁶ This was not the only night he caused problems in the Brontë family's parsonage; rather, he grew increasingly manic (Wilson 280). Additionally, he experienced a "violent cough" not unlike young Linton's "suffocating cough" in *Wuthering Heights* (Ross 87; Brontë 182).

¹⁵ Just as Lawlor writes about the consumptive female beauty, he also writes about the creative consumptive man. While Branwell's creativity would never truly rival that of his sisters, he does in his own right become the "drug-addled, self-destructive poet" of his imaginings (Ross 87). In fact, Branwell's "final poem was an obscene lampoon on his physician" (Ross 87), once again calling to mind the nineteenth-century issues emerging between the restructuring of medical practice and doctor-patient relationships.

¹⁶ This specific incident is credited with not worsening due to Emily Brontë herself. Ross writes, "Emily's presence of mind in tossing him and the burning bedclothes to the floor and dousing the flames" is what prevented the fire from spreading (87).

Ross explains that because Branwell's decline from TB might seem very rapid, we should consider the medical facets of the disease. He writes, "[h]eavy drinking is probably an independent risk factor" for the quick spread and strong enhancement of tuberculosis in ill persons (80). This risk of contracting TB and having it worsen at an alarming rate was clearly compounded by his family's history of the disease. We cannot ignore further similarities between Branwell and young Linton. It is not clear whether Branwell contracted the TB from his sisters or from the disreputable places where he would spend time drinking (Ross 90), just as it is unclear whether or not Linton contracted the disease from his mother. What is obvious in Branwell's case, however, is that the disease caused a shift in personality that made him insufferable, a decline that was then mirrored in the only male consumptive of *Wuthering Heights*.

In "Branwell at the Heights: An Investigation into the Possible Influence of Branwell Brontë upon *Wuthering Heights*," Everard Flintoff writes that the Brontë brother "was, in fact, perhaps the most important outsider regularly to pay visits to the Heights" (334). He bases his argument on the idea that Branwell's influence on Emily Brontë's text stems from his knowledge of assorted dialects, a knowledge his reclusive sister did not have (323). Flintoff further contends that because the Brontë siblings shared their work with one another, and offered ideas to each other, it is not unlikely that Branwell had previously unconsidered influences on Emily's text:

By the mid -1830s, then, Branwell had mastered the art of writing dialect and, if, as I strongly suspect, the young Brontës used their juvenilia as material for a sort of writers' workshop to amuse each other and to expose

their work to each other's criticism, Emily would have become increasingly aware of Branwell's proficiency at it by this time. (329)

While it is hard to tell for certain what influence Branwell had on the dialect in *Wuthering Heights*, what is obvious is that the temperament and writing style of the Brontë brother allow for the argument that "Branwell anticipated and probably invented many of the situations in *Wuthering Heights*" (Flintoff 331-32), thus providing, intentionally or otherwise, a model on which to base Linton Heathcliff. The difference between these two men is almost as apparent as their similarities: while Branwell's illness would soon lead to Emily's—and perhaps later to Anne's and Charlotte's—contraction of TB, Linton Heathcliff is the last one so afflicted in *Wuthering Heights*. Branwell thus began a contagion that Linton ended, perhaps hinting at Emily Brontë's own hope that consumption's relationship with her family would end with the death of her brother.

Emily and her sisters experienced the disease differently from their brother, however. Romer Wilson of *All Alone: The Life and Private History of Emily Jane Brontë* (1928), explains "[s]he absolutely refused to admit that she was ill to anybody, and performed all the duties she was accustomed to perform as usual" (281). For the young Maria and Elizabeth [Emily's younger sisters], the disease came on rapidly while they were still in school, and after some suffering from "a chronic cough and subsequent breathing treatments," it resulted in their deaths at the ages of ten and eleven, Elizabeth's not long after Maria's (Ross 76-77). For Anne, the diagnosis of tuberculosis came with periods of recovery and relapse, not unlike those experienced by Virginia Poe (Ross 83). Lastly, in Charlotte's case, the doctors attributed her symptoms to pregnancy. She had

just recently married, and doctors assumed that she was simply fulfilling her role according to nineteenth-century expectations by becoming pregnant.¹⁷ Ross explains how this misdiagnosis could have occurred when he writes that among her symptoms were “weakness and sickness and frequent fever” (94), maladies not exclusively attributed to pregnancy; however, because Charlotte was also vomiting and nauseous, doctors assumed she had hyperemesis gravidarum, a form of severe nausea resulting from pregnancy (Ross 94).

Just as interesting as the spread of this disease throughout the Brontë family is the fact that with the infection of each of the Brontë sisters, a clearer portrayal of the female consumptive emerged: the creative, consumptive woman. By using her tubercular family as a sort of model for her fiction, Emily Brontë created an additional space for discussing the existence of tubercular females—not as objects of beauty to be admired but as creators who challenged the preexisting ideas of what a tubercular woman was. By creating characters in *Wuthering Heights* that went against the consumptive norms—using Linton Heathcliff as a male, invalid consumptive, Catherine Earnshaw Linton as a passionate, female consumptive, and Isabella Linton Heathcliff as a female consumptive existing outside of class stereotypes—Brontë rejected the past ideals and standards of what a gendered consumptive diagnosis meant. She thereby aided those similarly afflicted by providing a model for how to document and deconstruct their own diagnoses and treatment regimens.

¹⁷ Pregnancy in this era—and later—was treated in much the same way as a disease: with confinement of the pregnant woman until the birth of her child. Write Gilbert and Gubar: “the confinement of pregnancy replicates the confinement of society” (89). Thus, just as diseased women are treated as outcasts, so too, are pregnant ones.

Emily Brontë did not just give feminine space in her fiction to the creative consumptive, however; she also embodied this figure, both through her own work on *Wuthering Heights* and the work of her siblings that she helped to edit. Sandra Gilbert and Susan Gubar argue that “Emily Brontë uses the novel form to give substance—plausibility, really—to her myth” of her own female origins (256). While Gilbert and Gubar were not focusing on tuberculosis when they made this claim, we can readily apply its meaning to the ways in which that disease manifested in female writers like Brontë and her contemporaries. After all, it is through the literary consumptive that the clearest voices of diseased females emerge, hopefully unencumbered by social expectations or stereotypes, to explore their experience of being consumptive. Furthermore, it is through works like Brontë’s that the myth of the consumptive takes on a new meaning in the creation of the writer recording her own experience more accurately than her male, medical counterparts could possibly do.

Due to its infectious nature, TB is still a pestilence today in many parts of the world despite its rather slow-moving infection rate. Day explains:

[...] infectious diseases adhere to an epidemic pattern. Initially they increase very quickly; then, having attained a certain level, slowly fade in intensity and incidence. Despite the fact that tuberculosis is less “flashy” than other contagious illnesses, it still follows a typical epidemic cycle of infection, though progress is often extraordinarily slow, taking decades rather than weeks or months. (7)

What this quotation shows us perhaps better than literature from the nineteenth century can is the fact that, for a time, TB hit a critical mass in populations throughout Europe

and the United States. It infected large numbers of both men and women in many age groups and locations and of many social classes. However, over time, the number of cases of infected individuals declined, a fact seen easily in death certificates and studies done on tuberculosis, such as *The Bioarcheology of Tuberculosis*.¹⁸ Therefore, it's easy to understand how when consumption was at its peak, writers like Keats, Poe, and the Brontës would have been not only affected by the disease but also infected with it.

In much the same way that death comes for the seemingly tubercular patients in Poe's short story, it follows closely behind the consumptives in *Wuthering Heights*, marking them as victims of the epidemic. Dennis Bloomfield articulates why this haunting existence of death might be present in Emily Brontë's work. He explains that she "has used illness, injury and death exclusively to direct and advance" the plot of her novel (289). He expands on this notion, clarifying that "[e]arly death and illness were prominent elements in the writings of Victorian novelists" such as Brontë and her literary siblings (293). This familiar theme, coupled with the prominence of tuberculosis, made the perfect set-up for composing and publishing a novel. Bloomfield is inclined to agree, noting that "[t]hroughout history illness has always carried with it societal implications" (296) that influence its consumer products such as literature. Here we see Brontë's work perform this very action: it calls into question the societal implications of disease as it

¹⁸ In fact, if scholars consult the article, "Differential Tuberculosis Deaths Among a Late Nineteenth and Early Twentieth Century New York City Population: an Analysis of Death Certificate Data" Teresa Leslie and Diane Bitenas, we can see the ways in which tuberculosis was a disease indifferent to class, even though only the wealthy tubercular patients often were portrayed in literature. Leslie and Bitenas write, "[s]pecific environmental factors (dietary, substandard living conditions, substandard working conditions etc.) leave individuals immunocompromised and more susceptible to developing tubercular disease" (163). They also specify that while these factors include birthplace, age, sex, and immigration status, the scope of their study was not to explore how much each of these influenced contagion but simply that they did (Leslie & Bitenas 163). For more on death certificates and TB in the nineteenth century, see Chapter 4 of *The Bioarcheology of Tuberculosis*.

manifests both in the poverty-stricken Isabella Linton Heathcliff and the wealthy Catherine Earnshaw Linton alike, rejecting the notion that only the poor got TB. Thus, tuberculosis as plot device becomes something that unsettles many readers, regardless of social caste.

In *Wuthering Heights* Catherine Earnshaw Linton suffers from tubercular manifestations that are more obvious than Isabella's—though perhaps less obvious than Linton's—likely because we encounter Catherine more frequently in the novel. As she reaches adulthood, Catherine Earnshaw Linton finally appears to advantage before Isabella, her sister-in-law, a family friend exclaiming on this difference: ““Why, Cathy, you are quite a beauty! I should scarcely have known you—you look like a lady now! Isabella Linton is not to be compared with her”” (41). However, as mentioned above, it is clear that Catherine continues to feel the sting of this comparison for the rest of her life.¹⁹ Even as Isabella runs away to join Heathcliff—and even though it appears as if Catherine would have abandoned her new husband for Heathcliff, too—the focus in her house is on making Catherine's life better. She has her family in her thrall as they struggle to “preserve around her perfect and constant tranquility” as she has fallen ill with “a brain fever” (102, 103). Thus, we come to two realizations simultaneously: first, Catherine may have previously been of what she considered a “lower class,” but now she has the care and attendance that many an invalided woman of the higher classes would have enjoyed. Secondly, Catherine is legitimately ill, experiencing a disease she had first suffered through in her youth.

¹⁹ Even though Catherine grew in beauty, according to Nelly “she was the queen of the country-side; she had no peer” she still grew up “a haughty, headstrong creature!” (51).

Catherine Linton's illness—the rapid advance of which happens to coincide with her pregnancy, just as Charlotte's tuberculosis would, years later²⁰—seems to come at a more rapid pace than Isabella's, perhaps exacerbated by her confinement.²¹ In *The Madwoman in the Attic* Gilbert and Gubar speculate on why Isabella seems doomed to be a pale parallel of Catherine Earnshaw, explaining that “Isabella is perhaps the most striking of these parallel figures, for like Catherine she is a headstrong, impulsive ‘miss’ who runs away from home at adolescence. But where Catherine's fall is both fated and unconventional, a fall ‘upward’ from hell to heaven, Isabella's is both willful and conventional” presumably because she ends up married to Heathcliff (287). We see this contention borne out in the way Brontë describes Catherine in her younger years as having “her cheeks flushed” with tears gushing over them as if she was experiencing an excess of passion (46). These impassioned moments, so clearly captured in Catherine, also hint at a possible tubercular state, as she is flushed, as if by fever like a typical consumptive. Later, once she is married, she is “in danger of being seriously ill” (90). Readers also encounter Isabella's analysis of Catherine from a letter the former wrote, noting that Catherine “has been, and is yet, very ill” (105). Not long afterwards Isabella, recently married herself and thus at the right age for contracting consumption, begins to take on the appearance of a nineteenth-century woman infected with TB: “her pretty face

²⁰ Charlotte Brontë's tubercular symptoms led to what was one of the most common misdiagnosis of nineteenth-century women. It was assumed, based on her nausea and vomiting, that she was pregnant, not tubercular (Ross 94). By the time it was discovered that Brontë was in fact both, her consumption was too far advanced and both she and her unborn child died (Ross 95).

²¹ Buikstra and Roberts explain that today, some research seems to support the idea that “Pregnancy leading to stress is suggested as a possible reason for higher rates [of TB] in women” (45). There is no doubt that Catherine Earnshaw Linton's pregnancy is stressful, particularly coming as it does alongside her sister-in-law's elopement with the man Catherine most likely loves, in her own selfish way.

was wan and listless,” notes Brontë’s narrator (114).²² We realize that Mrs. Healthcliff will retain her prettiness even as she begins to lose her health. It is not long after this that both women pass, leaving their children behind them to begin the next generation of feuds at Wuthering Heights.

Catherine’s bout with TB can be read as starting long before her pregnancy, however, and as being exacerbated by the experience of childbearing. Earlier in her life, she comes down with a fever which seemed to linger for the rest of her life, a common sign of consumption. Dormandy explains that TB patients were understood to experience “characteristic spikes of low-grade fever” daily (8). Further, in Ellen’s description of Catherine’s illness and, specifically, her treatment we see more ties between her fever and TB: “It proved the commencement of delirium; Mr. Kenneth, as soon as he saw her, pronounced her dangerously ill; she had a fever. He bled her, and he told me to let her live on whey and water-gruel” (68). The fact that Catherine is bled is very much in keeping with nineteenth-century TB treatments: Dormandy explains that “blood-letting could produce dramatically beneficial results [...] it was the best first aid treatment in acute pulmonary oedema—the sudden onset of choking breathlessness with copious blood-stained sputum, the face pale and cyanosed, the expression one of intense anxiety, the skin bathed in cold sweat—and tuberculosis was a rare cause of such an emergency” (15). Additionally, the disease Catherine is experiencing is dangerously contagious and not respective of class as it kills both of her future parents-in-law—they “died within a few days of each other” (Brontë 69). Thus, Catherine’s TB is perhaps the most interesting

²² According to many studies like Roberts and Buikstra’s *Bioarcheology of Tuberculosis*, “tuberculosis tends to target people in their most productive years” (48-49). The increase in cases in the young—as evidenced by earlier citations and nineteenth-century medical texts cited in *Chapter 2*—is thus mirrored in the literature through examples like Isabella and Catherine.

depiction from this era as it most clearly matches Day's description of the disease (see *Chapter 2*): it was slow moving, with signs appearing only towards the end of her life. Furthermore, it manifested in someone ostensibly not as beautiful as other female sufferers of TB, complicating the theory and well-established literary convention that consumption made the sufferer beautiful.

In another case of gender, class—and beauty—influencing notions of consumption, the experiences of Isabella Heathcliff Linton come to light. Isabella is initially described in comparison to her future sister-in-law, Catherine Earnshaw. Brontë writes that Isabella is a year younger than Catherine and ““has not [Catherine's] natural advantages”” (37, 41). However, later in the novel, we get a more detailed picture of Isabella as fueled by Cathy's jealousy when she says the opposite: ““I'm not envious: I never feel hurt at the brightness of Isabella's yellow hair, and the whiteness of her skin; at her dainty elegance, and the fondness all the family exhibit for her”” (76). Soon after, we get a less biased point of view from Ellen, who describes Isabella Linton as ““a charming young lady of eighteen; infantile in manners, though possessed of a keen wit, keen feelings, and a keen temper, too, if irritated”” (78). Isabella's beauty seems undisputed, but we are left to wonder what this beauty might indicate about her state of health as it has undoubtedly increased since her initial comparisons to Catherine, a woman who might have brought TB into the Linton home.

In addition to being compared to her sister-in-law on the basis of her beauty, Isabella is also compared to Catherine in terms of class, at the latter's prodding. Catherine tells Ellen how to arrange the seating for tea: ““I cannot sit in the kitchen. Set the two tables here, Ellen; one for your master and Miss Isabella, being gentry; the other for

Heathcliff and myself, being of the lower orders” (74). Here, Catherine forces into the open another comparison between the two women, focusing on how she herself has risen in the social order but how Isabella, if she persists in her flirtation with Heathcliff, will fall. Isabella’s fall comes not long after. Fortunately for Isabella, she still has a champion in Ellen, who tries to protect her, telling Heathcliff: “I hope you’ll consider that Mrs. Heathcliff is accustomed to be looked after and waited on; and that she has been brought up like an only daughter, whom every one was ready to serve” (116). However, Heathcliff is not to be convinced, and much like Catherine herself, seems to compare the two women and finds one lacking: “the nuisance of her presence outweighs the gratification to be derived from tormenting her!” (117). Thus, Isabella’s class is not an asset to Heathcliff despite his desire to social climb. Nor is it, as we will soon see, a protection against the contraction of tuberculosis.

Because she is unable to best her sister-in-law, Isabella Heathcliff has come down in the world even as her status has allowed her husband to rise. In *Reading the Brontë Body: Disease, Desire, and the Constraints of Culture* (2005), Beth Torgerson explains this shift as arising from Brontë’s desire “to critique the very worst aspects of patriarchy. Heathcliff manipulates the inheritance and property laws to gain illegal access to lands. In addition to gaining control over land and property, Heathcliff uses his knowledge of the law to gain control over people” (102). It is this control that simultaneously allows Heathcliff to rise in power even as it distances him from the other characters, especially his wife and her family. In fact, Isabella Heathcliff begins to hate her husband. She explains to Ellen, “[h]e has extinguished my love effectively” (133). While his use of the patriarchy allows him to gain control over others—despite his initially menial status—the

control comes at a price. It is clear from Isabella's use of the word "effectively," however, that she believes her husband has intentionally distanced himself. Even as he gains power over land, he loses the control he had over his wife. She abandons him in the country, moving to London, giving up her land and the fresh country air in order to escape him.

After Isabella leaves her husband, Ellen tells readers that Isabella Heathcliff came down with a slow-moving illness. She explains, "Mrs. Heathcliff lived above a dozen years after quitting her husband. Her family were of a delicate constitution: she and Edgar both lacked the ruddy health that you will generally meet in these parts. What her last illness was, I am not certain; I conjecture they died of the same thing, a kind of fever, slow at its commencement, but incurable and rapidly consuming life towards the close" (146-47). To nineteenth-century readers, it would have been clear that Isabella Heathcliff's move to London has negatively impacted her health: as Day explains, "[g]iven that phthisis was primarily conceptualized as an urban condition, due to its heightened visibility in cities, it logically followed that there was an increased susceptibility to the illness owing to the unhealthy nature of life in the metropolis" (29). Thus, Isabella Heathcliff's move to London—compounded by her descent in class, as she is now living as a single, unpropertied woman—can be read as contributing to her illness. As urbanization was seen as the "predominant explanation of tuberculosis in the working classes" (Day 29), Isabella's move from a highly prominent position in the gentry to one that is less respected as an estranged and dislocated wife sent away from her life of privilege to a desolate corner of the country seems to echo this shift.

Given Ellen's explanation of Isabella's illness, we realize that even if her move to an urban center did not infect her with TB, her family's presumed susceptibility might have been responsible for her contracting the disease. After all, Isabella Linton Heathcliff's "delicate constitution" as well as her faded love for her husband—some might argue lovesickness or love melancholy—make her a very easy target for consumption, according to nineteenth-century understandings of the disease. Based on patients like those in the Linton and Brontë families, nineteenth-century physicians argued that "it was not the disease that was inherited but rather a constitutional predisposition to it" (Day 20).

It is likely that as a member of a family full of consumptives with delicate constitutions, Brontë wrote this depiction of Isabella Heathcliff with TB in mind. Furthermore, even if TB as the cause of Isabella Heathcliff's death was not obvious immediately to the nineteenth-century reader, the further they read in the text, the more they would have understood the likelihood that Isabella Linton Heathcliff—and her other family members—would die of consumption. After all, Brontë specifically describes Isabella Heathcliff's illness as "rapidly consuming life" towards the end just as nineteenth-century physicians thought consumption did (hence its name). This idea of her illness eating up her body clearly calls to mind a wasting disease, like tuberculosis, which fed on the host in which it was discovered. Finally, in linking the beautiful Isabella Heathcliff's unnamed disease to a fever Brontë makes it appear unlikely that she is suffering from anything other than consumption.

While the female consumptive was often thought to be a languishing sort of beautiful damsel in distress, however, Isabella strikes out on her own, defying at least for

a while these social stereotypes. She moves from being the woman Ellen blames for “bringing it all on herself” (114) to the woman who moves away from her husband and the only home she has ever known “never to revisit this neighbourhood” (140). Having escaped her mad husband’s clutches, as well as those of her unhelpful family, she gave birth to a son “a few months subsequent to her escape” and raised the “ailing, peevish creature” entirely on her own (141). This strength of her character marks Isabella as a female consumptive defying the characteristics of her stereotypical counterparts. She does not languish, entreating others to care for her, but instead moves away from the moors to London, only asking when she does die that her son Linton come under her brother’s guardianship instead of that of her husband (156). By writing Isabella this way, moving her from a beautiful society woman to a responsible mother, Brontë gives the female consumptive more agency than her male counterparts have.

Isabella Heathcliff’s predisposition to phthisis also affects her son and brother, as TB was thought to work this way among families of the upper classes. Ellen describes Isabella’s son, Linton Heathcliff, in relation to Isabella Heathcliff’s brother, Edgar Linton, explaining that the young Linton was “a pale, delicate, effeminate boy, who might have been taken for my master’s younger brother, so strong was the resemblance” (153). Here Brontë not only reinforces the idea that TB appears in families—even if they are not lower-class city dwellers but instead live at their ease in the secluded splendor of their manor on the moors—but she also depicts a clearly consumptive young man as one who is “effeminate,” thereby calling us to reflect on the gender biases toward those who suffer from this disease. We recognize the symptoms of TB in Linton Heathcliff, who is not only pale, but also a member of a family given to delicate constitutions. Ruddock

explains that one of the problems exacerbating the symptoms of TB is “defective ventilation,” in which people struggling to breathe, especially those in situations with poor air, as is Linton, who has come from London now that his mother has died, “soon become pale, partially lose their appetite, and gradually decline in strength and spirits” (36). Therefore, Brontë’s writing Linton as an authentic consumptive, as becoming pale due to poor air and also because of a weakened appetite, which further enervates him.

Interestingly, while his mother moved a great distance and struck out on her own, Linton seems predisposed to do the opposite, expecting others to care for him and cater to his whims, showing once again he is not the typical male consumptive traveling to healthier climes. Brontë writes of one visit between Cathy and Linton, showing just how imperious Linton could be when he demands they shut the door and then complains about his servants: ““Will you shut the door, if you please? you left it open and those—those *detestable* creatures won’t bring coals to the fire. It’s so cold!”” (180). Not only do we see how frail Linton’s body is—and thus susceptible to the cold—we also see how fragile his temperament is in dealing with those around him. He proves his frailty not long after when he complains that writing letters to Cathy was an onerous task: ““It tired me dreadfully, writing those long letters. I’d far rather have talked to you”” (181). We cannot read Linton as a creative consumptive after these lines. He is unwilling to suffer for any sort of creative undertaking—such as the writing of long letters to his beloved. Here readers begin to see a different side of the sickly youth. He complains, saying his father ““called me a pitiful, shuffling thing;”” and perhaps, most damning of all, he shatters the illusion of their innocence from the machinations of the previous generation when he informs Cathy, ““Your mother hated your father [...] And she loved mine”” (182). Here

we see a very different consumptive emerge. His is not the flushed, passionate consumption of Catherine Earnshaw Linton; nor is he the inspired, melancholy consumptive like Keats. Rather, his disease is cruel and self-involved.

Ultimately, each of Brontë's characters reveals that the stereotypes surrounding nineteenth-century tubercular people are rather one-dimensional. The woman is not always a languid beauty, the man is not always a creative genius. Additionally, Brontë's own family life and their experiences with TB further the ideas introduced in her portrayals. Because of their early and continued experiences with loss, writes Ross, "the surviving [Brontë] children [...] withdrew into a lush fantasy world of their own making. Emily would never emerge from it" (81). It is this "lush fantasy world," a place of escape from disease into which Catherine's daughter of the same name and Isabella's son, Linton, at first appear to withdraw in *Wuthering Heights*. For Linton, this place is "a bank of heath in the middle of the moors, with the bees humming dreamily about among the bloom" (188). Here, Linton is away from the crowded places where TB festers. He and Cathy can roam the moors in a way their female, consumptive, real-life predecessors like Deborah Fiske could not. For Cathy, then, the lush world begins "in a rustling green tree, with a west wind blowing, and bright, white clouds flitting rapidly above" (188). Eventually, the two agree to visit both worlds once the weather clears, and it is this agreement into which they settle. They now have two places to which to escape.

As they flee to their hiding spots on the moors, Cathy remains stalwart and unaffected by the exercise, fresh air, and invigorating experience; Linton, on the other hand, sees his disease progressively worsen, creating a juxtaposition between male and female experiences that is very different from what we've encountered previously. This

gendered difference in Brontë's writing is unique even though her own experiences with tuberculosis and the need to escape confinement are not. Furthermore, the idea of escape wasn't uncommon in tubercular, fictional literature. According to Ruddock, because there were those with a possibility of inheriting TB, they were only likely to "escape its influence by avoiding the other agents which concentrate and precipitate any special disorder" (28). For Linton, then, he can continue to "grow very snappish" (Brontë 189) with his uncontaminated cousin, ignoring the fact that he is already consumptive—much like Poe's revelers—as a result of living with his mother and seemingly being genetically susceptible to the disease from his grandparents' generation onwards. He is not the lovesick male consumptive, nor is Cathy the genetically predisposed weaker female consumptive.

Given the distinct portrayals of phthisis in Brontë's characters, we must ask why she exposes male consumption in a way that contrasts with that of her female consumptives. In fact, there is something almost harsh in Brontë's criticism of the male invalid that seems personal in nature. As the other characters describe him, they use terms that indicate impatience with his personality and behaviors. For example, Ellen—the Linton family housekeeper—studies Linton's uncle and notes "[h]e had been greatly tried during the journey, I felt convinced, by his fretful, ailing charge" (154). Using the terms "fretful" and "ailing" to refer to Linton marks him as quite distinct from the contemplative, creative consumptive we see Keats embody. Further, Linton's own father, Heathcliff, describes his son as possessing a "paltry spirit" (204). Therefore, none sees him in a flattering or strong light. In fact, Brontë has her male consumptive, Linton, describe himself: "I doubt whether I am not altogether as worthless as he calls me,

frequently; and then I feel so cross and bitter, I hate everybody! I *am* worthless, and bad in temper, and bad in spirit, almost always” (193). In this portrait, readers wonder if Brontë is echoing some of the sentiments her own tortured brother expressed, especially with regard to his own consumption. This departure from the typical ideal of the male tubercular patient is perhaps the result of his resemblance to Branwell Brontë, another tubercular male.

While Linton’s consumption is not passionate, like his aunt’s, it is also not gentle, like his mother’s. Instead, his disease brings about “a sickly peevishness” (153) that has little in common with his real-life consumptive predecessors. He expects to be cared for, and the other characters comply, reinforcing the idea that he is an effeminate man in need of coddling as opposed to a man who can care for himself or suffer stoically, like his father, Heathcliff. Cathy ministers to him the most, “stroking his curls, and kissing his cheek, and offering him tea in her saucer, like a baby” which “pleased him for he was not much better” than the irritable infant he appears to be (154-55). His consumption appears as that of the stereotypical nineteenth-century invalid, a figure typically associated with females, a fact supported by multiple nineteenth-century literary portrayals of ill, older women, including Marie St. Clare in *Uncle Tom’s Cabin*, Mrs. Bennet in *Pride and Prejudice*, and Alice James, among others. While his effeminate TB may come from being predisposed to the disease on his mother’s side, Brontë imbues Linton with this brand of TB, throwing into question the problematic dichotomy of creative male consumptive set in contrast to the beautiful female consumptive.

Linton isn't entirely atypical of the male invalid, a stereotype Brontë was familiar with from her extensive reading and her experiences with her own brother.²³ In *Invalidism and Identity in Nineteenth-Century Britain*, Maria Frawley comments that “artistic renderings tend to depict invalids as young and female” (13). Thus, at first glance Linton seems a departure from the typical invalid. However, Frawley explains that male invalids were also common in nineteenth-century life—if not in the corresponding art—noting that “women faced with extended illness received conflicting cultural messages comparable to those directed to their male counterparts but with different, perhaps higher, stakes” (50). Thus, while male invalids were common, the female invalid often experienced less sympathetic treatment than her male counterpart. She was “told that they could become ill through idleness, but they faced equally certain punishment, in the form of nervous collapse, if they denied the natural differences between the sexes and attempted to compete with men” (qtd. in Frawley 50). In Cathy's tender treatment of Linton, we see the reverse of the stereotyped TB relationship wherein the female cares for the male.

The spread of TB in *Wuthering Heights* was something contemporary audiences would have understood, considering the historical, epidemical studies done on

²³ It is necessary to note that the timeline between Branwell's decline and the writing of *Wuthering Heights* at first seems to create a problem with the idea that Linton and Branwell share any characteristics. In fact, Emily Brontë published her novel before Branwell was expressing symptoms of the disease. There are several explanations for this. First, it is possible that Branwell was the model for at least one of the men in *Wuthering Heights* simply due to his proximity to Emily. Ross quotes her as writing “scornfully of the ‘self-absorbed moroseness of a confirmed invalid,’ perhaps with Branwell's dramatic excesses in mind” (87). Thus, even if she did not know his illness was tubercular in nature, she could still be using him as her figure of a male invalid. Furthermore, despite Emily Brontë's familiarity with tuberculosis from her sisters' suffering, “she adopted the equally harmful position of steadfast denial” (Ross 87) in recognizing the ways in which this disease manifested in herself. Finally, because of Branwell's death at an early age—Charlotte Brontë wrote that she wept for his “wreck of talent, the ruin of promise” (Wilson 281)—he also had mortality in common with the young Linton. Therefore, even if Emily did not yet realize her own brother was consumptive—just as she fought against recognizing her own symptoms—he was still ill enough to provide a model for a somewhat accurate portrayal of a diseased man for her to use in her novel.

consumption during this era. Ross writes, “England was the epicentre of a TB epidemic that went global. At its peak in 1800, TB killed off up to 1 percent of the English population yearly, and death rates from TB remained high for most of the nineteenth century” (78). Given the rate of infection, it was not surprising that the disease would soon contaminate the Brontë family in much the same way it did those afflicted in *Wuthering Heights*. And it all started with Branwell. The sole Brontë brother reportedly caught consumption not long after he, too, was disappointed in love. Ross acknowledges that Branwell “was seduced by [...] a woman fifteen years his senior,” who, not long after their affair started, was able to marry him but declined to do so, so that she could keep her income (86-87). Her loss hit Branwell hard, ultimately contributing to his death via alcoholism and tuberculosis (87). It has been argued that of all of Emily’s siblings, Branwell had the greatest influence on *Wuthering Heights*.

It is apparent to readers that Catherine Earnshaw also experiences symptoms of tuberculosis that Bloomfield ascribes to other Brontë characters.²⁴ These symptoms include shortness of breath, weight loss, and general weakness (Bloomfield 295). Catherine has not only the flushed cheeks of a consumptive, as mentioned earlier, she also “had no breath for speaking” and seemingly begins to hemorrhage, leaving the other characters to exclaim that Catherine “has blood on her lips” (Brontë 92). These, as has already been mentioned, are all very clear manifestations of consumption to the nineteenth-century medical way of thinking. Despite obvious symptoms of the disease in

²⁴ Bloomfield acknowledges the relationship between the illnesses of the Brontë family and the illness of Emily Brontë’s characters. He writes “[t]his was an illness known too well to Emily Brontë, who observed three of her siblings die of it before she, herself, succumbed” (Bloomfield 295), thus establishing Brontë’s familiarity with TB, a disease of which her sister Charlotte would also eventually die.

Catherine, Bloomfield attributes her disease to lovesickness, claiming the culmination of her ailment comes from a “highly charged emotional encounter” (291) with Heathcliff, whereas nineteenth-century readers would likely have seen the blood on her lips as a symptom of her progressing disease.

In so doing, Bloomfield fails to acknowledge that tuberculosis and love melancholy are not mutually exclusive. In fact, according to Lawlor, early diagnoses of consumption were directly tied to the manifestations of lovesickness. He writes that consumption was compared to “wasting away with love-sickness” as in Shakespeare’s time (qtd. in Lawlor 15). Lawlor further explains that while men “are at least as vulnerable to lovesickness as women,” they do not fall to it as often as women, who were perceived during this era as physically weak and tending to experience bouts of “emotional instability” (23). Then, Lawlor acknowledges the belief that “women who cannot forget their first loves are particularly prone to love madness” (23) and with it the resulting consumption.²⁵ Thus, not only do their emotional, romantic weaknesses leave women prey to consumption, but their physical attributes do as well. These connections between lovesickness, consumption, and strength, further link Catherine Earnshaw to the disease. After all, this woman’s “flushed cheeks betrayed signs of warm talking” (74) after seeing Heathcliff—her first love, for whom readers are to assume she still has feelings—for the first time in ages, however, these flushed cheeks might also hint at TB. Further, even if we remove the tubercular symbolism of the flushed cheeks, we can still read an agitation in her presence that has everything to do with Heathcliff, the man she

²⁵ Lawlor’s assertions are logical if one considers that the median age of consumptives throughout this disease’s history has generally been younger than patients who experience other gendered illnesses, such as breast cancer.

has not moved past, thus implying lovesickness, which also correlates to TB.

Additionally, despite the misleading bloom of her physical appearance, Catherine Earnshaw Linton also worries about her strength. These fears become apparent when she asks Ellen if interceding on Heathcliff's behalf with Edgar Linton would "not show great weakness?" (76), thereby displaying, admittedly subliminally, a fear of emotional enervation, which many from this time acknowledged could lead to consumption in women.

Sontag expands on where this connection between strength and weakness comes from in regard to tuberculosis when she writes, "TB and cancer have been used to express not only (like syphilis) crude fantasies about contamination but also fairly complex feelings about strength and weakness, and about energy" (61). We see this fear not only in Catherine's fear as expressed above, but also in the life of Emily Brontë herself. When Emily was seventeen, she was sent away with her sister Charlotte to a boarding school far from home, where Charlotte was an educator (Wilson 137). Charlotte writes of Emily during this time that as she failed to adjust, "her health was quickly broken: her white face, attenuated form, and failing strength threatened rapid decline" (qtd. in Ross 82). Ultimately, because of their elder sisters' deaths—perhaps as a result of untreated tuberculosis—when Charlotte sees the above, similar characteristic symptoms emerge in Emily, she asks for her younger sister to be returned home (Wilson 139). She writes, "I felt in my head she would die if she did not go home, and with this conviction obtained her recall" (qtd. in Ross 82). Emily appears to recover physically when she is back at home, even though the obvious symptoms of tuberculosis never completely leave her and she eventually succumbs to the disease (Ross 82-83). Even though Emily Brontë was

initially physically weak, she ultimately became robust enough to continue to care for her surviving family after losing nearly all of her siblings. Unfortunately, her strength did not last and she eventually died from TB herself. Her death illustrates the complicated influence of TB on one's strength and the fact that even though Emily Brontë's strength bought her several years in which she successfully fought off her disease and achieved literary fame, it ultimately deserted her and she succumbed to phthisis.

As this chapter has shown, it is through works like Brontë's that the myth of the nineteenth-century female consumptive comes to more closely mirror that of her male counterparts. By the middle of the century, we have texts that present the consumptive female as written by a woman author. These works question society's stereotypes of consumptive women and men while also showing readers how consumption might be seen, imagined, and experienced from a female perspective. While Keats's poetry does remarkable work showing the creativity of the middle-to-upper-class male consumptive unable to do much more than write, and Poe does an impressive job of examining the impact of widespread devastation as a rally against consumption, it is Brontë's novel that provides the most realistic look at how consumption moved across class and gender lines to infect and affect those who found themselves either diagnosed with the disease or watching one they loved suffer from it.

Chapter Four: The Beautiful, Spiritual, and Creative

Consumptive Leaves Readers Breathless

Because of consumption's influence on representations of the female sex, many texts created by women writers in the long nineteenth century allow readers to study the ways in which definitions of class, gender, and diseases like tuberculosis shape understandings of femininity and disturb the balance of social power structures. As shown in *Chapter 3*, writers of the mid nineteenth century was no longer content to describe the consumptive female in terms focused solely on her beauty. Moreover, as physicians and writers came to believe that upper-class tubercular women were able "to distance themselves from the filth, degradation, and related implications that marked the approach to the illness in lower orders" (Day 53), they began to explore the influence tuberculosis had not only on physical appearance but also on spirituality. Thus, writers considered the consumptive female to be spiritually redeemed by her disease due to her suffering as a result of her illness (Day 53). This spiritual redemption continued to inspire creativity among writers as medical and literary minds' understandings of the condition developed further. Social class, creativity, and beauty retained a place in the study of consumption, but the added spiritual redemption Day identifies created a new characterization of the disease in females. This additional component allowed for reconsideration of the disease as the beauty moved from a strictly physically attractive ideal to one focused on spiritual as well as physical perfection.

In addition to studying the ways in which the female consumptive became a spiritualized ideal as the century progressed, at least according to popular literature, this chapter examines the approaches writers took to rebelling against this juxtaposition

between spiritualized female and creative male. To this end, I consider Harriet Beecher Stowe's depiction of a child consumptive in *Uncle Tom's Cabin* instead of the more mature spiritualized woman: a depiction that desexualizes the consumptive. Then, I turn to the poetry of Emily Dickinson, whose own eye ailments as well as the Brontë sisters' illnesses and deaths influenced the poet's representation of diseases in her poetry.

Chiefly, I consider the ways in which Dickinson looked at disease and invalidism not as exclusively beautiful and spiritual but rather explored the truly painful nature of female suffering. In tandem with these rebellions against the status quo and rejections of stereotyped consumptive pain, I examine the extent to which Stowe and Dickinson were able to use their class and racial privilege to draw attention to the struggles of female invalids.

Finally, I consult a male, end-of-century perspective on spiritualized consumption through a reading of James Joyce's short story "The Dead." While nineteenth-century readers continued to look to literary portrayals of the female consumptive for amusement, comfort, and edification, the consumptive woman took on a more realistic, three-dimensional characterization by the end of the nineteenth century and the start of the twentieth. This tubercular woman maintained in large part her beauty and her spiritualized form; however, she also reshaped the previous myths of the consumptive as either beautiful and sexualized or beautiful and spiritual; she revealed her hidden depths. In Joyce's story, we encounter clear evidence of the dismissal of Victorian and Romantic attitudes regarding a (consumptive) lady's expected place and behavior in society in favor of a more holistic personality mirrored in the literature of an author who had experience with TB. Examining the tubercular figures in "The Dead," this chapter closes with an

exploration of the more modernized portrayal of the female, fictional consumptive and her male counterpart.

In her article “Lovely Apparitions and Spiritualized Corpses: Consumption, Medical Discourse, and Edgar Allan Poe’s Female Vampire,” Aspasia Stephanou explains the addition of spiritual perfection to consumptive beauty that the diseased woman experienced as the century progressed. She writes that these women became “angelic and ethereal beings by the wasting of blood, made beautiful by disease and imminent death” (43). While Stephanou seems only to focus on the spiritual inspiration the beautiful consumptive provided, it is important to note that society still considered the consumptive a creative influence. In fact, authors of literary and medical texts continued to write about the tubercular figure in order to capture their readers’ attention. If an author created a character who wasted away quietly from her disease, the fictitious figure appeared angelic in her suffering, and thus ethereal. In so doing, her disease began to appear less terrifying and became even desirable, thus attracting readers perhaps even more fervently than the beautiful consumptive alone. Because no cures for TB had yet been found, it appeared the consumption was here to stay. Therefore, the fears of the contagious consumptive were replaced by society’s fanatical fascination with the spiritualized tubercular woman as a means of coping with the omnipresent disease.

Through her frailty *and* her divinity, Harriet Beecher Stowe’s Evangeline St. Clare from *Uncle Tom’s Cabin* exemplifies the redemptive consumptive, a figure who rose in popularity in the mid-nineteenth century.¹ Evangeline (Eva) is described early in

¹ Lawlor explains, “Christian Americans were particularly prone to poetry about consumption within a wider poetry of consolation,” making particular note of the collections of poetry that arose during this era, including George B. Cheever’s *The American Commonplace Book of Poetry* (1831) and Dickens’s novel *Nicholas Nickleby* (1838-9) as well as the poetry of Keats (164; 171).

Stowe's novel as “frail and earthly” yet also worthy of worship “as something heavenly and divine” (379). Here, with the use of the word “frail,” we are alerted to the fact that Eva is likely suffering from a disease like consumption that causes her body to weaken substantially. Given its coupling with “heavenly” and “divine” in the second description, modern readers might be confused about this opposing juxtaposition. However, those who read *Uncle Tom’s Cabin* in Stowe’s time would begin to consider consumption as the cause of Eva’s distress based on her emerging spirituality and the disease’s epidemic nature. As Day explains, with a diagnosis like consumption, “femininity intertwined with suffering to provide both moral and spiritual redemption” (57). Because of the developing attitudes regarding the tubercular female, authors like Stowe created consumptive figures to impart moral lessons using the redeeming nature of the disease.² It is no surprise, therefore, that Eva appears against a backdrop of American literature’s most famous novelized condemnation of slavery.

As Eva's illness worsens, we finally get the first symptoms indicating she might be consumptive. She produces “a cough that all her medicaments could not cure” alongside a fever that burns “that fervent cheek and little hand” (383). Here, we encounter first the cough, perhaps the most common indication of TB as it implies the progressive wasting of lungs. Then, we notice Eva has a fever—another common symptom of TB—which we can also link to the idea of religious fervor, or the connection

² Even as far back as Samuel Richardson’s *Clarissa* (1748), authors were interested in writing about consumption in relation to spirituality. Further, just as Stowe connects the immorality of others to her consumptive, so, too, did Richardson. Stowe’s work is more modern and up-to-date in the historical events and moral impetus that encouraged her to write during an era in America when moral guidance was desperately needed.

of religion with burning intensity.³ In writing about Eva in this manner, Stowe makes clear the correlation between TB and the burning passion of religion, with the name Evangeline lending itself well to a discussion of spiritual significance based on its similarity to both the word “evangelist” and “angel.” In fact, Eva proselytizes to the enslaved African Americans: “‘don’t you know that Jesus loves all alike? He’s just as willing to love you, as me’” (Stowe 410), so speaking right after she pronounces “‘I love you, and I want you to be good. I am very unwell [...] and I think I shan’t live a great while; and it really grieves me to have you be so naughty’” (Stowe 409). Eva uses her spirituality here to echo Stowe’s larger points about the immorality of not only slavery but bad behavior as well. Her spirituality despite her suffering also furthers Stowe’s goal to “appeal to Christian sympathies” (Thompson 61) by making her into an exemplar who bears her suffering calmly and spends time in caring for the slaves on her father’s plantation. Further, Eva’s good works indicate that she knows to use the time she has to do the most lasting good—a message that no doubt Stowe hoped would encourage those lacking spiritual fortitude, such as slaveholders, to behave in the most moral way possible.

Susan Sontag explains this spiritual connection between the tubercular patient and her disease, pointing out that “TB takes on qualities assigned to the lungs, which are part of the upper, spiritualized body,” further pointing to the idea that while modern diseases like cancer—which often seem epidemic—attack parts of the body “that are embarrassing to acknowledge,” TB is more often associated with the “with the traditional imagery

³ The *Oxford English Dictionary* defines fervor as “[w]armth or glow of feeling, passion, vehemence, intense zeal; an instance of the same” (“fervor”). If we consider this definition in relation to religion, it is no surprise that a connection is made between zeal and faith in a text written by an abolitionist.

(breath, life) associated with the lungs” (17). Thus, as Eva’s tuberculosis worsens and her lungs waste away due to her disease, her spirituality increases because she knows “I’d rather be in heaven” (Stowe 402) and that soon, because of her condition, she will be. At the same time, comparisons between Eva and the Christ child become more apparent: Eva tells Uncle Tom one day, “I can understand why Jesus wanted to die for us,” and when Uncle Tom asks her why, she explains “Because I’ve felt so, too” (400). In Stowe’s quasi-allegorical abolitionist work, Eva’s diseased body becomes the sacrifice exacted for her plantation-holding family’s misdeeds towards their slaves. Just as Christ offers himself up as a sacrifice for the sins of mankind, Stowe offers up Eva. Both figures suffer for others, both are admired for their spirituality, and both serve as moral lessons to those men and woman who sin and / or suffer.

Stowe’s idealized presentation of consumption through Eva—the child’s calm acceptance of her fate, her explanation to her father “I am not nervous,—I am not low-spirited” (402)—may seem unbelievable to readers who understand the devastation of this disease; however it had its uses. First, by crafting the consumptive Eva, Stowe showed not only how consumption increased spirituality but also how readers could, and should, be more empathetic towards enslaved Americans. Stowe’s son explains in *The Life of Harriet Beecher Stowe* (1891) the driving force behind *Uncle Tom’s Cabin*. Charles Stowe writes, “‘Uncle Tom’s Cabin’ is a work of religion; the fundamental principles of the gospel applied to the burning question of negro slavery [...] Mrs. Stowe spoke to the understanding and moral sense through the imagination” (154). Using characters like Uncle Tom and Eva and focusing on their suffering to point out the problems with slavery was what Stowe’s novel is about. However, the modern reader can

also learn a lot about how TB impacted not only the consumptive but also his or her audience, and, at the same time, how this disease was enlisted figuratively in novels and poetry to attract readers.

Stowe's text is particularly useful not only for focusing on its obviously abolitionist cause, but also for studying what is absent—any depiction of a truly ill enslaved person. In fact, very few pieces of literature exist that accurately represent the experience of the enslaved nineteenth-century man or women of color as he or she suffered from tuberculosis, or any other ailment for that matter. Before going further into a study of Stowe's work, however, two points need to be considered to provide some context regarding nineteenth-century American culture and the influence not only of tuberculosis but also of slavery on that culture and its perceptions of illness and wellness. First, this portion of the chapter addresses the problematic “white savior” narrative. Second, it provides an examination of some of the negative impressions many had during the era regarding enslaved men and women of color to give further cultural context to white nineteenth-century Americans' prejudices.

First, then, the white savior narrative: a particularly troubling trend in antebellum and postcolonial literature, and a trend that continues today in products of popular culture, is the narrative of the white savior, or the person who is positioned in a text—or society—to help those “deserving or, in some cases undeserving, black people” (Garcia, Young, & Pimentel 8). While the white savior is not the focus of my study—indeed, the white savior is often a male figure, and here we are clearly focused on a female one—several sources on the subject address child counterparts to *Eva St. Clare*, including Mark Twain's infamous *Huckleberry Finn* and *Tom Sawyer*. To fully explore why precisely the

white savior myth is so troubling and how it relates to *Uncle Tom's Cabin* and consumption, we must consider the fact that much of the published American literature we have from the nineteenth century was written largely about and almost always by white people.

The collection *From Uncle Tom's Cabin to The Help: Critical Perspectives on White-Authored Narratives of Black Life*, edited by Claire Oberon Garcia, Vershawn Ashanti Young, and Charise Pimentel, explores scholarly entries on the problematic nature of white authors writing white characters that “save” enslaved people and / or people of color in their texts, while also portraying their characters of color inaccurately and unfairly. Of particular note is Katrina Dyonne Thompson’s chapter, “‘Taking Care a White Babies, That’s What I Do’”: *The Help* and America’s Obsession with the Mammy,” which addresses the inaccurate and racist portrayals Stowe provides of her black characters in an effort to promote abolitionist causes. Here Thompson writes, “[t]hough intended as an antislavery novel, Stowe’s work portrays a romanticized view of enslaved blacks based on the stereotypes of the era” (61). Rather than presenting a true portrayal of slavery, Stowe provides us a romanticized one in a rhetorical move that parallels the romanticized portrayal of Eva as a spiritual, suffering consumptive.

Also useful in critiquing white-authored narratives of black lives is Luminita M. Dragulescu’s chapter “Bearing Witness?: The Problem with the White Cross-Racial (Mis)portrayals of History.” Dragulescu critiques *The Help*, noting: “The novel merely skates through the social turmoil of the civil rights era to nitpick on petty domestic fights and society gossip” (19).⁴ The same claim can be applied to *Uncle Tom's Cabin*

⁴ Another article that puts into perspective the myth of the white savior juxtaposed with modern (mis)understandings of racism is Nicole Maurantonio’s “‘Reason to Hope?’: The White Savior Myth and

regarding the antebellum era in American history. Reading *Uncle Tom's Cabin*, readers might expect to encounter a continuously harsh denouncement of the worst atrocities of slavery but instead see these tempered by the spiritual evangelization of Eva. In a novel about slavery and the cruelties of that institution, Stowe, in the St. Clare chapters, shifts readers' focus instead to the household dramas among white, plantation-owning families and the redemptive death of one white child. In this section, then, Stowe is able to explore a different kind of suffering. Here she looks not only at the suffering of slaves, which she still considers in the conversations between Topsy and Eva and Uncle Tom and Eva, but also the suffering of others in the broader society, thus appealing to a wider audience than those strictly supporting her abolitionist cause.

No doubt these troubling representations of what it means to be black as written by white writers are in part due to the problematic notions about people of color that existed throughout the nineteenth century—and persist today—which involved a small focus on these men and women in fictional and medical literature. Coupled with this lack of interest and attention were texts that provided some information on consumptive men and women of color while also maligning them as often faking their illness or otherwise misrepresenting their experience of health, or lack thereof. Harriet Washington in *Medical Apartheid* (2006) explains: “By 1851, Cartwright [an infamous physician] had

Progress in ‘Post-Racial’ America.” Here, Maurantonio defines the white savior, focusing on the discourses that allow this myth to continue to propagate in some circles today. Of particular note is the way in which Maurantonio looks at the suffering of the white savior. Here, she cites the case of the shooting death of Walter Scott, a South Carolinian black man who was killed by police. Maurantonio studies the way in which many journalists who reported on this story foregrounded “the experience of the traumatized White leader” thus privileging his emotional response to the shooting as opposed to the larger community which this man’s death undoubtedly affected (Maurantonio 1140). Just as so much time in *Uncle Tom's Cabin* is devoted to Eva and the ways in which she reacts with a broken heart to Uncle Tom’s distress, so, too, do modern journalists and writers continue this trend of the suffering-because-caring white savior. We still do not get the perspective of the people of color; it is drowned out by the white voices who do the enslaving.

also discovered and described a host of imaginary ‘black’ diseases, whose principal symptoms seemed to be a lack of enthusiasm for slavery” (36).⁵ And, even when enslaved African Americans might have expressed symptoms of a disease presumed to only impact white people, they were given different names and diagnoses. For example, TB that manifested in an enslaved body was called *struma Africana* (Washington 36). This notion that enslaved African Americans were not susceptible to disease is also present in fictional literature from the era. In fact, Eva’s mother, Marie, contributes to the notions of the hypochondriacal slave when she speaks about her house-slave, Mammy, quickly and somewhat caustically dismisses the headaches of her slave after just expounding on her own. She tells Eva that slaves make “such a fuss about every little headache or finger-ache; it’ll never do to encourage it” (263). As a hypochondriac herself, Marie St. Clare refuses to acknowledge her purported connection with the slaves for fear that it will somehow eliminate or at least dramatically hinder her superiority; thus, she regards her illness as real while representing her slaves as simply lazy and, therefore, feigning disease. If she acknowledges her slaves as experiencing genuine pain, she would have to consider further the implications of this pain. Marie doesn’t acknowledge it, therefore, and Eva is put into the role of the savior on whom the slaves rely for less miserable treatment.⁶

Stowe’s abolitionist goals within this text tie reformist rhetoric together with disease literature. While Stowe writes Marie as an archetypal hypochondriac character

⁵ Dr. Samuel A. Cartwright was a physician from Louisiana. For more on his racist medical practices in the antebellum American South, see Christopher D.E. Willoughby’s “Running Away from Drapetomania: Samuel A. Cartwright, Medicine, and Race in the Antebellum South.”

⁶ The disturbing notion that slaves were not often sick is expanded upon in the conclusion to this project, in which I address the continued implications of racialized medicine. For more on this topic, see the *Afterward*.

with distinct selfish tendencies, she also does the same for many of her enslaved characters. She creates similar, stereotypical behaviors for them to exhibit, such as docility in Uncle Tom and a reliance on Eva's protection in Topsy. In his article titled "Abolition's Racial Interiors and the Making of White Civic Depth," Christopher Castiglia explores the motivations for these stereotypes of enslaved people and American slave owners. He asserts that writing in this manner was a way for abolitionist writers to create sympathetic rhetoric while also distancing themselves from both of these groups. He further argues that by virtue of their being sympathetic in writing, white reformists set themselves apart from their contemporaries: "white reformers claimed a public authority that differentiated them from other whites, even while it maintained an affective difference from persecuted blacks" (34). Thus, just as Marie sees her slaves as a means to an end—chiefly financial stability and freedom from household tasks—Stowe sees them as a means to proving her point.

With intentionally unsympathetic characters like Marie and pathetic characters like Mammy and Uncle Tom, Stowe believed she was doing good work to share her message of abolition through her spiritual consumptive. In documenting his mother's life, Charles Stowe strove to focus on the impact *Uncle Tom's Cabin* had on pre-Civil War America. In a particularly important line, he writes that this novel "aroused the public sentiment of the world by presenting in the concrete that which had been a mere series of abstract propositions. It was, as we have already said, an appeal to the imagination through a series of pictures" (154-55). While her son rightly applies this point to Stowe's obvious abolitionist rhetoric, this claim can also be easily connected to her use of Eva's disease as a means of explaining the connection between spirituality and suffering. By

using Eva as a concrete example of a tubercular infection, Stowe draws attention to the way a consumptive can appear in society. She moves past the early nineteenth-century stereotypes of the beautiful, wealthy consumptives languishing away to focus on a consumptive who is acting, even as her body is wasting away. Eva provides a new possibility for consumptives to not just be the redemption for others but also for themselves—through Eva, mid-century tubercular patients can see the possibilities of being more than simply invalids. They can continue to act as long as they continue to live.

Eva becomes a figure worthy of emulation by those who are suffering from tuberculosis, or those who simply need moral guidance. First, those afflicted with TB who read Stowe's work may find Eva's spirituality inspiring and thus look at their own diseases as less of a burden and more of a gift. Dormandy explains of this notion about the suffering, spiritualized tubercular patient that the aura surrounding her, "with its optional religious overtone, [...] provided an explanation. It justified what would have otherwise been unbearable: the suffering and deaths of the pure, the innocent and the beloved" (61-62). By making Eva's sacrifice the focus of part of her novel, Stowe writes her own "luminous literary creation," which appeals to those in her audience who are suffering or watching their loved ones suffer. Secondly, Eva's spiritual transcendence can also serve to remind those struggling with TB to choose the moral options to move past their burdens and decide on what is just. Again, here, we see Stowe use her spiritual consumptive in an attempt to shift the moral balance of a slave-owning country in the hopes her readers will realize that recognizing the humanity in slaves is so easy that even an ill child can do it.

Eva's pain also serves a second purpose. By studying Stowe's portrayal of the tubercular girl, we can see the ways in which society viewed that woman by the middle of the century. True, she was no longer exclusively a beautiful pawn; however, she was still being used by those who wanted to prove a point about diseased women. Day explains that, due to the limited role women played in nineteenth-century society, "illness, especially consumption, became part of what it meant to be a Victorian lady" (57). This Victorian lady soon develops into the myth of the angel woman, as explained by Gilbert and Gubar (though they do not explicitly link her to disease or suffering). She is

[...] her husband's holy refuge from the blood and sweat that inevitably accompanies a 'life of significant action,' as well as, in her 'contemplative purity,' a living memento of the otherness of the divine. At times, however, in the severity of her selflessness, as well as in the extremity of her alienation from ordinary fleshly life, this nineteenth-century angel-woman becomes not just a memento of otherness but actually a memento mori, as Alexander Welsh has noted, an 'Angel of Death,' as in the case of little Eva. (24)

They further articulate that this woman is an angel because "[t]he arts of pleasing men, in other words, are not only angelic characteristics; in more worldly terms, they are the proper acts of a lady" (Gilbert and Gubar 24). Thus, the angel woman is the exemplar for Victorian ladies, and if she can be modeled—despite suffering through illness—then the illness must be truly linked to the spiritual.

By writing Eva as a frail sufferer of TB, then, Stowe makes her character fit directly into the role society assigned to her on the basis of her gender and class. Day explains that medical documents “overwhelmingly presented women of the upper orders as more liable to phthisis than men, largely because of the constraints society placed upon them” (31). If we consider the constraints mentioned in *Chapter 2*, we’ll recall that keeping wealthy women in their confined domestic spaces, requiring them to dress in literally constraining fashions, and prohibiting them from some of the cures more readily available to men increased the likelihood of their contracting the disease but also limited severely their ability to treat it. Day further explains how the angel-woman role impacted the spiritual nature and the societal confinement that consumptive women faced:

The nineteenth-century rhetoric of separate spheres embraced the idea that women were inherently affectionate, emotional, and religious, while men were intelligent, vital, and pragmatic [...] women occupied the domestic sphere, as virtuous ‘angels’ who provided comfort and moral direction for both their husband and children. The gender-based boundaries tended to highlight the independent healthy male body as a central comment of the work world, and as a fundamental attribute of respectable masculinity. On the other hand, respectable femininity was allied to physical frailty, domesticity, and dependence. (54)

In some ways, Eva breaks from this stereotype as she is not old enough yet to have a family of her own. However, if we recognize the positive influence she attempts to have on her slave-owning parents, we can acknowledge the lengths to which this consumptive will go to provide spiritual direction. Stowe’s angelic Evangeline proves the point that by

the mid-nineteenth century, a tubercular female was not only viewed as beautiful but also as fitting appropriately into her role in society based on her (high) social class, gender, and spiritual enlightenment.

Lawlor argues that Stowe's story is representative of female writers from her era. He claims: "she is typical because she expresses the values of her Victorian, female, middle-class readers" (*Romantic* 168). What Lawlor doesn't consider, however, is the ways in which Stowe expresses but then also clearly calls into question these values. First and foremost, Stowe questions many of her contemporaries by opposing slavery. Stowe's focus on abolition sets her apart from other Victorian women who may have had opinions on the ongoing, inhumane practice of slavery but dared not express them in such a public forum, let alone publish on these or other topics. Additionally, Stowe made her consumptive character a female child, a departure from the more mature female consumptives in many other novels at the time. Finally, Stowe's use of Eva's spirituality makes her consumptive a more fully-developed character than someone like Beauty in "The Masque of the Red Death", who is only remembered in relation to her influence on the male characters, or Isabella Earnshaw Heathcliff, who literally wastes away. By making her character not only a spiritual figure but also a generous and thoughtful young lady, Stowe begins to change the narrative about female consumptives.

Because of developing ideals as the century progressed, TB's link to spirituality was not limited to the sacrificial suffering of the female patient. It was also connected to the state of the sufferer's soul and her desire for resurrection in the next life. Sontag explains that TB was considered—and in some circles is still believed to be—a "disease of the lungs [...] metaphorically, a disease of the soul" (18), therefore a disease more

focused on the afterlife and the means of getting to said afterlife instead of being preoccupied with the earthly day-to-day. This categorization of the illness becomes very clear in the case of Eva St. Clare when Stowe writes that Eva was aware of the fatal nature of her consumption: “it rested in the heart of Eva, a calm, sweet, prophetic certainty that Heaven was near” (399). Lawlor articulates that this portrayal of consumption and the patient’s accompanying awareness of death was not unusual for this era, and in fact leads to “one of the most well-known deaths in literature” (*Romantic Disease*, 168). Once the consumption diagnosis is given, the patient begins to focus on the afterlife as it approaches.

Eva’s maturity does not come from adult status, as is the case with many other female consumptives, but rather from her spiritual awareness. This awareness keeps focused on her goal of helping others because of her knowledge that her time is short, while her father, meanwhile, continues to “[sugarcoat] Eva’s poor health, blaming her worsening condition on over-rapid growth” (Mamunes 22), ignoring the fact that TB inordinately affects women reaching reproductive age. (See *Chapter 2*.) Thus, Eva’s consumption allows her, even though she is a child, to be much more aware of societal issues, including diseases and slavery, in a way her own parents—adults in their own right—are unable to acknowledge.⁷ Eva’s consumption does not only increase her spiritual beauty, then, but also her spiritual maturity.

Eva’s beauty is not without import, however. It shows society’s inability to completely cast off the idea of the appealing consumptive. In fact, Eva’s beauty

⁷ Lawlor then further articulates that, in literature, consumption was a means of restoring figures to spiritual health, thereby purifying them, especially if the figures were “fallen women” (*Romantic Disease*, 167). In light of this interpretation of nineteenth-century disease, spiritual consumption—even while it infected younger individuals—could also be connected to their adult counterparts, particularly if they were female.

resembles that of a stereotypical consumptive's attractiveness. Stowe describes a scene between Augustine St. Clare and his daughter in particular detail to touch not only on the young girl's appearance but also on another's reaction to it:

St. Clare had called her to show a statuette that he had been buying for her; but her appearance, as she came on, impressed him suddenly and painfully. There is a kind of beauty so intense, yet so fragile, that we cannot bear to look at it. Her father folded her suddenly in his arms and almost forgot what he was going to tell her. (401)

The above passage articulates that just as the tubercular woman was not immune to spirituality, so, too, was the tubercular child not precluded from being beautiful.⁸ Eva's effect on others is therefore comparable to Brontë's Catherine Earnshaw or Poe's Virginia; in other words, her spirituality did not detract from her beauty but rather added to it. Mamunes comments on this characterization, noting that in writing Little Eva's character as remarkably spiritual and fatally ill, Stowe "is challenging the reader to recognize a darker truth" (22). In the nineteenth century, consumption might be spiritually-influencing and beauty-augmenting, but when all facets of this illness are considered, readers know the truth Mamunes comments on: it is still going to cause the death of someone who is beloved.

In creating Little Eva, Stowe develops a sympathetic white figure living on a slave plantation. In *The Key to Uncle Tom's Cabin* (1953), she notes that Eva "is an impersonation in childish form of the love of Christ" (51). She writes of this child's

⁸ See also: Glenn Hughes, *A More Beautiful Question: The Spiritual in Poetry and Art* (University of Missouri, 2011) and Christine Hult, "Uncle Tom's Cabin: Popular Images of Uncle Tom and Little Eva, 1852-1892," *Nineteenth Century* 15.1 (March 1995), p 3-8.

empathetic relationship with the slaves as observed by others who explain, “she’s so loving! After all, though, she’s no more than Christ-like” (411), thus once again linking Eva’s tubercular pain to something else entirely—an allegory of the ultimate sacrifice and suffering of one human for another. Eva becomes the idealized spiritual consumptive, embodying Christ as a model for other suffering individuals to follow.

To better illustrate how unique Eva’s empathy is, Stowe contrasts Eva with Marie.⁹ Stowe writes of Marie St. Clare’s interaction with Topsy, whom Marie refers to as “baggage”—as ending with “the sound of a smart slap” (413). This distinction between mother and daughter shows the contrast between a truly ill figure, Eva—who exists on another spiritual plane—and a falsely ill character, Marie—who exists entirely in the material present.¹⁰ Mamunes comments on this mother-daughter relationship at some length, noting that “Augustine St. Clare blames his wife” for Eva’s condition, citing Marie’s “delicate constitution” as inherited by the daughter (22-23). Stowe’s placing the blame on Marie hints at an understanding of genetics as being at fault for many

⁹ See: Varina A. Davis’s “The Southern Woman: The Traditional Languid Dames of Antebellum Times” printed in the *Los Angeles Times*, February 19, 1893, p. 18, for more nineteenth-century perspectives on this stereotype. Varina was the wife of Jefferson Davis and presents an interesting perspective on the notions of southern womanhood.

¹⁰ Marie St. Clare often appears as an unsympathetic mistress, apathetic mother, and truly detestable figure of womanhood. However, she is not without her own literary merit due in large part to these facets of her character, particularly in relation to diseases and manifestations of them as they relate to stereotypical, female, patient behavior. It is through her tantrums, headaches, and running diatribe of all the wrongs done to her that a picture of her hypochondriacal tendencies begins to emerge. From the tension Marie St. Clare and her psychosomatic ailment create within *Uncle Tom’s Cabin*, an unflattering picture of a Northern, city-dwelling, abolitionist’s attitude towards her Southern contemporary emerges. This tension can be used to study not only the ailments of hypochondria but also the historical relevance of its relationship to the larger issue of the nineteenth-century Northern versus Southern United States. For more on this topic see “Hypochondria and Racial Interiority in Robert Montgomery Bird’s ‘Sheppard Lee’” by Justine Murison in *Arizona Quarterly* 64.1 (2008): 1-25, in which Murison tackles the basics of the disease that ravaged Southern plantation inhabitants in relation to a specific text.

contracting tuberculosis easily, an attitude we know was prevalent in the nineteenth century, and makes Marie an unsympathetic foil to Eva's spiritualized person.¹¹

While Marie's illness appears to readers as false and is thus not spiritualized, Eva suffers from a dread diagnosis and works despite that illness to better the lives of others. Not surprisingly, the development of both characters' experiences were influenced by their author's own diagnoses.¹² Harriet Beecher Stowe, before she became an author, was herself sick. In a letter to her sister in 1827, Stowe wrote, "[y]ou don't know how perfectly wretched I often feel: so useless, so weak, so destitute of all being" (C. Stowe 37). Here she indicates a tone that is almost as dramatic as Marie's but is saved from complete melodrama by her son's report that not much later, in 1832, Harriet again fought her unnamed illness and "labored diligently with her sister Catherine in establishing their school" (64). Thus, it is likely that the also genuinely ill and melancholy Stowe would feel a kinship with the ill Eva St. Clare, who still offers to assist others despite her disease. Further, Stowe's vitriolic treatment of Marie St. Clare is unsurprising as she cannot feel sympathy for a woman who languishes in feigned ill health.

In religion, Stowe seems to find a reason for suffering, and thus applies it to good works in both her own life and the lives of her truly ill characters. Thus, Eva's transformation from healthy to diseased beautiful child presents TB in a way that readers would recognize as the disease became better understood throughout the century. Her

¹¹ As mentioned in *Chapter 4*, Day argues that "an inherited susceptibility [to tuberculosis] was thought to be complicated by an exciting cause, leading to the creation of an acute or persistent illness, which in turn, amplified the likelihood of further illness by magnifying an individual's susceptibility" (28).

¹² In my final chapter, on hysteria, I draw a connection between Stowe's illness and that of her great-niece, Charlotte Perkins Gilman, and consider how each woman was treated.

spiritualized, classed, gendered, racialized bodily experience of illness is further mirrored in other works of the mid-nineteenth century U.S. such as Louisa May Alcott's *Little Women*. In Alcott's novel, we see the character Beth March, lovingly described as gentle and kind, succumb to her disease, which some argue was also indicative of consumption (Gilbert and Gubar 25). Gilbert and Gubar acknowledge this relationship between the consumptive and spirituality in their discussion of *Little Women*, arguing:

Louisa May Alcott's dying Beth March is a household saint, and the deathbed at which she surrenders herself to heaven is the ultimate shrine of the angel-woman's mysteries. At the same time, moreover, the aesthetic cult of ladylike fragility and delicate beauty—no doubt associated with the moral cult of the angel-woman—obliged “genteel” women to “kill” themselves (as Lederer observed) into art objects: slim, pale, passive beings whose “charms” eerily recalled the snowy, porcelain immobility of the dead. Tight-lacing, fasting, vinegar-drinking, and similar cosmetic or dietary excesses were all parts of a physical regimen that helped women either to feign morbid weakness or actually to “decline” into real illness. (25)

Here Gilbert and Gubar also turn to the idea of the invalid as beautiful; in this case, they specify that she is as a work of art for men's pleasure, toying with the idea that to reach one's full potential as “angel-woman,” one has to be ready to meet *all* society's expectations: spiritually, physically, and emotionally.

In fact, the appeal of the consumptive continued to arouse the interest of popular society so much that women continued to mimic this idealized figure even when she was

no longer exclusively a beautiful or sexualized idea. Day writes that literature “elevate[d] the frail woman laboring under consumption to a position of not only acceptance, but also emulation—all under the umbrella of sentimentalism” (54). As a result, girls and women like Eva St. Clare became models of morality and thus worthy of emulation due to the sentimental nature of mid-nineteenth-century literature. Additionally, the consumptive females remained models of beauty. Nineteenth-century women were still preoccupied with tubercular beauty and how to emulate the consumptive appeal: “Beyond the ‘natural’ beauty conferred by consumption, there was a growing element of emulation associated with the disease during the nineteenth century, as beauty practices were co-opted into the rage for illness” (Day 91). Women used lead-based powders to appear pale, cosmetics to make their eyes appear large, and dresses to highlight their thin figures, all in an effort to appear consumptive (Day 89-91). The consumptive woman was thus commodified by a consumerist society.

Both Beth March and Eva St. Clare are selflessly devoted to the society from which they come, thereby furthering the angel-woman trope. For Eva, her spirituality comes directly from her care for others. She confides to Uncle Tom her negative views regarding her family’s slaveholding, focusing on her fears regarding the suffering of the slaves on her family’s plantation; she explains, “I’m not nervous, but these things sink into my heart” (347). In much the same way, Beth worries over her loved ones. “‘I’ll do my best, for your sake,’” she promises Laurie before he leaves for Europe (Alcott 305). In this way, the spiritual and ill continue to give of themselves even as their diseases deplete their physical forms; ultimately, they are suffering illness’ efforts to kill while still trying to help others with their own acts of kindness. Thus, this illness of spiritual

redemption becomes one of physical ruin, and the “angel-women” leave behind their consumed corpses to become angels in fact, having earned their heavenly reward and suffered just as society prepared them to.

Lawlor explains the rhetorical purpose of Eva’s suffering succinctly when he writes “Eva’s evangelical mission is aided by consumption’s emotive and aesthetic powers; it is as if her spiritualizing condition radiates her influence beyond her own body and into other people’s” (169). By placing Eva-as-white-savior in the midst of enslaved men and women considered less-than by the larger society, Stowe crafts two important points. First, she draws readers’ attention to the suffering slavery creates even for those who are white. Eva is already ill, of course, but this illness is further exacerbated by her family’s practice of keeping slaves. She works to help those slaves, looking at their conditions as—justifiably—worse than her own. Stowe can only hope Eva’s goodness will reach beyond the confines of her text to influence those who read it. Secondly, Stowe parallels the suffering of a woman’s disease with that of slavery. She shows how each confines the person in which it is housed differently, unfortunately conflating two conditions that are distinctly different and yet both awful. As a result, Stowe’s representation of a white woman suffering from disease, something she undoubtedly had more familiarity with as someone who suffered illness herself, comes across as more genuine and serious than the plight of millions of enslaved Americans throughout history.

To better comprehend representations of tuberculosis in the nineteenth century, we must study its impact on class relationships and class distinctions and vice versa. While *Uncle Tom’s Cabin* focuses in large part on those at the lowest or highest strata of society, juxtaposing slaves and slaveowners, other texts alluding to consumption look at

class more holistically. A contemporaneous author we can look to for further insight on the intersections between illness and class is Emily Dickinson. Class distinctions as they pertain to TB become especially apparent when we consider their relation to Dickinson and her family's experiences as upper-class Americans who were diagnosed with the disease and were also friends with consumptives. In *'So has a Daisy vanished': Emily Dickinson and Tuberculosis*, George Mamunes explains: "The Dickinsons were the First Family" in the village of Amherst (113). However, despite their wealth and illustrious position, tuberculosis still came for several of their family members and close friends just as it did for the wealthy Eva St. Clare and just as the Red Deaths came for Poe's privileged revelers. In *Lives Like Loaded Guns: Emily Dickinson and Her Family's Feuds*, Lyndall Gordon describes the place of Dickinson's birth as part of "chilly, tubercular New England," a place that posed serious risks "for women weakened by constant childbearing" (27). Mothers were not immune, a fact brought home by the death of the consumptive Mrs. Fiske, the mother of one of Emily's classmates (Gordon 34). These cases and many others throughout the mid-nineteenth century show that phthisis was not a disease that only affected those of the lower social classes despite being associated with overcrowding and poor air quality.

The ways in which tubercular femininity and its relationship to social class was represented in the nineteenth century are the focus of the poems I highlight in this chapter. Cristanne Miller, author of *Emily Dickinson: A Poet's Grammar* (1987), studies plot elements of Dickinson's writing. She explains, "the most common plot of Dickinson's poems involves a speaker who is the victim of some monstrous power, usually ambiguously sexual or romantic and usually specifically male" (156). She

clarifies that this victimization is an element that Dickinson modeled upon aspects of works by other female writers of this era, including the Brontës (155).

Rumors abound that not only was Dickinson influenced by tubercular individuals but she herself was afflicted with tuberculosis. In fact, in his text on consumption and Dickinson, Mamunes focuses on the possibility that the poet herself was diagnosed, based on the research of Dr. Norbert Hirschhorn: “her symptoms suggest to observers at the time that she was suffering from tuberculosis” (qtd. in Mamunes 5).¹³ Even if there is not enough definitive proof that Dickinson was afflicted, however, from her references to the Brontë sisters as queens to her close connection to Deborah Fiske—the mother of Dickinson’s classmate, Helen, who kept a diary of her experiences with tuberculosis (Gordon 34)—Emily Dickinson’s work does a lot for modern scholars who desire to further the discussion of tuberculosis because of her personal connections to tubercular woman (Mamunes 11).¹⁴ Wendy Ann Powers, author of “Emily Brontë and Emily Dickinson: Parallel Lives on Opposing Shores,” explores Brontë’s influence on Dickinson, writing: “To Dickinson as an incipient author, it must have been especially inspiring to discover a woman writing with the kind of fervent honesty towards which she was inclined” (147-48). However, as Emily Brontë died when Dickinson was eighteen

¹³ Dr. Norbert Hirschhorn’s article “Was It Tuberculosis? Another Glimpse of Emily Dickinson’s Health” (*New England Quarterly* 72.1 [1999]: 102-118) focuses primarily on the possibility of Dickinson’s having contracted TB and the effects this would have had on her poetry.

¹⁴ It is important to note that not everyone agrees with Mamunes’s belief that Dickinson was preoccupied with tuberculosis. In fact, researchers such as Lyndall Gordon in *Lives Like Loaded Guns: Emily Dickinson and Her Family’s Feuds* contend that Dickinson was far more preoccupied with her own illness and mortality than those of others. Gordon goes as far as to name Dickinson’s ailment as epilepsy, citing her family’s history with the disease (including a young nephew and a cousin) and the fact that Dickinson herself was treated with drugs commonly prescribed for epilepsy (216). However, based on the experiences of many Americans during this time and their connection to someone who had tuberculosis—if they themselves were not diagnosed—it is not a stretch to conclude that Dickinson, a poet deeply engaged with the theme of death, cultivated more than a passing interest in the topic.

and Charlotte died not long after, it is easy to imagine that Dickinson keenly felt the loss of her heroines just as she was at her own peak of creativity. Further, she must have been disturbed by not only the lack of recognition afforded to the Brontë sisters but also by the continued spiritualization and glamorizing of a disease she knew to be incredibly cruel. Additionally, in a letter about her youth, Dickinson does make mention of consumption, noting “when I was a baby father used to take me to the mill for my health. I was then in consumption!” (*Letters* 515).¹⁵ However, we cannot conclusively state whether Dickinson here refers to the disease or her consuming interest in the mill—particularly as she was an infant when this happened and she’s writing about it retrospectively—which distracted her from her poor health.

Thus, based on Dickinson’s interest in consumption, and her own possible diagnosis, I have identified a pair of poems that seem most appropriate for further examination, recognizing that each articulates a different experience of the tubercular patient from Dickinson’s time.¹⁶ Further, I studied the influence of the color red in her poetry based on Mamunes argument that in Dickinson’s regular use of red, there exists “a TB subtext” (6), meaning that when we see the color red mentioned or hinted at in Dickinson’s work, we should consider possible tubercular influences. For example, in the first poem in this cluster, “The Red—Blaze—is the Morning —” the word “Red” is the second one in the opening line, connected to a “Blaze,” implying a fever in a construction in which Dickinson highlights the importance of the word “Blaze” with her characteristic

¹⁵ This is letter 401 written in 1873 to her cousins, Louise and Frances Norcross.

¹⁶ Keeping Dickinson’s experiences with consumption in mind—even though we have no record of her being diagnosed herself—I visited the *Emily Dickinson Lexicon* to find poems that used some form of the word “consume.” I then eliminated poems that did not set the word “consume” apart in some way from the rest of the poem’s discourse. Finally, I selected and include below the study of the three poems I felt were representative of consumption’s appearance in Dickinson’s work.

punctuation. In the second poem, “Hope is a subtle Glutton—” the word consume ends the second to last line, naturally drawing the audience’s attention to it and the ultimate end that comes from being diagnosed with this disease. Finally, to start the Dickinson section, I open with a study of her poems “Purple—The Color of a Queen, is this” and “A Mien to move a Queen.” These poems are about Dickinson’s heroines, or her “queens.” These are women who inspired her, among whom are the Brontë sisters.²⁶¹⁷

In “The Red—Blaze—is the Morning —” (Fr. 603), Dickinson describes the course of the sun throughout the day in language that is strongly reminiscent of a fever which accompanies the consumptive, placing color on his or her cheeks:

The Red—Blaze—is the Morning—
 The Violet—is Noon—
 The Yellow—Day—is falling—
 And after that—is None—
 But Miles of Sparks—at Evening—
 Reveal the Width that burned—
 The Territory Argent—that never yet—consumed—¹⁸

Here, Dickinson could be alluding to several fevers that pervaded nineteenth-century America—yellow, scarlet, and brain particularly—each of which consumed an ill person until he or she was no longer recognizable. By beginning with the color “Red” and ending with the word “consumed,” another possibility exists: Dickinson is writing about

¹⁷ For more on Dickinson’s queens and the influence they had on her work, see the collection of her letters compiled by Thomas Johnson titled *The Letters of Emily Dickinson* published through the Belknap Press of Harvard University Press.

¹⁸ This poem was Franklin number 603 and was likely written in 1863. 1863 was a year that began with the death of Dickinson’s Uncle Loring Norcross (the brother of Emily’s mother) which left her cousins, Louise and Frances orphans (ed. Johnson 420-1). Emily would stay with Louise and Frances the following year while she received treatment for her vision problems.

the white plague, a disease known for its consumption of the ill person and yet, at the same time, what it leaves behind: a red-cheeked wisp of one's former self. Furthermore, consumption appears in the way the ill person becomes the "Width that burned" while the body and area they occupy represent the "Territory Argent" (ll. 6-7). The consumptive's fever and wasting disease are taking over her body, burning it up not only metaphorically, but literally as her temperature reach unsafe levels.

Additionally, the use of "Argent"—defined as something "silvery" and "sparkling"—resonates with the literary portrayals of spiritual female consumptives during this time. Here they are the beautiful, angelic women seen rising above and away from their tubercular physical forms, and ultimately dying from their disease to be reborn again in heavenly peace. This ethereal description of the "Territory Argent" has much in common with the previously articulated views of spiritual consumptives during the nineteenth century. However, Dickinson seems to be studying and critiquing these idealistic views here as she calls to mind the almost otherworldly beauty of the consumptive. However, as she ends this part of the poem, Dickinson changes tacks, reminding readers that while the "Territory Argent" is "never yet—consumed" the same is not true for the tubercular body.

However, another possibility exists as we reach the ending of this poem. Here, we realize Dickinson has also just taken us through a sort of spiritual death and rebirth. Death is a common theme of her poetry; however, what stands apart as noteworthy about this poem is her focus on the spiritual rebirth in the celestial beyond. If we look at the verb construction and the end of each of the first four lines, constructions Dickinson has set apart from the rest of this work, we can follow the progression of death and new life.

The first, “is Morning” (ll. 1), clearly indicates a beginning; from these words, we can ascertain a journey is being undertaken. Then, “is Noon” (ll. 2) creates a shift, moving the narrative along as we arrive at the midpoint of our journey. Next, she writes “is Falling,” (ll. 3) showing an end is coming. Finally, we encounter the seemingly hopeless “is None” (ll. 4), showing a physical end to something. However, the poem is not over yet, and we must therefore explore why. We realize in this moment that the body may have burned out—no doubt a reference to fever as well—but now has been replaced. It is not gone; it is a Territory Argent instead. It can no longer be consumed as the physical body can, and instead offers a lovely alternative—an eternal body (figured metaphorically as a celestial body—a star) that exists long after the Red Blaze has waned. In this poem, we can see a metaphorical rebirth of the truly spiritual consumptive after her death.

This poem has not been studied as much as some of Dickinson’s other work. However, Baron Levi St. Armand, in *Emily Dickinson and Her Culture: The Soul's Society*, writes of Dickinson’s continued focus on “the dark night of the soul” and how this ongoing struggle to not submit to the bleak night is reflected in this poem (288). St. Armand contests that for Dickinson “night was necessarily black,” arguing instead, “yet because it could harbor hope and faith as well as doubt and despair, it became either the sum of all colors or the complete negation of them” (288).¹⁹ However, while I agree that

¹⁹ I would be remiss if I did not acknowledge the obvious importance of the word “Red” in this poem as well. However, much time has already been devoted to the blush of the beautiful consumptive’s cheeks and the flush of red left as her fever burned in a red blaze. When used to describe consumptives, red calls to mind the idea of blushing, as if one is embarrassed of her diseased state, hence the previously mentioned red stain on the ill individual’s cheeks. However, it is the physiology of the blush that is most important as it implies the blood rapidly relocates to the consumptive’s face. This movement of blood is interesting to scholars in the medical humanities as one of the common symptoms of advanced pulmonary tuberculosis in this era was “a profuse hemorrhage,” in which blood was “pouring from the mouth and nostrils and causing an almost instant suffocation” (Rothman 16). In fact, it is the hemorrhaging that killed Virginia Poe. Thus, the idea of a red blaze being something else entirely is also possible, but does not seem to be borne out by the rest of the poem’s color scheme.

the poem embodies hope, I maintain that this poem is about more than night in the general sense. In my reading, I contend that these words focus on the fear night brings to the consumptive and the thought that they might not rise to meet the next day, even as they hope to be “never yet consumed.” Thus, while “the day is falling,” we see the consumptive’s hope born of faith even as they are being consumed by a fiery fever, a Red Blaze.

It is not just the words that begin and end this poem, however, that indicate Dickinson and her readers may have had consumption on their minds as they encountered this work. Much of what comes between “red” and “consumed” provides additional focus for audiences sensitized to the devastation caused by TB. Of particular note is the idea of burning that the poet introduces with the fifth and sixth lines: “But Miles of Sparks—at Evening—/ Reveal the Width that burned—” (ll. 5-6). With these words Dickinson echoes the progression of a fever. The speaker moves through a day in much the same the way a fever sweeps through the human body, rapidly reaching the point where night will fall, as the sun sets and life leaves the corporeal vessel, consuming it almost—but not quite—entirely.

To study the influence of people with TB as well as the disease itself, Dickinson’s poem “The Color of a Queen, is this” seems particularly important. This poem, Franklin 875, was likely written some time in 1864. Dickinson writes:

Purple—

The Color of a Queen, is this—

The Color of a Sun

At setting—this and Amber—

Beryl—and this, at Noon—
 And when at night—Auroran widths
 Fling suddenly on men—
 'Tis this—and Witchcraft—nature keeps
 A Rank—for Iodine—

Immediately readers are struck by the parallel between Dickinson's poem and Keats's "Ode to a Nightingale" with the reoccurring focus on the color purple. Purple is associated with royalty, so it is logical that Dickinson uses it to refer to her Queen. Furthermore, as mentioned in *Chapter 3*, Keats uses purple ostensibly to allude to the stain hemlock leaves behind on its victims' mouths, hinting at illness as a sort of poison working its way throughout the body. However, Keats, and Dickinson, too, could also be referring to hemoptysis and the dark red, or purplish, blood a tubercular patient coughs up as they suffer from the effects of their wasting lungs. Dickinson's beautiful turns of phrase also catch readers' attention: the queen here is a flushed, bright figure of importance who is unfortunately waning, "The Color of a Sun / At setting" (ll. 2-3). Because the setting sun is often a pinkish red, we might notice the similarity to the color of flushed tubercular faces in this moment. As tuberculosis leeches the color from her skin, only the red flush on her cheeks remains. In the same way that her skin color fades, so does the female poet's influence, or so Dickinson seems to feel. This disappearing influence could then lead to society forgetting the presence of the creative female consumptive—the sun is setting on her, so to speak—and return to old stereotypes of the angel of the home and the beautiful consumptive. It is natural for the female consumptive to be beautiful; it is "witchcraft" for her to be creative.

In the next part of the poem, if we pursue its intimations of consumption, the speaker can be interpreted as exploring how the creative female consumptive strays away from her beautiful and spiritual counterparts, seeking the “Auroran Widths” of night instead of a man’s admiration or heaven. Dickinson may be critiquing society in these lines, hinting that the perception of the creative consumptive woman is that their rising sun still “fling”s its influence “suddenly on men” (ll.6), reminding her readers that the female writer can be read as imposing on her male counterparts when she expects recognition. Instead of behaving as a docile, Victorian lady, the speaker implies these women might try to capture society’s attention through their “witchcraft” (ll.7) as opposed to allowing this attention to remain solely focused on the patriarchy. Not only do these creative women then become atypical in terms of their activities but also in terms of their faith. They are not the good angels of the home exemplified by literary figures like Beth March and Eva St. Clare. They are instead the demonic witches, echoing their foremothers who died due to their own inability to conform to social norms.

Further, if we consider the date during which this poem was written in relation to events in the poet’s life, we discover that during 1864-1865, Dickinson was treated for several months for painful eye injuries: “her eye problems [...] confined her to Cambridgeport for a great part of 1864 and 1865” (Wand & Sewall 400). While a writer like Stowe might have experienced her disease as in some way spiritually stimulating, Dickinson seemed to have no such consideration. In a letter from the time during which she was being treated, Dickinson writes to a friend who was injured during the American Civil War, “I was ill since September, and since April, in Boston, for a Physician’s care—He does not let me go, yet I work in my Prison, and make Guests for myself” (ed.

Johnson 431). Dickinson labors creatively with “Guests,” here perhaps an illusion to the influence other female writers, her queens, have had on her own creative process. They are imprisoned not only by their disease but also by society and their gender. As Dickinson makes clear in this instance, illness does not lead to higher spiritual awakenings; rather, it imprisons the sufferer. Thus, in the poem she alludes to “Witchcraft” and “nature keeps” the ill person while they wait impatiently for their treatment of iodine.²⁰

Red is not the only color that plays an important role in this poem as well as in diagnoses of TB, as was mentioned in *Chapter 2*. Therefore, the fact that iodine has a violet hue has interesting implications for the poem. Dickinson’s last line, then, could simply be a continuation of her dusk and dawn imagery in the poem, indicating the deep colors the sky turns as day becomes night. Additionally, however, iodine was one of several treatments used for tubercular lesions in the nineteenth century (Dormandy 44). Therefore, it is possible that Dickinson is directly focusing on her tubercular heroines at the end of her poem. In fact, Sir James Clark addresses iodine’s uses in treatments of TB, explaining that if a patient uses iodine, he or she will recover “flesh, strength, and colour: hitherto pale, relaxed, and feeble, he becomes full, strong, and florid [...] scrofulous ulcers heal” (313-14).

²⁰ Iodine was also used as a treatment in eye maladies, as it still is today. The French collection *Essays on the Effects of Iodine in Scrofulous Diseases* (1831) by Jean Guillaume Auguste Lugol, explains how iodine was not only a nineteenth-century treatment for diseases like TB (also sometimes referred to or diagnosed as scrofula), but also for eye diseases and symptoms including conjunctivitis, sore eyes, and poor vision among other eye complaints (30; 99). For more on iodine and its nineteenth-century discovery, see Louis Rosenfeld’s “Discovery and Early Uses of Iodine.” Rosenfeld does caution, though, that “the employment of iodine requires judgment” as in situations where the patient has an upset digestive or nervous system, or when the patient is emaciated, it might cause irritability and pain (qtd. in Clark 314).

Another Dickinson poem that questions the perceived role of queenly women like the Brontës and Dickinson herself is “A Mien to move a Queen”:

A Mien to move a Queen—
 Half Child—Half Heroine—
 An Orleans in the Eye
 That puts its manner by
 For humbler Company
 When none are near
 Even a Tear—
 Its frequent Visitor—
 A Bonnet like a Duke—
 And yet a Wren's Peruke
 Were not so shy
 Of Goer by—
 And Hands—so slight,
 They would elate a Sprite
 With merriment—
 A Voice that alters—Low
 And on the Ear can go
 Like Let of Snow—
 Or shift supreme —
 As tone of Realm
 On Subjects Diadem—

Too small—to fear—
 Too distant—to endear—
 And so Men Compromise—
 And just—revere —

The playful tone of this poem works to hide Dickinson's underlying message about the perception of women in society. Her rhyme scheme here mimics that of other, more banal poems, for example "Eye with "by" and "slight" with "Sprite." However, even the somewhat nursery school style of her rhyme scheme grows more dour as the poem progresses. For example, in lines 22 and 23 she rhymes "fear" with "endear," hinting at the close relationship between those two and the ways in which the modern woman—Dickinson's "heroine"—might be feared by the larger society if she chooses to step away from the role of the endearing, angelic woman.

Unsurprisingly, from the beginning of this poem, Dickinson's speaker presents the dual nature of her role models as Queens that are "Half Child—Half Heroine" (ll.2) due to their status as women in society but as women who resisted the constraints placed upon them. This poem, Fr. 254, was likely published in 1861. In that same year, Dickinson wrote several letters that mention her "Queens." Of particular note is one in which she mentions several of her women writer role models by name: "That Mrs. Browning fainted, we need not read Aurora Leigh to know, when she lived with her English aunt; and George Sand 'must make no noise in her grandmother's bedroom.' Poor children! Women, now, queens, now!" (ed. Johnson 376). Johnson comments, "ED especially liked and often alludes to in her letters" Aurora Leigh. He further explains, "[i]t is Mrs. Browning's vehicle for expressing her views on a variety of subjects, social,

literary, and ethical” (376). Therefore, it is no surprise that as Dickinson draws strength from her queens, she, too, explores the motifs they focused on in their own writing and poetry. Furthermore, if we consider Elizabeth Barrett Browning’s and the Brontës’ deaths from consumption at relatively young ages, as well as their gender, the second line, Dickinson’s “Half Child—Half Heroine,” seems like a clear commentary on these heroines—these “Poor children! Women, now, queens, now!”—while also being a denouncement of society’s perpetuating stereotypes about the inherent weakness and innocence of women. At the same time, it is important for Dickinson to acknowledge the influence of her Queens as heroines as they blazed a trail for future female writers to follow. She sees them here as two sides to the same coin: the incorrect perception of society on one side (the childish woman in need of a man’s protection) and the influential role model as writer on the other (the heroine to other women struggling against the patriarchy).

This poem also hints at the lengths to which women writers like the Brontës and Dickinson went to protect not only their work but also their social standing. Modern readers can look at this as a call to action for female writers to put “its manner by / For humbler company / When none are near” (ll. 4-6). These lines reflect the desire to hide oneself except among exclusive and—societally perceived—“humbler company,” like that of other women writers. By placing themselves in this protective seclusion, these female writers avoid societal censure while still finding space in which to express themselves. When we consider the fact that the Brontë sisters initially published under male pseudonyms, we can understand the ways in which these female writers subverted the patriarchal culture to share their writing and their messages, perhaps the only way

they could gain recognition for their work, hiding the “Tear” that was a “frequent Visitor” on the productive female writer’s face (ll. 7-8).²¹ Further, this subversion indicates not only why Dickinson looked to the Brontë sisters as heroines but also explains why she herself shared very little of her work—and published even less—during her lifetime.

As the poem continues, clear echoes of the Brontës’ wasting away from TB begin to coincide with Dickinson’s gendered message. She writes, “And Hands—so slight, / They would elate a Sprite/ with merriment” (ll. 13-15), immediately calling to mind the stereotypical, delicate woman but also hinting at the wasting away of the slight consumptive patient. Here, Dickinson directly confronts the idea of the beautiful, spiritual consumptive by again questioning whether or not suffering is truly spiritual, as she draws attention to the slight hands, the frequent tears, and the fact that one is often alone in her suffering. In the same year this poem was written, Elizabeth Barrett Browning died and Dickinson offered the following epitaph of sorts: “Yet, if she sees us fainting, she will put out her yellow hands. When did the war really begin?” in her letter to her cousins, Frances and Louisa Norcross (ed. Johnson 376). Here, Dickinson addresses again the wasted, almost jaundiced skin and also, potentially, the war between the sexes for equal treatment. She could also be referring to the American Civil War and the fact that women were not yet emancipated. Dickinson thus appears to understand better than many of the medical minds of the time not only how disease takes those who are at their peak, in

²¹ To avoid social censure, and presumably to get their works published, the Brontë sisters sometimes published under male names. For Charlotte, it was Currer Bell; for Emily, Ellis Bell; and for Anne, Acton Bell. For more on this fascinating connection between gender and writing (as well as publication) in the nineteenth century, see Stephen Whitehead’s article “The Bell Pseudonyms: a Bronte Connection?” *Brontë Studies: The Journal of the Brontë Society* 40 (2015): 59-64.

regard to creativity, life, and success but also how unfairly women are treated despite suffering the same conditions as men.

Dickinson ends her poem with a commentary on the lack of stature a woman has in a patriarchal society. She writes that while her queen can hold forth “On Subjects Diadem –” (ll. 21) she is “Too small—to fear –” (ll. 22). Therefore, she has no place in a society that rejects her based on her gender twice over: once, because as a woman she is perceived as weak and again because as a woman she should not be creative but instead should remain the spiritual center of her home. Sadly, due to the creative female consumptive’s presumed nature, she is perceived as holding herself “Too distant—to endear –” (ll. 23). Therefore, men are not able to admire her up close and share with her their admiration but instead “Compromise –/ And just—revere” (ll. 24-25).

These debates about the role of the female consumptive show how the literature of this era echoes the medical texts of the time, thus supporting the idea that women in this era experienced “emotional extremity and dependency time and time again” (Lawlor *Romantic Disease* 57). In Dickinson’s poetry, we again see the literature mirroring the larger society, as the need to protect the supposedly weaker women was deemed chivalrous throughout the century. This is no doubt due in part to the fact that many doctors in the nineteenth century followed the teaching proclaimed by Alfred-Armand-Louis-Marie Velpeau that ““the young girl becomes more timid and reserved,”” indicating that as she becomes a woman, she becomes more demure, an idea widely accepted by the larger nineteenth-century society.²² Velpeau further notes that ““the sensations she

²² Alfred-Armand-Louis-Marie Velpeau (1795-1867) was a French surgeon known for his skill and knowledge regarding obstetrics and human anatomy (Dunn F184). A well-known medical writer, it is estimated that Velpeau published “340 titles and 10,000 pages” throughout his lifetime (Dunn F185).

experiences, and the sense of her own weakness, are the reasons why she no longer approaches the companions of her childhood but with a down cast look” (qtd. in Shew 85-86). Thus, women are seen not only as weaker but also less likely to go about in society, and therefore as needing to be protected from the vanquishing nature of not only their disease but their character. Therefore, the men have to visit her, or worship her from afar as in “A Mien to move a Queen.”

Dickinson’s work also gives readers a much more gender-centered portrayal of the path of consumption, as she alludes to society’s focus on the tubercular patients and the male’s desire for the beautiful, but dying, consumptive in “Hope is a subtle Glutton –” (Fr.1493):

Hope is a subtle Glutton—
 He feeds upon the Fair—
 And yet—inspected closely
 What Abstinence is there—
 His is the Halcyon Table—
 That never seats but One—
 And whatsoever is consumed
 The same amount remain—²³

This poem highlights the idea of the “*spes phthisica*” or the “hope of the consumptive” discussed in Lawlor’s work “Transatlantic Consumptions: Disease, Fame, and Literary Nationalisms in the Davidson Sisters, Southey, and Poe.” Lawlor explains this concept as the idea that as a woman becomes consumptive, she also hopes to become a beauty,

²³ This poem was likely written in 1879 according to Franklin.

energized by her disease even as it consumes her (110). In Dickinson's poem, if we read "Hope" as referring to the "hope of the consumptive," the poem can be read as articulating the "gluttony" of tuberculosis as it consumes the beautiful woman's whole person despite the consumptive's hope that it will not end their life.²⁴ The hope is born out of a spiritual awareness that even if one dies, one is reborn, and thus "The same amount remain" (ll. 1, 8). However, as many stories of consumption indicate, death was almost always the result of consumption despite a dedicated effort to avoid its clutches.

The hope associated with the effort to avoid consumption is one of the few continuities throughout the nineteenth century with regard to tuberculosis. This dedication to staying alive despite a dread diagnosis is a theme that necessarily, carries throughout the entire century in literature as evidenced in Keats's biography and poetry, in "The Masque of the Red Death," in the concern of Augustine St. Clare regarding his daughter, Eva, in Dickinson's rejection of notions of beautiful and spiritual diseases, and in the early twentieth century by authors like James Joyce. While the added comfort of spirituality provides some solace for consumptives and their loved ones by mid-century, the struggle to come to terms with the diagnosis continues and can still be seen in the modern era when a disease we now view as curable in the developed world still claims the lives of over a million people per year.²⁵

However, it would take some time for literature about consumption to catch up with medical treatises. One such example of a story that lagged behind the medical

²⁴ This idea of consumption eating up its host was a fact that Emily Brontë—one of Dickinson's influences—was also known to comment upon in her work. In *Reading the Brontë Body: Disease, Desire, and the Constraints of Culture*, Beth Torgerson notes that "Emily Brontë uses a multitude of interrelated metaphors for eating and drinking, including the contrast between the body's consumption of food and consumption's consuming of the body" (130).

²⁵ This fact comes from recent reports from the Centers for Disease Control.

knowledge is James Joyce's "The Dead" (1914). Joyce's story has roots in nineteenth-century consumption and therefore provides somewhat updated representations of the male- and female-influenced manifestations of tuberculosis. The characters Gretta Conroy, her erstwhile and long-dead lover Michael Furey, and Mr. Bartell D'Arcy all embody different aspects of the disease, and they do so in a way that disturbs the notions of earlier, nineteenth-century figures. Gretta describes Furey—a young man nearing his prime—as “very delicate” (249). She explains, “he was such a gentle boy [...] He was going to study singing only for his health” (251), indicating quite clearly the sensitive, creative spark to which Lawlor refers in regard to tubercular men while also adding the feminine fragility we previously encountered almost exclusively in female characters like Stowe's Eva. For Furey, his disease inhibits his creativity—he cannot go away to study because he is in poor health—instead of enhancing it, as it had done previously for men of the nineteenth century, like Keats. With Furey, Joyce begins to disturb the notions of what disease does to the gendered body—its affects are no better for the consumptive male, regardless of how creative he might become, than the consumptive female, as Brontë begins to prove with Linton Heathcliff—and how that gendering of disease can be reshaped.

Furey has been dead a long time by the start of the story so the descriptions of him that we receive are second-hand and come from Gretta Conroy. Gretta tells Gabriel that she used to “go out walking with him” (249) when she lived with her grandmother in Galway. Soon after, she informs Gabriel that Furey “died when he was only seventeen” (250). She then asks, “[i]sn't it a terrible thing to die so young as that?” (250). Gabriel responds to her question with another question, asking, “[a]nd what did he

die of so young, Gretta? Consumption, was it?” (251). While Gretta does not respond in the affirmative, her descriptions of Furey leave little doubt that he was a consumptive youth. She mentions that Furey’s family said ““he was in a decline”” (251), implying some sort of lingering illness like TB. She further specifies that ““he was ill at the time in his lodgings in Galway and wouldn’t be let out”” (251), indicating he was in some form of quarantine or too weak to move, either of which would be consistent with TB at this period in Ireland’s history.

D’Arcy, also a singer with “a lovely voice, a lovely voice” (208), is depicted in similarly consumptive terms in Joyce’s short story. His voice, despite reputedly being lovely, is now as “hoarse as a crow” (240), implying perhaps prolonged bouts of coughing. Furthermore, he denies his illness as nothing more than a cold, desiring to repress any concerns that he might have something more serious, concerns many living in Ireland at the time “The Dead” takes place would logically have had. Sarah Marsh writes about D’Arcy in her article ““Consumption, was it?: The Tuberculosis Epidemic and Joyce’s ‘The Dead,’”” arguing that D’Arcy is a “newly affected tubercular patient” (116). She reasons that “D’Arcy’s symptoms fit historical descriptions of tuberculosis onset,” citing several of these symptoms including “a series of ‘colds,’ or complaints of bronchitic seizures” (116) which would then explain his hoarseness and general ill feeling. However, due to the fear of contagion—and its accompanying “paranoia and secrecy” (Marsh 117)—D’Arcy continues to gruffly deny his disease, even snapping at his hosts. He then tells the accommodating women “in a repentant tone” about “the history of his cold” (Joyce 241), indicating that he feels guilty for snapping at them and also perhaps for bringing consumption into their home with the new understanding of

how germs spread. With D'arcy, we again see tuberculosis inhibiting the creativity of the male body as opposed to enhancing it. Joyce's story allows us to study TB as something that is not simultaneously positive for strong males and negative for weak females but rather equally detrimental to all.

While many researchers, such as Martin Bock in his article "James Joyce and Germ Theory: The Skeleton at the Feast" and Fergus Shanahan and Eamonn M.M. Quigley in their article "Medicine in the Age of *Ulysses*: James Joyce's Portrait of Life, Medicine, and Disease on a Dublin Day a Century Ago," have studied Furey and D'Arcy's tubercular tendencies, nearly as many have failed to recognize the TB symptoms that Gretta Conroy's state of health suggests. Even though these scholars focus on the "colour in her cheeks," they do not draw the connection between tuberculosis and Gretta, instead just speaking of death in general in "ominous" terms (Bock 31) or of linking her apparent illness to a cold she caught the previous year (Bock 27). However, if D'Arcy's cold signals something sinister for scholars, why can't Gretta's as well? On the other hand, there are a few literary scholars who do see the connection between tuberculosis and Gretta. Marsh notes, "Gretta, who once fell in love with a consumptive, is now presenting the long-dormant signs of that connection" (119), based on her cold and complexion. As mentioned in *Chapter 2*, TB takes some time to appear; therefore, Marsh's argument that Gretta may have caught it from Furey and the disease simply remained latent for a period of time is quite valid. However, Marsh, too, stops short of focusing on how Gretta, supposedly a member of the weaker sex, survived far longer than Furey despite being afflicted by the same disease. In Gretta, then, we watch the resilient female consumptive take shape, remodeling society's previous—and preconceived—

notions of feminine vulnerability and illness. Furthermore, since Joyce provides in Furey a foil to which we can compare Gretta, we are able to recognize that in much the same way he has written Furey, Joyce has also created an atypical female consumptive as well.

Despite her emergence as a woman of the new century, the other characters' reactions to Gretta Conroy do not acknowledge or hint at her personality in any depth. Instead, the other figures in the story focus on Gretta's physical appearance. For example, Gabriel notices "that there was colour on her cheeks and that her eyes were shining" (241). Here we see the ways in which Joyce focuses his protagonist's attention on Gretta's consumptive-like flushed, excited beauty. Additionally, Gretta informs their family, "you'll never guess what he makes me wear now!" (204), indicating that Gabriel looks at her as if she were a doll, or someone he could dress in his own styles for his own pleasure. For his part, Gabriel lets this conversation wash over him as he stands by with his "admiring and happy eyes [...] wandering from her dress to her face and hair" (204), indicating a male pride in the woman he has fashioned. He attempts to take on the role of creator in much the same way men of the past did with consumptive-seeming women. At least in her husband's eyes, she is a subject simply to be studied. Gabriel uses both the medical gaze here as he protectively hovers around his recently-ill wife and the male gaze as his eyes wander all over her form. As he stares at her, dresses her, and contemplates her, Gabriel objectifies Gretta, doing what many men in the nineteenth century did. Thus, to mirror this objectification for this portion of the story, we get only Gabriel's analysis of Gretta. However, as the story progresses and Joyce proves Gabriel to be an outdated reminder of the past instead of the messenger of the future as his name implies, the narrative focus shifts as Gabriel becomes aware of his wife's hidden depths.

By the middle of the story, we see clearly society's biases and uncertainties about who the female consumptive is, as mirrored in Gabriel's musings about his wife. Joyce writes, "[t]here was a grace and mystery in her attitude as if she were a symbol of something. He asked himself what is a woman standing on the stairs in the shadow, listening to distant music a symbol of? If he were a painter, he would paint her in that attitude" (239). The first sentence of his contemplation clearly indicates Gabriel's attraction to his wife, an attraction many nineteenth- and twentieth-century men would consider socially acceptable because of her illness and their relationship as husband and wife. Gabriel is drawn to Gretta and the mystery he perceives as surrounding her; instead of simply asking his wife why she seems so pensive, he determines that her being mysterious makes her worthier of his artistic aspirations. The second part of the above quotation displays Gabriel's confusion about his wife's place in society as the new century begins. He is asking: of what is a modern woman symbolic? Once again, here, we see Gabriel objectifying his wife. Readers must ask, why does a woman need to be symbolic? Why can she not just be a woman? She is not the allegorical Eva St. Clare of the previous century; Gretta Conroy is something else entirely.

Part of the confusion about Gretta arises from the ways in which her disease appears to have manifested. Today we understand that there are two types of TB, one termed latent TB infection and one called TB disease (CDC "TB"). Latent TB will never express symptoms of the disease if the patient receives treatment; however, in Joyce's time, the treatments and detection of latent TB were such that eventually, nearly every latent case of TB developed into TB disease. The second type is a full-blown case of tuberculosis complete with expression of symptoms, a need for more advanced treatment,

and the potential for death from the disease (CDC). Since latent tubercles “cannot spread TB bacteria to others” (CDC) but do arise from a person coming into contact with a patient who already has TB disease, it is not illogical to assume Gretta Conroy appeared to be suffering from latent TB infection initially and thus, while exposed, did not spread the illness to her husband as her disease wasn’t transmittable. However, now that she is showing symptoms of the disease—such as her flushed cheeks and general feeling of illness—due to a lack of treatment, it might not be long before everyone who came into contact with Gretta at the dinner party will join “The Dead.”

On the other hand, what if Gretta does not die from her tuberculosis? She has suffered through lovesickness after the loss of Furey; could not the same be true of her tuberculosis? By the start of the twentieth century, deaths from tuberculosis were slowly on the decline due to better understandings of germ theory and Koch’s discovery of the bacteria responsible for the disease and the subsequent vaccinations that emerged as a result. However, as shown above, many of the stereotypes about an ill woman persisted. Women continued to be subjected to the expectations of society and men in particular. For example, when Gabriel cannot figure out what ails his wife, he reflects on how previously “[h]e had felt proud and happy [...] that she was his, proud of her grace and wifely carriage. But now [...] the first touch of her body musical and strange and perfumed, sent through him a keen pang of lust” (245). He no longer knows Gretta as someone who is fitting her Victorian role of the wifely figure but rather as a New Woman who inspires lust. For him, the two emotions—pride and desire—are mutually exclusive and thus the woman he married is someone with whom he is no longer familiar. She is a sexual being of the new century instead of a sexualized object of the previous one.

Gabriel works to reconcile his new concept of his wife with his former understandings of who she was before they met. Unaware that his biases haven't changed, he tries to understand what is "wrong" with Gretta. He asks her as they arrive at their hotel, "[y]ou don't feel ill or weak?" (247), trying to place what is happening with her. Gretta replies, "[n]o, tired: that's all" (247). In his nineteenth-century mindset, Gabriel cannot contemplate any other reason for this perceived shift in Gretta's personality. He has studied her as clinically as any doctor might and used his own biases to determine something is amiss. It would be unfair to judge Gabriel for possibly fearing Gretta is consumptive as she was closely associated with the tubercular Furey. Readers can even understand when he asks her directly about Furey's death, as mentioned above, indicating it was consumption. However, Gretta articulates, "I think he died for me" (251), once again hinting at the implications of lovesickness and how it can weaken the body enough to cause death, especially when comorbid with a serious disease like TB. However, this time the illness impacts both the consumptive, Furey, and the person he desires, Gretta.

While Gabriel's stream-of-consciousness runs through much of the narrative and many of the descriptions we get in the text are his, Gretta's voice emerges strongly in the last part of the story. Here, she provides the narrative of Furey and also offers subtext on her love for him, ending her story with the tragic line: "O, the day I heard that he was dead!" (252). In asking about what Furey died of, Gabriel opened himself up to listening to Gretta. Instead of making presumptions about who she is because of the societal role she fills, Gretta has an opportunity to show not only who she is but who she *was*—a young woman in love. However, when Gabriel hears what she has to say, he realizes he

has never known or truly loved Gretta: “It hardly pained him now to think of how poor a part he, her husband, had played in her life” (253). He is not saddened by their lack of a connection, but rather, it appears, by what he has learned. He indicates this a few moments later when he recognizes, almost clinically, as he studies his sleeping wife, “[h]e did not like to say even to himself that her face was no longer beautiful, but he knew that it was no longer the face for which Michael Furey had braved death” (253). Now that he has heard Gretta’s story, he cannot reconcile her with the woman from the story and he cannot see in her the woman he admired only hours earlier, either—whether or not he would “like to say it to himself.” Gretta has emerged from her social roles and will awake to a day of new, hopefully better, expectations.

As this analysis suggests, “The Dead” clearly brings to the fore perhaps the most concerning element of woman’s health and society’s understanding of it: the male gaze. As horrifying as the medical gaze—the inability to see past a patient’s illness—the male gaze is equally pervasive but less readily noticeable. The male gaze prevents men from seeing past a woman’s gender in much the same way in this context. As a result of the male gaze, men looked at the ill women of the long nineteenth century as desirable, equating painful illnesses like tuberculosis with sexual appeal, leading to harmful effects on not only the literary and medical portrayals of females but also on the women themselves. Like Gretta, whose beauty Gabriel believes has faded from the simple act of telling a story, the women are not the focus of their own stories. Instead, the men who love or are repulsed by these ill women continue to be the focus for study; their perceptions, as written by male authors about male characters, color the presentation of not only the illness but the female herself. Here, however, Joyce has offered a contrast as

Gretta goes to sleep peacefully while Gabriel remains awake, fixating on what his wife has told him. In this moment, Joyce seems to mock Gabriel's ignorance of his own wife, pointing out that Gabriel's "own identity was fading out into a grey impalpable world" (254). Just as Gretta emerges as a figure able to tell her own story, Gabriel fades away.

As is clear from Joyce's story, spirituality in the story of the consumptive has also begun to fade away. There are moments where spirituality is hinted at in "The Dead," but most of them occur in relation to non-tubercular characters. First, the obvious link between Gabriel's name and the Angel Gabriel is apparent. However, Gabriel's message sometimes confuses his audience—"Aunt Julia did not understand but she looked up" (232)—and is further hampered by his nerves—"Gabriel leaned his ten trembling fingers on the tablecloth and smiled nervously at the company" (229). Further, when religious phrases are used, they're almost exclusively uttered by those of the older generation of Gabriel's wealthy aunts and their friends: "'The Lord have mercy on his soul,' said Aunt Kate" (236) as Gabriel tells a story much of the rest of the company finds humorous. However, there are no moments in which religious or spiritual language is applied to the characters who express symptoms of consumption. Joyce thus rejects the previous notions of the century and strikes out, creating a worn-out, aspiritual woman who seems to express symptoms of consumption but never definitively indicates she is tubercular and two men who lose their creativity as a result of their disease. He rejects the romantic notion of the consumptive for something closer to the truth, something Sir James Clark himself would likely have recognized in these characters as similar to his real-life consumptive patients.

An unfortunate downside of most studies of this nineteenth-century consumption is the minimal focus on both genders in diagnoses of tuberculosis. While Buikstra and Roberts do mention that TB was thought to start at the onset of menses in women—and in fact provide many of the useful details cited above about TB treatments for young women sent to sanatoria—the nature of their studies as generalized research prevent them from exploring gender in greater depth as it relates to the medical side of this illness. In much the same way, Lawlor’s comprehensive overview of tuberculosis in literature prevents him from going into detail about gender with any specificity. Fortunately, other texts such as Mary Ann Gardell Cutter’s *The Ethics of Gender-Specific Disease* (2012) provide comprehensive studies of gender’s relationship to disease and so we can turn to those for the last important argument of this chapter’s reading of “The Dead.”

As shown by the selected works discussed in this chapter, towards the middle and end of the nineteenth century, consumption was one theme among many that found its way into both female and male writers’ work. By reading these stories of consumption alongside other nineteenth-century understandings of the disease, modern scholars can get a glimpse of the ways in which illness pervaded the social consciousness of writers from this era and the readers who read their works. Furthermore, by studying consumption in literature and the way it manifested in both fictionalized and real-life female bodies, readers can get one step closer to understanding the evolution of a particular disease over time. Ultimately, the impact of disease on literature is an on-going source of discussion for scholars of the medical humanities, but, by reading works like those by Dickinson, the Brontës, Stowe, and Joyce, we are that much closer to understanding the ways gender impacted the experience and representation of diseases

like tuberculosis and, in turn, the ways this understanding of gendered diseases impacted society.

Chapter Five: It's Not Easy Being Green: What Is Chlorosis?

Mary, aged 14, an out-patient, Jan. 6, 1835, is reported by her mother to have been, from birth, a delicate sickly girl, and frequently the subject of cough, with mucous expectoration and pain in the left side. Her symptoms are entirely chlorotic. There is pallor of countenance, coldness of surface and especially of the lower extremities, lividity of the hands and of the tips of the fingers, and emaciation. Puberty appears partially established, as there is some development of the mammae; the pulse is 120, and feeble; respiration quick and short; cough distressing at night, with slight mucous expectoration; the bowels generally constipated, but occasionally purged; appetite capricious; dislikes all animal food; is fond of pastry, tea, and bread and butter.

— Dr. Samuel Ashwell, “On Chlorosis and Its Complications”¹ (556-57)

By the start of the nineteenth century, medical practitioners understood chlorosis to be a disease that predominantly affected young woman. Helen King, author of the most comprehensive text on chlorosis, *On the Disease of Virgins* (2009), explains that “the typical sufferer was still expected to be female and pubertal” (8).² In fact, the roots of chlorosis reach back to the Early Modern period, and from the beginning the influence of gender impacted understandings of this diagnosis, which was further complicated by class and age. These connections between chlorosis and categories of identity set it apart from diseases such as cholera, which could affect anyone regardless of class, age, or gender. Because of this combined influence of gender and age on diagnostic practices, the fictional figures and historical actors I examine in this section of my dissertation are

¹ Dr. Samuel Ashwell was an American, nineteenth-century OBGYN whose most well-known work is the book *A Practical Treatise on the Diseases Peculiar to Women: illustrated by cases, derived from hospital and private practice* (1845). This text, reviewed in 1855 for that edition, was called “the most useful practical work on the subject in the English language, if not in any other” and the reviewer further explained the “superiority it derives from the extensive experience, and the philosophical mind of the author” makes it a text “indispensable to the medical practitioner” (“Biographical Notes” 282).

² Helen King is a Professor Emerita of Classical Studies at Open University. She continues to publish and research much work on ancient medical practices and the human body. Several of her most well-known texts include *Once upon a Text: Hysteria from Hippocrates* (1993) useful in providing historical background in *Chapter 1* and *Chapters 8-10* of this dissertation and *The One-Sex Body on Trial: The Classical and Early Modern Evidence* (2013), useful for understanding notions of gender and physiology that still persist today, addressed some in the afterward of this project.

young women who appear to exhibit signs of chlorosis.³ Further, as each figure is a wealthy young woman — and the disease was assumed to predominantly affect said women, as mentioned in *Chapter 1 — Chapters 5-7* study the effects of chlorosis on affluent women. Due to its clear manifestation and its strong prevalence in young women, chlorosis allows modern scholars to engage in a study of its influence over the wealthy female body in the nineteenth century. Finally, because these chapters consider the impact of the various cultural constructions of and responses to chlorosis, my study includes an exploration of descriptions from medical texts to popular understandings to characterizations in literary texts.

This chapter presents a brief history of chlorosis from the Early Modern era through the nineteenth century to reveal precisely how that history influenced nineteenth-century understandings of and treatments for this illness. Part of the reason this disease was studied intensively arises from the continued preoccupation with women's health, especially as it related to marriage and procreation. To keep a young woman on the correct, procreative path, everything from her menstrual cycle to the condition of her skin was “fair” game for study by midwives and physicians. As King argues, their scrutiny is the result of the idea that marriage was favored “as the goal for a faithful Christian girl” (4). Because of this fixation on a young woman's reproductive health, medical practitioners studied chlorosis—or green sickness as it was known during the Early Modern era—at length. These same physicians and midwives were attuned to the dangers chlorosis presented to the particular population of affluent young women of marriageable

³ King does note that in some instances, chlorosis was thought to affect older women. She quotes the midwife Jane Sharp, who explains that menstrual suppression is often seen in young women ““whereas women vomit, do not want to eat, or crave unnatural foods”” (qtd. in King, *Disease* 16). Typically, however, “chlorosis remained tied, above all, to virgins at menarche” as King puts it (*Disease* 17).

age — those who could ostensibly afford their care — and thus worked and researched many methods of treating the disease. By the nineteenth century, however, “green sickness” remained only as “‘the popular name’ and chlorosis [became] ‘the technical one’” (qtd. in King 19).⁴ Thus, the disease could be diagnosed using a variety of terms and yet patients and their families would have understood what it meant.

To understand chlorosis, we must begin with its earliest diagnoses. Throughout the Early Modern era, chlorosis was believed to affect only women of substantial means (Potter 380-81). The bond between Early Modern British nobility and chlorosis has been thoroughly studied. Ursula Potter, for example, explores this connection at some length in her article “Pubertal Process and Green-Sickness in Renaissance Drama” (2009). Potter claims the condition itself was “attributed to the effects of an idle but well-nourished lifestyle” (381) in women of the Early Modern era. She distinguishes those who develop green sickness, arguing that “working classes who might display similar symptoms could never be diagnosed with melancholy or green-sickness simply because they did not share the same causal conditions” (381). Here, Potter refers to the ways in which the leisure classes were “idle but well-nourished” (381), particularly compared to their poorer, working class counterparts. This interpretation of chlorosis as a class-associated illness continued into the nineteenth century. Joan Jacobs Brumberg, author of “Chlorotic Girls,

⁴ King notes that “[i]t is sometimes claimed that, in the nineteenth-century, chlorosis ‘became’ hypochromic (iron deficient) anemia, finally moving from being an ill-defined condition to the haven of diagnostic certainty as a result of increasingly sophisticated blood testing” (15). However, Elizabeth Poskitt explains that even into the twentieth century, there was a lack of understanding about whether or not hypochromic anemia was “a specific disease process” (558). Thus, it is not surprising that in some cases of chlorosis, blood testing supported the findings of visual scans of the pale patient, proving that she was suffering from an iron deficiency but that there was still much to be understood about this disorder. Interestingly, today many argue that the modern equivalent of chlorosis is iron-deficiency anemia, also known as hypochromic anemia (Uthman 4). For more on modern understandings of this condition, see Ed Uthman’s *Understanding Anemia: Medicine for the Lay Reader, a Book Detailing Causes and Treatments of the Various Forms of Anemia* (1998).

1870-1920: A Historical Perspective on Female Adolescence” (2009), clarifies these class distinctions, noting that they were more nuanced in the United States than in England. She writes, “[i]n England, chlorosis was linked to the idle daughters of the aristocracy and the bourgeoisie; yet their physicians [...] were only ‘marginal members’ of the middle class” (Brumberg 1469). Further articulating this link between the middle-class doctor and his noble patient, she explains that “both the cure and the explanatory etiology of chlorosis were shaped by class tensions” (Brumberg 1469). Here, Brumberg directly correlates the disease to class, indicating that for the middle-class doctors taking care of their higher-class patients, complications and judgment emerged in which “British doctors promoted a ‘medicalized condemnation’ of the luxurious habits associated with the leisure of girls in the privileged classes” (1469). This point is important to the entirety of this project: women of the upper classes were rebuked for falling ill as a result of doing little even as they were simultaneously prohibited from doing anything by virtue of their gender and class.

Irvine Loudon compiled much of the material regarding mid-eighteenth- and nineteenth- century diseases, including chlorosis, in *Medical Care and the General Practitioner: 1750-1850* (1986). Of particular note is his study of the ways in which these diseases propagated in certain areas and are labeled differently depending upon the location where they are uncovered. In his chapter on the predominant medical disorders of the time, readers discover a vast array of illnesses to which patients could fall victim. However, Loudon explains that this array could be different based on two factors: 1) “diseases of the rich and poor were not identical” and 2) visits to areas inhabited by different social classes “would present lists of diseases widely different” from one

another (55). Thus, even if people of lower social orders had chlorosis, it would likely have gone by a different name and their concerns would have been focused on a different set of symptoms. In this social class, they would likely be less interested in marriageability and instead would be more concerned with the chlorotic's shortness of breath and inability to move around with ease as these would have impacted her ability to work.

While class consciousness played not only into British representations of gender-specific diseases and also treatments for these same diseases, in the United States during the nineteenth century, things were a bit different with regard to chlorosis. Brumberg explains, "the diverse social settings in which chlorosis developed undercut a strictly class explanation" (1469). She thus considers class as just one cause for the development of and treatment for the disease but also cites "the complex interplay of adolescent physiology, medicine, and social and family life" (1469). I would further argue that because medicine was undergoing so many changes in the nineteenth century due to the emerging understandings of contagion brought about by germ theory, diseases like chlorosis were understood as not contracted but rather developed. Such diseases were not epidemic diseases affecting specific places but rather endemic, affecting specific people. Thus, these illnesses created more room for study but also for confusion as scientists and medical practitioners struggled to find a reason for diseases not spread by microbes. Still, by looking at all of these influences, we learn that chlorosis was a disease affected by social formations and constructions including—but obviously not limited to—class and gender, and as a result is most often associated with wealthy women as the primary patients.

This bond between affluence and illness explains why literature continued to hold the idea of the chlorotic young woman as an object of fascination. Potter, for example, writes, “health was a fashionable preoccupation of the wealthier classes,” and “women’s health held particular interest for the public” (381). To be sick because of one’s wealthy status as opposed to one’s poverty—and thus able to afford care—was a relatively surprising experience by nineteenth-century standards, especially when compared to diseases like TB and cholera. As a result of the departure from traditional disease epidemiology, green sickness and later chlorosis take center stage in a collection of private reminiscences, letters, plays, and poetry in addition to its presence in medical literature.

One example of a place in which green sickness occurs in a private reminiscences is in English noblewoman Elizabeth Isham’s *Booke of Remembrances* (1638), a text scholars have just begun to study in detail. Isham’s reflections in this personal diary allow us to develop a better understanding of this disease’s Early Modern manifestations. In Isham’s text, readers begin to comprehend not just the medical statistics and connotations of the disease but also the personal experiences of a young woman suffering through an affliction with no universal cure. Isham writes of her “coldnes of stomacke,” deciding that it comes “from the abundance of ill humers” plaguing her body (17r).⁵ She then details some of her own attempts at treatment, in which she does everything from eating “warne spone meat“ to praying for deliverance (Isham 17r).⁶ Several lines before

⁵ *Chapters 1 and 2* of this dissertation address humoral medical practices of the Early Modern century. For more on these practices, see also “A Short Guide to Humoral Medicine” (2001).

⁶ It seems here that Isham is referring to spoonfuls of meat offered to her as part of her treatment regimen. Considering the disordered eating habits of a chlorotic and the fact that many showed an aversion to meat (King, *Disease* 101), it is likely that she felt only able to ingest small amounts of meat at a time.

her musings turn to prayer, Isham records a telling statement. She writes of her excessive vomiting and wind — symptoms that clearly coincide with the gastrointestinal distress and disordered eating mentioned in *Chapter 1*—stating that chlorosis “might be as painfull as a womans trauell“ (Isham 17r). If one interprets Isham’s comparison of her disease to that of a woman suffering—or her “trial”—through some of the more distressing experiences of labor, scholars can better understand the far-reaching effects of such a condition and the painful toll this illness takes on a young woman’s body.

Symptoms like those Isham experienced were not limited to the Early Modern era. In fact, consulting *The Common Diseases of Women* (1872) by E. H. Ruddock, we see that nineteenth-century chlorosis took on many of the same manifestations as its Early Modern counterpart. Referring to chlorosis or green-sickness, Ruddock explains:

This is a condition of general debility chiefly affecting young women about the age of puberty, in which there is *Anaemia*, or deficiency of the red corpuscles of the blood [...]. The temperature of the body is diminished and the patient is morbidly sensitive to cold. Menstruation, though occasionally natural and regular, is more frequently either delayed, suppressed, or imperfectly performed. The breathing is short, the circulation and nervous system are easily disturbed, digestion is imperfect, and the appetite lost or depraved (64).

In the same way that Isham is cold in her stomach, the nineteenth-century chlorotic experienced a lower body temperature. Furthermore, the population suffering from this disease continued to be primarily young women who had experienced menarche but who

at best found subsequent periods to be irregular and at worst suffered from amenorrhea.⁷

Isham was not the only noble woman documented as fighting this illness in the Early Modern era. She is, however, the only one who shares her experience firsthand in an extant journal. King details the fact that several young women had similar conditions documented and studied by medical professionals (376). One such woman is Anna, the daughter of a friend of doctor Johannes Lange, a physician well-educated in Early Modern understandings of female complaints (King, “Galen” 376). Knowing Lange’s background, Anna’s father consulted him regarding her illness with the hope of effecting a cure when so little had worked. The translations from Latin indicate that Anna is pale in her cheeks and lips ““as if bloodless”” (King 378). While Isham’s account clearly indicates the condition as a sickness affecting the female body, Anna’s father portrays it as afflicting her ability to make an advantageous marriage, according to Lange, in 1554:

You will have complained to me, your faithful companion, that your first born daughter, Anna, & now sad, is desired in marriage by many suitors, of great excellency and illustrious birth, and also with an abundance of wealth, descended by ancestry from your forebears not from your inferiors; whom you are compelled to refuse because of the weakness of your daughter. Neither is this as obnoxious to you, as that thus far none of the Doctors have been able to explain the internal cause & essence of her disease, and at the same time prescribe the treatment. (qtd. in Ruhräh 394)

In reading this account of Anna’s disease, one begins to understand just how much of a

⁷ Menarche, as defined by the *OED* is “The first menstrual period; the age at which this occurs” (“menarche”). Amenorrhea, as defined by the Oxford’s *A Dictionary of Psychology* is the “[p]athological absence of menstruation” (Colman “amenorrhea”).

concern this illness was for the chlorotic's family—they struggled to marry her as they “are compelled to refuse because of the weakness of your daughter”—and at the same time how much of a struggle the medical community faced in being unable “to explain the internal cause and essence of her disease.” With such descriptions, including her melancholy bearing, we encounter chlorosis as a threat not only to the woman and her family but also to her social standing and future security.

Anna's father plainly believed the doctor needed a detailed account of his daughter's condition to make an informed decision and help Anna regain her social cachet. Therefore, he lists her other symptoms in his letters. He also indicates that her skin color is not of as much importance as other complications, including the sadness and weakness. Lange further recounts in his letter back to Anna's father the symptoms indicating her chlorotic state:

[...] since the qualities of her face, which in the past year was distinguished by rosiness of cheeks and redness of lips, is some how as if exsanguinated, sadly paled, the heart trembles with every movement of her body, and the arteries of her temples pulsate, & she is seized with dyspnoea in dancing or climbing the stairs, her stomach loathes food and particularly meat, & the legs, especially at the ankles, become edematous at night.⁸ From these accidents indeed, & from the pathognomonic signs of the disease, which betray the cause and nature of the disease, point out its treatment, I marvel that old physicians do not know the cause & nature

⁸ Dyspnoea, more modernly referred to as dyspnea, is a symptom we also encounter with TB, as noted in the introduction to this dissertation. The *OED* defines it as “[d]ifficulty of breathing; laborious breathing” (“dyspnea”). Edematous is the adjective for edema, or swelling, as defined “a swelling in a body part caused by an abnormal accumulation of fluid in cells” (Garner “edema”).

of the disease. Although indeed they have not mentioned its name, which moreover contributes nothing to its treatment, that is nothing of importance [...] Nor has this disease a proper name, as much as it is peculiar to virgins, might indeed be called “virgineus,” which it is the custom of the matrons of Brabant to call white fever, or pale face & the fever of love: since every lover becomes pale, & this color is proper for a lover, although a fever very rarely is present. (qtd. in Ruhräh 395)

Several key words and phrases from Lange’s response intrigue those studying the pathognomonic signs of chlorosis. First, his focus on Anna’s loss of blood (indicated by his use of “exsanguinated”) and heart palpitations indicates she has symptoms of chlorosis that medical practitioners continued to study throughout the nineteenth century. Further, her struggles with breathing, or dyspnoea, and her disordered eating also reveal commonalities between her illness and that which afflicted nineteenth-century young women.⁹ However, of most interest to those studying the pathology of chlorosis is the fact that Lange shares that in the Early Modern era it did not have a “proper name.” Green sickness clearly stumped Early Modern doctors, and chlorosis continued to confuse medical practitioners of the nineteenth century.

Further, Lange’s response indicates one of the most common comorbid conditions of women experiencing illness in the nineteenth century. He writes that the paleness of chlorosis is associated with “the fever of love: since every lover becomes pale, and this

⁹ Over two hundred and eighty years later, in 1836, Dr. Samuel Ashwell writes with similar specificity about the symptoms of his patient Charlotte, who suffered from “palpitation, dyspnea, cough, pains in the chest and loins and between the shoulders.” Moreover, “[h]er legs are edematous: she has no appetite” (560). Here, Charlotte expresses many of the same symptoms as Anna, including swollen legs and disordered eating. The commonalities of these symptoms indicate the state of these women as chlorotic and further imply that over time neither the symptoms nor the diagnosis changed significantly.

color is proper for a lover, although a fever very rarely is present” (qtd. in Ruhräh 395). In so writing, Lange connects lovesickness with chlorosis, a not uncommon link. In fact, by the nineteenth century, many medical practitioners were linking lovesickness and chlorosis. Ruddock cites “long continued grief, unrequited love, anxiety, fright, or fatigue” as causes for chlorosis (69). Each of these causes comes into play as I examine novels and other texts in *Chapters 6* and *7*.

However, these medical accountings of diseases are not the ones that capture scholar and reader interest. Rather, it is the personal explanation Isham sets forth in the *Booke of Remembrances* that draws readers in even as they, too, wonder what disease she is suffering from based on her seemingly odd array of symptoms. The literary text appeals in a way that the medical one cannot due to the latter’s lack of intimacy with the afflicted individual. Perhaps if Anna were writing the letters to Lange herself, the medical report would carry its own allure, but without that first-person perspective, much detail is lost in the female-to-male communications. Readers grow absorbed in Isham’s struggles and begin to identify with her as a strong figure, while Anna’s ailment, distanced from the patient herself as a result of the male and medical gazes, becomes a list of outdated symptoms that read more clinically than Isham’s personalized accounting.

As noted earlier, the general population affected by green sickness during the seventeenth, eighteenth, and nineteenth centuries is inarguably that of wealthy, young females. Further, because of their beauty and sex as the cure connected to this disease, the comorbid condition of desire spread in a corollary fashion among the males, as documented by those who wrote, read, or listened to poetry and prose wooing these chlorotic ladies in public. This correlation is readily apparent in literary texts from these

centuries, beginning with poetry from the Early Modern era in which the diseased damsels in distress are offered salvation at the lascivious lechers' hands and extending to nineteenth-century texts in which marriage appears as a treatment for ill women. Edward Herbert's poem "The Green-Sick Beauty" provides another example:

Though the pale white within your cheeks compos'd,
And doubtful light unto your eye confin'd,
Though your short breath not from itself unloos'd,
And careless motions of your equal mind,
Argue your beauties are not all disclos'd,
Yet as a rising beam, when first 'tis shown,
Points fairer, than when it ascends more red,
Or as a budding rose, when first 'tis blown,
Smells sweeter far, than when it is more spread,
As all things best by principles are known,
So in your green and flourishing estate
A beauty is discern'd more worthy love
Than that which further doth itself dilate,
And those degrees of variation prove,
Our vulgar wits so much do celebrate.
Thus though your eyes dart not that piercing blaze,
Which doth in busy Lovers' looks appear,
It is because you do not need to gaze
On other objects than your proper sphere,

Nor wander further than to run that maze.
 So, if you want that blood which must succeed,
 And give at last a tincture to your skin,
 It is, because neither in outward deed,
 Nor inward thought, you yet admit that sin,
 For which your cheeks a guilty blush should need.
 So if your breath do not so freely flow,
 It is because you love not to consume
 That vital treasure, which you do bestow
 As well to vegetate as to perfume
 Your Virgin leaves, as fast as they do grow.
 Yet stay not here. Love for his right will call:
 You were not born to serve your only will,
 Nor can your beauty be perpetual.
 'Tis your perfection for to ripen still,
 And to be gathered, rather than to fall.

Here, Herbert portrays the desired relationship between chlorotic girl and lustful man as his speaker proclaims, “So if your breath do not so freely flow,/ It is because you love not to consume/ That vital treasure” (ll. 30-32). In these lines, the speaker alludes to the fact that so long as the beautiful maiden thus spoken to retains her “treasure” — her virginity, which allows her to marry and increase her social position — and does not allow it to be consumed, she will never be free of the disease.¹⁰ For Herbert’s speaker, the loss of

¹⁰ Here, modern readers can see the link between consumption and chlorosis form. The idea that chlorosis also consumed a woman, shortening her breath, links it with another disease which changed the physical

virginity paints a beautiful picture of perfumed “Virgin leaves” and blushing cheeks (ll. 30, 25). This imagery of the plant-like nature of the chlorotic is one that will come up repeatedly throughout the next chapter as we read about “Rappaccini’s Daughter” and the titular character’s plant-like associations.

For the men attracted to chlorotic girls, the loss of virginity and the act of sex bring out the perfection of a woman, transforming not only the females’ pallid features but also their standing as sexual beings as they transmute from chlorotic girl into healthy woman. The wearisome innuendo of the lovesick poet parrots the science of the time, which argued that sex and pregnancy were in fact the best cure for chlorosis. Lange writes that “marriage in itself often provides a cure for the symptoms” of chlorosis (qtd. in King 79). In more direct terms, King explains the science behind Lange’s claim, arguing that since pregnancy was viewed as the best way to restore balance to the young girl’s body, “marriage is simply the only socially acceptable situation in which the virgin’s body can be put under proper male control, opened, entered, and seeded” (79). Thus, supported by the science of the time, Herbert’s speaker entreats, “Nor can your beauty be perpetual. / ‘Tis your perfection for to ripen still, / And to be gathered, rather than to fall” (ll. 33-35). Scholars can see here one last rhetorical attempt on the part of Herbert’s speaker to sway this perfect beauty towards sex, implying that she can either sow her sexual oats or die as a result of her disease despite the cure being so near at hand.¹¹ He invokes plant imagery again, focusing on the idea of gathering the ripe woman

appeal of a woman—pulmonary tuberculosis. For more on TB and the symptoms with which it presented, consult *Chapter 2* of this project.

¹¹ This carpe diem idea of enjoying oneself while death is near recalls the attitude of the revelers in Poe’s short story, “The Masque of the Red Death,” making another connection between chlorosis and consumption.

and deflowering her in order to cure her illness. Concentrating instead on the plant imagery and his allusions to sex, Herbert's speaker mentions the idea of premarital sex as a sin only once towards the end of the poem (ll. 25). So, while society may judge the woman for her loose behavior, the male speaker still encourages it, seemingly out of a concern for the diseased but truly out of desire to have sex with the chlorotic in question.

The cure for green sickness is not without its problems, however, as evidenced by the literature from this era. Not only does the green-sick beauty have a disease, Herbert shares, but she has one over which she can exercise no control. Instead, the illness manipulates her body, forcing her to succumb to the man's lust if she wants to be cured. The speaker reminds his beauty that she has no true free will when it comes to the desires of her body, tauntingly stating, "Love for his right will call" (ll. 31). It is easy to see, then, from these persuasive, lewd, and often jesting lines, that there is another cure for green-sickness aside from the dietary and spiritual ones Isham employs; the green-sick beauty can become sexually active and then procreate to restore the flow of blood in her body. However, even in this cure there lies danger as the chlorotic woman might soon become pregnant and thus exposed to the risks of childbearing in the Early Modern era, including societal censure if she remains unmarried. The question of course then become one of side effects: is it better to bear a child, pleasing society and one's family, and potentially die as a result or is it better to suffer with chlorosis, a disease which on its own caused no deaths?

Thomas Carew attempts an answer that is far more explicit than Herbert's as he, too, campaigns for sex as a cure. The speaker in Carew's poem "On Mistris N. to the Green Sickness" outlines in detail not the beautiful benefits of sex but rather the

detriments of avoiding sexual intimacy despite its restorative effects on the pallor of the skin:

Stay coward blood, and doe not yield
 To they pale sister, beauties field,
 Who there displaying round her white
 Ensignes, hath usurp'd thy night;
 Invading thy peculiar throne,
 The lip, where thou shouldst rule alone;
 And on the cheek, where natures care
 Allotted each an equall share,
 Her spreading Lilly only growes,
 Whose milky deluge drowns thy Rose.
 Quit not the field faint blood, nor rush
 In the short salley of a blush
 Upon thy sister foe, but strive
 To keep an endless warre alive;
 Though peace doe petty States maintain,
 Here warre alone makes beauty reign.

He proclaims of his pale subject's fading beauty, "Her spreading lilly only grows, / Whose milky deluge drowns thy rose" (ll. 9-10). Carew draws here on the symbolism of the lily: "the lily is an emblem of chastity, innocence, and purity" ("lily") and also a white (or pale) flower. The maiden's purity — or lily — grows as she resists the men who attempt to seduce her, but so does her likelihood of getting ill. Green sickness

creates a physical threat for this maiden just as her virginity presents a physical barrier to the speaker's seduction. Early Modern readers and modern scholars can clearly delineate alternate readings of these lines. Even as he describes, metaphorically, the girl's lily-like pallor, Carew discourses on the actual practice of sex, with the speaker discursively pushing past the boundaries of the spreading female genitalia to ejaculate in a restorative "milky deluge." If she has sex, the erstwhile virgin's color will be restored, as will her full beauty, and the speaker will accomplish his goal. For Carew, in his cure for green-sickness, everyone gains as long as the restrictive nature of society's values regarding the pure woman is glossed over.

At a time when women were considered to have little to recommend them outside their looks (if they were beautiful), wealth (if they were rich), physical labor capabilities (if they were poor), and health (so they could bear children), it is easy to understand that the writers of the Early Modern era evidently felt that their flattering words about beauty and suitors would prove persuasive enough to sway young, chlorotic girls to ruin. However, each of these male speakers fails utterly to consider the other important facet of a young woman's character: the regard she has for her virtue as a result of social standing and religion. King writes on this subject, claiming that for a young maiden, her "virginity is both socially desirable and medically dangerous" (387). It is dangerous to be a virgin because of the desires of opportunistic men. More importantly, however, virginity puts women at risk for chlorosis, which causes a host of painful symptoms and endangers their looks and health, as well as opportunities to marry well (thus jeopardizing their long-term security and ability to cultivate further wealth).

Unfortunately, while virginity could create a complex series of symptoms in the

young female, it was also socially and religiously advantageous, meaning that wealthy women awaiting marriage were put in an uncomfortable position between illness and wellness. Isham makes it clear in her writing that her stance on sin is strict and unforgiving, which means she would have been averse to premarital sex on the basis of the religious teachings of the era. Soon after the lines in which she records her first experiences with green-sickness, Isham writes of her sins and repentance, stating that God “reclamed me knowing in what case I began to be in which might haue bene a soule sinne and shame unto me but now hath been a warning to me euer sence“ (17v). She is referencing here her earlier bouts with green-sickness and her subsequent indecorous behavior, which involved a variety of “sinne[s]” ranging from overeating to being cruel to her ailing mother (17v). Her comprehension of what she sees as a warning and ensuing remorse are genuine. Therefore, it is unlikely that these smaller infractions would build to what she sees as larger ones, like the loss of her virtue. For Isham, the fear of retribution for her sins carries a stronger weight than the need to be cured from an unfortunate and painful condition, indicating that while she might believe sex is a genuine cure—after all, she has no cause to doubt those men who profess to understand medicine—she fears divine retribution.

Anna’s experience with chlorosis offers further perspective regarding the discourse of premarital sex and societal censure as Lange offers Anna’s father his aid in helping Anna avoid the trap of seduction and ruin while still curing her disease. Her father admits to Lange that his daughter’s disease is affecting her ability to select a man for marriage, as quoted: “you are compelled to refuse [her suitors] because of the weakness of your daughter” (qtd. in *Ruhräh* 395). Anna may be beautiful, but she is also

weak, and this weakness causes instability in her family, who desires—and potentially even needs—her to make a successful marriage and contribute resources as opposed to being a “drain” on her family. The need to restore his daughter to health, and thus build their family’s position in society through an advantageous marriage, spurs this father to contact Lange for his medical expertise. Lange, in turn, utilizes Hippocrates’ ancient techniques of medicine, including bloodletting, to prescribe medical care for the ailing girl (King, “Galen” 379). This doctor then ends his letter full of advice to his friend in which he recommends that Anna marry over all else—ignoring the fact that she is currently prevented from doing so because of her illness—stating that he would be more than happy to attend the wedding (King, “Galen” 381). Scholars again encounter the cure for chlorosis as marriage instead of merely sex. For a noble woman to maintain her tenuous position in society, she must be married to engage in sexual intercourse. Therefore, Lange advises wedlock, knowing that sexual intercourse and likely pregnancy and childbirth will follow.

Each treatment presented to Isham, Anna, and women like them starting in the Early Modern era and continuing through the nineteenth century must be considered to determine their rate of success. First, according to King’s article, is bloodletting (“Galen” 381). Because medicine in the Early Modern era was focused predominantly on the need to balance the humors, the removal of blood deemed to be in excess was considered practical. Isham’s repeated references to humors are relevant in this context, as is the balancing of blood in the poetry of this era. For example, in one such text, the speaker proclaims of the spread of blood throughout the body that every portion is “[a]llotted each an equal share” (Carew ll.8). As mentioned in this dissertation’s introduction, those

living in this era considered balance in all bodily fluids important in order to maintain the stability of the body. In fact, while marriage—followed by sex and conception—was considered the best cure for chlorosis, bloodletting was viewed as one way to “return stability to the unruly uterus,” thus compensating for the lack of a menstrual flow and affecting a temporary cure, if nothing else (Potter, “Drama” 382). This desire for balance in the body continued into the nineteenth century. Ruddock explains that the “function of menstruation is one probably by which the blood is freed from morbid elements; but when this function ceases, or becomes irregular, the perturbed nervous system induces disordered digestion, and the balance between secretion and excretion is lost” (52). Once again the focus on a woman’s agitated nerves and the relationship between the exclusively female functions of her body—such as menstruation—is the focus of diagnosis and thus treatment. Therefore, the recourse to bloodletting was seen as a way to restore balance to the female body and void “morbid elements.” Furthermore, this treatment provided a “cure” that removed sexual relationships from the equation, allowing a woman to retain her purity when marriage was not convenient or advantageous.

The second cure that Hippocrates and, through him, Lange, promotes is the most common and has been mentioned previously. The idea that marriage and conception could cure a chlorotic woman persisted through the nineteenth century (King, “Galen” 381). This cure also focuses on the circulation of blood; through the spreading of the “lily” that Carew writes about and breaking of the hymen, blood will resume its normal flow and conception will be possible (King, “Galen” 379). The population in general understood this cure as simply another way to balance the humors so that blood could

flow evenly to each extremity. However, if blood did not spread evenly, chlorosis could worsen. Potter writes about this dilemma, stating that since the chlorotic girl is “sexually mature” her “ripeness is now a risk factor in her health” (“Drama” 382). This “ripeness” was a serious concern for anyone who had this disease and easily explains the desperation of Anna’s father not only to get her married to one of her suitors but also to affect a cure for her through pregnancy and childbearing. This concern also carried through to the nineteenth century, when socially advantageous marriages were still important and sexual purity before marriage was considered a necessity.

Potter explores this Early Modern family dynamic further, especially in regard to the presentation of chlorosis in drama. She examines how the presence of this disease provides additional contexts for analyzing socialization within the family and larger society. Potter claims that “dramatists use the threat of green-sickness as a trigger for paternal concern and the introduction of family dynamics” (382). If scholars consider this use of the disease in relation to historical Early Modern parent-child relationships, we can not only understand Isham’s obedience to her parents but also the relationship between Anna and her father outside of the mercenary and noble marriage boundaries. Potter continues on these lines, claiming that as a result of these relationships in early dramas, “the audience will be alert for signs of sexuality in the girl [...] and for developing family conflict” (382). By starting with her green-sickness and then progressing to her mother’s illness and death, Isham unconsciously mirrors this development in her own writing.

By the nineteenth century, this familial dynamic was under further investigation. Nancy Theriot, in “Psychosomatic Illness in History: The ‘Green Sickness’ Among Nineteenth-Century Adolescent Girls,” focuses on this relationship, explaining how

chlorosis comes to be a part of mother-daughter relationships (462). Theriot explains the reasoning for the impacts mother-daughter relationships had on the disease. She notes this effect resulted from a shift from the patriarchal rulings of green-sickness to the mother-daughter dynamics established towards the end of the nineteenth century (466). Furthermore, this correlation between mother-daughter relationships and the disease also rests uneasily alongside an increase in diagnoses of anorexia, which allowed chlorosis to begin “to disappear as a disease” (Theriot 464). As the daughters viewed their mothers’ rounded forms, and began to make decisions for themselves instead of allowing society to dictate to them, they started to resent the metaphor of feminine suffering that their mothers had, for all intents and purposes, accepted (Theriot 469).¹² They no longer wanted the same things as their mothers—family, social status or stability, and subjugation to men; they wanted careers, educations, and, most importantly, control over their own lives. Chlorosis—and by the end of the century, anorexia—became a way for a daughter to control her body’s growth as well as her future (Theriot 474). Isham’s acceptance of her disease and the suffering that ensued had officially been replaced by something seemingly different but in actuality much the same as before: negative reactions to puberty and the developing feminine form.

There is another commonality that appears as a result of chlorosis in Isham’s and Anna’s stories. Each of them experiences shortness of breath when climbing up the stairs. In Anna’s case, her father claims, “the girl Anna ‘has an attack of dyspnoea when

¹² Often, physicians associate the disordered eating portion of chlorosis with the modern diagnosis of anorexia nervosa (King, *Disease 2*). King explains that if a seemingly-chlorotic girl came in for treatment, modern medical practitioners “would focus on the eating patterns, not worry unduly about the absence of menstrual periods, quiz the sufferer about her body image, and most probably diagnose anorexia nervosa” (King, *Disease 2*).

dancing or climbing stairs” (King, “Galen” 384). Lange explains that this attack is a blockage of blood in her arteries, which causes “rapid, shallow breathing,” supporting the fact that one of the symptoms of chlorosis is heart palpitations (King, “Galen” 384). Again, Anna and her father will have to consider each of Lange’s treatments to determine which one will work for her. Isham’s father, on the other hand, already believes he has encountered the solution to the shortness of breath. Because Isham is reputed to have green-sickness—with its resulting heart palpitations and dizziness—her father requests that she run up and down stairs at intervals (17v). Presumably, he does this to test the severity of her symptoms. Soon after, he grows rather doubtful of her condition because Isham’s “wind was so good” (Isham 17v). While Anna’s cure or lack thereof is not recorded, Isham’s condition does grow better through home remedies. It is not long after her initial report of the disease that she pronounces herself cured, writing of her mother’s death to say, “I was the better able to bare it because I had ouercome that dull desease of the green sicknes before she died” (19v). This seems to show, then, that the home remedies are at least of some success, particularly when influenced by the family dynamics of the patient.

Other family dynamics are not as helpful in caring for the chlorotic. The less therapeutic, more marriage-focused parent-child dynamic is shown in the relationship between Juliet Capulet and her mother and father in Shakespeare’s *Romeo and Juliet* (1597). As the play progresses, Juliet’s relationship with both of her parents disintegrates as a result of her newfound headstrong nature. Because she is a noblewoman of a marriage age, she should be more agreeable with her parents’ wishes than she is, despite the freedom she might want (Vandereycken & van Deth 188). However, Juliet is not the

typical Early Modern female. Instead, she resists her parents' machinations to marry her to her cousin Paris. This resistance causes her relationship with her parents to decline further as they attempt to force her into marriage towards the end of Act III, Scene v, when Juliet informs her mother, "He shall not make me there a joyful bride!/ I wonder at this haste, that I must wed" (ll.117-18), to which Lady Capulet responds, "Here comes your father. Tell him so yourself,/ And see how he will take it at your hands" (ll.124-5). In this conversation we see a stubborn Juliet attempt to circumvent her father's plans, noting that they seem hasty, while her mother responds that this circumvention is Juliet's problem and thus her daughter must refuse Capulet's plans on her own as she cannot understand why Juliet is resistant. In fact, Lady Capulet becomes so frustrated by her daughter's willful nature that she tells Capulet, "I would the fool were married to her grave" (ll.140), uttering lines which are ultimately full of foreshadowing.

Capulet does not take the news of Juliet's lack of desire to marry much better. In fact, by the end of their discussion, his anger builds and he calls Juliet a variety of names which are among some of Shakespeare's most famous insults even today:

"But fettle your fine joints 'gainst Thursday next
 To go with Paris to Saint Peter's Church,
 Or I will drag thee on a hurdle thither.
 Out, you green-sickness carrion! Out, you baggage!
 You tallow face!" (ll.153-57)

Ostensibly, the above lines indicate the most prevalent deterioration of the Capulets' relationship with their daughter; however, they also provide the biggest clue to Capulet's haste, which Juliet has pondered earlier. Towards the end of his ranting, he calls his

daughter a “green-sickness carrion,” implying that not only does she have some semblance of chlorosis but also that she is rotting away.¹³ In examining the first part, the disease, we can see why Capulet is in haste to marry his daughter off as chlorosis was understood to be cured only by marriage and procreation. Therefore, to restore her health—and his family’s chances for advancement—he can kill two birds with one stone and rush Juliet to the altar. The second part of this insult is a more pointed shot at the fact that while Juliet is unmarried, she is useless, decaying on the metaphorical shelf, instead of helping to provide for her family with an advantageous marriage as a woman of her class should.

A possible second reading exists for the Capulets’ treatment of their daughter. Perhaps as loving, if misguided, parents they are afraid of what will happen if her green sickness is not cured. King argues that for Juliet, her greensickness is a direct result of her virginity and Capulet’s haste to have her married off because “while virginity, as physical integrity, may express autonomy and power, it is highly dangerous to maintain it beyond its proper season” (*Disease of Virgins* 81). Therefore, it is likely the Capulets see Juliet’s illness, recognize what it might mean for her, and desire to have it rectified as quickly as possible, thus bringing in once again the idea of Capulet’s haste. However, while we can understand King’s perspective, we must also acknowledge that not only does Capulet’s haste benefit his daughter, it of course aids him, too, as he will gain further prestige following her marriage. Thus, the complicated relationship among class, parent-child dynamics, and disease presents itself for the first time in relation to the illness that by the

¹³ Juliet is not Shakespeare’s only character inflicted with green sickness. Falstaff in *Henry V* is also reputed to have this illness as are several others including Desdemona from *Othello*. However, Juliet’s case is by far the most clear. For more on other Shakespearean characters with green sickness, or chlorosis, see Robert F. Fleissner’s “Falstaff’s Green Sickness Unto Death.”

nineteenth century medical minds call chlorosis.

While the poets, Shakespeare, Ashwell, and Lange all share some views in common regarding the disease and its treatments, Isham seems to stand alone in the Early Modern period for her and her father's unique, restorative methods—methods that would become more popular in the nineteenth century. For the most part, Isham attempted to cure her disease through diet. She tried everything from eating seeds to chewing on “bitter orringe pilles without sugar” to eradicate the “coldnes” of her stomach (17v).¹⁴ She also keeps away from spices in an effort to calm her digestive system, particularly after eating meat (17v). In the nineteenth century, dietary complications again arose in the chlorotic girl with King implying a connection between chlorosis and eating disorders when she writes that sometimes a young girl going through puberty would reduce “her food intake too radically” (*Disease* 100). By the end of the century, however, this symptom became its own diagnosis as chlorosis lost its footing in favor of anorexia as the new nutritional deficiency. Vandereycken and van Deth write in *From Fasting Saints to Anorexic Girls: The History of Self-Starvation* (1994), “[i]n the same period in which physicians related chlorosis to anaemia and no longer considered absence of menses and eating disorders to be chlorotic symptoms, anorexia nervosa acquired a permanent place within medicine” (243). While this diagnosis of anorexia as separate from chlorosis or hypochromic anemia is problematic as it ignores the fact that iron-deficiency can itself be

¹⁴ The reason Isham treats her chlorosis in this manner instead of through marriage is due to the complicated familial relationships in her home at this time. When Isham officially acknowledges that she has the disease, she is also facing her mother's far more severe disease. While, the specific illness her mother has contracted is unclear—though Isham offers reasons ranging from birthing children to old age—an adequate picture of this unnamed disease is still apparent. Isham writes that her mother “would complane of coldnes saying she had truly undergone the infermities of olde age” (17v). Scholars encounter a unique dynamic here that allows Isham to simultaneously create a discourse about two illnesses while offering explanations that would keep her close to home to care for her mother and the rest of her family in her mother's place instead of being sent off to marry.

the result of an eating disorder, it does allow for an explanation for why the diagnosis of chlorosis began to disappear.

Even though Isham never labels her treatments with names like therapy and exercise, modern readers recognize commonalities between her attempts to find a cure and those treatments developed by nineteenth-century medical professionals. Therapy and exercise, according to King, were used as a combined treatment through the nineteenth century but actually had their roots in regard to chlorosis much earlier. She writes, “[d]ietary adjustments were used from the sixteenth century onwards, with behavioral therapy: the rest cure and exercise” (*Disease* 124).¹⁵ However, as the nineteenth century progressed, electricity also appeared as a treatment option, hitting its peak between 1880 and 1890 (King, *Disease* 124). Many believed the use of electricity alleviated symptoms in the chlorotic but, perhaps more importantly, ““has been followed by a speedy cure”” according to one nineteenth-century physician (qtd. in King, *Disease* 125). Thus, the nineteenth century saw not only an increase in cases but also in potential cures for chlorosis.

From the various perspectives on chlorosis and treatments, one can begin to comprehend the effects this disease had on female populations from the Early Modern period to the nineteenth century. With the multiple cures, symptoms, and social structures that occur in tandem with the disease, we can understand why this illness drew not only medical but also literary attention. Chlorosis may have harmed the populations it affected, via the men who wanted to “cure” it, but it also proved a rich source of exploration in medicine and familial relationships. It is an Early Modern disease that

¹⁵ For more information on the rest cure, see *Chapters 8 - 10* on hysteria, particularly the section on S. Weir Mitchell and “The Yellow Wall-paper” by Charlotte Perkins Gilman.

carries with it a considerable relation to diseases society faces today, such as anorexia and hypochromic anemia. Therefore, if one studies green-sickness and its treatments, then one is also exploring the diseases of the past as they relate to those found in the modern period.

Despite its shifting nomenclature and because of its long history, portrayals of this illness, which in Early Modern literature range from the lewd to the ludicrous, are mirrored in nineteenth-century writings. Based on these literary portrayals and medical records about the disease, we note that the symptoms and presentation of chlorosis did not noticeably change over 300 years. Additionally, in each medical or fictional account of chlorosis, from the Early Modern period to the nineteenth century, there is a common thread of privileged patients that allows readers to further understand the classist components of a society interested in studying this disease. These stories of chlorotics in fiction and nonfiction, then, create an impact on the socialization of ill women within and without society throughout the time during which they were written. Bearing this impact in mind, *Chapter 6* offers several close readings of literary texts from the beginning to the middle of the nineteenth century. Each text reveals young women who exhibit signs of chlorosis. Using these young women's experiences, the chapter explores the ways in which chlorosis functions within the plot of each text and the ways in which the medical gaze further pathologized this illness. Then, *Chapter 7* closes with a study of the relationship between lovesickness and chlorosis, examining how grief plays into this diagnosis.

As a result of this section's focus on chlorosis as it spans a long stretch of time, I look at several works throughout that period and consider how they relate to one another.

Having provided the necessary background of the Early Modern understanding of chlorosis and those texts which contributed to that understanding, I move away from these works towards the nineteenth century. *Chapter 6* opens with a study of Jane Austen's *Pride and Prejudice* (1813) in order to understand how we continue to look at chlorosis in the twentieth and twenty-first centuries as compared to the nineteenth century. I then examine Nathaniel Hawthorne's short story "Rappaccini's Daughter" (1844) as a means of exploring the sometimes plant-like imagery of chlorosis as well as the sexualized othering that chlorotics experienced as a result of their symptoms. After I analyze these works in conjunction with one another, *Chapter 7* examines the ostensible heart conditions of female protagonists in Bram Stoker's *Dracula* (1897) and Henry James's *The Wings of the Dove* (1902) to show how these conditions have underlying roots in the medical and cultural histories of chlorosis.

*Chapter Six: Green Gardens: Expressions of Chlorosis in
the Early to Mid-Nineteenth Century*

By the start of the nineteenth century, family dynamics were changing in the rapidly industrializing Western world. Arlene Skolnick addresses this progression of family relationships in “Changes of Heart: Family Dynamics in Historical Perspective.” She explains that by the nineteenth century, shifts in family were “closely linked to a set of rapid social and economic changes that took place,” noting that these social and economic changes

...led to a profound alteration in the functions and cultural meaning of family life, in the roles of men, women, and children inside and outside the household, as well as in the relations between family and society. With the industrial revolution, work and family work was no longer based in the home. As men left home to work in offices, stores, and factories, family roles were restructured. Further, the new household functions and the new roles within the family were elaborated in a compelling and pervasive belief system that has been labeled the “cult of domesticity” or the ideology of the “separate spheres.” The glorification of motherhood, and the notion that “women’s place is in the home” were born in this era. (Skolnick 53-54)

Thus, outside influences—both economic and social—were coming into the home at the same time that women were still largely confined to it. However, these changes came more slowly for women than they did for men; married women were still subject to the idea that motherhood and housework were “seen as an expression of women’s selfless, spiritual nature, not as work” (Skolnick 58). Skolnick further indicates that due to these

continued misperceptions about the effort women put into childrearing and maintaining the home, “large numbers of women suffered from a host of psychological and psychosomatic maladies” (58). We need look no further than chlorosis for an example of how these maladies manifested and were further influenced by shifting gender roles and expectations. Then, by tracing these influences, we can examine the reactions society in general and women specifically had not only to their shifting roles but also their popular diagnoses.

As suggested in *Chapter 5*, one of the most distinctive aspects of chlorosis is the influence of familial relationships. Because of these shifting dynamics throughout the nineteenth century, the lives of children varied dramatically from those of their parents. Gendered roles were delineated more clearly than ever before, and these distinctions led to friction in parent-child dynamics for those children who may have wanted something outside already established social expectations, such as a young woman seeking an education. These differences in experiences influenced the relationship the chlorotic young woman had with her mother and father because of their separate lived experiences and the relationship she had both with her own body and the societal expectations for that body, which typically included motherhood and work in the domestic sphere. As shown in *Chapter 5*, this difference becomes clear in both biographical and fictional texts from the Early Modern era, as Dr. Langes’s patient, Anna, and her father’s concern prove, as well as with Elizabeth Isham’s relationship with her own parents and Juliet’s quarrel with her mother and father in *Romeo and Juliet*. These familial reactions to shifting familial roles continue throughout the long nineteenth century and can be seen in works such as

Jane Austen's *Pride and Prejudice* (1813) and Nathaniel Hawthorne's "Rappaccini's Daughter" (1844).

Nancy Theriot explains part of this connection between illness and the experience of the female chlorotic with her parents, articulating that "chlorosis was an indication of mother / daughter stress and adolescent ambivalence about adulthood at a time when mothers' and daughters' worlds were becoming increasingly different" (467).¹ The idea that a daughter might be ambivalent about her choices—marriage and family or spinsterhood—would not be a shock to modern readers; however, in the nineteenth century people affected by this ambivalence would be surprised by the young woman's expressed uncertainty regarding marriage and childrearing. If we consider, for example, the rise of the middle class and the ways in which shifting class structures impacted perceptions of upper-class superiority and also take into account the changing views regarding marriage, motherhood, and women's rights, it is no surprise that young women suffering from chlorosis, a predominantly female diagnosis, found themselves in the midst of these struggles over changing social and family dynamics. Further, if we consider the father's reaction to these changes and the lengths he might go either to shield his daughter, as does Hawthorne's Rappaccini, or cast her off, as occurs in *Romeo and Juliet*, we cannot help but empathize with the conflicted, chlorotic woman.

The complex intersectionality of parent-child, class, and social expectations feeding into expressions of chlorosis does not fade by the end of the Early Modern era. In fact, if anything, these intersections intensify due to shifting social stratifications and

¹ In "Psychosomatic Illness in History: The 'Green Sickness' Among Nineteenth-Century Adolescent Girls," Theriot makes this and several additional arguments about the shifting of gender dynamics in the nineteenth century and the ways in which these shifts impacted the psychological components of chlorosis.

women's rights movements. Juliet was ahead of her time, a harbinger of further social issues to come. However, the disease was still defined in similar terms with regard to symptoms and expressions; Theriot describes the symptoms of chlorosis in *Mothers and Daughters in Nineteenth-Century America: The Biosocial Construction of Femininity* (2015): "Besides the age and sex of its sufferers and the expectation of recovery, the most outstanding features of the disease were amenorrhoea (the absence of menses), a disturbed mental state, a pronounced disturbance of appetite [...] and a tendency to relapse in the third or fourth decades of life"² Theriot also focuses on the influential nature of the mother-daughter relationship, clarifying that one possible reason for the increase in chlorotic young girls in the nineteenth century was "the chlorotic girl [...] simply trying to approximate the maternal generation's ideal of feminine beauty" (*Mothers* 106). Phrased another way, the chlorotic girl ended up diseased in an effort to appease her mother's old-fashioned ideas of beauty.

Chlorosis, as shown in *Chapter 5* and as a continued theme in this chapter, then, was a disease which afflicted women set to make advantageous marriages; in other words, it was a disease of the higher, more established classes. In fact, in 1795 John Coakley Lettsom wrote the brief treatise "Hints Respecting the Chlorosis of Boarding-Schools" which was, interestingly, his follow-up to "Hints Respecting the Distresses of the Poor." In this work on chlorosis, Lettsom turns his attention to the higher classes, focusing first on chlorosis's symptoms and presentation before moving into treatments, which included a complicated mixture of salt of iron, gum myrrh, salt of wormwood, and nutmeg water (8). However, it is when Lettsom writes about exercise that we encounter

² King also comments on this phenomena, explaining that older women who experienced this diagnosis were treated for "late chlorosis" or "chlorosis tarda" (8).

direct points about class and movement: “Exercise is so essential to the restoration of this class of patients, that, whatever remedies are recommended, this must be a concomitant” (10). Thus, those who could afford time to exercise, and a doctor’s treatment—mostly the wealthy—had to be prescribed activity, something the less well-to-do used daily in their active work lives. While chlorotics of higher classes languish, chlorotics of lower classes (such as Miss R. mentioned in *Chapter 1*) anguish over when their ability to move and breathe easily might be restored since many of the available treatments were actions they already performed regularly. As a result, the treatment of chlorosis became less about one specific regimen—such as exercise, procreation, or iron pills—and more about class distinctions accompanied by corresponding shifts in nomenclature.

Regardless of the patient’s class, however, symptoms of the disease were established as similar among women. As the nineteenth century progresses, we see the anemic young woman’s symptoms become synonymous with her disease. Because in some diagnoses, chlorosis was referred to by name and in others was simply called by one of its symptomatic presentations, such as amenorrhea, medical practitioners began to presume the disease was strictly one of somatic manifestations brought on by the social changes in a woman’s place as mentioned above (King, *Disease of Virgins* 57). Here, however, we again have to assume that the women who could afford the prominent physicians who published their findings on the disease were of a higher class and so their presentation of symptoms are the ones that get recorded.³

³ Further, the complicated nomenclature—referring to the disease as chlorosis, green sickness, white fever, and anemia as mentioned in *Chapter 1*—means that those who did not have access to medical texts or were illiterate, and thus likely of a lower class, may not have picked up on the changes in nomenclature as quickly and thus would also have incomplete medical records, if they had them at all.

Despite the inconsistent nomenclature and the uneven study of symptoms, scholars can still learn about chlorosis in eighteenth and nineteenth centuries by studying medical documents and literary texts written during this time frame. In a text published in London in 1786, for example, Dr. John Aitken writes about chlorosis, observing that this disease or “(green-sickness) is an asthenic state, incidental to the younger subject, and much connected with irregular menstruation” (136).⁴ He concludes that the disease manifests in symptoms such as dyspepsia, a decreased appetite, sluggishness, paleness, edema (swelling), and syncope (or fainting), among others (137). Aitken ends by noting that to cure chlorosis, “passive menorrhagia” is best (137).⁵ Although he does not explain how this blood flow can be restored, based on other studies from the time period, we can assume that bloodletting was employed either through cupping or leeching.⁶ Jerome Gaub, a physician practicing by the start of the nineteenth century, published additional information about chlorosis that modern scholars continue to study. Gaub argues that chlorosis is related to melancholy and lovesickness. His point is commented on by scholar L. J. Rather who notes that these ailments were closely linked for Gaub (150).⁷ Rather further indicates, however, that the main symptoms of chlorosis to study are the “digestive and nervous disturbances” that young girls who have developed chlorosis

⁴ For more on what an asthenic state might involve, see the introduction to this dissertation (*Chapter 1*), particularly where hysteria is defined. To recap: an asthenic at the time would have referred to a state in which the patient is weak or debilitated. Thus, asthenic became a frequent term to coincide with a disease centered squarely around young women with disordered appetites who were cured largely through a prescribed shift in their blood flow.

⁵ Menorrhagia is, according to the *OED*, “[e]xcessively heavy or prolonged bleeding during menstruation” (“menorrhagia”).

⁶ *Oxford Reference* defines cupping as a noun, meaning “the traditional Chinese practice of applying a heated cup to the skin and allowing it to cool, which causes swelling of the tissues beneath and an increase in the flow of blood in the area. This is thought to draw out harmful excess blood from diseased organs nearby and so promote healing” (“cupping”). In some cupping practices, the skin is cut first to allow the blood to leave the body, but in others, as the one shown above, it is not.

⁷ A modern scholar, Rather has compiled Gaub’s work into *Mind and Body in Eighteenth Century Medicine* (1965).

would experience (151). From these medical specialists we can conclude that chlorosis in the late eighteenth century was much like chlorosis during the Renaissance.

Having investigated the disease from the doctor's point of view, we can turn our attention to a closer inspection of the signs, symptoms, and cures of chlorosis from the perspective of women in the eighteenth and nineteenth centuries who suffered from symptoms indicating chlorosis. With an understanding of how precisely the disease makes itself known to female sufferers, we can then look at how these symptoms are reflected in the literature of the time. With this in mind, we need to consider the fact that several scholars note the importance not only of a loss of blood but also the resulting paleness in chlorotic patients. King writes that this idea of paleness in illness started as early as the fourth century when "blood was believed to rush towards the heart, away from the surface of the body" when one was feeling strong emotion, thus tying the ideas of lovesickness and chlorosis together, just as Gaub did (39). Theriot explores further the concepts forming about chlorosis by the start of the nineteenth century, explaining that it was just beginning to be tied to psychosomatic ailments and anorexia ("Greensickness" 462-63). She argues that "many recognized the malady as a 'nervous disorder' and some even identified malnutrition as the most significant symptom" ("Greensickness" 464). Thus, we can see a picture of general symptoms emerge that includes disordered eating, pallor, trouble with nerves, and irregular blood flow.

While many symptoms of this disease were consistent across diagnoses, treatments were much more varied. In the beginning of this disease's history, treatments ran the gamut from marriage and pregnancy, as we saw in *Chapter 5*, to antidotes for poison as medical practitioners believed that chlorosis was "a form of internal poisoning"

(King, *Disease* 26), something we see in my below examination of Beatrice Rappaccini. By the start of the nineteenth century, however, doctors who diagnosed their wealthy patients with chlorosis had even more options for treating their disease. Jan Marsh writes that popular treatments for many diseases in the Victorian age included a “‘change of air’ (to the coast, for example), together with emetic and laxative purgation and bleeding by cup or leech (a traditional remedy only abandoned in mid-century) to clear ‘impurities’ from the body” (“Health & Medicine” n.p.). She explains that although nineteenth-century Britons and Americans may have been great medicine takers, as Loudon contends, there was still only a “limited range of medication” available, which led to “the power of prayer” often being invoked (Marsh “Health & Medicine” n.p.). Specific treatments for young women with chlorosis, however, tended to focus on which symptoms were most obvious when the patient met with her doctor. In one instance, for example, a doctor noted that chlorosis was occurring in patients who had a body weight of “95 pounds or less” and so prescribed a “high protein diet” (Theriot, “Greensickness” 465). Additionally, as many young women experienced shortness of breath and fainting in tandem with their chlorosis, medical practitioners cautioned against “the practice of tight corsetry” despite its popularity at the time (Hudson 457-58). Another treatment the medical establishment recommended as a result of this shortness of breath was exercise. Despite—or perhaps because of—the multitude of options available for suffering young ladies, sometimes many treatments had to be tried and combined to meet with success.

Because of the population it affected as well as the fact that there was not an agreed-upon, go-to treatment method—though of course interest was spiked by the association between chlorosis, lovesickness, and sex—this illness captured the interest of

the population at the time, finding its way into textbooks, artwork, and literature. In fact, based on the textual and cinematic representations of one of Austen's lesser-known—and lesser liked—characters from *Pride and Prejudice* we can conclude that Anne De Bourgh exhibits signs of chlorosis provided we also acknowledge the historical background regarding diseases and cures in Austen's time. One of the most-read novels of the nineteenth century, *Pride and Prejudice* examines the combined nature of treatments for chlorotic symptoms. In this novel Austen's characters of the higher classes exhibit unexplained illnesses that leave them quiet and withdrawn—as is Georgiana Darcy—or sullen and placated—as is Anne de Bourgh. While Miss Darcy's causes for concern are eventually explained by her caring older brother, Anne's illness remains a mystery for the duration of the novel. Sometimes presumed to be nothing remotely serious by unsympathetic Austen characters, perhaps even a bid for attention, and other times thought to be everything from a means of escaping her mother to a more serious concern, Anne's condition is intriguing. I posit, based on her physical presentation of symptoms, her social class, and the descriptions provided by other characters, that Anne de Bourgh exhibits signs of chlorosis. Moreover, if we think of Anne as attempting to please an ill mother, just as Elizabeth Isham did some centuries before her, we may have all the explanation we need for why Austen attributes to the younger woman symptoms of the illness as a means to examine, and for her readers to examine, the increasingly complex family dynamics of the nineteenth century.

Characters generally describe Anne's physical appearance in mainly negative terms. In fact, the only ones who praise her looks are her mother and Mr. Collins, both of whom have a vested interest in her appearing better than she actually does. However, our

first introduction to Anne describes her in flattering terms and comes directly from Mr. Collins, who claims “Miss De Bourgh is far superior to the handsomest of her sex” (46). He soon after states that she is also “of a sickly constitution” but that she is nevertheless “perfectly amiable, and often condescends to drive by [his] humble abode in her little phaeton and ponies” (46). Immediately, readers realize that not all is well with Anne but are confused by Mr. Collins’s misleading representation of her; is she sick or is she well enough to drive around in her phaeton? Later, upon watching Anne sit outside in her carriage, Elizabeth shares her (also potentially biased) opinions of the young lady, thinking that Anne “looks sickly and cross” (106). Not long afterwards, Elizabeth meets Anne face to face and expands on her initial conclusions about Anne’s personality, marveling with Maria Lucas that Anne was “so thin and so small” (108), thereby linking Anne’s appearance to that of a much younger girl, or one who is wasting away from her lack of appetite, a symptom mentioned in *Chapter 1*. She further describes this initial encounter, noting that “Miss De Bourgh was pale and sickly; her features, though not plain, were insignificant; and she spoke very little, except in a low voice” (108). These portrayals are important to consider in relation to Anne’s position within society as a woman of a solid upper-class standing who lives in the country and appears to have little to no contact with any outside locales or persons, thus leaving her susceptible to her mother’s domination.

By the Victorian era, as previously mentioned, society and medical practitioners assumed that “all adolescent girls were potentially chlorotic,” according to King. However, the prevalence of this diagnosis is not enough to attribute the ailment to Anne De Bourgh. We must also consider the symptoms that have been mentioned above as

well as Lady Catherine De Bourgh's own analysis of her daughter's illness. In her typically overbearing manner, Lady Catherine expounds upon her daughter's lack of appropriate accomplishments for a young lady of the time as if this lack itself is an accomplishment. Talking about musical inclinations, Lady Catherine says: "If I had ever learnt, I should have been a great proficient. And so would Anne, if her health had allowed her to apply. I am confident that she would have performed delightfully" (115). Thus we see the first connections between a parent and a child symptomatic for chlorosis simply because of her age and social class weave their way into Austen's novel.

In her analysis of the psychosomatic and familial issues that can lead to chlorosis, Theriot considers the possibilities of mother-daughter conflict and its contribution to daughters experiencing the disease.⁸ The problematic nature of growing into adulthood for a young woman was, no doubt, due in part to Theriot's previously-cited point that the lives of women in the nineteenth-century were becoming increasingly different from their eighteenth-century counterparts ("Greensickness" 467). For an overbearing woman like Lady Catherine who is quite clearly stuck in the past century, then, the effort to control her daughter and avoid these differences would be strong. Theresa Kenney supports this assertion with her interpretation that Anne's "physique also helps to give the reader the sense that Anne is completely dominated by her mother" ("Anne Smiles" n.p.). Further, Elizabeth's earlier impression of Anne as "so small" plays into this chlorotic trope as a commentary on her diminutive frame and the protracted adolescence of a chlorotic. Considering her lack of marriage proposals and her mother's characteristic domineering, narcissistic style as well as the way societal expectations for women were shifting around

⁸ While Theriot's study does focus on the latter half of the nineteenth century, there is no evidence it cannot be applied to the earlier half, and in particular, to Anne's own case.

them—even just the idea that Anne’s beau was interested in another woman, of a lower class—indicate a change in the ideals of the time to which both Lady Catherine and Anne would have needed to adapt. Austen’s imposition of these symptoms—evidence of a disease of previous centuries—onto Anne heightens the sense that these characters need to adjust as it is a disease of the previous centuries still finding its way into nineteenth-century parent-child dynamics without a conclusive cure.

The dynamic between herself and her mother that Anne’s illness exposes provides an interesting subtext in the middle portion of the book by way of the symptoms she exhibits. Scholars argue that Austen writes about Anne’s disease as a way to show ideas of “dominance and submission” (Gorman 198) by comparing Anne not only to Elizabeth but also to her mother.⁹ Anne’s submission becomes very apparent, as do symptoms of her illness, when we read the scene in which her companion, Mrs. Jenkinson, is attempting to get Anne to “try some other dish” as she feared Anne “was indisposed” (109) and Anne submits, despite her disordered appetite. This scene portrays well not only Anne’s previously mentioned submission but also one of the most common symptoms of chlorosis: an unusual appetite. Loudon explains that a “constant feature of chlorosis was a ‘capricious or depraved’ appetite. This included anorexia, or at least a reduced food intake” (1672). After reading the scene at dinner between Anne and Mrs. Jenkins, with particular focus on Anne’s decreased food intake, there can be no doubt that this young lady suffers from chlorotic habits, if not the full-blown disease. Further, we should consider how her eating habits are perhaps attempts to assert control though she

⁹ Very few studies of Jane Austen’s *Pride and Prejudice* include any examination of Anne de Bourgh. In fact, as she is minor character, most scholars devote only a line or two to her presence, if they mention her at all.

eventually submits under her mother's watchful eye.

Our last encounter with her, if it can even be called that, also makes Anne appear chlorotic. When Lizzy, Maria, and the Collins family depart from Rosings, Austen writes that Miss De Bourgh “exerted herself so far as to curtsy and hold ou[t] her hand to both” (141) as if she could not rouse herself to do anything more. King explains that a weakened state is also a sign of chlorosis, probably due in part to the decreased appetite and anemia; she introduces the illness by describing it as a disease of “dietary disturbances, altered skin colour, and general weakness” (King 1). From the way in which Austen portrays Anne and her symptoms, then, it is not unreasonable to imagine she can be read as a chlorotic character between her sickliness, perhaps noticeable because her color has changed, her disordered eating, and her weakness. Thus, new readings of Austen emerge if we look at Anne as chlorotic. We can understand in her character as a more sympathetic figure, suffering quietly from the constraints of her class and gender, particularly those imposed by her mother, who often speaks for her. Anne's silence takes on new meaning, showing her submission as she communicates largely through weak gestures and moments of subtle resistance like the one mentioned above.¹⁰

Because of the ways in which Anne's mother dominates her, it is hard not to feel sad for the submissive chlorotic. Further, she is not the only chlorotic in literature dominated by a manipulative parent. In “Rappaccini's Daughter” (1844), Nathaniel Hawthorne explores the poisonous effects of disease as well as misguided attempts by

¹⁰ The idea of relapse that is cited from Theriot and mentioned in the introduction to this chapter is particularly interesting as we consider the mother-daughter relationship between Lady Catherine and Anne. While it is beyond the scope of this chapter to consider, the idea of relapse at an older age may hint at Lady Catherine's suffering from chlorosis and also show why she is so bent on making her daughter appear healthy. Further, we could also consider how this exhibition of renewed symptoms on the part of Lady Catherine may affect her daughter, Anne.

doctors to eradicate illnesses afflicting females, eliciting both the horror and empathy of his readers.¹¹ Because Hawthorne's story is set in the Early Modern era, we are able to examine the ways in which nineteenth-century society looked at the period in which chlorosis was established and the ways in which the underlying concerns about the female invalid and the effect her disease has on her relationships were keenly felt throughout the nineteenth century. "Rappaccini's Daughter" explores the intricacies of doctor-patient dynamics—a theme that is common in discussions of chlorosis—as well as parent-child relationships—another common trend in studies of chlorosis throughout the nineteenth century. While Hawthorne never explicitly writes that Rappaccini's daughter, Beatrice, has chlorosis, certain symptoms she expresses indicate that Hawthorne is interested in examining the poisonous nature of a woman's place in society.

"Rappaccini's Daughter" tells the story of Beatrice Rappaccini, a young woman, the daughter of a scientist, living in seclusion in Early Modern Italy. She has been, unbeknownst to her, slowly rendered poisonous as a result of her father's experimentations, thus he keeps her away from the male population as much for their own good as for hers. However, Beatrice falls in love with a young medical man named Giovanni and complications ensue as a result of her poisonous nature combined with her pretty appearance. Very early on in the story, we recognize that Beatrice is beautiful in a somewhat atypical way. Hawthorne's depictions of her as a beautiful flower hint that

¹¹ This theme is common in Hawthorne's romantic works. Consider the short story "The Birthmark" (1843) as well as his romance *The Blithedale Romance* (1852), both of which focus at least in part on the efforts of men to perfect the ideal woman with disastrous results. Further, Hawthorne uses the reoccurring theme presented here of a physician harming a patient through his care of said patient, as evidenced by the doctor-patient relationship in *The Scarlet Letter*. For additional insight into nineteenth-century doctor-patient relationships, see also: Anthony Cerulli and Sarah L. Berry, "Nathaniel Hawthorne's Warring Doctors and Meddling Ministers" and Rima D. Apple, *Women, Health, and Medicine in America*, specifically "Chapter 19: Physicians." For more on the complex relationship between the female patient and the male doctor, please see *Chapter 1* of this project.

Beatrice can be read as a chlorotic woman because of the similarities between this nutritional deficiency and one which affects plants. In fact, these portrayals bear a startling resemblance to those found in the greensick poetry of the Early Modern era discussed in *Chapter 5*.¹² Additionally, Beatrice showcases an Early Modern component in representations of chlorosis—a startling similarity to beautiful plants in need of pollination by male speakers implying the cure of sex for chlorosis. Hawthorne repeatedly writes that Beatrice refers to the plants in her father’s garden as her sisters because both the beautiful plants, her only companions, and the attractive Beatrice are poisonous, bonded not only by their proximity but also by their similarities: ““Yes my sister, my splendor”” she says in “rich tones” to a flowering bush, as she bends to embrace the plant, ““it shall be Beatrice’s task to nurse and serve thee”” (226). Only Beatrice can care for the poisonous plants in her father’s garden because Rappaccini has slowly—through some unclear medical means—inoculated his daughter with poison, thus making her immune to the plants’ dangerous effects as she becomes one of them, as poisonous as they are.

Interestingly, Hawthorne compares Beatrice to a flower throughout the short story as a means of not only introducing us to her illness but also to her social status. He writes, she was like “another flower, the human sister of those vegetable ones, more beautiful

¹² King cites Andrew Fogo, a nineteenth-century physician who equates chlorotic women to plants, flowers in particular, noting “Fogo uses many plant analogies based on the common idea that the menses are popularly called the ‘flowers’ because they appear at the proper season and wither when the ‘fruit’ sets, in that they cease when a woman is pregnant” (110). Further, this diagnosis of plants no doubt also arose because chlorosis was so prevalent during the nineteenth century. The *OED* explains that chlorosis was used as a diagnosis of yellow-green plants: “The loss of the normal green coloration of leaves of plants (esp. as a symptom of disease or disorder), caused by conditions which reduce or prevent the formation of chlorophyll, such as iron deficiency in lime-rich soils, disease, or lack of light” (“chlorosis”). This link between iron deficient plants and iron deficient women is nowhere clearer than in “Rappaccini’s Daughter.”

than the richest of them” (226). Here, as above in which Beatrice’s voice is described as crying in “rich tones” (226), the influence of class appears clearly. Furthermore, forms of the word “rich” appear twenty-two times in the story, with fifteen of those being used to describe Beatrice, either in reference to her appearance—“a young girl, arrayed with as much richness of taste” (226); voice—“her rich voice that came forth as it were like a gush of music” (232); or perfumed scent—“there was a fragrance in the atmosphere around her rich and delightful” (238). Beatrice—the daughter of a well-known scholar and doctor—is set above the flowers as a rich feast for the senses. Her beauty is equated with her status, and neither is found lacking.

When we first encounter Beatrice, she is described as a young woman at the peak of health. The first time Giovanni sees her fully, for example, Hawthorne writes:

Her face being now more revealed than on the former occasion, he was struck by its expression of simplicity and sweetness; qualities that had not entered into his idea of her character, and which made him ask anew, what manner of mortal she might be. Nor did he fail again to observe, or imagine, an analogy between the beautiful girl and the gorgeous shrub that hung its gem-like flowers over the fountain; a resemblance which Beatrice seemed to have indulged a fantastic humor in heightening, both by the arrangement of her dress and the selection of its hues. (230)

The plant connection once again comes to light in the above passage as Giovanni notes precisely how much his love resembles the greenery around her, and even seems to be playing on that resemblance. Further, it would seem her health and bloom are clearly strong and thus audiences are to admire her as they read about Giovanni observing her

“simplicity and sweetness,” once again seeming to link chlorotic symptoms to a childlike attitude as characters do with Anne de Bourgh. However, by the end of the story, Beatrice is weakened, clutching her hand to her heart, as she asks her father, ““wherefore didst thou inflict this miserable doom upon thy child?”” (251). Readers must therefore wonder what shifted so dramatically in this story as to allow for such a change in Beatrice’s appearance. The onset of disease provides the answer.

But how can a chlorotic woman compare to a plant, and in fact why would this comparison be an understandable one? Hillary Nunn examines this comparison in “On Vegetating Virgins: Greensickness and the Plant Realm in Early Modern Literature,” which studies women and their experiences as somewhat indicative of a chlorotic woman during the era in which this story takes place. Nunn writes, “plants and people shared at least some biological characteristics” (159). Nunn links the relationship between plants and people to chlorosis explicitly, writing, “[t]he era’s plant-derived representations of greensick women portray those suffering from the disease as largely inhuman, estranged from their socially constructed bodily destiny, and squandering the fertility so key to their biological niche” (162). Thus, just as a person would grow weak from limited sunshine and air, so too would their plant counterparts if denied these necessities. In fact, this connection between the inhuman chlorotic losing her color and the plant became so pronounced that by 1805, the diagnosis for paling plants was also diagnosed as chlorosis (“chlorosis”). Near the close of the nineteenth century, J. Christian Bay explored this link between diagnoses of chlorosis in plants and people in “The Plant and Its Relation to Iron” (1893). He writes that studies “on chlorosis showed that deficiency of iron in the protoplasm of any plant which may be subject to chlorosis causes a general pathologic

state of the plant” (312). Further, Nunn explains that this pathologic state leaves the plant “a vegetable counterpart to anemia” (171), an apt description that shows just how important Hawthorne’s use of sunlight, iron, and air become in combating the chlorosis of Beatrice and her plant sisters.

As Hawthorne’s story progresses, Beatrice’s relationship with one of her plant sisters becomes particularly emphasized. Jonathan Cook in “The Biographical Background to ‘Rappaccini's Daughter’” notes this dynamic, arguing that Beatrice seems especially close to the purple-flowering bush (224). Hawthorne describes this poisonous, blooming plant in Rappaccini’s garden as “set in a marble vase in the midst of the pool, that bore a profusion of purple blossoms, each of which had the luster and richness of a gem; and the whole together made a show so resplendent that it seemed enough to illuminate the garden, even had there been no sunshine” (224). Again, this plant-based depiction focuses not only on beauty but also on wealth as indicated by the expansive pool set with a marble vase and the phrase “richness of a gem.” Cook argues that this description is lifted in part from Sophia Peabody Hawthorne’s journal before she married: “‘The petals open! And reveal a sanctuary of exquisite beauty, from which comes forth an overpowering perfume like musk’” (qtd. in Cook 56). While Cook appropriately grasps that this illustration is important—note again the focus on sunlight and lack thereof—“suggesting the quasi-sexual allure of the purple-blossomed shrub in Beatrice’s Rappaccini’s garden” (156)—he shies away from a more in-depth look at what this sexualization might mean. However, those familiar with chlorosis cannot help but be attracted to further study of both Beatrice’s and the plant’s allure and the “perfume like musk” that surrounds them both. In these two manifestations of toxicity in the story, we

see organisms that are simultaneously enticing and deadly. The plant is as poisonous in its pure form as Beatrice is in hers—both will lure men in with disastrous results.

Beatrice's toxicity arises from the plants around her as they simultaneously poison her so that mankind cannot be with her—thus ruining her chances for procreation as a cure for chlorosis—but also protect her against that same mankind as they will not be able to take advantage of her innocence, kind nature, and wealthy status. However, her toxicity has negative consequences for more than just the men courting her. At one point in Hawthorne's story, Beatrice encounters a "beautiful insect" (231). As the story continues, we are treated to an unfortunate occurrence: "while Beatrice was gazing at the insect with childish delight, it grew faint and fell at her feet; its bright wings shivered; it was dead" (231-32). In this brief incident of the bug and the poisonous woman, we can draw a connection between the chlorotic and society. As the chlorotic refuses efforts to marry her off—much like Juliet—she becomes less appealing to the society she rejects, thereby rendering any chance she has of marriage unlikely, losing in the process social stability and approval. The chlorotic, then, is a dangerous woman because she may not want to marry; she may not want society's approval, either. She is moving with the times and laying to rest the outdated expectations of a changing nineteenth-century society that finally has some options for women besides exclusively marriage and childrearing. The chlorotic woman, then, is as toxic to the social order which has existed for centuries as Beatrice is to the beautiful insect.

Unfortunately, her beauty and virginity are not the only facets of her person which put Beatrice in danger of being chlorotic. She also is tightly "girdled" in a metaphorical sense, but there is no reason to imagine she is not also literally corseted. In Poskitt's

“Early History of Iron Deficiency” she explains that some medical texts claimed tight binding of a woman’s corset would exacerbate symptoms of chlorosis: “Lettsom (1795) had attributed chlorosis to tight stays among other issues” (558). In fact, as mentioned earlier in this chapter, Lettsom’s text on chlorosis is particularly useful for studying the disease from a class standpoint. In his treatise on chlorosis in boarding schools, he cautions:

The custom of wearing stays must hence appear a monstrous appendage of female attire, as most unhappily calculated to press upon and injure the parts so essential to the health of the sex and their offspring. It is no unnatural inference to ascribe the Chlorosis, the female weaknesses, perhaps even cancer and various uterine diseases, in some cases to pressure from this cause. The uterus is cramped from taking its necessary evolution and growth; and consequently pregnancy and parturition, instead of being easy changes in the constitution, become real pains and diseases.

(20)

Here, being a man of his time and station, Lettsom quickly focuses on the idea of a woman with chlorosis having difficulty becoming pregnant as he mentions first offspring and secondly the “easy change” of pregnancy and childbirth. He looks at chlorosis as problematic to (preserving) society and thus recommends cures for it. In focusing so closely on chlorosis, Lettsom gives us the first indication of why male doctors may have been moved to study the disease in the first place while other “feminine” ailments got no such consideration. Chlorosis is once again shown to be toxic to the social order and hierarchy of classes as a chlorotic upper-class woman cannot bear children while a

healthy, less corseted lower-class woman would presumably not struggle as much.

Because the Beatrice is confined to the garden, her captivity essentially guarantees her maiden condition. Rappaccini's rival, Dr. Baglioni, explains that Beatrice is a lady "whom all the young men in Padua are wild about, though not half a dozen have ever had the good hap to see her face" (229). Thus, given that virginity is presumed in part to lead to chlorosis, Beatrice is exposed to the possibility of getting chlorosis simply because she is not in contact with the male population of Padua. This lack of contact guarantees her maiden status, which means it is unsurprising that she expresses symptoms of the disease "peculiar to virgins" (qtd. in Guggenheim 1822). In addition to her virginity being an influencing factor in regard to the potential for developing chlorosis, the nature of her confinement provides additional breeding grounds for the disease. In fact, Guggenheim explains that physicians in the nineteenth century believed chlorosis could result from "deficient air, exercise, and light" (qtd. in Guggenheim 1823). Even though Beatrice has access to light, her air is poisoned by her own breathing and that of the flowers' toxic fragrances and her exercise is limited to the small garden and attached house as she never leaves them. Thus, the protection of Beatrice's maidenly virtue by containing her in a small courtyard garden is in fact harming her by limiting her exposure to these same components.

Despite the fact that Beatrice is kept in relative seclusion, she is still encountered by some within the city. In fact, Beatrice's appeal is not lost on the young medical student, Giovanni, who finds himself spending more and more time in her company as the story progresses. First, the prospect of marrying her seems to allow him certain benefits as he wants to be a doctor and she is the daughter of a renowned one. This

potential marriage exposes the class structure of the nineteenth century and the problematic nature of upward mobility through marriage. Secondly, the attraction between Giovanni and Beatrice offers Hawthorne a chance to condemn the shallow nature of nineteenth-century society's obsession with the beauty associated with disease.

Because chlorosis was an endemic disease, populations tended to experience the disease in waves. In fact, eventually Giovanni himself appears chlorotic as a result of his time with Beatrice. Towards the end of the story, he turns to stare at himself in a mirror and realizes "his features had never before possessed so rich a grace, nor his eyes such vivacity, nor his cheeks so warm a hue of superabundant life" (246). He comments to himself on his beauty only to realize his breath, like that of his lover's, now has the power to kill as it wilts the flowers in his hands. With this realization, our lovely youth's color fades: "Giovanni grew white as marble" (246), not unlike the other chlorotic beauties who pale as their disease progresses. It is soon after this moment that the purple-flowered shrub makes another appearance as Giovanni himself mirrors Beatrice's earlier actions and leans towards it "himself inhaling the fragrance of the flowers" (248). He is well and truly seduced in part by Beatrice—"a healthy angel" (247)—and in part by the plant, which appeals to his own poisonous state and sexual frustration.¹³

Because Beatrice's toxicity also affects Giovanni, he decides to find a remedy. To do so, he consults Professor Baglioni for an antidote and is provided with "a medicine, potent, as a wise physician has assured me, and almost divine in its efficacy" (250). Beatrice, far from being assured, determines to try this "divine" cure first to protect her

¹³ Here again we see a connection between the ill woman and spirituality as Giovanni is drawn to compare Beatrice to an angel. Further, however, we notice the danger of leaving chlorosis untreated. The longer Beatrice remains unmarried, the closer she is to becoming a healthy angel—presumably removed to heaven—instead of a healthy woman living in society and fulfilling her role in the social order.

love. The antidote proves too much for Beatrice and she begins to die as the poison her body has grown accustomed to leeches from her. Her aforementioned feeble inquiry to her father, ““wherefore didst thou inflict this miserable doom upon thy child?”” (251) reflects what readers are wondering at this point: why did Rappaccini poison his own daughter, his only child? Perhaps, much like Dr. Peabody, Sophia Hawthorne’s father, and the father of Anna who wrote to Dr. Lange at least a century earlier, Dr. Rappaccini was simply trying to cure his daughter of a terrible condition with poisonous symptoms of its own. In fact, King writes that “green sickness operated as a form of internal poisoning” (*Disease* 26) just as Lettsom mentions the ways in which it is closely linked to other diseases which prohibit a woman’s internal systems from operating properly. Thus, it is possible that in incorporating the poisonous plants into his daughter’s life, Rappaccini was not just experimenting with botany but also with a cure. Ironically, he has only exacerbated his daughter’s symptoms.

While society critiques Rappaccini for his treatment of his daughter, that same society does not view his daughter with empathy. Instead, due to her unusual nature and intellect, society studies and critiques Beatrice Rappaccini carefully, connecting her to the plants with which she associates so closely. Brumberg writes that the “coexistence of both disease and physical attractiveness among chlorotics was also a telling reflection of the state of medical and scientific knowledge” (1472). This “telling reflection” is indicative of the biases inherent in the male-dominated medical profession as studied by Foucault and as indicated by the relationship not only between Beatrice and her father but also between her father and his relationship with his rival, Professor Baglioni. While we do not get much of an introduction to Baglioni, we know he is a friendly man “of genial

nature, and habits that might almost be called jovial” (Hawthorne 227). Hawthorne depicts him very differently from his rival, Rappaccini, who is described as in possession of “a face singularly marked with intellect and cultivation, but which could never, even in his more youthful days, have expressed much warmth of heart” (225). Therefore, we can trust to some degree Baglioni’s reading of Rappaccini based solely on the fact that he is of a far more kind nature as compared to Rappaccini.

Hawthorne never explicitly states from what the rivalry between Dr. Rappaccini and Professor Baggolini stems. He does, however, provide readers with clues and intimations regarding the troubling nature of these men’s estrangement. When Baglioni cautions Giovanni against a relationship with the Rappaccini family, he hints at the problematic nature of Dr. Rappaccini’s studies, noting that despite that same doctor’s skill, many in Padua and beyond offer “certain grave objections to his professional character” (228). Thus, Hawthorne appears to set Baglioni up as the foil to Rappaccini because many understand Baglioni, a doctor and professor of medicine himself, to be a “a physician of eminent repute” (227). Soon after Baglioni indicates more directly what is troubling with Rappaccini’s scientific bent, noting that many say Beatrice has been taught by Rappaccini ““deeply in his science, and that, young and beautiful as fame reports her, she is already qualified to fill a professor’s chair”” (229). The problematic notion of an educated woman disturbs Baglioni. He is afraid of Beatrice’s intelligence—he tells Giovanni that because she is so qualified, her father might desire Beatrice for his chair as a professor (229)—and this fear is not uncommon among medical men of the day. In fact, one of the risk-factors for getting chlorosis was often thought to be an over-educated woman, just as education was one of the fears associated with hysteria (King, *Disease*

122). Thus, Baglioni's rivalry with Dr. Rappaccini isn't limited to the doctor himself, but also to his budding botanist daughter.

If we position "Rappaccini's Daughter" as a critique of medical professionals in the nineteenth century, we cannot fail to recognize Hawthorne's chastisement for what it is—a denouncement of the medical community's propensity to label women sufferers as either attractive or overeducated as a means of not studying further their female patients' symptoms. Here, society understands women's pain as attractive, and thus medical men see their illness as a benefit. The diseased woman will attract a man and marry well, and quickly, especially if these same medical professionals assign procreation as part of her treatment regimen. On the other hand, if the intelligent woman sickens, the physician can prescribe rest and a turn away from her studies in the form of S. Weir Mitchell's Rest Cure or something similar.¹⁴ Thus, once the ill woman can no longer study, read, and learn, her threat to their "professor's chairs," their jobs, and their social order is neutralized.

Cerulli and Berry touch on the treatment of female patients by nineteenth-century physicians when they write that the competition between the two doctors in "Rappaccini's Daughter" reveals "Hawthorne's larger commentary that ideological competition among medical men bears significant consequences, which inevitably play out among unwitting subjects, such as aspiring students and the young women who take medicine" (121). However, this critique makes it seem as though only women took medicine during this century—and only men practiced it which invites its own

¹⁴ The Rest Cure is addressed in more detail in the chapters on hysteria as scholars of medicine most often associate it with neurasthenic or hysterical woman due to S. Weir Mitchell's medical foci.

problematic line of thought.¹⁵ Cook goes a bit further in studying the ways male doctors inflicted medicine on their female patients. He writes of Hawthorne's own experiences with the doctors who treated his often-ill wife, Sophia, noting that she bears a marked resemblance to Beatrice, as Sophia's father was also a doctor who treated his own daughter, much as Rappaccini did (42).¹⁶ Sophia's sister, Elizabeth Peabody, claimed Sophia's invalidism came from the "drugs administered by her father to her as a baby experiencing the pain of teething, in keeping with the current 'heroic' system of medical treatment that involved large doses of purgative and emetic drugs" (Cook 42-43).¹⁷ However, while both articles in some way touch on this issue of female patient care, neither directly interacts with the problems Brumberg points to in a general sense: the medical men look at these beautiful women and are so blinded by their appeal that they fail to grasp the severity of their patients' symptoms.

Rappaccini's personality makes it difficult to read him objectively, however, especially as we consider his last words to his dying daughter:

"Dost thou deem it misery to be endowed with marvelous gifts against which no power nor strength could avail an enemy—misery, to be able to quell the mightiest with a breath—misery, to be as terrible as thou art beautiful? Wouldst thou, then, have preferred the condition of a weak woman, exposed to all evil and capable of none?" (251)

¹⁵ Women were practicing medicine and getting degrees by this time in many parts of the developed world. see Laura Lynn Windsor's encyclopedia *Women in Medicine* for a comprehensive and chronological approach to women practicing medical careers, including as midwives, physicians, and surgeons.

¹⁶ Interestingly, Sophia Hawthorne's own family thought she was too sickly to marry and attempted to keep her at home to avoid complicating her illness (Cook 40).

¹⁷ Donald G. Bates defines heroic medicine as a distant cousin of the Hippocratic and Galenic methods of practicing medicine, noting that "'Heroic' medicine did not involve any basic change in theory or practice, but rather the vigorously increased application of such things as purging and bloodletting, as advocated, for example, by Benjamin Rush" (502).

Rappaccini's inability to empathize with Beatrice here shows not only the danger of the medical gaze but also the problematic nature of the female patient-male doctor relationship as evidenced by his misunderstanding of his daughter's "misery," a word echoed three times in this speech. First, due to the medical gaze, Rappaccini only looks at his daughter as someone who must be cured.¹⁸ She needs endowment of "marvelous gifts against which no power nor strength could avail an enemy" (251) so she can endure. Without these gifts, by implication, Beatrice would be entirely unable to survive. Therefore, Rappaccini isolates what he perceives as her problem. Secondly, Hawthorne cleverly attacks the female patient-male doctor relationship when he has Rappaccini call other women "weak" and "exposed to all evil but capable of none" (251). Here, Rappaccini clearly indicates the bias he holds in regard to females; they need to be fundamentally, biologically changed from "weak" women to something terrible and beautiful in order to be worthy of praise. Thus, he believes Beatrice will be pleased to be "as terrible as thou art beautiful" (251). By not consulting with his female patient—and his own daughter—Rappaccini has made the same mistake as many other doctors and parents; he has presumed to know what was best and has been wrong, with deadly results.

By the end of Hawthorne's story, there is little doubt regarding the author's attitudes towards both inept fathers and doctors.¹⁹ Beatrice's last lines prove this point

¹⁸ The medical gaze is studied and explained in the introduction to this dissertation.

¹⁹ In addition to his wife suffering from illness, Hawthorne's daughter Una suffered from psychological disturbances—sometimes referred to as "brain fever" (Herbert 292). As a result of the author's inability to understand what plagued his daughter, Una and her father had their own complicated relationship. T. Walter Herbert explains, "Una's psychological difficulties arose not because her father had imposed the external necessity of returning to America but because the potential conflict between them spoke to the cultural contradictions inherent in her experience of herself" (292). Una was maturing into womanhood during a time in which expectations of women were changing and she was reacting accordingly. Herbert also compares her to the Beechers (mentioned in *Chapter 4* on TB and *Chapter 10* on hysteria) and Alice James (mentioned in *Chapter 9* on hysteria). For more, see Herbert's article, "Nathaniel Hawthorne, Una Hawthorne, and *The Scarlet Letter*: Interactive Selfhoods and the Cultural Construction of Gender."

when she tells her father, standing up for herself for no doubt the first and last time, ““I would fain have been loved, not feared”” (251). Here Beatrice indicates that for all his dedicated medical experimentation on her—and despite all of his assumptions about what she might want—Rappaccini never provided the thing Beatrice desired most, love. Further, when she sought that love from others, Rappaccini’s experimentation on her also impacted those she desired to attract, from the small insect all the way to Giovanni. Further, he used his daughter to test theories about human and plant biology, maintaining a distance from both his daughter and her sister plants. In fact, his distance is so calculated that when he is in the garden, he is observed as “one walking among malignant influences, such as savage beasts, or deadly snakes, or evil spirits, which should he allow them one moment of license, would wreak upon him some terrible fatality” (225). The socially-constructed fear of the ill or unusual woman comes across here through Hawthorne’s use of words like “malignant” and “savage,” as embodied by Beatrice and her “sisters.” They are to be feared as they have in some way deviated from society’s norms. It is important to note, however, that it was not Beatrice’s choice to be poisoned by her father any more than it was an anemic woman’s decision to attract men as the result of her chlorosis. Thus, while doctors may examine chlorotic women and find much about them to blame for their disease, Hawthorne appears to have no such motivations.

What this chapter depicts, then, is the problematic nature not only of medical professionals in the nineteenth century who studied chlorotic women but also the social stricture placed on those same women, including their suitors’ desire to “cure” them. If chlorosis had been a less visible disease, perhaps women in the early nineteenth century could have suffered more privately, able to still pursue those things that interested them.

However, much like Elizabeth Isham and Juliet Capulet of more than a century earlier, chlorotic women of the nineteenth century were treated as attractive sufferers, often confined to marriage, exercise, and an avoidance of more intellectual pursuits. Thrust into the positions society placed on them, these same women found conflict not only within their body but within their society as they resisted their parents' notions of what both ill and healthy women of a certain class should do and how they should appear, particularly in regards to retaining their virginity until marriage to make an advantageous match. In the next chapter readers encounter the ways in which a resistance to standard notions of medicalized beauty were born out of symptoms of chlorosis as seen in Bram Stoker's *Dracula*. Further, I explore the means by which a chlorotic girl could circumvent society, as illustrated by Milly Theale in Henry James's *The Wings of the Dove*.

Chapter Seven: Green with Envy—The Difficult Experience of a Lovelorn Chlorotic

From the long history and wide-ranging symptoms of chlorosis, readers can easily see how this illness played on society's anxieties about diseased women. In the Early Modern era, a disease like chlorosis physically inhibited a woman's chances of marrying as it made her ill and unable to leave her home with any degree of comfort even while also making her more sexually appealing to the men she felt too ill to marry. In an attempt to cure these women and also avoid drastic social change, however, doctors of this era determined that marriage and childbearing were the best means of eradicating chlorosis. Because they believed childbirth restored the natural flow of bodily fluids in chlorotic women experiencing, among other symptoms, amenorrhea, it became the most often prescribed treatment, removing the threat of high-class women engaging in premarital sex by allowing the chlorotic woman to marry. However, as time progressed, shifts in care for the chlorotic occurred.

As medical science made advancements in cures, women were now treated with iron pills and suggestions for healthier lifestyles in addition to recommendations for marriage (Poskitt 558). No longer concerned exclusively with her marriage, however, the chlorotic suffered new societal pressures born from misunderstandings about gender-specific disease in addition to expectations about how she would fulfill her role in society. Adding to the chlorotic's health problems were the struggles she faced in getting not only her doctor and loved ones but also the larger society to understand her plight. Too often dismissed as symptomatic of her nerves, when subjected to the male gaze, or the result of a weakened heart, according to the medical gaze, the disease the chlorotic

woman faced made her life more difficult, especially when it was compounded by misunderstanding and misdiagnoses.

As mentioned in the previous chapter, one of the most common comorbid conditions to appear alongside chlorosis was an affliction diagnosed as lovesickness or love melancholy, which seemingly arose from the symptoms the chlorotic patient expressed. From the Early Modern era onwards, medical professionals often associated the diagnosis of chlorosis with some form of thwarted or repressed love, not unlike diagnoses of their hysterical and tubercular counterparts. Part of this connection between the emotionally ill lover and the chlorotic arose from the expression of symptoms in the patient. Helen King explains in *On the Disease of Virgins* that society considered both emotion and unrequited love “to play a role in the development of chlorosis” (36). However, I argue that the nineteenth-century medical and fictional literature shows chlorosis was diagnosed as a result of the male gaze directed at the anemic woman to fulfil the romantic ideal of the damsel in distress. With the chlorotic, according to the nineteenth-century mindset, only a man could save her from her illness by impregnating her or by prescribing the correct medical regimen. However, if a woman was left untreated, she suffered from weak blood and became lovesick.

In addition to the gendered, and therefore often stereotyped or biased, components of the disease, there was also a classist component to these ailments. As King explains, both lovesick and chlorotic women were thought to turn a yellow or greenish color, which arose in part from “excess wealth and leisure” (37). Medical minds and nineteenth-century society at large further associated chlorosis with wealth—those women who have little money and resources cannot afford to be picky about their diets—and leisure—those

women who need to work for their living are well used to exercise as most often in the nineteenth century they were employed in some form of domestic service. Additionally, scholars find the jaundiced or green color particularly interesting to study in regard to lovesick, chlorotic women. King cites Shakespeare, noting that green is called “the color of lovers” in *Love’s Labour Lost* (37). She further explains that “paleness is the colour most appropriate for a lover,” showing that the yellow tinge must indicate some sort of love or love repressed (37). Further, the connotations of green in terms of envy (the chlorotic has an enviable beauty), plant life (the chlorotic is new or green when it comes to courtship and her womanly curves; she is like a freshly blossomed flower), and youth (as mentioned, most chlorotics are young, recently having experienced puberty) are hard to miss here. Thus, the patient’s colored complexion can indicate the status of her health, emotional state, age, and position as a lovely young woman.

Finally, by the end of the nineteenth century both chlorosis and lovesickness were thought to have arisen in part from the weakened condition of the patient’s heart. In the case of lovesickness, it was an emotionally weakened heart presenting with a “feverish pulse” (qtd. In King 118). For chlorotics, as medical advances were made, the disease was understood to arise from a misshapen or damaged heart, complete with systolic murmurs, an impaired mitral valve, and shortness of breath (King 121).¹ However, we must recognize that in the nineteenth century, the complex link between mental and physical health was just beginning to be understood, and chlorosis was one of the

¹ Blakemore and Jennett describe systolic murmurs as part of stenosis (“heart sounds”). They write, “[s]tenosis, for example, of the aortic valve leads to an abnormal turbulence during ejection of blood through it from the left ventricle, so it is a systolic murmur because it occurs during the phase of contraction (systole), preceding the second heart sound at the closure of the valve” (“heart sounds”). The mitral valve is “[t]he bicuspid valve between the left atrium and left ventricle of the heart. The valve prevents backflow of blood from the ventricle to the atrium during ventricular systole” (Kent, “mitral valve”).

diseases at the forefront of this understanding. In fact, in his study of chlorosis, Robert Hudson remarks, “[c]hlorosis serves as a reminder of the complex interplay with cultural and social elements in the production of human pathology” (456). Thus, the pressure to marry, have children, and be domestic and demure that society exerted on young women also played into this understanding, complicating the connection between diseases and the bodies in which they manifested. In light of this new pathologizing of illness in the later nineteenth century, this chapter focuses on the codependent relationship between lovesickness and chlorosis in Bram Stoker’s *Dracula* (1897) and Henry James’s *The Wings of the Dove*. In particular, the study of the symptoms and death of Stoker’s Lucy Westenra and James’s Milly Theale illuminates the conversation surrounding chlorosis, lovesickness, and heart complications. By studying Lucy and Milly as diseased—potentially chlorotic—women exposed to the male gaze and society’s expectations of the female gender, we are able to explore this emerging understanding of human pathology and the ways in which the dominant groups in society influenced it based on their stereotypes and biases regarding women.

Lucy Westenra, in *Dracula*, is not often recognized for her chlorotic characteristics. Because she is regularly assumed to be just the victim of Dracula’s basest desires, little focus is given to the effects of his attraction to Lucy. The first effect of this attraction combined, no doubt, with the fresh country air and exercise is Lucy’s heightened beauty. Mina notes in her diary that the first time she sees Lucy after a long absence, her friend “was looking so sweetly pretty in her white lawn frock; she has got a beautiful color since she has been here” (74). We can presume this beauty has in part attracted Dracula and due to her blood loss, society now considers her more attractive as

she models the chlorotic look. As the century ended, medical practitioners understood blood loss to be one cause of chlorosis as the disease's pathology unfolded—and thus her potentially chlorotic state. A second effect occurs when readers encounter her restless spirit, evidenced by her many bouts of sleepwalking, an activity in which no healthy woman of this era would willingly engage.² Lucy's friend Mina writes about one of these somnambulant moments in particular, focusing on how society would look on a woman found outside at night, in a state of undress, with little to no recollection of how she got there. Mina writes that “Before falling asleep” a somewhat nervous Lucy “asked—even implored—me not to say a word to any one, even her mother, about her sleepwalking adventure [...] and thinking, too, of how such a story might become distorted—nay infallibly would—in case it should leak out, I thought it wiser to do so” (103). When Stoker uses the nervous Lucy to key readers into the fact that something is causing her to sleepwalk.

It is not surprising that Stoker understands sleepwalking has a set cause. In the nineteenth century, several factors affected understandings of sleepwalking. In *On Certain Conditions of Nervous Derangement, Somnambulism—Hypnotism—Hysteria—Hysteriod Affections, Etc.* (1881), William Alexander Hammond writes that the first cause of somnambulism arises from “a particular nervous temperament, which predisposes individuals otherwise in good health to paroxysms of somnambulism during

² See: “‘Kiss Me with those Red Lips’: Gender and Inversion in Bram Stoker's *Dracula*” by Christopher Craft for a source that focuses on how Lucy's restless wandering might have contributed to her illness: “Here four males (Van Helsing, Seward, Holmwood, and Quincey Morris) communally read a masculine text [...] in order to justify the fatal correction of Lucy's dangerous wandering, her insolent disregard for the sexual and semiotic constraint encoded in Van Helsing's exegesis of ‘God's women’” (118). Further, Craft also focuses on Lucy's blossoming attractiveness, which will be discussed in more detail later.

their ordinary sleep” (1).³ This information, connected with Stoker’s passage above, clearly indicates society’s fears about the woman who strays from what is socially acceptable. A woman whose health appears otherwise strong but is prone to sleepwalking at night must be experiencing something causing her to be nervous and / or stressed. Further, Lucy’s concerns upon waking about what might happen to her—a pure, wealthy woman who wanders from her bedroom at night and the nasty speculations that might arise from association with such a woman—are echoed by Mina’s use of the word “distorted” to describe the societal censure and reaction to reports of such behavior. This diary entry therefore indicates how much society dominates over a woman’s life and experiences. Additionally, nightly escapades like those of Lucy, according to E. H. Ruddock in *The Common Diseases of Women* (1872), create the perfect breeding grounds for chlorosis as “anxiety, fright, or fatigue” (64) are all symptoms which contribute to this illness and, as evidenced by Mina’s diary entries, Lucy experiences each of these symptoms as the novel progresses.

Because it is unclear precisely why Lucy is nervous, her condition mystifies even the expert, Dr. Abraham Van Helsing, who has been called upon to help diagnose and get to the root of her problem. Van Helsing notes the first time he examines her that “there is no functional cause” despite the fact that she has lost a lot of blood (123). Thus, Lucy’s disease opens her up to many treatments and attempts to find a cure, subjecting her repeatedly to the medical gaze as she becomes a problem to solve. Because Seward calls Van Helsing in to help Lucy some subjection to medicalization of her symptoms is

³ The other three causes for somnambulism Hammond mentions include production if one has a disease (he does not specify which) (1). He also attributes it to animal magnetism, and finally, to mental exaltation (Hammond 1-2).

expected. However, readers do not learn for some time why Seward chose Van Helsing for this task instead of relying on his own medical knowledge. In fact, Stoker never explicitly mentions Van Helsing's medical specialization, although he does provide certain clues regarding the specialist's unique set of skills. For example, after an examination of Lucy's blood, Seward writes to Van Helsing, acknowledging that his mentoring doctor "knows as much about obscure diseases as any one in the world" (121).^{4,5} Soon after Seward sends this letter, Van Helsing arrives to perform his own examination. At this time, readers get another clue regarding Van Helsing's specialties. He examines Lucy, asking her jovially at one point, "How can he," meaning Dr. Seward, "know anything of a young ladies?" (123). Van Helsing further points out that his protegee may have trouble diagnosing Lucy because Dr. Seward "has no wife nor daughter" (123) and so is less capable of understanding the ailments that affect younger women. Thus, Stoker identifies Van Helsing as a specialist who has more knowledge of the female body and its complaints than his colleague Dr. Seward. Further, we now know that Van Helsing is well- practiced in focusing the medical gaze on female bodies to explore the pathologies present in those bodies.

Stoker most clearly portrays Van Helsing's concentration on the female body but not on the patient as a whole when the doctor examines Lucy. First, Van Helsing lulls Lucy into a sense of calm by chatting "of all things, except ourselves and diseases" (123),

⁴ By the end of the nineteenth century, King explains, laboratories were "able to distinguish between chlorosis and its imitators" through the study of blood (117). If we consider the fact that Dr. Van Helsing studies Lucy's blood, we also have to recognize the fact that he definitively would have been able to diagnose her as chlorotic and yet never does. Still, it is inarguable that she expresses symptoms of the disease and of lovesickness even though no clear diagnosis beyond vampirism is voiced.

⁵ While ostensibly the "obscure disease" Van Helsing is investigating is vampirism, it could also be chlorosis, which had started to decrease in diagnoses by the end of the nineteenth century and was thus more difficult to understand and treat than it had been previously (Guggenheim 1825).

thus avoiding any form of real discussion with her about her condition. Then, he downplays Lucy's illness, saying, "They told me you were down in the spirit, and that you were of a ghastly pale. To them I say, 'Pouf!'" (123). Finally, once Van Helsing has had "a little talk all to ourselves" with Lucy, he tells her—the patient—nothing. Instead, he leaves her alone in the room now that he has been able to examine her and determine there is a mystery to be solved. He then moves on to tell Dr. Seward about Lucy's condition, thus consulting with another doctor—and man—instead of the patient, saying, "I have made careful examination, but there is no functional cause. With you I agree that there has been much blood lost" (123). Lucy thus falls victim to Dr. Van Helsing's male and medical gaze as well as Dracula's lustful one.

Van Helsing is not the only one in whom Lucy evokes a reaction consistent with the male and medical gazes. In fact, we learn that Lucy's beauty is such that she receives three proposals of marriage. Dr. Seward offers one of these proposals—one which Lucy does not accept—explaining his devoted interest in her and her health. Even more interesting than the proposals themselves, however, is the fact that Lucy "never had a proposal till today, not a real proposal" (66), as she confides to Mina. Something has changed the twenty-year-old and made her more appealing to the opposite sex. Lucy's beauty—and no doubt her status as a young, unmarried woman of means—attracts the attention of these men, also of high statuses, and she is unlikely to shun them all. Instead, she accepts a proposal of marriage from the wealthy and titled Arthur Holmwood and heads towards marriage in much the same way her green sick counterparts of the Early Modern era did. While it would be a stretch to say that Lucy is hoping to cure her chlorosis through her marriage, as we cannot definitively claim she has this ailment (only

that she expresses symptoms of it), we are not wrong to assume that she is attempting to fulfil a societal role expected of her while she has the attention of such men.

As the novel progresses, we are given indications that Lucy's condition, while seemingly healthy at first, worsens rapidly. Mina initially describes Lucy in her journal as "looking sweeter and lovelier than ever" (72), implying that Lucy's beauty has increased since the last time the friends met, hinting at the admiration of the mimetic male and medical gazes and explaining why many of the men in the novel have fallen in love with her. Van Helsing, for example, when he first meets Lucy proclaims, "[t]he disease—for not to be all well is a disease—interest me, and the sweet young dear, she interest me too. She charm me, and for her, if not for you or disease, I come" (124). Not long after this initial entry, Mina again writes about her friend in her diary, noting, "[s]he is a trifle stouter, and her cheeks are a lovely rose pink. She has lost that anaemic look which she had and I pray it will last" (82). Readers begin to believe all is well with Lucy Westenra because of her friend's care of her. However, soon after this entry, Mina writes again and we learn that Lucy has begun to appear wan following her sleepwalking episodes. Mina records in her diary her impression that Lucy "is paler than her wont [...] languid and tired" (105). Readers know that Lucy is losing sleep and spending her days making calls and walking with Mina, exercising perhaps in part to treat her seemingly chlorotic symptoms. Despite her best efforts, however, because of Dracula Lucy's chlorosis stems not only from a lack of iron but also a lack of blood, and, therefore, her exercise is not enough to cope with her loss of blood or its effects on her diseased state. As a result, she continues to oscillate between becoming worse and getting better.

An alternative explanation for Stoker having Lucy's symptoms abate and return

exists if we study the way that chlorosis was often thought to be cured. From the Early Modern era onwards, medical practitioners prescribed marriage and sexual relations to restore the flow of blood to one's extremities, a course of treatment that in Lucy's case would have been expected to remove that anemic look that Mina mentions in her journal entry. However, because Stoker's text was written for a Victorian audience, these relations are replaced with the blood transfusions that Lucy undergoes at several points throughout the novel. Instead of the exchange of bodily fluids through passion and sex, Stoker writes about the relatively new clinical procedure of blood transfusions wherein the flow of blood can be restored. While Stoker provides no background regarding the actual medical procedure, he does once again use the male gaze to study Lucy as she undergoes this treatment, noting that even though she is weak, it astonishes Seward "how long the drug took to act" (131). Lucy once again becomes the object of clinical study, even as she also remains the focus of the men's affections.

The first time her lover, Arthur, gives her blood, Van Helsing describes him as "so young and strong and of blood so pure that we need not defibrinate it" (132).⁶ The connection of the upper-class Arthur to these positive adjectives of youth, strength, and purity is hard to miss here; coupling these terms with Arthur's blood indicates his is of a superior quality, drawing attention to the Victorian idea of superiority of the upper classes' blue blood.⁷ Thus, when Arthur's pure aristocratic blood merges with Lucy's, it

⁶ According to Kim Pelis's article "Blood Transfusion" (2006): "In 1821, J. L. Prévost and J. B. A. Dumas [...] argued that one could transfuse more simply and effectively by first whipping the blood with a fork, twig, or rod — a process called defibrination. Debates over whether to use defibrinated or unaltered blood, direct or indirect transfusion methods, continued through the 19th century" (Pelis "blood transfusion").

⁷ Blue blood was a common term throughout the nineteenth century. In *Dictionary of Phrase and Fable, Giving the Derivation, Source, Or Origin of Common Phrases, Allusions, and Words that Have a Tale to Tell* (1895), Ebenezer Cobham Brewer defines this term under "true blue" as follows: "This is a Spanish phrase, and refers to the notion that the veins shown in the skin of aristocratic families are more blue than that of inferior persons" (149).

strengthens her, allowing Stoker to provide a study of the societal stereotypes regarding what is and is not socially approved. The novel then turns to Lucy's reception of his "pure" and "strong" blood: "As the transfusion went on something like life seemed to come back to poor Lucy's cheeks, and through Arthur's growing pallor the joy of his face seemed absolutely to shine" (132). As Arthur exerts himself and his fluid rushes into Lucy, both parties of the couple are brought to fulfillment. Despite Arthur's vigorous efforts, Lucy continues to decline without regular transfusions. She does not receive enough blood from her lover and finds herself depleted by another man, Dracula, in a commentary that subtly denounces the sharing of fluids—intercourse—between multiple partners. The vampire preys upon the young woman, turning her away from her aristocratic partner and into something horrifying that others, including her doctors, treat as an embodiment of her illness, pathologizing her.

Another contribution to Lucy's cycle of healing and illness is her bloodletting at the hands of Dracula and her subsequent need for blood transfusions from Dr. Van Helsing and the three men who have proposed marriage. Stoker describes one of the later transfusions, with Van Helsing explaining to Quincey Morris, an erstwhile suitor of Lucy's, "[a] brave man's blood is the best thing on this earth when a woman is in trouble. You're a man, and no mistake. Well, the devil may work against us for all he's worth, but God sends us men when we want them" (157). Here, we see not only the restorative and balancing nature of blood, echoed in so much previous medical literature that fixated on the humors of the body. We also encounter the idea of a "brave man" being able to treat a woman for whom he cares and restore her to her previous health in much the same way marriage would restore a chlorotic female to her previously enjoyed

health. Thus, *Dracula*—and Lucy’s illness in particular —reveals the impact of the gender hierarchy on a woman’s social position and health as women still need men to effect their cures.⁸

A further reason Lucy’s healing process is impeded is due to her lovesickness. Inexorably, Lucy is torn between several men and one monster in the guise of the Count. While her gothic horror unfolds, so, too, does her romantic nightmare. First, she is upset about having to reject the two men in whom she is not as interested, explaining in a letter to Mina:

Being proposed to is all very nice and all that sort of thing, but it isn’t at all a happy thing when you have to see a poor fellow, whom you know loves you honestly, going away and looking all broken-hearted, and to know that, no matter what he may say at the moment, you are passing quite out of his life. My dear, I must stop here at present, I feel so miserable, though I am so happy. (67)

Lucy shares her intimate reckoning here, noting that she is decidedly unhappy, perhaps herself even a bit broken-hearted, at the idea that she is not only losing suitors but also friends, as she mentions she is “passing quite out of his life” due to her rejection of Seward’s suit. As she ends this entry, Lucy is torn between misery—“I feel so miserable”—and ecstasy—“I am so happy” (67). She clearly values these men who have proposed and recognizes that they love her; however, she also knows that she does not

⁸ Blood was just beginning to be examined and understood by the end of the nineteenth century. However, medical colleges and university presses were publishing findings regarding the nature of blood, particularly the presence of “red corpuscles” in this blood. One such comprehensive example is Cambridge University Press’s *Histology of the Blood: Normal and Pathological* (1900) by Paul Ehrlich, Adolf Lazarus, and German Sims Woodhead.

love them enough and it makes her “so miserable” that she has to stop writing to Mina for a time. This theme of being sick because of love progresses as the novel continues.

The second time this romantic nightmare contributes to Lucy’s physical condition comes when her fiancé, Arthur Holmwood, is hurriedly called away to the bedside of his dying father. Lucy is distraught at not having him near her when she is also clearly suffering. Dr. Seward writes to Arthur, saying that Lucy “is woefully different from what she was when I saw her last” (120). Seward further explains that while Lucy tries to maintain a pleasant façade, it appears to be for the benefit of her mother—who is also ill and suffering from cardiac complaints⁹—in order to “prevent her from being anxious” about her daughter’s condition (120). We observe a specific moment when Seward concludes that Lucy is suffering from a mental condition as well as a physical one as Lucy grows concerned for her mother but also trains herself not to show it (120). Readers now know that not only has Lucy’s condition worsened, but she has deteriorated dramatically enough that her rejected lover, Dr. Seward, can hardly recognize in her the woman to whom he proposed. To those around her, the only explanation that makes sense for such a drastic change in Lucy’s condition is the exacerbation of lovesickness on her illness. The comorbid relationship between these two diseases has left her looking “somewhat bloodless” (121); thus, Seward, concluding that her condition has been enhanced by “something mental” (121), sets out to determine what that is with the help of Van Helsing.

⁹ If we consider the influence the mother-daughter relationship had on chlorosis—discussed more in *Chapter 6*—we recognize that even Mrs. Westenra’s illness has an impact on her daughter’s conditions as Lucy simultaneously worries for her mother as an ill woman but also because her own illness prevents her from giving Mrs. Westenra the care she needs, which results in further conflagrations of lovesickness and heart trouble.

As Seward's above consideration indicates, there is a clear connection between mental illness and chlorosis in nineteenth-century texts, as well as lovesickness. As the physical strain of the disease builds, it also affects the patient's mental well-being, causing moments of anxiety and distress as we see in Lucy. King acknowledges that dual suffering like Lucy experiences was often the case in situations of chlorosis as a result of the age of the afflicted young woman, noting that doctors saw puberty as "a period of mental instability and 'extreme nervous sensibility'" in girls (92). Thus, the young chlorotic woman's condition and the cessation of her menstruation left her in an almost pubertal state, exacerbating her mental strain. Further contributing to this strain was the condition of lovesickness, especially as it relates to the "virgin's disease." Galen was among the first to argue that unrequited passions—in his case, those of a woman towards a man of an inferior social class—could affect those suffering from the comorbid condition of chlorosis: lovesickness (King 4).¹⁰ As a result, we not only see a connection between mental disturbance and the disease but also the struggles among the different classes.

The third and final correlation between Lucy's condition and lovesickness comes from the Count himself, who slowly depletes the defenses of an unwilling woman. Lucy's parents and the larger society raised her with tight Victorian strictures to have no sexual relationships outside of marriage, and yet Dracula forces her into one. He causes her to be unfaithful against her will, thereby contributing to her heartache and exacerbating her condition, which is already complicated by multiple proposals and the distance of her

¹⁰ Galen was a Roman philosopher and physician from the second century who also practiced surgery (Garebian "Galen"). He wrote many medical texts that were still be consulted when chlorosis was first diagnosed during the Early Modern era. These texts offered "information on the use of caustics, unguents for healing wounds, and opium and other drugs for anesthesia" (Garebian, "Galen").

fiancé. We know from Mina's earlier diary entry that Lucy has been put in a compromising position at least once before by Dracula; however, these compromising moments soon increase in severity as Lucy's condition continues to worsen. She writes in her diary:

I tried to keep awake, and succeeded for a while; but when the clock struck twelve it waked me from a doze, so I must have been falling asleep. There was a sort of scratching or flapping at the window, but I did not mind it, and as I remember no more, I suppose I must have then fallen asleep. More bad dreams. I wish I could remember them. This morning I am horribly weak. My face is ghastly pale, and my throat pains me. (119)

While Stoker's characters do not know what has happened to Lucy, his readers do. We realize that the flapping and scratching she hears at her unlocked window are from Dracula gaining entry to her room. We further recognize the impropriety of his entrance as a young, upper-class, unmarried woman during Stoker's era would never have been allowed to entertain a man in her bedroom. Thus, Lucy subconsciously knows something is amiss, and this knowledge leads to further depletion of her energy. She is now weak, pale, anxious, and in pain.

As evidenced by the blood transfusion procedures, Arthur is perhaps most successful in revitalizing Lucy from the above painful state, if only for a few moments, despite the ravages of Dracula's bloodlust. Arthur's desire to help her, even to his own detriment, marks him as a noble foil to Dracula. While both men are of a high social

status—Dracula is a count, Arthur becomes an earl as the novel progresses¹¹—Stoker clearly wants his readers to see the English Arthur as the more noble choice over the foreign count. He is the “brave lover” who has provided Lucy with good blood despite how much it weakens him (132). We cannot fail to notice the ringing endorsement given to the known quantity of the Englishman as compared to the denouncement of the monstrous foreigner. Unfortunately, despite Arthur’s bravery and attempts to revitalize his lover, he proves no match for the foreign count.

Lucy’s association with the monstrous, Dracula, ultimately leads to her death; however, readers should note that Arthur’s leaving her at the moment she needs him most also contributes to her destruction. She receives no protection from her lover against the embodiment of invasion represented by the count, and as a result she herself turns vampiric. She now is tainted, and she’s tainted in an explicitly sexual way. Christopher Craft explains in “‘Kiss Me with those Red Lips’: Gender and Inversion in Bram Stoker’s *Dracula*” that “Lucy grows ‘voluptuous’ (a word used to describe her only during the vampiric process), her lips redden, and she kisses with a new interest” (119). She is no longer the pure woman in need of care whom everyone has tried valiantly to protect; instead, she is the satiated lover willing to share her new expertise. As argued by Vandereycken and van Deth in *Fasting Saints*, the ill “lover seems to be filled with voluptuousness despite a weakened body” (138). Lucy may be physically weak, but she is also sexually mature. She no longer needs blood or sex from a socially acceptable male as a cure for chlorosis; now she will only be satisfied by sex. Based on Vandereycken and

¹¹ A count and an earl are equivalent titles, count being the “foreign” version of the English earl. Therefore, the term “count” marks Dracula as the foreign entity when compared to Arthur, further indicating how the outside influence of others impacts the chlorotic’s girl’s health as the times change.

van Deth's point, then, Lucy becomes what society fears most—a sexually liberated woman unconstrained by their expectations.

In *Dracula*, the rejection of society's domination over acceptable courtship practices and marriage candidates manifests itself in the figure of the vampire. The way in which Lucy moves outside the socially accepted constraints for a woman means she no longer needs socially-sanctioned marriage and childbirth; she can find a sexual partner on her own and reject him once she has used him for her pleasure. Figures like Lucy prove that the liberated, vampiric woman seeks male companionship on her own—admittedly still problematic—terms. Consider the vampiric women who accost Jonathan Harker at the beginning of Stoker's novel: "There was something about them that made me uneasy," Harker explains, "some longing and at the same time some deadly fear" (48). The vampiric women attract the man, making him crave them in a way their non-vampiric female counterparts might long for a sexual cure. The female vampire, then, hasn't succumbed to the male gaze in the way her human female counterparts might. Social expectations do not make her bow down to the expectations for her gender; instead she seeks her own pleasure. In *The Vampire in Nineteenth-Century English Literature* (1988), Carol Senf writes, "the vampire generally inspired fear, horror, and revulsion" (10), much as Harker explains the vampiric women do. The diseased female body is treated in much the same way; it is an abnormal representation of femininity. The female chlorotic who rejects society's machinations in favor of an unacceptable marriage, or an education, or life experiences outside the domestic sphere, would horrify society in much the same way as the monstrous, female vampire. She is repulsive because she is outside the norm.

Thus, as we watch society react to the vampiric Lucy in Stoker's novel, we can draw parallels with how they react to the diseased female body. Stoker writes that the men go to finish off the undead Lucy, only to first find her coffin empty (213). Soon after, they encounter her, noting that she has changed—understandable considering she has died—explaining that “[t]he sweetness was turned to adamantine, heartless cruelty, and the purity to voluptuous wantonness” (Craft 215-6). The vampiric Lucy is sexualized and no longer the demure society miss from the first half of the novel. The men respond to her in much the same way Harker reacted to the other vampiric women, with a sort of longing and also horror; as Seward explains, “[t]here was something diabolically sweet in her tones” (216) as she implores Arthur to come to her. The men, somewhat predictably, are unable to avert their gaze from Vampire Lucy in the same way they could not stop staring at the beautiful, diseased Lucy of earlier in the novel. Senf provides insight into why their male gaze has once again come to the fore when she writes that authors “use the vampire motif to explore sexual roles and human identity” (11). While the men could see Lucy as attractive before, she wasn't necessarily sexualized. Now that she is a vampire and no longer a socially acceptable woman, the men can admit to their lust for Lucy.

The influence of the lustful male gaze and the clinical medical one persisted as the nineteenth century drew to a close and the twentieth began. One of the most interesting—and interestingly contested—literary portrayals of chlorosis as influenced by these gazes appears in Henry James's *The Wings of the Dove* (1902). In this novel, the young and wealthy Milly Theale is described as having a disease. Although no specific diagnosis is mentioned, based on the presentation of symptoms, we can see that James writes Milly as

exhibiting symptoms akin to those that arise from chlorosis.¹² If we read Milly as chlorotic, we can explore the ways in which her disease manifests—as a result of her grief from the loss of her family, lovesickness because of vile suitors, and social status as the sole heiress of her family’s fortune. Moreover, we can see how this manifestation leaves her open to the machinations of others throughout James’s novel—mostly because Milly desires to find love and is wealthy enough to have her pick among the duplicitous suitors vying for her hand.

Other characters comment on not only Milly’s appeal but also her disease. For example, when Milly and one of her suitors, Lord Mark, are discussing a portrait, Milly jokes about the green complexion of the subject in the painting: “Of course her complexion is green... but mine’s several shades greener” she jests (138). Not one to dismiss her disease so easily, Lord Mark attempts to discuss this similarity in complexion further with Milly, who tries to deny the likeness as anything other than a joke. Undaunted, Lord Mark unhelpfully exclaims, “But you’re a pair. You must surely catch it” (138). In “‘Consumption, heart-disease, or whatever’: Chlorosis, a Heroine’s Illness in *the Wings of the Dove*,” Caroline Mercer and Sarah Wangenstein remark on this moment, noting that “Milly is deeply troubled, but she hides the fact with humor” (274). She knows her illness is not a socially acceptable topic of conversation—remarkably better than a peer like Lord Mark does—and so attempts to move past it with a joke.

Not long after, Milly’s unacknowledged rival, Kate Croy, also remarks on this resemblance. Kate is unwilling to end the conversation even though Milly clearly would

¹² Milly Theale’s disease has often been associated with Minnie Temple’s, a cousin to the Jameses. For more on Minnie’s connection to Milly, see Lyndall Gordon’s *Henry James: His Women and His Art* (2012).

prefer not to focus on her illness, thus showing that as the nineteenth century ended and the twentieth began, women were also guilty of using the medical gaze. Kate comments in particular on both the portrait's and Milly's beauty: "But the likeness is so great ... and you're superb" (138). In this way, Kate not only calls attention to a second—often mentioned—symptom of chlorosis, beauty, but she also confirms Lord Mark's first impression. Both Milly and the woman in the picture have skin of a greenish pallor. While King explains that the "idea of girls with green sickness turning green seems implausible to modern scholars from non-medical backgrounds" (5), she also acknowledges that even today there are medical writers "who continue to maintain that the skin of a chlorotic is indeed green" (5). We need look no further than the article "Chlorosis Revisited" (2006) by Eva Perdahl-Wallace and Richard Schwartz for photographic proof of this point: Drs. Perdahl-Wallace and Schwartz diagnose their pubertal female patient with chlorosis, or hypochromic anemia, based on the greenish color of her skin.²⁷¹³

Despite her jokes about her condition, Milly acknowledges her illness and herself in a way many invalids do not. In fact, she comes across as equally self-aware of her chlorotic state as Elizabeth Isham more than two centuries earlier. However, Milly's introspection focuses predominantly on the embarrassment and distress her disease causes her due to the social expectations of her era. James writes, "[s]he had long been conscious with shame for her thin blood" (178). Not only does this quotation indicate that she most likely has chlorosis—her thin blood is a pathological feature of the anemic presentation of that disease—but it also indicates that her shame is felt in part because

¹³ "Chlorosis Revisited" (2006), published in the journal *Clinical Pediatrics*, is about a modern adolescent girl who expressed symptoms of chlorosis, including a greenish tint to her skin.

she recognizes she *should* be ashamed since she is not meeting social expectations of a wealthy, marriageable woman. Rita Charon explains this self-awareness in “The Great Empty Cup: The Doctor and the Illness in *The Wings of the Dove*,” writing that Milly is the only character “aware of herself within and beyond the book” (121). Her self-awareness is caused in part by her recognition that a disease like chlorosis makes her ill, and thus places her in a social position of inferiority that damages not only her prospects of marriage but her placement within her higher social class.

While Charon does not offer a careful study of Milly’s symptoms, she does explore Milly in her entirety, particularly as James’s character reacts to her diagnosis. Charon particularly focuses on the fact that Milly’s understanding of her disease “merges with what she projects to be [Dr. Luke’s] grave prognosis” (113). This understanding proves that while Milly is very self-aware, her diagnosis leaves her confused, as any undereducated woman no doubt would have been. In fact, chlorosis very rarely killed; however, nineteenth- and early twentieth-century doctors still considered this disease a grave prognosis as it inhibited a woman’s ability to move about in society and achieve an advantageous marriage. Just like Milly, James’s audience doesn’t understand much about his main character’s illness, either, which means we need more interactions between her and characters like Kate and Lord Mark to help provide context, and sometimes further confusion. For example, towards the middle of the novel, several of the characters are discussing Milly in her absence, and they explain that ““she has none of the effect—on one’s nerves or whatever—of an invalid”” (215). Thus, Milly doesn’t meet their expectations of a diseased individual, which explains why modern audiences continue to debate what precisely her diagnosis was. However, this commentary also indicates that

the characters do not know Milly well. Despite her unique personality, they still label her as an invalid and begin to plot how to use that invalidism to their advantage soon after.

Because of the way other characters pathologize her condition, Milly is inarguably among the most interesting examples in literature of the intersection among gender, disease, and class. More specifically, her story clearly portrays the ways in which gender and class influence the medical gaze. First, as already mentioned, Milly has access to personalized medical care in the form of several doctors throughout her travels. Most predominantly, the renowned Sir Dr. Luke Strett supports Milly as she struggles not to despair over her illness. This ready access to quality medical attention shows how beneficial wealth can be in treating one's illness. However, this care also represents a negative correlation between gender and illness because Dr. Strett never actually tells Milly what is wrong with her—echoing Van Helsing and Seward's treatment of Lucy—but instead explains in response to her claim that “I think I must be pretty easy to treat” that she is not, saying, “Oh no, you're extremely difficult to treat. I've need with you, I assure you, of all of my wit” (254-5). Thus, not only does Dr. Strett keep information from his patient, presumably because he believes she wouldn't understand it, but he also unintentionally elevates her fears. In these interactions, also, we see the influence of the medical gaze as Dr. Strett focuses solely on the process of curing his patient's body instead of devoting some time to alleviating her fears. He looks at what is physically wrong with her, neglecting her mental state in much the same way that Dr. Seward and Van Helsing do with Lucy.

Furthermore, the relationship between Dr. Strett and the wealthy Milly complicates notions of chlorosis in the era because it offers a sort of alternative to the

idea of sexual healing. Instead of having Milly marry, Dr. Strett tries to cure her with a sort of therapeutic listening by asking questions and providing encouragement as indicated above. The other characters begin to take note of the effects of his methods with Kate mentioning at one point, however, that they may not be working in quite the way Dr. Strett intended: “‘She’s doing it for *him*’—and she nodded in the direction of Milly’s medical visitor. ‘She wants to be for him at her best’” (305). Kate assumes Milly has replaced her search for a love interest with the attention she gains from her doctor and their more intimate relationship. However, as the treatment seems to work for a time, James—likely influenced by reading the work of his psychologist brother, William—hits on something it would take time for others to realize: in disease diagnoses, a focus on the psychosomatic as well as the somatic can only benefit the patient.¹⁴

A second advantage Milly’s wealth gives her that not all ill patients have is the ability to travel. In fact, when she “had suddenly been taken ill [...] from some obscure cause” one of her doctors recommended a change of environment as “highly advisable” (89-90). As a result, due both to her illness and her social status, Milly’s treatment takes the form of a journey to Europe. It is while there that James describes Milly: “She was alone, she was stricken, she was rich, and in particular was strange” (77). Because of her vulnerable state, in Europe Milly meets most of the other characters who play a role in her distress, becoming ripe for the machinations that are to come at her expense—both literally and figuratively—due to her solitary and “strange” state. Soon—by Jamesian standards—a plan is set into motion to trap the young woman into marriage with Mr.

¹⁴ For more on William James’s notions regarding anemia and other disorders he classifies as nervous, see his review “*Du sommeil et des états analogues*, by Ambrose A. Liébeault (1868)” under his collection of texts on moral medication in *The Works of William James* (2008).

Merton Densher (Kate Croy's secret lover) so that Kate and he can access Milly's money. Kate justifies their plan, articulating that if Densher leaves, Milly will die but then reminds him that the invalid won't die, "Not if you stay" (310). Thus, while the invalid resists the stereotypes developed by society, she still is a pawn for other people's pleasure due to the male gaze and social expectations regarding marriage, a cure for chlorosis. The beautiful, apparent chlorotic then becomes open to lovesickness as any attraction a male has to her is likely due to her condition and physical appearance, not her personality, as Densher, Lord Mark—and even Kate to some extent—soon prove.

Milly's lovesickness is much less dramatic but no less tragic than Lucy's. While there are no vampires literally sucking her blood, there are leeches in the form of Kate, Densher, and Lord Mark draining her without her knowledge all the same. However, they are not the only figures to impact Milly's lovesickness and illness. In fact, three different moments create the perfect situation in which Milly's illness can fester. First, there is the loss of her family. Early on, James explains that Milly is the sole survivor of a family from New York. He writes "[i]t was New York mourning, it was New York hair, it was a New York history, confused as yet, but multitudinous, of the loss of parents, brothers, sisters" (77). Milly's loss weighs on her, contributing to her decline. Mercer and Wangenstein explain, "[h]er sombre costumes—for instance, 'the helplessly expensive little black frock that she drew over the grass' as she strolled, or her 'sable-plumed hat'—accentuate her pallor and are constant reminders of her tragic background" (270). In these moments we realize Milly is suffering not only from a physical decline but an emotional one as well.

While love melancholy is almost always exclusively related to a romantic

relationship, the loss of the family she loves also contributes to the difficulties Milly experiences with her health. First, of course, is her obvious grief following the deaths of those she loves; her melancholy here is not specifically identifiable as lovesickness, but she is clearly experiencing heartache at their loss, telling Kate Croy soon after they meet for the first time that she has no relations left and indicating that her grief understandably weighs heavily on her: “I’m a survivor—a survivor of a general wreck. [...] When I was ten years old there were, with my mother and my father, six of us. I’m all that’s left” (149). Ruddock articulates that “long continued grief” (64) is a common factor in contracting chlorosis, as mentioned in *Chapter 5*. Second, and more subtly, is the impact the lack of her parents has on the presentation of her disease. King writes, citing an 1889 document, that “the pubertal sufferer from the disease of virgins is usually seen as the ideal patient, entirely passive, controlled [...] by her parents and by the father-substitute of the physician” (7). However, because Milly does not have parents to control her situation, she is missing the presumed benefit of having a nuclear family. Vandereycken and Van Deth explain, that by the end of the nineteenth century, the family and domestic life created a “peculiar blend of intimacy and hierarchy” (187). But, because Milly is missing this family, she has only the “father-substitute” provided by Dr. Strett. Therefore, he becomes her motivation for much of her action, as Kate points out to Densher. Meanwhile, the loss of her family opens Milly to disreputable suitors and the selfish plots of those who desire her (and her wealth).

Milly not only suffers melancholy from the loss of her family; she also suffers from the rivalry her suitors create. In much the same way that Morris, Holmwood, and Seward put strain on Lucy, so, too, does Milly suffer due to the self-serving interests of

Lord Mark and Densher. When Lord Mark proposes, Milly responds vehemently in the negative: “I don’t at all events want *you!*” while experiencing “sadness [...] of his being so painfully astray” (274). In this moment we do not have Milly’s own point-of-view as we do Lucy’s, but we do understand that soon after this scene Milly is indisposed (289). Kate tells Densher why, noting that Lord Mark “came to make Milly his offer of marriage—he came for nothing but that. As Milly wholly declined it his business was for the time at an end” (291). The fact that Milly has to take to her bed after she rejects Lord Mark indicates that her condition has worsened; she is no longer able to socialize in society as she had before. The man that she by all accounts wants has not yet proposed, and Milly takes this omission to heart. Interestingly, by rejecting the higher-ranking of her suitors, Milly opens herself up to societal censure as she not only has avoided a possible cure for her disease but also has rejected the expectations for her class and social placement.

This moment of rejection is not the one that makes Lord Mark partially responsible for Milly’s decline, however. First, he has to learn about Kate and Densher’s plot. This plot, the third and final factor that contributes to Milly’s condition, is borne out of the couple’s desperation. Kate speaks to Densher about a way to get the money they need to marry, determining that since Milly is already significantly unwell—and, of course, wealthy—Densher should court her. Densher is mildly uncomfortable at first at Kate’s proposition, exclaiming, “[w]hat you want of me then is to make up to a sick girl” (216), which, while not in itself considered morally problematic in the time—after all, to make up to her was to cure her—bothers Densher nonetheless as he loves Kate, not Milly. Kate, after a lifetime of disappointments, is not one to let this opportunity slip

through her fingers. She brushes aside Densher's moral quandary, arguing, "[a]h but you admit yourself that she doesn't affect you as sick" (216). Thus, the couple sets into motion their plot to pretend they are no longer interested in one another and also to woo Milly in the process, making her illness their gain.

At first, Milly's sickness is of little concern to those who are planning to use her for their own personal reasons; in fact, her illness is a means to their ends as they themselves won't have to suffer long because if she is not chlorotic, her marriage to Densher will end with her imminent death, and even if she is chlorotic, the risks of pregnancy and childbearing are still very high. However, as the novel progresses, this unnamed illness does trouble Densher, who realizes how much their future focuses on the death of another person:

It was before him enough now, and he had nothing more to ask; he had only to turn, on the spot, considerably cold with the thought that all along—to his stupidity, his timidity—it had been, it had been only, what she meant. Now that he was in possession moreover she couldn't forbear, strongly enough, to pronounce the words she hadn't pronounced: they broke through in her controlled and colorless voice as if she should be ashamed, to the very end, to have flinched. "You'll in the natural course have money. We shall in the natural course be free." (308)

In this moment, Densher recognizes that not only has he put too much faith in Kate, he has also made little effort to analyze how far he would need to go to make their plan work. He chills because he recognizes just how cold-blooded this entire plot is; even Kate cannot put into words what they have set into motion. However, where Kate takes refuge

in “her controlled and colorless voice as if she *should* be ashamed” (emphasis mine)—indicating she is in fact not—Densher finds no such comfort.

To modern sensibilities, it is ironic that at this point in the novel, the male character, Densher, feels more guilt regarding the medical gaze than his female counterpart, Kate, even though as a woman she is far more likely to experience the negative impact of such a gaze. This lack of concern indicates just how pervasive the medical interpretations of the female body were throughout the long nineteenth century. In fact, they were so insidious that many readings of Kate today still tend to demonize her instead of looking at her as a product of the carefully crafted historical understandings of female pathologies. Brenda Austin-Smith points out in “The Reification of Milly Theale: Rhetorical Narration in *The Wings of the Dove*,” however, that this reading of Kate is not entirely fair, arguing that “the more lasting tragedy of the book is not Milly’s death, but Kate’s defeat [...] Kate’s position in the novel’s final paragraphs echoes her entrapment in the opening scenes” (203). In the opening volume, we encounter Kate as she struggles to escape her position as a female, waiting for her selfish father (a clear patriarchal metaphor) with “a face positively pale with the irritation that had brought her to the point of going away without sight of seeing him” (21). As Kate finally escapes, she knows she cannot go back and so begins to play with the society that had trapped her in the first place. Undoubtedly, she is more concerned about herself than other females, but in so being, she not only resists the stereotypes of her gender as more sensitive and sympathetic, but she also strives to resist the social machinations which have brought her to this point.

Guilty of similar actions to those perpetrated by Densher and Kate, Lord Mark

wants the heiress's money for himself and so goes to Milly and reveals Kate and Densher's plot. Her companion, Mrs. Stringham, informs Densher in the aftermath, when Milly declines to see him, that Lord Mark "'told her you've been all the while engaged to Miss Croy'" (339). In this discussion, readers get indications that Milly is suffering as a result of her thwarted love, once again harkening back to the idea of lovesickness. As a consequence of this devastating information, readers might expect Milly to cower; instead, she uses her last reserves of strength to not let Lord Mark see her reaction. Mrs. Stringham explains, "[h]e dealt her his blow, and she took it without a sign [...] She's magnificent'" (340). Densher, even more guilty than he was before, can only echo "'Magnificent!'" (340). James makes a clear commentary on the swiftly- changing social classes in England as peers no longer have the money and must marry wealthy Americans to keep their lands. Her suffering silently marks the end of her life. The other characters apparently seem to know this with Kate, perhaps experiencing her first "feminine" sympathies, asking Densher: "'Is it very terrible?'" to which he replies after a moment, "'The manner of her so consciously and helplessly dying? [...] Well yes—since you ask me: very terrible to *me*'" (355). With Milly's death, Kate loses her chance to escape society, Densher loses the object of his male gaze, and undoubtedly, the doctor loses the object of his medical one. It seems to matter less to the characters and readers, as Austin-Smith points out above, that Milly loses her life.

Milly's death is not only a punishment for Densher, who receives her wealth but ultimately chooses not to use it. More obviously, it is a commentary on social stratification and the pathologizing of a woman within that stratification as Milly veers from the set path of marrying well and quickly and instead chooses to seemingly chase

after a man who had been recently involved with another woman. While we know Milly is wealthy and thus all the more susceptible to this disease—after all, “[c]hlorosis occurred ‘almost endemically’ in beautiful young girls of noble birth” (Vandereycken & van Deth 141)—when she rejects the men of higher class and goes for the lower-class one who was recently in love with someone else, she is effectively further postponing her cure—after all, if she does not secure marriage to Densher, she may die—and opening herself up to lovesickness. Sadly, she realizes that Densher does not truly love her, and to capture her defeat, James writes possibly the most famous and debated line in this book: “‘She has turned her face to the wall’” (333).¹⁵ Milly’s disease kills her, but Densher strikes the mortal blow.

Much argument surrounds Milly's particular illness. Some debate her condition, claiming she is everything from tubercular to hysterical to suicidal.¹⁶ However, as this chapter and other scholars like Charon, Mercer, and Wangenstein have shown, we can explore the possibility that Milly manifests symptoms of chlorosis, a disease that encompasses many components of these original diagnoses. Consider, for example, the fact that these authors cite Milly's general fatigue as indicative of hysteria (McLean 128), her melancholy as symptomatic of depression (McLean 129), and her pale beauty as a likely indicator of tuberculosis (Spunt 164). Each of these symptoms points to a different diagnosis according to the scholars who study them. However, chlorosis is the only

¹⁵ This line has often been cited as proof Milly was suicidal, much like James’s dear friend Constance Woolson and his only sister, Alice.

¹⁶ For more on what scholars have argued about Milly's disease, see "'Love by the Doctor's Direction': Disease and Death in *The Wings of the Dove*" by Robert C. McLean in *Papers on Language and Literature*, Volume 8, 1972 and F.O. Matthiesson's biography of the James Family cited in this dissertation's second hysteria chapter. Further, it is important to note that as the introduction to this project articulates, there were commonalities between these diseases that many saw in the nineteenth and early twentieth century as proof that they were comorbid conditions.

disease in which every symptom mentioned above is apparent. While it is inarguable that the influences of women on James—particularly his sometimes hysterical sister, Alice, his tubercular cousin, Minnie Temple, and his friend and confidant Constance Woolson, who ended her own life after battling depression (McLean 128)—affected his writing, it is irresponsible to propose that only one of these woman extended a strong enough influence to contribute to the creation of Milly Theale. Rather, it is likely that Milly's disease is a somewhat ambiguous combination of each ailment mentioned above, leading readers to imagine whichever illness they choose, or to look at her symptoms as a whole and understand she is exhibiting chlorotic tendencies, showing precisely how much risk there was for women of higher classes during this era if they remained within society's norms.

By reading each of these novels, we come to terms with the problematic nature of society's expectations for the diseased woman by the end of the nineteenth century. We encounter the way these women are only truly free from these expectations when they die and the means by which they find themselves continually subjected to the medical and male gazes leading up to their deaths. Most unfortunately, perhaps, we see the way these patterns are replicated in society today as we acknowledge that women suffering from a diagnosis like ovarian cancer are looked at as statistics while women suffering from mental illnesses like anxiety are seen as indicative of their gender. In order to properly grasp the full import of these novels, then, we must recognize that women are still subjected to the male and medical gazes, and thus not always able to get quality care, in disproportionately large numbers if they are a member of a minority group, as the conclusion to this project addresses.



Figure 3: Alice James (reclining) in her sick room in England, being assisted by her longtime friend, Katherine Loring (standing).

*Chapter Eight: Hysteria and Neurasthenia in the Nineteenth-Century:
Introducing the Invalid: Hysterical Nineteenth-Century Culture*

I have been going downhill at a steady trot; so they sent for Sir Andrew Clark four days ago, and the blessed being has endowed me not only with cardiac complications, but says that a lump that I have had in one of my breasts for three months, which has given me a great deal of pain, is a tumour, that nothing can be done for me but to alleviate pain, that it is only a question of time, etc.

—*The Diary of Alice James*, May 31st, 1891

The Diary of Alice James (1889), a journal written by an American intellectual who moved to England as an adult, offers an illuminating example of what living with a diagnosed disease was like for a nineteenth-century white woman of means. Alice James, a member of the illustrious James family that included novelist Henry and psychologist William, provides a personal narrative of living with chronic illness. Because of her self-awareness regarding her diagnoses, as well as her resistance to being labeled exclusively as an invalid, James's account continues to appeal to modern readers. Ostensibly, James recounts her day-to-day existence, incorporating snippets of gossip and relevant historical details, such as the ongoing troubles in Ireland, with which she sympathized. However, in her diary she is also doing something far more interesting in relation to the medical

humanities: she is documenting the life of a female patient diagnosed with, among other illnesses, neurasthenia, hysteria, and terminal breast cancer while also resisting the label of invalid.¹

Nineteenth- and early twentieth-century accounts of hysteria and its comorbid illness—neurasthenia—in cases like James’s are plentiful.² Because of this abundance of accounts, *Chapters 9 and 10* focus nearly entirely on the somatic manifestations of hysteria and neurasthenia (as they were understood in the nineteenth and early twentieth centuries) rather than the psychosomatic expressions of these diseases. I would be remiss if I did not acknowledge, however, that the subjects of both hysteria and neurasthenia must be approached, as J. Stuart Nairne argues, “from two very different points of view—namely the psychological and physiological—if it is to have sufficient justice done to it” (1140). Thus, these chapters mention the psychosomatic manifestations of hysteria and its comorbid diagnoses when the character or real-life figure expresses them.³ Medical professionals were continually making new discoveries about disease that influenced understandings of hysteria and its comorbid illnesses. However, because the physical manifestations are less-often-studied, this chapter devotes more space to those conditions

To fully understand what a nineteenth- or early twentieth-century diagnosis of hysteria entailed, one needs a description of the disease. As John Mitchell Clarke

¹ Unlike hysteria, a condition that contributed to James’s life-long invalidism, James’s cancer diagnosis came near the end of her life, in the spring of 1891 (Yeazell 1).

² Other accounts of hysteria and its comorbid illnesses include the autobiography of Charlotte Perkins Gilman, mentioned later in this dissertation and the diary of the German nun Marie Schmalenbach, which focused on her nervous weakness and was a useful source for the study of neurasthenia in religious life (Radkau 203). For more studies of nineteenth-century neurasthenia (and hysteria) in diaries, see *Cultures of Neurasthenia from Beard to the First World War*, edited by Marijke Gijswijt-Hofstra and Roy Porter.

explains in *Hysteria and Neurasthenia* (1905), “hysteria is probably as convenient a term as any other for a group of symptoms too wide and too varied to be easily comprised under a precise term of description” (4).³ As this quotation suggests, medical professionals were still determining the composition and manifestations of hysteria as the twentieth century began. Because of the limited ability to rigidly define hysteria and neurasthenia, gothic and imaginative literature throughout the long nineteenth century was by turns repulsed and fascinated with these diseases. In both fiction and nonfiction these illnesses captured the public’s imagination while also affecting ideas of either the resistant invalid—an invalid who questioned the typical socially accepted female patient–male doctor dynamic—or the nightmarish invalid—one who inspired novelists and writers and terrified their audiences.

To address these nineteenth-century studies and diagnoses of hysteria and neurasthenia, one must first be able to understand the historical contexts of each disease as influenced by both the gender and class of the ill individual. Then we can decide how, if at all, these diagnoses differ based on that gender and/or class. According to *The Oxford English Dictionary (OED)*, definitions of hysteria as a medical condition emerged in the early nineteenth century. For example, in an 1801 issue of *The Medical and Physical Journal*, one of the doctors shares the case of his patient, Mary Aitken, afflicted with violent hysteria, writing: “she was of the sanguine habit, and robust constitution: She had taken a number of medicines commonly used in that disease, but had

³ Dr. J. Mitchell Clarke’s work is reviewed in the *Edinburgh Medical Journal*, Volume 18 as a “succinct, and, so far as it goes, complete account of these disorders” (358) meaning neurasthenia and hysteria. The reviewer further specifies that “The chapter on treatment is well done, and the very explicit directions as to the dieting of Weir Mitchell cases should prove most serviceable” (358). The review ends with the point that “Dr. Clarke’s book may be recommended as a practical compendium of its subject” (358).

experienced no relief” (McLaren 235). Here we see not only the difficulty of treating hysteria but the lingering contexts of former medical practices such as humoral medicine as evidenced by McLaren’s use of the term “sanguine,” as this term implies a hormonal imbalance related to the presence and balance of blood in the body.⁴ As the century progressed, medical professionals moved away from humoral medicine to studying the nerves, describing hysteria as a pathology wherein the patient experiences variable moods and is of an emotional, excited temperament (Clarke 11).⁵ However, their description of hysteria also focused on what medical practitioners saw as somatic manifestations of this disease, including “disturbances of common sensation (anaesthesia, hyperanaesthesia)” as well as “disorders of the special senses” such as convulsions and amenorrhea (Clarke 14; 107), the last—indicating a diseased uterus or atypical menstruation—making it a diagnosis largely associated with the female body.

Sources from the nineteenth century also provide unique perspectives on how hysteria manifested in the body, affecting the patient. *A New Medical Dictionary* published in 1890 by George Milbry Gould defines hysteria as “a reflect neurosis; not with certainty known whether it is due to structural alteration of any part of the central nervous system, or to abnormal blood supply, etc. Paralyzes, impairment of vision, convulsions, etc. are usually prominent symptoms” (202).⁶ This structural alteration, an idea echoed by both Clarke and Lawlor, allows readers to consider not only the focus of the text but also the body of the patient and how hysteria changes this body, physically as

⁴ Chapter 2 of this dissertation addresses the practice of humoral medicine. See also William A. Jackson’s “A Short Guide to Humoral Medicine” (2001) for more information on this practice.

⁵ The *OED* supports Clarke’s notion, defining hysteria as “attended with emotional disturbances and enfeeblement or perversion of the moral and intellectual faculties” (“hysteria”).

⁶ Because of his background in medicine — Gould was a renowned ophthalmologist — and “his interest in medical lexicography,” he published “a number of dictionaries, the first of which was published in 1890; more than a half million copies of his dictionaries were sold” (Alewitz “George Milbry Gould”).

well as mentally, through (among other symptoms) incidences of localized paralysis and convulsions. Further, the ways in which scholars studied these changes allow us to examine how instrumental the male and medical gazes were in negotiating a female patient's treatment. As they studied the body in which the disease manifested, they became the experts. They told the patient what was wrong and believed implicitly the patient would trust them. This dynamic harkens back to Judith Butler's point about power dynamics shared in the introduction, chiefly that gender is a social construct created by social norms, thus making it a negotiation with power. The male doctor navigated this construct, supporting it in order to emerge as an expert in an era in which he had little competition for the role. It is no surprise, then, that based on these problematic relationships and negotiations of power, women grew resistant not only to notions about their health, but also about social power structures.

Gould's focus on these physical manifestations of hysteria is in keeping with other understandings from the time, including Clarke's knowledge of this illness. In fact, Clarke's text, republished fifteen years after Gould's, defines hysteria in similar terms. He writes that one "important feature [of hysteria] is the way in which the emotions quickly influence the motor, vasomotor, sensory and secretory functions of the body" (11). Here Clarke seems to find a connection between the emotional actions of the body and those [bodily actions] which are abnormal, thereby judging those who experience an emotional reaction to an event. Clarke further specifies that the "more permanent hysterical symptoms, such as various paralyses and anaesthesias, frequently appear as the immediate consequence of a fit" (12). So, while definitions were unclear on the cause of hysteria, they tended to agree on the physical manifestations of this disease.

As these descriptions indicate, a diagnosis of hysteria focused on more than just a disturbed womb, which means assumptions about the genders it impacted must consider more than female anatomy.⁷ In the somatic sense, it was linked with other nineteenth-century diagnoses that encompassed a patient's nervous system. For example, the disorder known as *hyperanaesthesia* was considered one of the physical manifestations of hysteria during this era.⁸ Clarke explains that hyperanaesthesia could occur in a specific location on the body, such as in “the conjunctiva of the skin of the eyelid, and over a zone surrounding the orbit” (73) as well as “over the left breast” (87) and in the abdomen, among others. In some ways, then, hysteria remained a disease that presented in different parts of the body, or at least its symptoms did.

By the nineteenth century, however, a strongly gendered component was the focus of studies about hysteria, with experts like Clarke claiming that hysteria “is undoubtedly far more common among women” despite larger numbers of men being treated for similar symptoms (6). In fact, medical society looked at sexuality in a woman,

⁷ Even in ancient medicine, practitioners blamed hysteria on the female anatomy. In *From Hysteria to Hormones: A Rhetorical History* (2018), Amy Koerber explains, “women in ancient Greece who were not pregnant were seen as subject to all manner of health problems caused by the dangerous, yet unseen, wandering womb” (xii).

⁸ Like hysteria, hyperaesthesia was characterized by both somatic and psychosomatic symptoms, thus reinforcing the need to take both into account when studying this disease and its related ailments. The *OED* defines hyperaesthesia as “[e]xcessive and morbid sensitiveness of the nerves or nerve-centres” (“hyperaesthesia”). Hyperaesthesia seems to be the ailment most clearly afflicting Roderick Usher in Poe’s “The Fall of the House of Usher.” Often diagnosed as a hypochondriac – David W. Butler’s article “Usher’s Hypochondriasis: Mental Alienation and Romantic Idealism in Poe’s Gothic Tales” argues this very point – Usher’s condition goes beyond the nineteenth-century definition of that disease. However, if we consider the physical manifestations of Usher’s disease as Poe’s narrator describes him: “Surely, man had never before so terribly altered, in so brief a period, as had Roderick Usher! It was with difficulty that I could bring myself to admit the identity of the wan being before me with the companion of my early boyhood. Yet the character of his face had been at all times remarkable. A cadaverousness of complexion, an eye large, liquid, and luminous beyond comparison; lips somewhat thin and very pallid” (Poe 173) we recognize he is experiencing a combination of mental and physical complaints. Roderick has changed since the last time these two men met. In fact, the narrator continues to describe his erstwhile friend’s changed temperament, explaining that Roderick is of “an excessive nervous agitation” (Poe 174). From this depiction, we see not only a man changed, but a man changed for the worse, who is exhausted, nervous, and ashen.

particularly sexual excess, as contributing to hysteria. Clarke explains that while at the beginning the nineteenth century it was understood that sexual organs in some way caused hysteria, by the start of the twentieth century “[s]exual excess and sexual irregularities on account of their exhausting effect, and, in the case of the latter, of its prejudicial action in many ways upon the nervous system, would increase a predisposition to hysteria” (8). Hysteria, then, became more common due to the fact that “[i]n the nineteenth century, especially young women were expected to be delicate and vulnerable both physically and emotionally, and this image was reflected in their disposition to hysteria and the nature of its symptoms” (Veith 209). Thus, medical practitioners tended to associate exhaustion of the systems particularly influenced by female anatomy with their diagnoses of hysteria.

It is important to note, however, that some from this time did believe hysteria could be diagnosed in men. Edmund A. Kirby, in *On the Value of Phosphorus: As a Remedy for Loss of Nerve Power and Functional Disorders of the Nervous System* (1881), explains how men who contracted hysteria were often afflicted by “worry, anxiety, overwork, late hours, accidental injuries, and dissipation” (52). He distinguishes this diagnosis from females, who often were diagnosed with hysteria due to “vexatious emotions, want of sympathy or success, disappointed or concealed affection, want of occupation, fear, and morbid conditions or supposed morbid conditions of the reproductive system” (52). Thus, despite the fact that the many of the symptoms and the diagnosis would be the same for both men and women, the underlying causes were still being distinguished according to gender even towards the end of the nineteenth century.

Although some experts, like Clarke, considered hysteria an umbrella term under which nervous diseases like neurasthenia fell, others argued that neurasthenia and hysteria were two distinct diagnoses. According to many American practitioners in the early nineteenth century, men who exhibited some of the same traits were diagnosed with a condition similar to hysteria known as *neurasthenia*. Gould defines neurasthenia as a “deficiency or exhaustion of nervous force. Debility of the nervous centers” (305).⁹ It is important to note, too, that Clarke carried on this idea that neurasthenia was due to a depletion of the body—mostly in men due to overwork and the other strictures of nineteenth-century, industrial life. He writes that while neurasthenia is not a terminal disease, it does sometimes take the “best years of a man’s life,” which are then “passed in a carefully restricted activity” (261) due to the constraints of modern living. Thus, it is not a surprise that for nineteenth-century practitioners neurasthenia—associated so much with work and energy—was more closely linked to men whereas hysteria—commonly associated with nerves and emotions—was seen as a woman’s disease.

However, these diseases were not always separated on gendered lines. Because both neurasthenia and hysteria focused on nervous complaints and physical symptoms, an overlap between these two diagnoses was not uncommon, especially if one went abroad, where the gendered distinctions were not as prevalent as in the United States. In “Writing Siblings: Alice James and Her Brothers,” Anne Golomb Hoffman explains that in the United States the difference in gender as it related to a diagnosis of hysteria or

⁹ Neurasthenia, as defined by the *OED*, is a “disorder characterized by feelings of fatigue and lassitude” that was accompanied by “vague physical symptoms such as headache, muscle pain, and subjective sensory disturbances” (“neurasthenia”).⁷ The *OED* further explains that neurasthenia was “originally attributed to a weakness or exhaustion of and only later was “considered a form of neurotic disorder” (“neurasthenia”). However, for women whose roles had not changed as much as their male counterparts, medical practitioners still more frequently diagnosed them with hysteria.

neurasthenia was most pronounced.¹⁰ She writes, “In its American context, the connotations of neurasthenia were masculine, although it was not restricted to men, and indicated the depletion of energies that had been employed in productive work” (7). This gender distinction may explain why the expatriate James first received a diagnosis of hysteria in the United States and only later was diagnosed as having neurasthenia, while she was in Europe.

Furthermore, authoritative dictionaries like the *OED* make no mention of gender in regard to this diagnosis. This lack proves there is only some historical grounding—mentioned in the work of scholars like Hoffman above—to separate hysteria and neurasthenia along gendered lines. The cases of several well-known hysterics, including Alice James, and neurasthenics, including Charlotte Perkins Gilman, support this point. In fact, many sources providing a historical perspective on these diagnoses argue that throughout the nineteenth century, there was much uncertainty about how to diagnose patients. For example, if we consult *Cultures of Neurasthenia from Beard to the First World War* (2001), the editors acknowledge that “confusion reigns over gender: some doctors, and later historians, may have presented neurasthenia as a primarily male affair—the counterpart of female hysteria—but others disagreed, and the known examples of British diagnostic practice and treatment indeed show a fairly mixed picture” (Gijswijt-Hofstra & Porter 7). This mixed picture prevailed throughout the nineteenth and into the twentieth century and impacted treatments and literary representations of these illnesses.

¹⁰ It is important to note, for example, that Alice James herself was diagnosed with both hysteria and neurasthenia at different points in her life and by different practitioners, thus indicating that gender biases only marginally separated these two diagnoses.

Gender, then, was how nineteenth-century Americans distinguished hysteria from neurasthenia, a distinction their British counterparts would not have recognized until the start of the twentieth century. Hoffman explains, “Hysteria, while not confined to women, retained the link to femininity that its etymology conveys. Associating femininity and the female body with disease became a commonplace in Britain and the United States toward the end of the nineteenth century, with bed rest and confinement almost a way of life for many women of the middle and upper classes” (7). In a sense, this wasn’t a new phenomenon: however, in the nineteenth century it became the new-old axe to grind. Thus, the diagnosis focused on the patient’s gender and his or her treatment was also gender-based. It wouldn’t be until 1905, when Clarke updated *Hysteria and Neurasthenia*, that we find a clearer articulation of the distinction between these two diseases and how they relate to one another.

As the lives and writing of these individuals illustrate, although the diagnoses and symptoms might have been similar among male and female neurasthenics, the treatments for each gender were not. In ““Americanitis’: The Disease of Living Too Fast,” Julie Beck expands on the way cures varied for men and women. She writes that

...there was a sharp divide between how the disease was conceptualized and treated for men and for women. The underlying notion of neurasthenia — that nervous energy gets depleted because people’s bodies weren’t built for modern life — provided an easy way to reinforce traditional gender roles. When men spent too much time indoors, when they couldn’t keep up with the pace of their work, or had money problems, they were susceptible to neurasthenia. Women were susceptible when they were too

socially active, or spent too much time outside the home. (Beck
 “Americanitis”)

Thus, even though the underlying cause for the disease was the same for men and women, treatments still relied on gendered expectations, roles, and stereotypes, which were integral to the lived experiences of men and women. Higher-class women who went beyond socially acceptable roles — such as Alice James teaching and Charlotte Perkins Gilman writing — were ready targets for diagnoses in a way their steadily domestic counterparts were not.

Neurasthenic men were sometimes prescribed Dr. Silas Weir Mitchell’s west cure, while the women were subjected to the unhelpful, milder rest cure. Anne Stiles elaborates on the differences between these courses of treatment in her article “Go Rest, Young Man”: “While Mitchell put worried women to bed, he sent anxious men out West to engage in prolonged periods of cattle roping, hunting, roughriding and male bonding” (32).²⁸¹¹ The rest cure for the hysterical female echoed that of the treatments tubercular woman experienced, keeping her “safely” at home or in some other appropriately domestic setting:

While men and women could experience the same neurasthenic symptoms, the different treatments they received reflected cultural stereotypes of the day. The rest cure ensured that women remained in their “proper” sphere: the home. Mitchell and his medical peers discouraged

¹¹ Silas Weir Mitchell, creator of the “rest cure” for female hysterical and/or neurasthenic patients, himself took the west cure. He went to Switzerland where “Each day he walked and climbed fifteen miles up the Bernina route and along the River Inn,” effecting what Nancy Cervetti in *S. Weir Mitchell, 1829 -1914: Philadelphia's Literary Physician* (2012) calls a “camp cure” for his own neurasthenic diagnosis (98).

female patients from writing, excessive studying or any attempt to enter the professions. (Stiles 32)

Thus, even though ostensibly the diagnosis of neurasthenia was not based on gender, the treatment most assuredly was.

According to Clarke, while hysteria *can* be found in men (127), “neurasthenia is more common amongst men than amongst women” (174). As previously mentioned, the *OED* indicates that hysteria results more from the excited state of the patient’s nervous system while neurasthenia is associated with the physical sensations the patient is experiencing and was only later connected to his or her nervous system more broadly. It appears, then, that medical practitioners looked at diagnoses of hysteria as diagnoses of psychosomatic illnesses with somatic symptoms, thus supporting stereotypes about women’s weaker – of necessity uneducated – minds. On the other hand, they considered neurasthenia to be a physical illness attendant with some psychological symptoms when left untreated. Clarke explains these distinctions further, defining hysteria as “a peculiar state of disturbance of the nervous system, affecting primarily and most profoundly the highest cerebral centres, as is evidenced by the mental and emotional characteristics that belong to the disease, but most commonly or obviously betraying itself by some derangement of action of lower cerebral centres,” such as limbs that are inexplicably paralyzed, or anesthetized (5).¹² Clarke distinguishes hysteria from neurasthenia by explaining the latter as follows:

¹² It is important to note that the *OED* defines anaesthesia during this era in comparison with how we define it today in terms of a medical perspective. The dictionary explains that anaesthesia is a “loss of feeling or sensation, insensibility” that can be limited to part or the whole of the human body (“anaesthesia”). Thus, when hysteria got particularly bad in a patient, he — or more likely she — was subject to localized or entire loss of sensation in the body.

Neurasthenia may be defined as a nervous disorder without any known alteration in organic structure, characterized by a persistent state of fatigue and hence of weakness of the central nervous system, in the absence of the causes which normally are adequate to include such fatigue, and at the same time by a loss of control on the part of the higher nerve centres, and hence by an excessive reaction in certain directions to slight irritations. Nervous exhaustion, or nervous weakness and irritable weakness, are synonyms frequently used. (189)

He further explains that by 1857, there was a concentrated effort “to distinguish the symptoms properly belonging to neurasthenia, to separate the diseases from hypochondriasis and hysteria, and to claim for it a position as a distinct malady” (174). Thus, we need to consider that for the works in this chapter written before 1857, hysteria and neurasthenia were likely interchangeable diagnoses.¹³ So, with *Jane Eyre* (1847), for the author as well as readers, understanding of this disease as identical to hysteria was different than it was for the authors and contemporaneous readers of later texts. Literature, both fiction and nonfiction, soon began to expose and sometimes critique the gendered treatment practices, both covertly and overtly.

In light of the shift regarding the understanding of these diseases, readers may wonder, what it is that changes in the representation of these illnesses as they appear in

¹³ *A New Medical Dictionary* published in 1890 by George Milbry Gould defines hysteria by this period as “a reflect neurosis; not with certainty known whether it is due to structural alteration of any part of the central nervous system, or to abnormal blood supply, etc. Paralyses, impairment of vision, convulsions, etc. are usually prominent symptoms” (202). Gould defines neurasthenia as a “deficiency or exhaustion of nervous force. Debility of the nervous centers” (305). Because of his background in medicine — Gould was a renowned ophthalmologist — and “his interest in medical lexicography,” he published “a number of dictionaries, the first of which was published in 1890; more than a half million copies of his dictionaries were sold” (Alewitz “George Milbry Gould”).

the works written after 1857, such as “Autobiography of a Quack” (1867), *The Diary of Alice James* (1889), and “The Yellow Wall-Paper” (1892). To contextualize these texts, we need to consider how their authors would have understood the diagnosis of neurasthenia as distinct from hysteria. To reach this understanding, we must consult once again the historical sources to see how recorded uses of neurasthenia were distinguished from recorded uses of hysteria around this time. In *A Treatise on the Principles and Practice of Medicine* (1866), Austin Flint described hysteria as a disease that “embraces a multiplicity of morbid phenomena” (“hysteria”). In 1869, however, G. M. Beard, in *The Boston Medical and Surgical Journal*, wrote of “neurasthenia, or exhaustion of the nervous system” that “[t]he morbid condition or state expressed by this term has long been recognized, [...] but the special name of neurasthenia is now, I believe, for the first time presented to the profession” (“neurasthenia”). Clarke credits Beard with “the more complete separation of neurasthenia as a morbid state distinct from the more or less vague nervous disorders [like hysteria] with which it had been previously confounded” (172).¹⁴ Even as the nineteenth century drew to a close, however, a precise definition of hysteria and neurasthenia as separate conditions was confined to those familiar with Beard’s work.

In fiction, hysteria and neurasthenia served as an impetus for action and character development by the figures within the text. In nonfiction, the diseases’ manifestations

¹⁴ Scholarship attributes many medical advancements throughout the nineteenth century to George Miller Beard, including the beginnings of electricity as part of therapy and the founding in 1874 of the journal *Archives of Electrology and Neurology* (Tuttle, “Beard”). According to *American National Biography Online*: “Among his most significant — and most controversial — contributions to medical knowledge were his argument for the causal relationship between social phenomena and mental ailments and his assertion that the roots of mental illness lay in physical rather than moral disorder” (Tuttle, “Beard”). Of most relevance to this dissertation, however, is the fact that “Beard is best known for his identification, study, and treatment of neurasthenia, a disease he named in 1869” (Tuttle “Beard”).

became the action on which to focus. Throughout narratives of disease in the nineteenth century, readers encounter illness as overpowering the diseased body. Thus, the disease's actions replace the actions of the (woman's) body. It overtakes her, making itself the focus instead of the person in whom it has manifested. This overpowering, however, is resisted by those ill individuals who want to be viewed as more than their disease, as more than an invalid. However, when diseases like hysteria and neurasthenia are not resisted, they become terrifying, creating gothic nightmares that chill readers and titillate the larger society simultaneously. Therefore, to fully focus on hysteria and its comorbid illnesses, I have chosen nineteenth- and early twentieth-century fiction and nonfiction texts to examine the ways in which these diseases are used to show resistance to traditional diagnoses or an exploitation of those same diagnoses.

Because the definitions of neurasthenia and hysteria are vague, we must recognize that as we read about nineteenth-century diseases in these categories, diagnoses of fictional characters in critical readings are of necessity theoretical and incomplete. Therefore, we must take caution when using the terms "hysteria" and "neurasthenia" to comment upon the symptoms, whether manifested by fictional characters or historical figures. Moreover, we should be careful not to use these terms interchangeably to interpret literary texts from this era even though many other critical texts addressing the literature do. Instead, I argue that while some women were diagnosed with neurasthenia and some men with hysteria, literature echoes the sentiments of the broader culture and keeps these diagnoses largely separated along gendered, national, classist, and chronological lines. Since by the start of the twentieth century there was still an indication that these diseases could be considered interchangeable, it would be unwise to

assume they were not; however, we must exercise caution in studying why different patients were diagnosed with different ailments. Clarke explains:

It is by no means intended to imply, however, that the current views as to hysteria and neurasthenia are final. Our knowledge of those diseases of the nervous system which are at present unconnected with any known alteration in its structure is of recent growth, and further research will doubtless separate out, more accurately distinguish, and assign to their proper causes disorders which we now group together under a too comprehensive designation, or which at present elude our understanding.

(189)

As I continue this study, I use both terms, hysteria and neurasthenia, with specific references to Clarke's descriptions of these diseases, to describe fictional characters' ailments. I then contrast these characters with their real-life contemporaries for whom I use the terms their doctors recorded to diagnose their illnesses. In discussing these fictitious characters in relation to historical actors, I have grouped them based on diagnosis, symptoms, and chronology. Accordingly, Alice James has been paired with *Jane Eyre's* Bertha Mason Rochester and Charlotte Perkins Gilman has been grouped with the narrator of "The Yellow Wall-Paper" as well as her doctor, Silas Weir Mitchell, and his short story "The Autobiography of a Quack." At the same time, by exploring the ways in which hysteria affected the general population, and the means through which that population treated hysteria and its comorbid conditions, we can better understand the disease's place within literature.

First, in *Chapter 9*, we encounter the unique resistance of the imprisoned Bertha Mason Rochester in Charlotte Brontë's *Jane Eyre* (1847). Bertha repeatedly flees her disease-imposed captivity, resisting the supposed safeguards placed on her by others. We also glimpse resistance in the figure of Alice James in *The Diary of Alice James* (1889), as she focuses on aspects of her life apart from her disease. *Chapter 9* explores the ways in which James purposely moves the focus of her diary off of her disease and how this shift in focus embodies the resistance of an invalid. Further, this chapter becomes a place to explore the repeated allusions and comments on structural alteration provided by Clarke and medical practitioners like him. If we take these alterations a step further, for example, and look at them in relation to the texts, we consider how hysteria can change a text, causing a stop while the hysteric once again gets his or her bearings, as in the case of Bertha and James when she succumbs at several points.

Finally, we discover resistance in *Chapter 10* through the ways in which Charlotte Perkins Gilman defies those medical practitioners treating her solely based on her illness instead of taking her entire person into account, as she writes about exclusively in her autobiography *The Living* (1935). However, if these manifestations are not resisted, they take on the qualities of a nightmare. The short, quasi-autobiographical story "The Yellow Wall-Paper" (1892) carries Gilman's monstrous hysterical character through to the end, imbuing in her narrator increasingly terrifying hysterical tendencies as she succumbs to her disease when she can no longer resist its terrors. Additionally, *Chapter 10* compares the narration Gilman provides of her illness both in her autobiography and in her fictionalized account with the representations of female illness Gilman's own doctor, S. Weir Mitchell, provides in his short story "Autobiography of a Quack." In examining

these works side-by-side, we can better comprehend the female patient–male doctor dynamic from this era on behalf of both woman and physician.

Ultimately, by investigating the diagnoses and the misunderstandings associated with them, we can discern how hysteria and its comorbid illnesses develop — or fail to develop — as a piece of literature progresses and why. Further, we can trace the ways in which hysteria and its comorbid illnesses resist the social notions of disease of the time and how this resistance occupies a place within the larger narrative created by society. Therefore, we can see how disease occupies a crucial place within the literal narrative, as each author develops complex portrayals and plot twists involving hysterics and the resistance to this diagnosis or begrudging acceptance of it. Even as these stories play out on the page and in readers' minds, the texts' incorporation of hysteria and related disorders—and the hysteric's resistance to labeling— contributed to the development of a social narrative that remains unsympathetic to diseased individuals, particularly if they are female. The patient, often reduced to a gendered stereotype, continued to be studied by their disease instead of their disease being studied according to each patient as an individual.

*Chapter Nine: Mad to the Bone: Hysteria's Physical
Manifestations in Fiction and Nonfiction*

Some of the clearest intersections of class, gender, and disease occur in texts that feature an individual with hysterical symptoms. These works explore the representations of disease without the added complication of sexualization of the patient due to her beauty, unlike the experiences of the tubercular or chlorotic woman. Unfortunately, they offer their own complication as society harshly judges the hysterical woman for her condition since her disease renders her entirely unsuited to marriage, placing her outside the social norms. However, it is this same placement that allows the hysterical woman to explore her own interests without constraint. Her disease creates a space in which she can interact with others outside her own class through treatment programs, stays in asylums, and isolation from society. These facets of her illness are not infinite, however, or even very pronounced. Hysteria burdens the woman of the nineteenth century, particularly as a result of the altered state it creates. She is still subject to both the male and medical gaze. She must overcome or resist the labels prescribed to her. Most of all, she must find her own voice so others can understand her experience from her perspective or risk becoming truly mad.

Charlotte Brontë's best-known work, *Jane Eyre*, introduces one of the most familiar madwomen of all time, Bertha Mason Rochester. This young woman's life as related by her brother was one of genuine tribulation, both for her and them. Brontë describes Bertha, explaining that as a young woman about to marry Mr. Edward Rochester, she appeared "pure, wise, [and] modest" (294). However, as Rochester soon saw a new side to his first wife, so too, does Brontë's audience when we, along with Jane

Eyre, are finally introduced to the madwoman in the attic. When Jane first openly encounters Bertha, she describes the original Mrs. Rochester as “the lunatic” possessed of a “stature almost equaling her husband, and corpulent besides: she showed virile force” (296). We see here Bertha as not representative of her gender—she is virile, and thus made masculine—but instead indicative of hysteria: she is too strong, too tall; she has too many of the qualities a nineteenth-century woman should not possess. Ilza Veith explains in *Hysteria: The History of a Disease* (1965) that Brontë’s masculinization of the hysterical female was not uncommon, quoting a medical text from the eighteenth century: “Manie women, when their flowers or terms be stopped, degenerate after a manner into a certain manly nature, whence they are called *Viragines*, that is to say, stout, or manly women” (qtd. 119).¹ These woman no longer fit the fragile, feminine ideal embodied by Jane but instead become representative of the men to whom they are supposed to appeal.

Veith further acknowledges that modern medical practitioners know of this shift towards the masculine resulting from changes in the endocrine system that are “generally believed to be the cause for emotional disturbance rather than the result” (119). In fact, in *From Hysteria to Hormones: A Rhetorical History* (2018), Amy Koerber explains that it wasn’t until the twentieth century that “endocrinology was established as a discipline, and experts could offer scientific explanations that referred to specific reproductive

¹ Readers might wonder, then, if hysteria has a particular place in discourses surrounding transgender identities as Bertha exhibits inarguably both male and female characteristics. While exploring this concept is beyond the scope of this project, it is important to note that sources do exist that address the link between hysteria and transgender identities. See: *Please Select Your Gender: From the Invention of Hysteria to the Democratizing of Transgenderism* (2011) by Patricia Gherovici. Here, Gherovici makes an excellent point, too, about hysteria, noting “certain symptoms appear only during a particularly time period and in accordance with its prevailing medical knowledge. This openness to medical discourse shapes hysterical symptoms” (56). Thus, if society is currently hysterical about transgender rights as a result of bathroom laws, rising anti-LGBT+ sentiment, and so forth, it is unsurprising that scholars draw a connection between a previously stigmatized social issue and a currently stigmatized one.

hormones as the cause for female symptoms that had for centuries been vaguely defined and often lumped together under the unspecific, constantly changing diagnosis of hysteria” (xiii).² As a result of the lacking knowledge in previous centuries, it is not a surprise that woman like Bertha—who perhaps had an imbalance in their hormone levels—were looked at askance as medical practitioners struggled to understand their illness.

Furthermore, before she jumps from the roof of Thornfield Manor, killing herself, Bertha is the focus of much discussion among the other characters. Because the manifestations of her disease are not uncommon for someone affected by hysteria, we can read in them the importance of the hysterical madwoman and her place in literature. Without Bertha’s somewhat contained madness, there would be no story once Jane arrives at Thornfield. In fact, Bertha’s hysterical symptoms are what move the novel along, using the mysterious bumps in the night and the cause of Jane’s departure and Rochester’s own madness as means of exploring the ways in which hysterics affect those around them. These events end only with Bertha’s death, and the novel closes not long after.³ The impact Bertha has, then, is not just on the story Brontë tells but also on the

² Koerber herself makes the rhetorical choice to continue to associate hysteria with the female gender, over a century after Brontë published *Jane Eyre*. She does, however, specify that “the distinctly gendered dimension to the concept of hysteria is part of [Charcot’s] legacy” (Koerber 59). Jean-Martin Charcot—mentioned in the introduction to this work in relation to S. Weir Mitchell—did have male patients present with symptoms of hysteria; however, he simply had more female ones and so they are where his concentration lay (Koerber 59).

³ Unfortunately, not everyone recognizes how Bertha’s hysterical symptoms influence the progression of the story. Gilbert and Gubar, for example, focus instead on what is happening to Jane. They argue that Jane’s “confrontation, not with Rochester but with Rochester’s mad wife Bertha, is the book’s central confrontation” (Gilbert & Gubar 339), again placing Jane in the central position of the actor instead of realizing she is the reactor to Bertha’s hysterical self. In the moment of confrontation mentioned above—in which Bertha is wrestled into submission by her husband and bound to a chair—we realize Jane remains silent and still while Bertha rages on, with “the fiercest yells, and the most convulsive plunges” (Brontë 296). (You’ll recall from *Chapter 8* that convulsions are among one of many somatic hysterical symptoms.) It is only once Bertha’s performance is at an end that all of the other figures withdraw, leaving her alone (Brontë 296) and proving Bertha is whom the other characters fix their attention upon. Just as without

larger society, likely to institutionalize and even vilify a woman for her insanity instead of listening to or truly helping her.

Bertha's seemingly masculine characteristics—particularly when she is portrayed as virile and equal in stature to Rochester—position her as a strong foe against her husband, who is representative of the patriarchy willing to keep women trapped, quite literally, in the domestic sphere. We see her as rejecting Rochester's captivity and fighting back; ostensibly, her symptoms are indicative of the disease of hysteria but, in reality, they point to much larger social issues—chiefly those of gender, social class, and disease. These characteristics also allude to the structural changes forced in the body by hysteria, which Clarke studies and which Freud expanded upon in his studies of this disease. Veith explains that while Freud saw “chemical alterations behind those neuroses which he termed ‘actual,’” modern scholars would better understand “if the term ‘endocrinological’ were substituted for ‘chemical’” (266). Just as the endocrine system guides the pituitary gland, and thus the development and growth of the body, it also guides the reproductive system and one's thyroid.⁴ However, understandings about the importance of the thyroid gland in one's development and maturation were just beginning to be studied. Today we may understand more about the chemical changes occurring in Bertha as a result of hysterical tendencies, which not only lead to her large size but also to her sexual nature – a nature that becomes apparent when Rochester calls her “a wife at once intemperate and unchaste” (309) – which goes against the norms of the Victorian

nineteenth-century knowledge of hysteria there is no understanding of Bertha's disease, without Bertha's madness, there is no novel after Jane arrives at Thornfield.

⁴ According to the *OED*, “endocrine” as a term wasn't broadly understood until 1914. For more information on emerging nineteenth-century understandings of how the endocrine system—and thyroid in particular worked—see: Cresswell E. Baber's “Researches on the Minute Structure of the Thyroid Gland.” 1881.

era; however, during her time, she would have unfortunately been viewed as an anomaly of her sex.

Soon after this initial description, we learn more about Bertha's marriage to Rochester when he explains her personality to Jane, stating that her mind was "common, low, narrow, and singularly incapable of being led to anything higher" (Brontë 308). She is of a class and race different from Rochester's own, and he finds this disgusting as her looks are no longer enough for him to find his wife socially acceptable. Instead, he seeks out a mistress as he cannot have a new wife, looking for a woman who is "the antipodes of the Creole" (Brontë 313) highlighting not only his problems with his wife but with her race. Interestingly, hysteria in the eighteenth century was thought to be a disease which befell "[o]nly the well-born and the idle" (Veith 174). However, by Brontë's period, there were those who disagreed with this assessment. Veith cites a nineteenth-century medical practitioner who studied patients with characteristics similar to Bertha's—coincidentally, the doctor's name is Carter, just like Bertha's own "medical man"—who realized that the disease also was diagnosed among those of other classes, "stating that it occurred frequently" amongst poor and rich alike (208). Thus, by the middle of the nineteenth century when Carter published his studies on hysteria, the disease was also seen as an illness affecting those who were morally or physically weak or of a lower social class (Veith 208) like Bertha, who is likely looked at as morally weak and of a lower social class due to her heritage.

Rochester further describes his wife, arguing that she could not sustain "kindly conversation" between them but instead would turn the topic of discussion towards something "coarse and trite, perverse and imbecile" (308). Bertha made Rochester

uncomfortable due to her interest in “perverse” and “coarse” topics unbecoming a woman of her era, thus indicating the aforementioned symptoms ascribed to hysteria. Not long after his conversations with her grow more erratic, we have medical confirmation from Bertha’s physicians regarding her sanity. Rochester explains, “[t]he doctors now discovered that *my wife* was mad—her excesses had prematurely developed the germs of insanity” (309). Her interest in these same immodest topics corrupted her and have made her appear hysterical.

To fully understand Bertha’s supposed depravity, we need to turn our attention to Sandra Gilbert and Susan Gubar’s *Madwoman in the Attic* (1979). The authors write: “while acting out Jane’s secret fantasies, Bertha does (to say the least) provide the governess with an example of how not to act, teaching her a lesson more salutary than any [Jane’s teacher] ever taught” (361). Thus, we not only learn that Bertha manifests as the improper nineteenth-century woman driven by excesses but we also discover that to some extent, Jane envies her this ability to step outside of the traditional Victorian role for women. Gilbert and Gubar explain further, noting that “What Bertha now *does*, for instance, is what Jane wants to do,” so she tears up the bridal veil, reveals herself soon after, and ultimately puts off the wedding so that Jane does not become an even more subservient Victorian female (359). The very size, excess, and desires which make Bertha a hysterical woman also make her stand out in sharp and delightful contrast as “rich, large, florid, sensual, and extravagant” when compared to Jane’s “poor, plain, little, pale, neat, and quiet” self (Gilbert & Gubar 361). As a result, Bertha’s purported depravity as studied by modern scholars like Gilbert and Gubar stands out as a remarkable alternative to the quiet and dominated nineteenth-century woman.

But Bertha's alleged depravity—we only have the word of the man who held her captive in an unused wing of the house—comes with its own risks. Mary Ann G. Cutter elaborates in *The Ethics of Gender-Specific Disease* (2012) that “if a woman's behavior violated expected gender-role norms, her behavior was attributed to various physical or mental illnesses [...] with labels such as ‘hysterical’” (39). Thus, the typical nineteenth-century man, a man like Rochester who prefers demure women, would easily read Bertha as hysterical based on her sexual drive and purported excesses, excesses which Rochester never fully describes. Additionally, nineteenth-century scholars of hysteria focused on the influence of sexual excess on the disease. For example, Clarke writes, “[s]exual excess and sexual irregularities on account of their exhausting effect, and, in the case of the latter, of its prejudicial action in many ways upon the nervous system, would increase a predisposition to hysteria” (8). Therefore, if Bertha is as Rochester claims – and these claims are not born out of frustration or racism – she is likely predisposed to hysteria, a predisposition exacerbated by environmental factors.

Showalter, for example, writes that women were susceptible to hysteria because of their upbringing (*Hystories* 52). In Bertha's case, this susceptibility may exist as readers discover in the middle of *Jane Eyre* that she “is mad; and she came of a mad family;—idiots and maniacs through three generations!” (294). Thus, it is expected that Bertha's upbringing must have been troubled, with inadequate intellectual stimulation, and restricted contact with a mother figure which was even more limited than Jane's own. Bertha Rochester's hysterical symptoms influence *Jane Eyre* so dramatically because they create situations that force the other characters to react.

Bertha's struggles reflect nineteenth-century understandings of heredity, social class and their complicated relationship with morality. In Angelique Richardson's *Love and Eugenic in the Nineteenth Century*, she explains: "morality was increasingly figured as a product of heredity" (23). Bertha, who is seen as less-than due to her status as a Creole with a mad forebearers, has her morality called into question. This questioning becomes apparent when we realize Rochester looks at his wife as base, imbecilic, and possessed: "my wife is prompted by her familiar to burn people in their beds at night, to stab them, to bite their flesh from their bones, and so on—" (Brontë 303).⁵ In this moment, it seems like Rochester will forgive his wife her madness as someone who is female, of a lower class, and possessing only a base morality because she is so susceptible to it. However, Rochester explains why he is incapable of being lenient when Jane tells him it is cruel to hate Bertha, reminding Rochester "she cannot help being mad" (303). But Rochester counters with the idea that while Bertha cannot help being mad, she is immoral, and that is unforgivable: "I did not even know her. I was not sure of the existence of one virtue in her nature: I had marked neither modesty, nor benevolence, nor candour, nor refinement in her mind or her manners" (307-08). Thus, Bertha's madness is not the only thing which has been bequeathed to her; she has also learned her mother's immorality as a result of her upbringing.

The aforementioned genetic link between an immoral and hysterical mother and her daughter addresses the question of gender and its relationship to this disease and race.

⁵ Demonic possession was commonly thought to be a cause for hysteria through this era, according to Veith. Influenced in part by religious understandings of retribution for moral wrongs, hysterics—particularly considering their sexual excesses—were seen as "acting out [...] demonic possession and the vast variety of physical and mental delusions related to it" (Veith 209). This notion of the demonic hysteric, then, appears in direct contrast to the angle woman trope examined in relation to TB and Eva St. Clare of *Uncle Tom's Cabin* in Chapter 3.

Showalter explains that women were more “readily recognized” as having “a ‘predisposition to derangement’” in reference to their genetically “inherited mental structure” (“Insanity” 170). Therefore, to nineteenth-century readers who have a knowledge of how hysteria might present, it is not a surprise that Bertha is insane since her mother was. Furthermore, because of the form her madness takes—specifically through the symptoms she presents with—it would be known in the later nineteenth century as “hysterical madness” (Libbrecht 8).⁶ Further, Libbrecht explains there is a connection between genetics and this madness, noting that this madness “finds its definition in hereditary degeneration” (8). Rochester unwittingly supports this understanding of hysterical madness when he tells Jane: ““Her mother, the Creole, was both a mad woman and a drunkard!—as I found out after I had wed the daughter: for they were silent on family secrets before. Bertha, like a dutiful child, copied her parent in both points”” (294). This focus on her race as Creole alongside Rochester’s subsequent expectation that his new wife will now move in his “elevated” social circles increased the pressure under which Bertha was likely already straining, indicating the troubling relationship of class and environment on hysteria as coinciding with one’s genetic predisposition.⁷

⁶ Hysterical madness is a distinct form of hysteria that is only properly defined after 1860. In her book *Hysterical Psychosis* (1995), Katrien Libbrecht defines it as “transformed hysteria” in which “the somatic disorders typical of neurosis feature less prominently” (7-8). She further explains that by distinguishing hysterical madness from hysteria, practitioners can “make way for mental disorders which mark the transition to mental derangement” (Libbrecht 8). Thus, the mental derangement we see in Bertha, while not capable of being diagnosed as hysterical madness in Brontë’s time, is clearly indicative of this disease.

⁷ Brontë makes many allusions to race and class throughout this novel. One of the most interesting comes when Rochester—with a family estate in desperate need of money—is married to Bertha. He explains, “[h]er family wished to secure me because I was of a good race” (307) indicating that the upward mobility provided by marriage protects or elevates not only social class, but also social desirability as any children Bertha and Rochester had would be a “a good race,” at least in part.

Rochester uses this genetic and racialized link—she is part Creole and likely to inherit her mother’s tendencies—to place blame on Bertha for her actions instead of recognizing she may not have control over them. This connection between genetics and madness was not particular to Rochester. In fact, this link among genetics, disease, and social structure was often acknowledged to exist with neuroses like hysteria. In 1905, Clarke explains that “[t]he influence of heredity is marked [in hysteria]; careful inquiry generally shows the presence of the neurosis in one of the parents or in near relatives” (127). Further, in his contemporary study of hysteria, Veith specifies that “this disease had slowly become a token of social distinction” (174). Thus, it is unsurprising that a woman married for her fortune and treated poorly due to her race and class, would show symptoms of hysteria and insanity, particularly considering her mother—other relatives—also was insane.

Since Bertha’s seemingly hysterical tendencies are now apparent, we must consider how her family and the medical minds of the time coped with these potential symptoms of hysteria. It is with the first Mrs. Rochester that readers are introduced to the idea of institutionalization, and the fears it inspired in many during the nineteenth century. We read about the option of either sending an ill woman to an asylum or locking her in her own home when we first learn what has happened to Bertha’s mad mother; according to Rochester: “My bride’s mother I had never seen: I understood she was dead. The honey-moon over, I learned my mistake: she was only mad, and shut up in a lunatic asylum” (308). Thus, just as Bertha has inherited her mother’s tendency towards madness, she is confined as well when Rochester determines to lock her away in the relative safety of their own home, after first tying her to a chair: “with more rope, which

was at hand, he bound her” (296). Those watching him then hear him explain sarcastically that ““I must shut up my prize”” (296).⁸ Soon after, he tries once again to justify his behaviors to Jane, arguing that his reasoning for keeping Bertha near—though imprisoned—was done out of an attempt to treat his hysterical wife kindly:

‘My plans would not permit me to move the maniac elsewhere—though I possess an old house, Ferndean Manor, even more retired and hidden than this, where I could have lodged her safely enough, had not a scruple about the unhealthiness of the situation, in the heart of a wood, made my conscience recoil from the arrangement.’ (302-03)

While Rochester’s concern for Bertha’s health shows that he holds himself at least somewhat accountable for his wife’s treatment, his care is in fact misguided. According to Showalter, readers can understand that Rochester’s captivity of Bertha inside her own home was most likely worse than what she would have received in a nineteenth-century asylum. Showalter writes, “one of the most striking ironies of women’s experience in the Victorian asylum was that despite its limitations, it probably offered a more tolerant and more interesting life than some women could expect outside” (“Insanity” 168). By locking Bertha up, Rochester not only limited his options—he can never remarry while she lives, for one—but hers as well. Bertha will never receive the treatment she needs and will instead suffer further from first the neglect of her parents and now the neglect of her husband.

⁸ Here readers cannot fail to note the double meaning of this phrase: on the one hand, he has shut up his prize, locking her once more into her prison. On the other, he has quite effectively silenced her, thus shutting her up and taking away her voice.

The fact that Bertha is “shut up”—both literally and figuratively—allows us to study her diagnosis in-depth in the vacuum that her captivity creates. Rochester tells Jane that ever ““since the medical men had pronounced her mad, she had of course been locked up”” (310). This “treatment” of her madness, while common in the nineteenth century, horrifies modern readers. However, Foucault points out in *The Birth of the Clinic* (1963), that there is a benefit to leaving a disease completely untreated, as in Bertha’s case. He writes of the essence of disease which is unaltered by treatment: “There is a ‘savage’ nature of disease that is both its true nature and its most obedient course: alone, free of intervention, without medical artifice, it reveals the ordered, almost vegetal nervure of its essence” (16). If we study Bertha’s disease as one which is alone and free of intervention, we can see what happens when her hysteria runs its course uninhibited by the complex “social space” which ultimately denatures a disease (Foucault 16). As Bertha’s madness is inherent, the result of a genetic predisposition, being able to see it run its full course allows readers to encounter Brontë’s representation of hysteric symptoms at their most organic. Her disease only becomes encumbered by her interactions—or lack thereof—with these “medical men” mentioned by Rochester.

Rochester continues her captivity, keeping Bertha largely cut off from most of these medical men once he and his wife move to England. He explains to Jane that Bertha’s caretaker, Grace Poole, ““and the surgeon, Carter [...] are the only two I have ever admitted to my confidence”” (312). As a result of her prison-like existence, Bertha’s time with others who have knowledge of her condition—and how to treat it—is severely limited. Furthermore, placing her away from the rest of the household leads those around her to treat her like an object, as if she’s an outdated wardrobe or an old trunk of clothes

placed in an out-of-the-way, little-used room. Bertha becomes a prisoner in her own home, bound not only by her madness, but also by her marriage.

According to Veith, hysteria first presents with “a great many negative traits such as inclination towards deception and prevarication, jealousy, malice, and other sorts of misbehavior” (Veith 195). Early on in *Jane Eyre*, we see evidence of Bertha’s malice when she tries to kill Rochester, who later explains, ““the lunatic is cunning and malignant; she has never failed to take advantage of her guardian’s temporary lapses [...] on the first of these occasions, she perpetrated the attempt to burn me in my bed” (312). Bertha becomes the actual embodiment of her disease, the malignant figure impacting those who attempt to repress or control her. In fact, curious about how he has captured and imprisoned his wife, Jane asks Rochester, ““what did you do when you found out she was mad?”” (309). At this juncture, Rochester explains he had a vision in which he was told, ““You may take the maniac with you to England; confine her with due attendance and precautions at Thornfield”” (311). As a result of this vision, Bertha is left largely alone, with only care “as her condition demands” (311). However, because she is left captive in inexperienced hands, we can safely assume her care is very limited and thus her disease runs its course uninhibited.

The relationship Bertha Mason Rochester builds on the most by this point in the novel is between herself and her guardian of sorts, Grace Poole. Foucault offers an explanation for this type of connection in medicine, articulating that “[d]octor and patient are caught up in an ever greater proximity, bound together” (15). Therefore, while Bertha is closed off from her family and the rest of the house, she still has her medical attendants, the only other people who realize she even lives in the home. However, if a

doctor or caretaker only sees the superficial in their patient, or listens only to the words of other people regarding the patient's symptoms, these medical practitioners are likely to miss the big picture and instead—as in the case of Bertha—use their medical gaze to treat or not treat the patient. In Foucault's explanation of the medical gaze, we can see a clear relation to the scrutiny under which Bertha suffers. This gaze “need hardly dwell on this body for long, at least in its densities and functioning” (Foucault 16). Thus, her caretakers assume they do not have to spend much time considering what is wrong with Bertha—she is simply hysterical—and they do not use any of the known options to cure her or actually treat her disease. She falls victim not only to her hysterical madness but also to the superficially-focused system of medicine desperately in need of change.

This out of sight, out of mind captivity wasn't an experience unique to Bertha Rochester. As Showalter shows, nineteenth-century hysterical women were held prisoner in more than one way as compared to their seemingly healthy counterparts. Showalter further explains the physical and emotional confines hysteria places on a patient, harkening back to Rochester's comment that “I must shut up my prize.” She writes, “[n]ineteenth-century hysterical woman suffered from the lack of a public voice to articulate their economic and sexual oppression, and their symptoms—mutism, paralysis, self-starvation, spasmodic seizures—seemed like bodily metaphors for the silence, immobility, denial of appetite, and hyperfemininity imposed on them by their societies” (*Hystories* 54-55). We see these bodily metaphors acted out through the figure of Bertha as she crawls around on the floor, unable to walk properly: she “grovelled, seemingly, on all fours” (Brontë 295). We see them again when Bertha cannot communicate her wants, but instead acts out her desires; attempting, for example, to physically assault those who

keep her locked up—chiefly her husband and brother (Brontë 312). Finally, we see them in Bertha's last, oddly triumphant moment, as she falls—either accidentally or purposely—off the wall, escaping both physically and mentally the confines her disease, her husband, and society placed upon her.

The idea that Bertha's voice is muted is not surprising considering her hysterical tendencies. Ankhi Mukherjee expands on Showalter's claims in her introduction to *Aesthetic Hysteria: The Great Neurosis in Victorian Melodrama and Contemporary Fiction* (2007), writing that this lack of voice is not uncommon when she defines hysteria as “both a disease, a nosological entity, with its own unspeakable or unspoken agonies, a stifled language, which tries to recover the ineffable in pathological signs” (4). The more severe Bertha's hysterical symptoms become, the more pronounced her lack of voice is and the less effectual she is in recovering her voice. Brontë writes of Bertha's sweet utterances when she first meets Rochester, her coarser speech as their marriage progresses, and finally reduces her character to emitting “a fierce cry” followed not long after by a bellow (295). The hysterical-seeming woman, stripped of her voice, attempts further communication but is effectively stifled as the other characters continue to speak of her as if she weren't present. She is relegated to the status of a troublesome object, worthy of being studied, examined, and ultimately shamed for not fulfilling her expected role within society.

Perhaps the most tragic part of the limitations her disease places on Bertha is the way in which others share the news of her death as relatively unimportant, only remarking on its significance in terms of the freedom it now offers Rochester. Of Bertha's final scene, Brontë writes only one line: “Mrs. Rochester had flung herself from

the battlements, there was a great crash—all fell” (432). This trivializing attitude towards the struggles of Bertha Rochester is mirrored in the literature about *Jane Eyre*. Susan Rubinow Gorsky in *Femininity to Feminism: Women and Literature in the Nineteenth Century* (1992) instead writes of the suffering of Rochester at this point in the novel, explaining that an “occasional male character suffers as do women from society’s views. Rochester in Charlotte Brontë’s *Jane Eyre* cannot divorce his wife, though her family failed to warn him of her hereditary madness,” which leads to pain for Rochester (77). Gorsky’s portrayal of the suffering man places Bertha—whom Gorsky does not even name—as less than, marking her suffering and subsequent suicide as smaller concerns than the struggles of her male counterpart. Society forces Rochester to honor his marriage vows; however, no one checks on precisely how he honors these. This disregard for the hysterical woman is troubling, but also far too common in narratives focused on this disease.

This neglect of the mad antihero is fertile grounds for studying not only hysteria’s place in society, but more particularly its place in literature.⁹ Gilbert and Gubar address Bertha’s purpose in *Jane Eyre* as threefold, arguing that Jane’s confrontation with Bertha sets up the outcome of the novel, “Rochester’s fate, and Jane’s coming-of-age” (339). Unfortunately, Gilbert and Gubar once again position Bertha as Jane’s foil, only writing about her in relation to the titular character: “Bertha [...] is Jane’s truest and darkest double: she is the angry aspect of the orphan child, the ferocious secret self Jane has been trying to repress” (360). Thus, in the literary criticism Bertha still has agency only when

⁹ Bertha is clearly seen as someone to be worked around; not studied or treated in either the novel or in the criticism of that novel; in fact, all the other characters and theorists are content to leave her to her madness instead of attempting to understand it.

she is working through another character, whether it be her husband or his new fiancée. When we separate Bertha from the other characters in the novel, however, we see a bleak portrait of what life could be like for a woman expressing hysterical symptoms in the nineteenth century. She is left alone to be cared for intermittently by another woman, she wanders what was supposed to be her own home privately at night, and she acts out her anger when she believes the others will not be around to witness it. Brontë, through Bertha, shows us the problems with not only misunderstanding a diseased individual, but also with mistreating her.

Bertha's encounter with Jane propels the novel forward. When Bertha realizes her husband is about to enter into a bigamous marriage with Jane, she "spent her fury on [Jane's] wedding apparel" (312), shredding it with a knife she stole when Grace Poole was otherwise occupied. Veith's focus on Carter again becomes important here as Carter was the one to realize that certain situations could trigger a hysterical attack in his patients (201). Her husband's second marriage, while Bertha is still clearly alive and living as a captive in his house, triggers her fury, which she vents on Jane's clothes, showing a clear comprehension and understanding of her situation despite Rochester's claims to the contrary. The mystery of who has ruined Jane's bridal clothes haunts Jane, showing how even in her absence Bertha drives the plot conflict more than those who are readily visible to the readers. Her hysterical reactions to Jane's presence move the story, layering it with foreboding of the difficult conversations and events to come.

Two other triggers for hysterical attacks, according to Veith's study of Dr. Carter, are first "the temperament of the individual" and second, "the degree to which the affected person is compelled to conceal or 'repress' the exciting causes" (201). Because

readers of Brontë are able to focus on the temperament and repression of Bertha, the first Mrs. Rochester once again becomes the catalyst to which the other characters react.

Rochester himself hints at the danger of repressing Bertha, admitting that “[c]oncealing the mad-woman’s neighborhood” from Jane was as fruitless as trying to hide someone under a cloak (Brontë 303). Madness will out, and it will lead to conversations like the one Rochester has with Jane following their aborted wedding. These discussions between Brontë’s other characters reveal Bertha’s hysterical temperament, but more importantly they call into question the personalities of those who interact with or repress this hysteric.

Bertha’s experiences with nervous afflictions were easily paralleled in the lives of women living during the long nineteenth century. In fact, the connection between nerves and the female body and the varying titles for these illnesses led doctors to, for many years, diagnose and misdiagnose Alice James, a member of the intellectually prominent James family. While James did travel and had periods of employment as an educator, her doctors theorized that because of her status as a woman she experienced serious bouts of depression, despondency, and other nervous conditions that were diagnosed as either hysterical or neurasthenic. Towards the end of her life, James began to keep a diary in which she documented her personal and semi-public struggles with both somatic and psychosomatic ailments, including the diagnosis of hysteria. At the time of Alice’s diagnosis, some of her symptoms mirrored those of women in Freud and Breur’s *Studies in Hysteria* (1895). Ruth Bernard Yeazell cites these psychoanalysts, explaining, “[f]rom the facial neuralgias and stomach pains to the fainting spells, the mysterious ‘attacks’ and the partially paralyzed legs, every one of Alice’s symptoms was to prove the familiar

currency of *Studies in Hysteria*” (12).¹⁰ Therefore, we are fortunate that James’s journal survives as a remarkable representation of an invalid’s ideas about her own experiences and how they are echoed in society’s larger conversations.

James was one of the most intimate and influential diarists of the nineteenth century. Her careful documentation of her somatic and psychosomatic ailments and her experiences with both British and American medical institutions makes James an integral figure to research on hysteria and resistance. Yeazell in her compilation of documents by or about Alice James (*The Death and Letters of Alice James* [1981]), shares a letter written in 1866 by James’s mother, Mary Walsh James, regarding her daughter’s recent hysteria diagnosis. In it, Mary writes:

All our time and thoughts are given now to dear Alice who is no better [...] her nervous turns are very frequent and brought on by the slightest exertion [...] It is a case of genuine hysteria for which no cause as yet can be discovered. It is a most distressing form of illness, and the most difficult to reach, because so little is known about it. (qtd. in Yeazell 11)

Here even James’s own mother accepts as fact that “so little is known about it” and that “no cause as yet can be discovered” instead of wondering why medical minds have not explored further this largely female-specific complaint. Through studying James’s diagnosis of hysteria—and later neurasthenia—then, we can begin to understand the ways in which female patients who fell into the nebulous category of “hysterical” were treated,

¹⁰ These same conditions are described in the 2004 translation of *Studies in Hysteria* published by Penguin. The translator, Nicola Luckhurst, interprets Freud and Breuer’s description of the symptoms of hysteria as: “all kinds of neuralgias and anaesthesias, which have often persisted for many years, contractures and paralyses, hysterical attacks and [...] *petit mal* and tick-like affections, persistent vomiting and anorexia to the point of refusing all food, a great variety of visual disturbances, constantly recurring visual hallucinations and so on” (8).

or left to find their own ways of confronting their diseases while resisting the stigmas they carried. Through a careful examination of James's representation of her illnesses and experiences as a patient, in her diary and letters, readers can learn much about not only what society thought of her debility but also what she thought of herself.

Even though James does, for the most part, an excellent job resisting the labels her diagnoses place upon her, they still find a way into her work, revealing her inner strength despite her dire diagnoses. For example, her diary entry dated August 9th, 1889, opens with the sentence "England is having one of its hysterical attacks over Mrs. Maybrick, what a spectacle it is!" (52). However, if we recognize James for the humorous writer we know her to be, we cannot fail to recognize that while hysteria enters into her diary, it does so in a way replete with sarcasm. In this entry, we see James relabel the society that has diagnosed her and left her to wallow in her condition. She forces the term "hysterical" back on them, which leaves her readers to consider what this word means not only as a diagnosis but also as a description. Additionally, the case of Maybrick is one that cannot help but cause a fascination of spectacle in much the same way James herself does. Leon Edel's footnote explains, "Mrs. Florence Elizabeth Maybrick was convicted of murder, circumstantial evidence showing that she had extracted arsenic from flypaper and administered it to her husband, a Liverpool cotton merchant. She was sentenced to death but this was later commuted to life imprisonment" (52-53). We learn, in a quick search for more details, that Maybrick was convicted quickly with minimal evidence (Voelker 481). Here we see parallels to James's own case, where she herself is repeatedly diagnosed with minimal study of the evidence presented by her illness.

In replacing what might be sympathy for Mrs. Maybrick with thought-provoking analysis, James highlights the dangers of a society fascinated with hysterical spectacle to the detriment of all else. She writes, “Mrs. M seems to be as debased a villain as one could wish to find and convicted herself out of her own mouth” (52-53). Her use of the word “seems” despite the focus on Maybrick’s conviction “out of her own mouth” indicates a sort of skepticism regarding Maybrick’s case. This skepticism replaces the sympathy James might otherwise feel for the “debased” villainess. In “‘A Barnum Monstrosity’: Alice James and the Spectacle of Sympathy,” Kristin Boudreau focuses on how sympathy James uses, writing:

By recasting sympathy as theatrical, James challenges the fiction of benevolent sympathy so prevalent in her age. Not only does her model offer no pretense of sentiment, it also mocks the sentiment that grieves for suffering: her drama, in fact, depends on the magnification of suffering. The sympathetic exchange, stripped of all sentiment, becomes akin to a circus sideshow, allowing the spectacle to taunt her indulgent spectators.

(58)

By retelling and casting doubt on the story of Mrs. Maybrick as told to the jury, James calls into question the decision of a jury made up of wealthier, male members from within her society. In questioning this jury, too, she creates a possibility of suffering by the convicted. She uses hysteria to describe not only the society itself but the spectacle it has created.

Boudreau further comments on how resisting the stereotypical diagnosis of hysteria plays into the role of spectacle in James’s diary. She writes, “[h]ysterical

fragmentation, likewise, signifies a feebleness of the will, an inability to preserve both mind and body; William James wrote that ‘An hysterical woman abandons part of her consciousness because she is too weak nervously to hold it together.’ If one begins writing a diary in order to preserve the self, then illness and sympathy, according to these models, defeat that purpose at the very outset” (59). Here, William James makes assumptions about the hysterical female, once again placing the problem solely on her weakness and her nerves. However, Boudreau pushes back against this notion, arguing that if William James were right, his sister’s diary would not have been a helpful means of escaping from her diagnosis and the label of invalidism. Further, her nerves and inherent weakness would prevent her from writing. But Alice James *does* write a diary and *does* move past her label of invalid to study the lives of others around her. Thus, she avoids becoming a spectacle and instead gets to take in the actions of those around her.

Even in her more miserable moments, James exudes a humor which is entirely her own, resisting the label of the miserable invalid in favor of studying other aspects of herself and others like her. On December 12th, 1889, she writes: “[o]ne day when my shawls were falling off to the left my cushions falling out to the right and the duvet off my knees, one of those crises of misery in short which are all in the day’s work for an invalid Kath. exclaimed ‘What an awful pity it is that you can’t say *damn!*’” (66). James ponders this and determines that she agrees with Loring, stating, “[i]t is an immense loss to have all robust and sustaining expletives refined away from one!” (66). Rather than indulge in self-pity, James looks at her situation with an ironic sense of humor. Boudreau focuses on this trait of James, noting that since hers is an “ironic voice in a sentimental age, James explodes the fiction of sympathy while re-enacting it” (63). In this moment

we learn more of James's sense of humor than in any of the guarded family biographies. We see her mocking her own invalid state, decrying her inability to do a true "day's work." But we also see her bemoan her status as a lady *of* status. She has been so carefully bred she can no longer care for herself. In the same passage, she questions her upbringing: "I wonder, whether, if I had had any education I should have been more, or less, of a fool than I am" (66). In this entry, we see James question the traditional role of gently-bred women and accept that these roles are potentially damaging in the same way she studies the role of the invalid and concludes that it is similarly detrimental.

At the same time, James acknowledges what is expected of an invalid but then moves past this expectation of docility towards a new definition of invalid born out of resistance. She writes a letter to a local editor in July of 1890. In this document, she explains that due to her presence as "an invalid in the house" another woman chose not to rent a nearby apartment (139). She furthermore signs the letter "Invalid," indicating a play on words here where she herself is in fact "physically so debile" (139) but also one who—due to her ill state—need not be considered, whose opinions are in fact invalid. In Joanne Jacobson's article, "Resistance and Subversion in the Letters of Alice James," the author addresses this very letter, writing: "In coopting its language, James aggressively turned the tables on the social discourse which threatened to 'in-validate'" (371). If we look back again at her entry on society's hysterical attacks, we see the ways in which James's writing returns to similar themes, questioning the validity of society when that society itself is susceptible to hysterical tendencies. Just as she coopted hysterical to question her very diagnosis in light of society's behavior, here she redefines "invalid," pointedly illuminating the treatment towards this type of person.

According to a James' family biographer, F. O. Matthiessen, throughout Alice James's life, she was diagnosed with hysteria and neurasthenia as well as “‘rheumatic gout,’ ‘spinal neurosis,’ ‘cardiac complications,’ and ‘nervous hyperaesthesia’”—which as one will recall is a condition often associated closely with hysteria (272). However, unlike more recent biographers, Matthiessen, writing in the mid-twentieth century, attributes these many illnesses to the fact that James “was the youngest child and the only girl in such an extraordinary family” (272), seemingly separating Alice James from the triumphs of her other family members. Furthermore, this quotation does not take into account James's entire experience. In fact, to get a better understanding of James we must look at her letters to see how her family impacted her health and her life. In actuality, her family seems to have positively influenced her health, much to the contrary of what Matthiessen posits. She writes in an 1882 letter to her brother Henry about the death of their father, noting that now that “the weary burden of life is over for him” she had “no terrors for the future” because he had left her with the “strength to meet all that is in store” (qtd. in Yeazell 87). By taking care of her father, James had found a purpose and thus it is no surprise that during this time, her illnesses had abated. Her aunt Kate even wrote that the death of her mother and the subsequent necessity of caring for her father “‘seemed to have brought new life to Alice’” (qtd. in Fisher 425). Unfortunately, just like her many diagnoses cited by Matthiessen above, Alice James's period of respite wouldn't last.

The more recent James family biography *House of Wits* (2008) by Paul Fisher, explores James's diagnoses of hysteria and neurasthenia, their brief abatements, and their subsequent return following the death of the James' family patriarch, Henry Sr. In

1866—when Alice was eighteen—she traveled with her aunt Kate to improve her health and was treated with the movement cure for what George Miller Beard had just identified as neurasthenia (Fisher 234).¹¹Fisher explains that since James had all the symptoms of this disease—“she suffered from lassitude and depression because (it was believed) she had read and thought too much”—hers was a rather obvious diagnosis (235).

Interestingly, a year later, at the age of nineteen, James’s case worsened and, as she was back in the United States, she was diagnosed with the seemingly more severe, definitely more gendered, hysteria. Fisher explains that “the young woman had advanced from quiet ‘neurasthenia’ to something more dramatic and desperate. Doctors labeled it ‘hysteria’—a passionate loss of control, originating from what was seen as a woman’s deeply emotional and irrational nature” (245). What Fisher fails to address in his analysis is the problematic nature of these stereotypes. In fact, he seems almost eager to perpetuate them, claiming “her admirable behavior as an invalid earned her the attention from her parents she craved” (237). Thus, even long after Alice James has died, her illness is still being examined as a means of criticizing and judging her and others like her instead of attempting to understand her narrative.

Because of her efforts to actively reveal the experiences of her illnesses in her diary and letters, Alice James creates a new lens through which we can view the female invalid and her resistance to, and ultimate acceptance of, disease. Anne Golomb Hoffman writes, “Alice managed in her last years to achieve her own distinctively Jamesian triumph in the form of a journal that documents the writer’s inner life, offers reflections

¹¹ According to Dr. A. L. Wood in his article “The Movement Cure,” the movement cure originated in Sweden and involved both exercise and massage for “forms of acute disease” when other cures had not worked (Wood 186). It was incorporated into the rest cure towards the end of the nineteenth century.

on embodiment and mortality, and sustains engagement with the world through acute social commentary” (2).¹² As Golomb Hoffman indicates, rather than focusing on her youthful illness, James’s diary is full of her current experiences and time on her sick bed, with only minimal reflections on the diseases of her youth.¹³ She writes, for example, of the lawyers and doctors who visit. Noting their morbid fascination with her invalidism, she describes these situations quite comically, explaining she was “draped in as many frills as could be found for the occasion” while “five little black figures” entered her bedroom and had to be restrained “from reading the Will aloud there and then” (89). Her ability to find humor in her predicament is one cultivated after a life of illness, and readers cannot help but be charmed by her retelling, even if her doctors and lawyers are not.

However, others do not see James’s resistance to disease as readily apparent and instead look at her limited focus on her illness as something which makes her appear as boring or lacking depth. Jana Rivers-Norton in her article “Writing the Self into Existence: Neurasthenic Women and the Rendering of Literary Form during the Victorian Age,” argues that Alice James only rarely portrays “herself as a complex human being with free will or with valid insights and concerns” (29), but those who fully

¹² Here it is important to note that Hoffman refers to James by her first name, an unfortunate decision when arguing James has finally stood out—in the creation of her diary—as a Jamesian figure. When we write about real women and use their first instead of last name, we take away some of their ethos, becoming familiar with them in a way we wouldn’t dream of doing with their male counterparts. I agree. In discussions involving multiple James’s, scholars will resort to William, Harry (Henry), Alice, etc., but when focusing on a single figure relying on the first name seems gratuitous.

¹³ For example, she focuses on June 16th on the idea that she saw very little growing up, we are to assume because of her invalidism. She writes, “I have seen so little that my memory is packed with little bits which have not been wiped out by great ones, so that it all seems like a reminiscence and as I go along the childish impressions of light and colour come crowding back into my mind and with them the expectant, which then palpitated within me, lives for a ghostly moment” (James 34).

engage not only with James's diary, but also her letters and biographies know otherwise. We read in James's thoughtful passages about her diseases an understanding about illness that transcends the stereotypical Victorian ideologies. For example, in her opening passage James writes about beginning her journal: "I shall at least have it all my own way and it may bring relief as an outlet to that geyser of emotions, sensations, speculations and reflections which ferments perpetually within my poor old carcass for its sins" (25). In portraying her illness in this upfront and ironic manner, James confronts the ideas about herself as an invalid and also hints towards a valid question: why was she previously not able to find a more personal outlet for her emotions?

Other scholars take a different view from Rivers-Norton's somewhat dismissive stance on James. For example, Hoffman argues that through writing about her body and its performance, James's text comes "alive with feeling, as if it were that animate body" (12). Hoffman's point is clear when we study passages like the one in which James describes her delight in laughter:

Shall I ever have any convulsive laughs again! Ah, me! I fear me not. I had such a feast for 34 years that I can't complain. But a curious extreme to be meted out to a creature, to have grown up with Father and W[ilia]m, and then to be reduced to Nurse and Miss C[larke] for humourous daily fodder. (45)

Here, again, we not only see that Hoffman's perceptions about James's animate body are correct, but we also see indications of an erstwhile hysterical nature. By reading about James's "convulsions" we can recognize symptoms of hysteria just as Freud and Breuer do in *Studies in Hysteria* (1875), writing that a hysterical patient often suffers from

“epileptoid convulsions that all observers had taken for genuine epilepsy” (8). Thus, even in her delight, James is very possibly exhibiting symptoms of this well-known nineteenth-century diagnosis. However, here again her focus is not only her illness but rather on the ways she resists becoming a stereotypical invalid. Instead, she looks at places to find enjoyment and escape from her disease instead of conforming to her terminal diagnosis.

Rivers-Norton’s emphasis on James as uninteresting is biased by her attention to only James’s diagnosis of neurasthenia as opposed to a more comprehensive focus that allows for a study of both of James’s diagnoses (neurasthenia *and* hysteria) and her life outside of those diagnoses. This narrow focus can be understood somewhat in terms of national biases regarding these illnesses. Hoffman explains why, for many Americans, the perceived gendered distinctions between hysteria and neurasthenia made diagnosing females particularly difficult: “Gender thus inflected categories of disease in a manner that linked femininity to debility and masculinity to a norm of activity that proved exhausting—for men and for women—to sustain” (7). For nineteenth-century Americans who perceived the differences in neurasthenia as relating to men and hysteria as relating to women, diagnosing patients based solely on gender proved easier than determining what the difference in nervous afflictions was between these two diseases. This distinction between diagnoses might explain the difficulties doctors faced in properly identifying James’s disease and certainly explain why Rivers-Norton did not give James her due but instead simply assumed she was exclusively neurasthenic instead of exploring her diagnoses in more depth.

Rivers-Norton is not the only one to express a dismissive view of James. Despite her remarkable life experiences, which included her time as a correspondent instructor and caretaker of the family, Alice James was repressed throughout her entire life. Even as her brothers left her to care for their parents, they did not credit her as being very capable. Fisher, in *House of Wits*, explains that it was not until after James's death when Henry James received her diary that her famous brother discovered "Alice's fiery internal life" (522). While Alice was loved by her family, she was also misunderstood by them. Her disease rendered her different even in a family full of incapacitated individuals: Henry and William both suffered from bouts of depression, nervous afflictions, and gastrointestinal distress and her father had had his leg amputated after he was seriously burned in a fire. However, her family viewed her status as the only daughter as cause for treating her oppressively. Alice James's parents repeatedly demanded her behavior conform to their wants. A classic example of these demands occurred following her 1868 breakdown in which her parents expected her to either provide "polite, uncomplaining resignation" to her disease—as her mother desired—or to utilize her "heroic self-control"—as her father wanted (Fisher 246). Instead, Alice James experienced "[w]aves of pent-up feeling" which "convulsed Alice as never before" (Fisher 245). Her condition had worsened, no doubt in part due to the oppression by her parents.

These convulsions indicated that something was seriously amiss with the nineteen-year-old Alice. As mentioned already, Fisher has argued that James's case of hysteria became full-blown around this time (245). His claim indicates a problematic understanding of hysteria as the worsening of neurasthenia, thereby associating the female-related disease with a more severe condition. Regardless of what her condition

indicated in terms of nomenclature, for both her parents and Alice James, her self-control was limited by her disease, referred to by Fisher as “the revolt of a woman’s body” (246). It is no wonder her body revolted, either, considering the ways in which her family used it as a means of acting out their desires every time James suffered a breakdown. Alice James might have known she was capable of more—and indeed, no doubt did achieve more—but the repression she submitted to on behalf of her family left her with no option but to run towards permanent invalidism just as Bertha does in her own captivity.

Fortunately, James found in Katharine Loring a peer, companion, and friend. Yeazell explains that for both Loring and James, their friendship was a gift. Yeazell quotes Loring, who claimed the first time she met James signified the start of “the great happiness of my life” (qtd. on 70). Alice James also valued Loring, explaining in her diary entry from November 19th that “Katharine has the most estimable habit of paying one compliments and delicately embroidering any outside reference to one’s humble personality which may occur” (59). For James, who inarguably suffered as the only sister and daughter of the intellectual James family, Loring proved a balm to her repressed spirit. It is no surprise, then, that with Loring’s presence, James’s quality of life improved. Loring, a friend and a colleague from the period during which Alice taught in a correspondence program, was “a better sign of Alice’s recovering” following her 1878 breakdown (Fisher 376). Furthermore, Loring’s experiences with her own sister, Louisa—“a fainting, ‘hysterical’ creature who seemingly inherited none of Katharine’s muscle or pluck” (Fisher 376)—proved to help soothe James more, and their friendship grew, easing some of James’s discomfort in a way her own family was not able to do.

While James's diary addresses these interactions and the effect her illness had on her relationships with her family, it is her more mundane diary entries that let her readers see just how much James resists being remembered only as an invalid. Less noticeable at first, but no less important, are James's descriptions of local events as well as events of national importance. She provides depictions of many events happening at the end of the nineteenth century—such as the vote for Home Rule in Ireland—often including newspaper clippings and eye-witness accounts. Additionally, her discussion of many important people living in this era in both the United States and England offers background into lives not often explored, including famous doctors and psychologists, such as her brother, William. Finally, her descriptions of her brother Henry, or Harry as she calls him, create a more complete picture of the famous author and his entirely empathetic relationship with his younger sister, a relationship that often put him in unenviable positions both due to the publishing of her journal and the amount of care her illnesses required.¹⁴ By sharing her knowledge of these people and events, James emerges as a well-read chronicler of the nineteenth century instead of being passed over exclusively as a well-bred invalid of the same era.

However, while James's diary appears to focus on the commonplaces—indeed, she tells us why she wrote it on the first page, calling it “a written monologue by that most interesting being, *myself*” (25), explaining it “may have its yet to be discovered

¹⁴ *Wings of the Dove*, a novel by Henry James, addresses the struggle of a female invalid and is thought to have been influenced by Henry James's experiences with visiting his sister in her sickroom. This novel is studied in *Chapter 7* on chlorosis. It is important to note that there is a link between chlorosis (hypochromic or iron deficient anemia) and hysteria as explained by Veith: “Coexistent pathological conditions, such as struma and anemia [...] increased the tendency to hysteria” (205). It is also important to note that Henry James was not opposed to publishing his sister's diary but wanted names and intimate details obscured in a way that her longtime friend and nurse, Katherine Loring, did not (Edel 20).

consolations” (James 25). Here readers cannot fail to notice the way disease underscores the narrative, and the last years of James’s life. She herself acknowledges this lingering presence of disease in all that she does when she writes about contracting influenza: “I collapsed too for a few days and cultivated as much ‘prostration’ as possible, but all in vain; the little beasties are too wise to think that they can make a feast off the pale fluid that stagnates in my veins, so I shall drag on a bit longer” (James 96).¹⁵ In this quote, we see James articulating what many a terminally ill patient still experiences today: a state of seemingly endless and yet all too short waiting accompanied by a need for distraction from that waiting.

James’s diary not only focuses on resistance, however. It also explores the ways in which class and gender at large are repressed by the unsuccessful ability of many doctors to build rapport with their patients. James does so by ridiculing her class and her doctors in a series of entries from January 1st through January 6th of 1892, making it easy to see why her brothers wanted her diary to remain unpublished even as Katherine Loring fought so hard for the invalid to avoid this final repression. James questions in her entry from the first, “[w]hen will men pass from the illusion of the intellectual, limited to sapless reason, and bow to the intelligent, juicy with the succulent science of life” (225). In so asking, James calls into question the doctors who dismiss her beloved Loring, indicating they are not as experienced or as knowledgeable as they’d like to believe. In

¹⁵ This idea links to another one presented later in my analysis of “The Autobiography of a Quack” in *Chapter 8* in which an invalid is told to record his thoughts simply for something to do. Ironically, this recording of thoughts as a way of releasing pent-up emotions is in direct contrast to one of the most popular cures for hysteria during this time, the rest cure by S. Weir Mitchell, who wrote “The Autobiography of a Quack.”

her next entry from the fourth, James focuses on her own doctor, Sir Andrew Clark, noting that he has a tendency to be like other doctors who all talk

... by the hour without *saying* anything, while the longing pallid victim stretches out a sickly tendril, hoping for some excrescence, a human wart, to catch on to, but it vainly slips off the polished surface, as comforting and nourishing as that of a billiard ball. In order to show K[atherine] how *en rapport* and sympathetic he was with my nervous state, he described his own sufferings in that way, and gave an account of his own pathetic youth. (226)¹⁶

In this depiction, the largest problem with doctors—the problem that some would argue continues today—appears when James satirizes her doctor’s attempt to remain *en rapport* with her in her nervous condition.¹⁷ Modern readers recognize his attempts at empathy as ineffectual as clearly as James does. This disconnect, the inability to find nourishment and comfort in her interactions with Sir Clark, and further his attempt to empathize with a condition supposedly only affecting women in large numbers showcases just how inadequate the male doctor / female patient relationship remains.

It is in James’ entry on January 6th that we see Sir Clark as James does—as a weak physician unable to build the rapport he so desperately wants with his patients, influenced by social stratifications instead of his own intellect. James describes this problematic side of Clark, writing:

¹⁶ Fisher acknowledges that Sir Andrew is the one who finally gives Alice James concrete diagnoses: She “had ‘cardiac complications,’ and the painful lump she’d had in one of her breasts for three months was a tumor” (512). The passage James includes about these diagnoses in her diary opens the hysteria section of this dissertation in *Chapter 7*.

¹⁷ For more on this take regarding establishing rapport in the medical profession, see Dr. David Watt’s article “Cure for the Common Cold” (2012) published in the *New England Journal of Medicine* about the lack of true empathy in the medical profession that persists even today.

... numbers of ladies come to Sir Andrew and never pay a fee—In answer to Mr. Cross' objection that perhaps they were nervous and forgot it, Sir Andrew said 'I should think so, if it happened the first time only, but it occurs again and again; and it is only *rich* ladies that do it, the poor ones always pay.' Etiquette prevents his sending any bill, and he is too shy to ask for his fee, so in this respect as in many others the poor pay for the rich. (227)

Here, the doctor is hindered not only by his own shyness but also by the social consequence of the ladies who do not pay. He brings up their wealth, and the fact that they continue to abuse etiquette, but he does nothing to stop it and his rapport with his patients is such that they continue to exploit his system, or lack thereof. Thus, not only does Sir Clark contribute to the problems with treating female patients, he also contributes to the situations that plague the poor who do attempt to seek treatment in favor of the rich who can actually afford it.

James's last entry comes not long after this series of characterizations of Clark. Sadly, she is too weak to write it, and so Loring does the work, explaining that for James "[t]his dictation of March 4th was rushing about in her brain all day, and although she was very weak and it tired her much to dictate, she could not get her head quiet until she had had it written: then she was relieved" (232-33). In this last entry, the true spirit of Alice James emerges. She is no longer the invalid for whom others speak. Rather, she uses the last of her strength and the love of a close friend to dictate her thoughts, sharing for a final time her resistance to the labels society has used for her. She describes one last commonplace as she teases Loring, calling her an old nickname: "the New England

Professor of doing things” (qtd. in James 232). Her teasing personality emerges as her depressive one ceases; she dictates, “I no longer go in dread” (232). In this moment, we take comfort not only in James’s words, but also in the fact that she has finally found comfort—a well-deserved discovery.

Both Bertha and James appear to have suffered for most of their life from a condition we recognize as symptomatic of other illnesses such as bipolar disorder and depression. Both were labeled mad, abnormal, and even insane simply because they were filed under another label, that of nervous, weak woman. Their diseases placed them outside of social norms either due to repression, as in the case of Bertha, or subversion, as in the instance of the older James. Each woman struggled against her family, society, and herself and sadly, only James found a modicum of comfort, explaining towards the end of her life that she was born too soon and that the “vast field of therapeutic possibilities is opened up to me, just at the moment when I have passed far beyond the workings of their beneficent laws” (222). We recognize in this moment, as James does, how far medicine progressed at the end of the nineteenth century. On the other hand, we also recognize, based on our modern understandings, how far it still needs to go.

Chapter Ten: Fictional and Actual Accounts of Hysteria

As the nineteenth century drew to a close, understandings of hysteria were not as clear as those of tuberculosis—due to the presence of the tubercle bacillus—and chlorosis—better understood due to blood screenings. Rather, the workings of hysteria, the most gender-bound disease in this project, still eluded medical professionals, no doubt in large part due to its more psychosomatic nature and the still-confounding human mind. Doctors were still expected to know everything, however, and so attempted to find solutions for treating hysteria in their female patients while often unwittingly spreading more misinformation about women’s supposedly weaker nerves and more delicate constitutions. Therefore, to close the study of hysteria, this chapter examines one of the most famous literary representations of the disease as presented by Charlotte Perkins Gilman in her short story “The Yellow Wall-Paper.” Then, to further understand the complicated social expectations of the female patient–male doctor dynamic, this chapter explores the life and writing of not only Gilman but also her erstwhile doctor and famous neurologist, Silas Weir Mitchell.

Charlotte Perkins Gilman presents what is inarguably one of the most interesting literary representations of hysteria in “The Yellow Wall-Paper” (1891).¹ Gilman’s personal story and her fictional one coincide with female patient–male doctor relationships in the treatment of nervous disorders. Jana Rivers-Norton explains in “Writing the Self into Existence: Neurasthenic Women and the Rendering of Literary

¹ The editors of *The Norton Anthology on Literature by Women* (2007) make note of the fact that Charlotte Perkins Gilman was the great niece of Catharine and Harriet Beecher Stowe (ed. Gilbert & Gubar 1389). This fact is interesting to consider as it hints at the close—potentially genetic—link between hypochondria—diagnosed in Stowe, her sister, and her mother, too—and hysteria—as found in Gilman (ed. Gilbert & Gubar 1389). It also contributes to the argument that in some cases hysteria was viewed as a type of hypochondriasis (Veith 191).

Form during the Victorian Age” that “Gilman’s fictive account of her own ‘nervous prostration’ and resultant rest cure at the hands of S. Weir Mitchell [...] immortalized the marginality of a woman’s voice” (26). But it did more than portray a marginalized voice; Gilman’s short story also caused many, for the first time, to question whether their doctor always knew best when it came to diagnosing and treating a female patient’s condition.

When Gilman first published her fictionalized account in 1891, the medical community still had a limited understanding not only of illness but also of the female body. Far more likely to inaccurately diagnose and treat a female for hysteria or neurasthenia than to consider other possibilities, the psychiatrists, neurologists, and specialists typically assumed ailments presenting in females strictly resulted from their biological sex and women’s supposedly weaker nerves. In Ilza Veith’s *Hysteria: The History of a Disease* (1965), he writes about the supposed susceptibility of women to hysteria based on nineteenth-century understandings of biology: “Because women were by nature more sensitive in their emotional structure than men, and being compelled by convention to repress their sexual needs, they were therefore far more susceptible to hysteria” (201). Thus, the alleged biological structure of the female took precedence in a doctor’s diagnosis of hysteria, and the variations in diverse types of female bodies were not considered.

Informed by recent studies in the medical humanities, a reading of Gilman’s “The Yellow Wall-Paper” through a medical lens offers three benefits: the first is the new understanding of the misdiagnoses and limited treatment options given to women experiencing hysteria or its comorbid condition, neurasthenia. Looking at these treatment options at the start of the modernist period and closely examining the female patient–

male doctor dynamic leads to the second benefit of studying society's normalization of gendered disease as presented in "The Yellow Wall-Paper." Finally, the third benefit enables us to see the ways in which both ill authors and authors with ill characters either subverted (Gilman) or accepted (Mitchell) social norms regarding diseases and treatments, using their literary expertise to critique or support a society with a limited understanding of gender and disease.

One of the most studied female patient–male doctor relationships is that between Gilman and neurologist and writer Dr. Silas Weir Mitchell.² According to an open letter she titled "Why I Wrote the Yellow Wall-Paper" (1913), when Gilman wrote her short story, she had just completed Mitchell's rest cure for treatment of her neurasthenia: "This wise man put me to bed and applied the rest cure" ("Why" 1403). Here, Gilman's use of irony cannot be missed as she terms him "wise" when readers already know from her story—published a little over two decades before the letter—that his cure is in fact anything but. She categorically calls into question the wisdom of Mitchell's rest cure, without even giving the doctor the dignity of using his name. As she continues to explain the diagnosis in her letter, we understand her disenchantment with Mitchell and his treatment. Gilman writes that she received the "solemn advice" to "'live as domestic a life as far as possible'" and to "'have but two hours' intellectual life a day,' and 'never to

² It is important to note that while many may have an unfavorable opinion of Mitchell due to his Rest cure treatment (as it pertained to women), the research he completed on "the effects of rattlesnake venom set the stage for subsequent work in toxicology and immunology" (Cervetti 1). Further, while the Rest cure seemed particularly ineffective in the treatment of women classified as hysterical, it "originated in his treatment of Civil War soldiers who suffered from burning pain and phantom limbs, the latter a term he coined" (Cervetti 1). Additionally, because of his work with soldiers, Mitchell is still considered one of the first neurologists in North America and also is often called "The Father of American Neurology" (Cervetti 1).

touch pen, brush or pencil again as long as I lived” (“Why” 1403). Gilman either had to accept the above treatment or risk going mad.

An obviously distressing course of care, it is one Jane—the main character of “The Yellow Wall-Paper”—herself experiences. Jane and Gilman describe their treatments in a similar manner, no doubt influenced by Gilman’s own interactions with Mitchell.³ Jane notes that her husband John, also a physician, “hates to have me write a word” (1393) just as Mitchell does Gilman and that Jane goes to “lie down ever so much now. John says it is good for me” (1399), just as Mitchell limits Gilman’s activities, too. It is in these moments of supposed treatment that we encounter one of the most troubling aspects of the female patient–male doctor relationship: the power dynamic. Suzanne Poirier writes in “The Physician and Authority: Portraits by Four Physician-Writers,” that in receiving Mitchell’s treatment, Gilman “suffered greatly from the administration of the Rest cure, which was founded on the belief that the doctor always knew—or must act as if he knew—what was best. Any disagreement with the physician on the part of the patient was only proof of the stubbornness of the patient’s illness—or of the patient” (27). Readers with any familiarity of Gilman’s work know the author suffered greatly, as reflected in her own fiction and nonfiction writing.

However, those with an interest in Gilman may not have considered Mitchell’s position before. The pressure for the doctor to know, and be able to treat diseases just gaining recognition or reaching epidemic proportions in this century was strong, as Poirier indicates. Further, Poirier explains that the Rest cure led to many women being cut off from their families and social circles, creating a greater dependence on the doctor

³ For more on Dr. Silas Weir Mitchell’s understanding of the doctor-patient relationship, see his text *Doctor and Patient* (1888) and available through *Google Books*.

to win her confidence (“Physician Authority” 24). On the other hand, it would be remiss not to acknowledge Mitchell was in a prison of his own making; he developed this cure which led to the patient’s isolation: “Such power over his patients did not bother Mitchell because, like so many of his contemporaries, he believed in the virtuousness and good intentions of most physicians” (“Physician Authority” 24). Thus, if we are to consider Mitchell’s position as this chapter progresses, we must recognize that it comes with not only gender biases but also biases about the work of the physician.

In addition to the female patient–male doctor relationship, texts by both Gilman and Mitchell allow us to examine the impact of gender-specific illness on society’s perception of disease. In fact, the rest cure and thus the female patient–male doctor relationship played directly into these understandings of gendered diagnoses. In 1873, Mitchell offered his first publication of the cure that he would continue to develop and publish about until his death in 1914 (Poirier, “Mitchell Rest” 15, 17). He based his cure on the idea that “with rest and food to give the body a chance to regain weight” many ill patients could be cured (Poirier, “Mitchell Rest” 18). In “The Weir Mitchell Rest Cure: Doctor and Patients,” Poirier explains that Mitchell developed the Rest cure at a time when male doctors controlled most aspects of female patients’ lives (“Mitchell Rest” 16). Further, as Poirier points out in another study of Mitchell, “he held the general Victorian beliefs about women’s frailty and ‘place.’ Such a bias was bound to color his medical advice to women” (“Physician Authority” 26). Mitchell’s professional career proves that society’s opinions about women were mirrored in the work done by male physicians, leading to a reinforcement of gendered biases about disease. As a result of his dissemination of this gender-biased cure through lectures and his continued publications

on treating hysteria and neurasthenia, Mitchell's rest cure received recognition in a century already inundated with other somatic and psychosomatic ailments and questionable cures.

There is no doubt Mitchell's cure proved questionable for Gilman. In fact, in obeying his directions, Gilman notes she came even nearer to utter mental ruin, much like Jane of "The Yellow Wall-Paper." So, she ultimately "cast the noted specialist's advice to the winds" ("Why" 1403). After writing "The Yellow Wall-Paper" in response to her narrow escape from mental collapse, Gilman sent Mitchell a copy of the published story, which he never acknowledged ("Why" 1403). In a triumphant twist of fate, however, Gilman "was told that the great specialist had admitted to friends of his that he had altered his treatment of neurasthenia since reading *The Yellow Wall-Paper*" ("Why" 1404), a fact which is corroborated by Mitchell's repeated efforts to improve the treatment. Gilman concludes her essay on why she wrote "The Yellow Wall-Paper" with the wonderful line that the story "was not intended to drive people crazy, but to save people from being driven crazy, and it worked" (Gilman, "Why" 1404). After reading Gilman's personal account, medical humanities scholars can see the ways in which disease—and ineffective cures—can create frustration in a patient and encourage him or her to go expressly against their doctor's wishes.

The need to alter treatments to make a disease curable is a theme brought to the forefront by "The Yellow Wall-Paper." Gilman herself says she casts the specialist's advice to the winds and that before she did this, she "came so near the border line of utter mental ruin that I could see over" (Gilman "Why" 1403). This rejection begs the question: why recommend the treatment if it didn't satisfy patients' needs? To answer

this query, we need to consider Poirier's explanation that Mitchell's purpose for the Rest cure was to allow "the body a chance to regain weight" through the rebuilding of "blood cells, thus restoring health, energy, eventemperedness" ("Mitchell Rest" 18). While the rest cure by today's standards seems cruel—not doing much of anything is in fact enough to drive many insane in our modern, on-the-go society—Poirier acknowledges Mitchell's reasoning was "not a totally preposterous conclusion" ("Mitchell Rest" 18). In fact, she quotes Mitchell as arguing, "[y]ou cure the body and somehow find that the mind is also cured" (Poirier, "Mitchell Rest" 17).⁴ Granting that Mitchell's reasoning behind his Rest cure was seemingly well-thought-out, the treatments themselves were not.

The treatments were not the only problem with the care of hysterical patients during this era, however. In fact, the lack of knowledge regarding the disease and the inability of doctors to relate to their female patients further complicated care. Just as Gilman struggles to respect her doctor and therefore has difficulty following his orders, so too, does Jane wrestle with the commands of her brother—a doctor—and husband—also a doctor—in "The Yellow Wall-Paper." She explains in her diary that "[i]t is so hard to talk to John about my case, because he is so wise, and because he loves me so" (Gilman, "YWP" 1397). Physician John has made himself unapproachable to his own wife, who clearly has concerns about her own treatment, in much the same way Mitchell alienated some of his female patients, including Gilman and other women in her family. This isolation becomes apparent when Mitchell dismisses her pain and suffering—which

⁴ The nineteenth century saw the rise of the Movement Cure and the Water Cure. The Movement Cure originated in Sweden and based its treatment on the idea that "the proper way to increase the power or function of any organ or part of the human system was to call that organ or part into judicious action" (Wood 186). The Water Cure, on the other hand, was "based purely on physiology, in which bathing was not the whole, but only an important feature" of treatment (Taylor 69). Therefore, the water cure and movement cure were often used together (Taylor 69).

Gilman describes in detail, explaining: “the dark fog rose again in my mind, the miserable weakness—within a month I was as low as before”—as “only hysteria” (Gilman, *Living* 95). Brushing what was still, as illustrated in *Chapter 8*, a terrible disease with frightening side effects off with his use of “only” seemed to dismiss Gilman. Further, this disregard for female patients shows not only how much male doctors still had to learn about hysteria and neurasthenia but how ignorant they were regarding the needs of female patients. However, where Gilman is eventually able to reject Mitchell’s suggestions, Jane is not. Through Jane, then, readers see the ways in which Gilman’s story could have been drastically different had she not rebelled against not only the expectations of her gender but the treatment of it as well.

Gilman directly engages with Mitchell in her text in a way that Mitchell does not engage with her. In all his writings on both the rest cure and neurasthenia, he never mentions his treatment of her along with his other patients. Fortunately, because of Gilman’s meticulous critique of her erstwhile doctor, we not only know he treated her for her disease but also that this treatment nearly drove her truly mad. She writes of her treatment that it ended “with what I considered the inevitable result, progressive insanity” (Gilman, *Living* 119). Thus, it is no surprise that not only did Mitchell never mention his treatment of Gilman due to its negative repercussions, but he did also change his cure, as already mentioned in part because Gilman mailed him a copy of “The Yellow Wall-Paper” (Gilman, *Living* 121). The change in cure is perhaps because of Gilman’s clear targeting of Mitchell in her short story, using his treatment as a threat if Jane’s health does not improve: “John says if I don’t pick up faster he shall send me to Weir Mitchell in the fall” (“Yellow” 7). Thus, Gilman sowed seeds of doubt regarding the gendered

treatments for hysteria and neurasthenia. Her unspoken question began to be answered: were doctors really treating the women suffering from these illnesses fairly ?

Mitchell himself, oblivious to his own medical and male gazes, articulates some of the problems with gender and class biases and misunderstandings of hysteria in his 1904 conference address “The Evolution of the Rest Treatment.” In this proceeding, Mitchell first introduces the idea of neurasthenia in conjunction with what we would now recognize as post-traumatic stress disorder in male soldiers, explaining neurasthenia was the result of “acute exhaustion” in men (368). However, then Mitchell turns his attention to hysterical women; he explains how many women were like his patient Mrs. G— of Maine who was “completely exhausted by having had children in rapid succession and from having undertaken to do charitable and other work to an extent far beyond her strength” (369-70). The men’s illnesses became those influenced by outside stimuli whereas the cause of the female’s complaint remained completely domestic.

Unfortunately, according to Per Fink in “From Hysteria to Somatization: A Historical Perspective,” it would take much longer for male doctors to begin questioning their ways of thinking regarding hysteria as it presented in the female patients. Fink explains that it wasn’t until the 1960s that gender-stereotyped misunderstandings of hysteria began to be questioned due to the previous “lack of interest in the somatizing conditions” like hysteria (360). In the meantime, solidly middle-class women with hysteria and /or neurasthenia were still neither fish nor fowl, stuck between “the business man exhausted from too much work, and the society woman exhausted from too much play” (Gilman, *Living* 95).

Mitchell addresses neurasthenic men—interesting because he himself was neurasthenic for a time following his experiences in the American Civil War (Cervetti 97)⁵— only briefly in his 1904 conference paper. He then devotes the rest of his presentation to the hysteric (or possibly neurasthenic) female. He focuses in particular on what he now deems, after years of study, to be the best treatments for this nervous complaint: “I had discovered that massage was a tonic of extraordinary value; [...] I had learned that with this combination of seclusion, massage, and electricity, I could overfeed the patient until I had brought her into a state of entire health” (Mitchell 371-72).⁶ While Mitchell is still advocating the confinement of his female patients, as evidenced by his use of the word “seclusion,” we can see that, as Gilman contends in her 1913 letter, “the great specialist [...] had altered his treatment of neurasthenia” (“Why” 1403). In a clear effort to defend the initial stages of his treatment, Mitchell further clarifies that it was unfortunate that so many had focused only on the rest portion of this cure, noting that by naming his book on this treatment *The Rest Treatment*, he had made the word “rest” too predominant, therefore the “one mistake in the book was the title” (Mitchell 372). Interestingly, however, in Gilman’s treatment some years earlier, it seems rest was also too predominant. She writes that while in Mitchell’s care, “I was fed, bathed, rubbed...

⁵ Mitchell treated his own neurasthenia by setting sail for Europe where he spent, according to one letter, “[t]en invigorating days in Pontresina, Switzerland,” during which “he walked and climbed fifteen miles up the Bernina route and along the River Inn, a spot ‘unmatched in Switzerland. Indeed the air 6000ft. above the sea is like the wine of life to folks who are nervous and—bloodless.’ In another letter he wrote that ‘never was atmosphere like this—so cool and pure and so energizing’” (Cervetti 98).

⁶ John Mitchell Clarke explains in *Hysteria and Neurasthenia* (1905 edition) that electricity is one important way to treat hysteria and neurasthenia, noting that it “may be employed either for its general effect, or to relieve special symptoms” (162). He further specifies in the same text that massage can be used after the patient has rested for a day or two, noting that it should involve stroking the whole body for approximately fifteen to twenty minutes and then “‘rapidly increased in duration to an hour or an hour and a half daily’” (Clarke 156-7).

and after a month of this agreeable treatment, he sent me home” (Gilman, *Living* 96). Unfortunately, as both the being fed and bathed by a team were not possible once she was home, Mitchell reinforced that Gilman should simply rest. As mentioned previously, the doctor warned her to “have but two hours of intellectual life a day and never touch pen, brush, or pencil as long as you do live” (Gilman, *Living* 96). Mitchell’s initial focus on the rest portion of the cure for his female patients shows him to be very much in line with the gendered distinctions in medicine throughout the nineteenth century.

As we see this overtly self-assured portrayal of Mitchell emerge, we notice clear similarities between historical depictions of Mitchell and Gilman’s contemporaneous one. Gilman described her encounter with him, noting in particular his response to her complaints as a genetic issue, explaining Mitchell “had a prejudice against the Beechers.⁷ ‘I’ve had two women of your blood here already,’ he told” Gilman dismissively while she was receiving his care (*Living* 95). In his treatment of her, Mitchell snubs Gilman as not needing further examination because, based on her family’s medical history, he can easily assume a diagnosis. His confidence in treating Gilman for the disease simply because her great-aunts were diagnosed with it, again shows not only the link between hysteria and genetics but also the link between Mitchell and his high opinion of his work as a physician in treating females.⁸ In fact, in his own *Doctor and Patient* (1888),

⁷ Gilman’s paternal grandmother was Mary Foote Beecher Perkins, the sister of famous abolitionists Harriet Beecher Stowe (see *Chapter 3*) and Catherine Beecher.

⁸ Additionally, we cannot help but wonder if his particular distaste for multiple generations of the Beecher family was the result of his ill-concealed jealousy and defensiveness in regard to his own writing—which he had begun generating by the period during which Gilman sought his treatment—as compared to the Beecher family’s literary achievements. Interestingly, in *Doctor and Patient* (1888) Mitchell gives vent to this bitterness in regards to a male Beecher when he writes of Henry Beecher Ward’s *Norwood* (1868) that “in this book are recounted many things concerning sick or wounded folk, and those astonishing surgeons and nurses who are supposed to have helped them on their feet again. The ghastly amusement which came to me out of the young lady in this volume, who amputates a man’s leg, made me reflect a little about the mode in which writers of fiction have dealt with sick people and doctors” (70-1). Mitchell clearly reveals in

Mitchell claims “no group of men so truly interprets, comprehends, and sympathizes with women as do physicians, who know how near to disorder and how close to misfortune she is brought by the very peculiarities of her nature” (11). Problematic as the first part of the sentence is when we consider the troubling female patient–male doctor relationships of the nineteenth century, the second part proves equally troubling when we recognize that this relationship is influenced by the binary and stereotyped nineteenth-century understanding of gender. Thus, Mitchell’s arrogance is not reserved only for critics but was also meted out to those who suffered from seemingly weaker blood and thus those he believed were more prone to disease.

While Gilman’s actual experience did not end with her ruin, she creates a narrator in Jane who is not so lucky, thus allowing readers to understand the limitations placed on nineteenth-century women. Early on in “The Yellow Wall-Paper,” there are only hints that something is amiss in Jane’s life. However, as the story progresses, we learn that appearances are not all they seem. In typical gothic storytelling fashion, we are at first led to believe that hers is a normal household, living happily in communion with one another. In fact, Gilman opens the story with her seemingly submissive female narrator, Jane, sharing, “[I]t is very seldom that mere ordinary people like John and myself secure ancestral halls for the summer” (“YWP” 1392). However, two sentences later, the merely ordinary Jane hints at something extraordinary, which will haunt readers long after they finish the story: “Still, I will proudly declare that there is something queer about it” (Gilman, “YWP” 1392). Jane hints at her class here—indicating she and John are likely not used to the luxury provided by this ancestral home, an indication of the generally

this moment a prejudice against the Beecher style of writing as well as a disappointment with regard to the ways in which medical care is described in such novels.

middle-class nature of doctors—and therefore at the seemingly social-climbing nature of her husband, a man to whom appearance is important. This proud proclamation that the house in which she lives for the summer is unusual clearly foreshadows future events, including Jane’s spiral into madness based on seemingly little more than queer feelings and suppositions and her husband’s lack of interest and support. An aspect of Jane’s situation makes her nervous—we as readers must determine if it is in fact the house or something else entirely.

Soon, Jane begins to more directly voice her fears of the house, giving space to concerns that will continue to plague her for the duration of the story, further impacting her already tenuous health. She wonders about the house in her diary: “why should it be let so cheaply? And why have stood so long untenanted?” (Gilman, “YWP” 1392). Of course, her readers wonder about these points, now, too. We wonder about the fact that in the middle of the summer, when most leave the cities for the cooler, more open countryside, they easily found an affordable house to rent, one described as “a colonial mansion, a hereditary estate” (“YWP” 1392), again implying the house belongs to a family of a higher class than Jane and her husband. We further wonder if she is not wrong in thinking it is “a haunted house” since it has been so long abandoned. As we consider her points, we suspect, however briefly, that it is the house and not her situation that is responsible for Jane’s nerves.⁹ However, soon we learn that Jane perceives herself as ill.

⁹ An area for further study that is currently unexamined in regard to Gilman’s short story is the relationship between our modern diagnosis of “sick building syndrome” (SBS) and the home in which her character resided for the summer. It is clear the former inhabitants of Jane’s home also wreaked havoc upon it and it is as likely the environment of the house and their captivity within it caused this destruction. Porta and Last define SBS as a “condition arising in a multiple-unit, high-rise apartment dwelling or office tower that is insulated against fluctuating environmental temperatures but inadequately ventilated so the indoor air stagnates, creating persistent odors and/or accumulated pollutants, such as stale tobacco smoke and fumes from carpet adhesives, copying machines, etc. The occupants of such buildings experience various symptoms, including respiratory distress, headaches, nausea, sleeplessness, and inability to concentrate,

She explains that despite the fact that her husband, John, and her brother do “not believe that I am sick” (“YWP” 1392), she believes herself to be ill since she is receiving treatment. We begin to wonder, has Jane made herself sick? Are all her concerns based on false perceptions?

One of the more interesting ways in which Gilman portrays the female patient–male doctor dynamic is through Jane and her husband, John. As Jane indicates, her husband is treating her for something as her doctor: “John is a physician, and *perhaps*—(I would not say it to a living soul, of course, but this is dead paper and a great relief to my mind)—*perhaps* that is one reason I do not get well faster” (“YWP” 1392). To the casual observer, it may seem Jane has no faith in her husband despite his exalted position, mirroring Gilman’s ultimate lack of faith in Mitchell. Interestingly, Mitchell is aware that to care for a patient properly, the physician “must carry with him that earnestness which wins confidence” (*Doctor and Patient* 9). Unfortunately, just as Mitchell proclaims, Gilman knows, and Jane suspects, a woman will not trust a doctor if he does not seem earnest. Thus, as the story progresses, we realize there is something unsettling lying in this faithlessness housed in their rented, eerie mansion in the countryside as Jane receives treatments for a condition her husband only describes as a “temporary nervous depression—a slight hysterical tendency” (“YWP” 1392). Jane explains she has gone

some of which may be causally related to the indoor environment and others perhaps attributable to the power of suggestion” (“sick building syndrome”). Based on the adhesive portion of this definition alone, especially considering how much old wallpapers contained arsenic, it is possible to read Jane’s hysteria as comorbid with SBS. For more on the interplay between sick building, gender, and housing status, see: Mimmi Barmark’s “Social Determinants of the Sick Building Syndrome: Exploring the Interrelated Effects of Social Position and Psychosocial Situation” which addresses the correlations between gender, reporting of symptoms, and education status. Additionally, for more on the SBS diagnosis and the hysteria surrounding it, consult Allan Rothman and Michael Weintraub’s “The Sick Building Syndrome and Mass Hysteria” published in volume 13, issue number 2 of *Neurologic Clinics* (1995).

through many treatments for this illness, despite her husband's dismissal of her: "I take phosphates or phosphites—whichever it is, and tonics, and journeys, and air, and exercise, and am absolutely forbidden to 'work' until I am well again" ("YWP" 1392). Unfortunately, despite Jane's earnest attempts to get well and listen to her doctor—with her writing being her only form of rebellion—she does not improve. Her doctor and husband, it would appear, has led her astray.¹⁰

Like other women labeled as hysterical—Alice James springs to mind—both Gilman and her creation, Jane, use writing as a form of escape from their nervous dispositions. Here I compare the historical James and Gilman to the fictional Jane to show that while fiction is horrifying, it's not completely dramatized. Therefore, the fictional Jane also is also in a state questionable mental health, as hinted at by her desire to hide her diary. As soon as they arrive in the country for her "air," for example, we realize Jane is keeping her writing a secret from her husband and his sister, Julia, who has traveled with them to take care of Jane and John's new baby.¹¹ Jane writes in her diary "for a while in spite of them" ("YWP" 1392). This secret journaling of course contributes

¹⁰ Interestingly, Gilman and her first husband, Charles Stetson, also struggled throughout their marriage as a result of the former's illness. Poirier explains that "Charlotte Perkins Gilman, social activist at the turn of the twentieth century, divorced her husband when both realized that she could not sanely live solely as a wife and mother" ("Physician Author" 26). In real life, Gilman defied social conventions of the late nineteenth century while through Jane she explored what might have happened had she stayed in her marriage.

¹¹ In the article "Whatever Happened to Jane's Baby: Still Another Examination of 'The Yellow Wall-paper'" by Hal Blythe, Charlie Sweet, and Barbara Szubinska, the authors examine the idea of a hysterical pregnancy and the resultant fall-out as what has led to Jane's disorder. They explain, "[o]ur hypothesis is that the narrator, who admits to being both a writer (of the forbidden diary) and a reader, quite likely dreams up portions of the story if not its entirety" (Blythe, Sweet, & Szubinska 76). They further articulate that "the story actually takes place in a 19th-Century version of a psychiatric ward, and we are arguing that the story provides the reflections of not only a woman suffering in general from Dissociate Identity Disorder, but more specifically a woman whose DID hallucinations are manifest also as pseudocycyesis," (Blythe et al. 76). also known as a false or hysterical pregnancy. All in all, this article provides a fascinating look at another angle to Gilman's well-known story. For more on a diagnosis of pseudocycyesis, see also: "Endocrinology and Physiology of Pseudocycyesis" by Juan J. Tarín1, Carlos Hermenegildo, Miguel A. García-Pérez, and Antonio Cano.

to her nerves as she hates “having to be so sly about it” (“YWP” 1392). However, Gilman herself was told not to work—or write—in her condition, and so, too, has John cautioned his wife against this pastime.¹² Jane explains, “he hates to have me write a word” (“YWP” 1393). As the story progresses, we see how Jane’s writing becomes intermittent, with gaps of up to two weeks. It only makes sense that her condition worsens as the thing which brings her relief—writing—also increases her fear and paranoia since she has to hide it from the rest of the household and her ability to engage in this therapeutic activity is, therefore, severely limited. At one point, she writes about concealing it from Julia in particular. “I must not let her find me writing,” Jane explains, “I verily believe she thinks it is the writing which made me sick” (“YWP” 1395). In this moment of concealment, we see what Charlotte Perkins Gilman is driving at: hysteria and other nervous conditions exacerbate the invalid’s worst fears about losing even the smallest things that bring them joy; it leaves those individuals these diseases affect in situations out of their worst nightmares and imaginings.

If we parse out each of Jane’s treatments and study how they were used in the nineteenth-century, we can explore the second benefit of reading “The Yellow Wallpaper.” Here we are looking at what these treatments did to contribute to or alleviate Jane’s nervous condition according to nineteenth-century medical texts, thus examining the influence of the larger society on the female patient–male doctor relationship. While for Jane her writing was a relief, a treatment often prescribed to women in Jane’s situation was the prevention of writing or any other form of stimulation outside the

¹² This directive issued to Gilman is studied in further detail in the next section of this chapter and mentioned in Gilman’s 1913 letter to the editor of *The Forerunner* titled “Why I Wrote ‘The Yellow Wallpaper’” which I quote throughout this chapter.

domestic sphere. Mitchell writes, “let her understand that letter-writing, of which many women are fond, must be altogether set aside” (*Doctor and Patient* 128). Mitchell’s treatment as already mentioned requires women have so little contact with the outside world that they are not even permitted to see, let alone write to, those they love.

However, he believes they can still do some of the chores inherently pleasing to their naturally domestic nature: “I have heard women say that men little know the moral value to women of sewing. It becomes difficult when people are nervous, but this or some other light handiwork is then invaluable” (*Doctor and Patient* 129). In trying to establish himself as an expert on women—he clearly believes he knows what they value—he also establishes himself as a chatelaine of society’s standards. Mitchell keeps women fulfilling their “natural” roles in that society even when ill.

To current readers and medical researchers, these drastic measures are rightly seen as a problematic means of keeping women in their place in the home; however, at the time, this lack of stimulation was justified as a way to calm women’s overexcited nerves—while undoubtedly also serving the added benefit of confinement to the domestic sphere. Mitchell writes of the benefit to women knowing their place in the social and biological order:

The women’s desire to be on a level of competition with man and to assume his duties is, I am sure, making mischief, for it is my belief that no length of generations of change in her education and modes of activity will ever really alter her characteristics. She is physiologically other than the man. (*Doctor and Patient* 13)

This stereotypical assumption that women who moved outside the domestic sphere (either literally, in instances when they went to work or receive an education as mentioned above, or figuratively, when they wrote or corresponded as a means of broadening their horizons) ended up in “mischief” was not uncommon, nor, as we have already seen elsewhere in this dissertation, was it limited to Mitchell’s work. Mitchell, however, is one of the best-known authorities from this century to dedicate a medical text to methods of keeping women confined to their proper social sphere as a means of preventing illness.

W. F. Bynum explains this misunderstanding in *Science and the Practice of Medicine in the Nineteenth Century* (1994), writing that medical minds advocated that a woman “was physiologically suited for the home, marriage, and childbearing rather than occupations in the rough and tumble of the competitive world,” in part because “her nervous system was incapable of absorbing too many vigorous impressions or her brain too much rational knowledge” (212). Thus, one of the treatments for hysteria involved keeping them solidly constrained by domesticity. Unfortunately, women who found themselves experiencing an “excess of nerves” had no outlet for these excesses, and the stresses the lack of stimulation placed on them further enabled what one doctor who wrote to Gilman described as “the best description of incipient insanity” (“Why” 1403). Gilman captures this thinking in her portrayal of Jane as becoming increasingly suspicious of the house in which she is physically restrained, articulating her growing concerns about the wallpaper, even getting up “to feel and see if the paper *did* move” (“YWP” 1397). By confining Jane to the summer house at first, and then to even one room, Gilman shows her belief, based on her own experience, that this seclusion, coupled

with a lack of any meaningful activity, sends women who are “treated” this way towards ruin.

Another treatment Jane mentions undergoing is the ingestion of phosphates or phosphites, but she is unable to recall which of the two. According to Dr. Edmund Kirby’s 1881 text on phosphorus as a cure for nerves, phosphates seems to be the treatment of choice for hysteria. He explains that in cases of hysteria, “[p]hosphorus may usually be employed with much advantage” (63). He further speculates that the form treatment takes “will depend entirely upon the exciting cause to which the affection may be due” (63). Since Gilman has John explain away Jane’s disease as only a “slight hysterical tendency” we must then ask why, in addition to phosphates, Gilman has John prescribe fresh air, exercise, no work, and so forth for Jane.

This assumption that Jane needed many treatments stems from the fact that some of her cures were most likely making her situation worse. Today we recognize the dangers of phosphorus when given in unrestricted quantities in a way that nineteenth-century physicians would not have understood. In *Phosphorus: Chemistry, Biochemistry and Technology* (2013), D. E. C. Corbridge explains how the mistaken understanding of phosphorus in the treatment of nervous complaints came about. He writes, “[i]n 1719, J. T. Hensing detected phosphorus in the brain, in unexpectedly large quantities. Subsequently there arose a widespread but unsubstantiated belief that phosphorous was ‘good for the brain’ as well as numerous other unwanted medical conditions” (Corbridge 1115). Corbridge further explains that towards “the middle of the nineteenth century, the use of certain phosphorus compounds (rather than the element) became the vogue” for treating many diseases including neurasthenia (1115). However, excessive phosphorus

treatment leads to hyperphosphatemia. Side effects of this condition include “muscle cramping, numbness or paralysis, confusion, seizures, irregular heartbeat or rhythm, or low blood pressure” (Mitrzyk “Hyperphosphatemia”), symptoms that are clearly recognizable as being the result of illnesses like hysteria and neurasthenia throughout the nineteenth century. Thus, what was being used to treat these nervous disorders could have actually been making patients’ conditions worse.

Gilman produces a terrifying climax in which we realize Jane’s situation has, in fact, worsened so much that she has become mad. “The Yellow Wall-Paper” ends in a crushing commentary on the physical and mental constraint of women as Jane’s fears are realized and the house finally drives her mad, showing the rest she has been prescribed only worsened her condition. Jane’s obsession with the woman whose “crawling shakes [the wall paper] all over” (“YWP” 1400) has slowly blinded her to the other events in her life and within the house. Gilman has created a character who can no longer defend herself against what society considers her nerves but in reality is the restraint society places upon her gender. In what is presumably her last entry, Jane’s shares her suspicions about the woman held captive in the yellow wallpaper. She clearly sees her own entrapment mirrored in this unknown woman’s experience and wants to shake the bars of her captivity just as the woman shakes the wallpaper. She confides in her journal, “I am getting angry enough to do something desperate. To jump out the window would be admirable exercise, but the bars are too strong even to try” (“YWP” 1402). Her use of the word “angry” here is enough to give the careful reader pause. In this passage, we see her nerves overtaken by the anger of the wrongfully imprisoned and we begin to hope Jane will be able to resist just as her author, Gilman, had.

This resistance does not come to pass as Jane chooses to give in to what she feared from the first line. The house as prison overtakes her and she believes she has become a part of it. She no longer sees herself as set apart from the woman held within the house itself but rather recognizes in that woman a kindred spirit, someone else who has been forced to utter mental ruin due to her own confinement in the wallpaper. Jane ponders where that woman came from, wondering if the woman can escape the wallpaper “as I did” (“YWP” 1402), thus conflating the identities of Jane and the wallpaper woman suffering from their relative confinements. Here we realize that while Gilman was able to escape, the house impacted Jane so much that she was unable to do the same and has instead become a fixture of the house. Instead, Jane has been written “to carry out the idea” (“Why” 1403) of incipient insanity and has succeeded admirably. She horrifies readers as much as she herself has been horrified, making her story one that remains in our minds and terrifies even as it instructs.

Soon after Jane determines that she is a part of the house, John comes to try to convince her to open the door. Eventually, after he recovers the key from the garden where Jane has thrown it, he enters the room with the yellow wallpaper only to exclaim, “[f]or God’s sake, what are you doing?” (“YWP” 1403) to his wife, who is now crawling around on the floor in a chilling moment of mimesis in which she mirrors the woman in the paper. In response, Jane’s voice embodies not herself but rather the house as she explains, “I got out at last [...] in spite of you and Jane” (“YWP” 1403). At this chilling pronouncement, John faints and Jane continues to mimic the woman in the wallpaper as she has “to creep over him every time” she makes a circuit of the room (“YWP” 1403). Jane has stayed in the house—following the advice of not one but two

physicians—and has gone inescapably mad as a result. In this scene, Gilman acts out how differently her own brush with hysterical madness could have ended, a fact she clarifies in the letter mentioned above and in her autobiography, when she explains why she made the difficult decision to leave her husband and child. She writes that it was “not a choice between going and staying but between going, sane and staying, insane” (Gilman, *Living* 97). By writing Jane’s experience as (narrowly) different from her own, Gilman provides us with an alternate alternative to her own escape from mental ruin by exploring her character’s descent into that madness. Thus, we end up with the two distinct results: one of the invalid who leaves everybody and one of the invalid who leaves her body.

Gilman’s personal resistance and fictional submission to Mitchell’s treatments are not the only examples of the doctor’s biases towards women. Modern readers can also see Mitchell’s gender biases clearly emerge from both his work as a doctor and as a writer. As previously mentioned, while Mitchell prescribed his female patients an end to writing and literary endeavors—in addition to copious amounts of rest—he did not issue the same moratorium to his male patients who were also writers. Mitchell justifies this choice in part by arguing, “the mass of women are by physiological nature more liable to be nervous than are men. It is a sad drawback in the face of duties of life, that a very little emotional disturbance will suffice to overcome the woman as it does not do the man and that the same disease which makes him irritable makes her nervous” (*Doctor and Patient* 137). Thus, the man does not need copious amounts of rest but rather a means by which to work out his irritability. In fact, a quick consultation of *The Walt Whitman Archive* reveals that Mitchell “blamed Whitman’s [nervous] spells on ‘habit,’ perhaps brought on by the stress of his upcoming Lincoln lecture, and prescribed mountain air and outdoor

activity. Mitchell even notes that men like Whitman “suggest out-door life as their source of inspiration” (*Doctor and Patient* 162) and therefore he does not want to take it away from these authors. In fact, after the visits, Whitman improved” (Hynes “Mitchell”).

However, modern readers find Mitchell’s medical care and writing style both in need of adjustment. In fact, even though Mitchell treated his male patients differently as evidenced by Whitman’s care, friends of those patients still questioned Mitchell’s medical practices, and, in some cases, his literary endeavors. Following Whitman’s death, Whitman’s longtime nurse, friend, and secretary Horace Trauble published a critique of Mitchell. In her eighth chapter of *S. Weir Mitchell, 1829–1914 : Philadelphia’s Literary Physician* (2012), titled “The Literary Physician,” Nancy Cervetti addresses this critique, explaining that Trauble said the physician was ““a little bitter”” and that his literary efforts ““don’t come to much”” (qtd. in Cervetti 172). Once again, Mitchell was offended by his critics—perhaps somewhat understandably this time—and attacked Whitman’s relationship with Trauble, explaining that the famous poet only kept company with his secretary because Trauble flattered Whitman to an extreme degree, which was what Whitman preferred (Cervetti 172). Mitchell also sent a critique of Whitman to the compiler of *Walt Whitman as Man, Poet, and Friend*. When asked to send something encouraging about Whitman, Mitchell wrote: “I am sorry to say that I have not altogether agreeable reflections in my mind nor perfectly pleasant memories in regard to the poet of whom you write . . . If Traubel rightly reports him as saying the things he did, I prefer to forget all about the man and as is too often the case concerning poets, to know him only in the future through his verse” (qtd. in Lozynsky 121). As indicated already by his

subliminal jealousy of the Beecher's and Gilman's literary success, Mitchell himself seems to have lost sight of the patient, if not the poet.

Interesting to note is that even as he was charging Gilman with never picking up pen or paper again, Mitchell himself was aspiring to become a writer of both literary and medical texts.¹³ One of his most interesting—and ironic—short stories is “The Autobiography of a Quack” (1900), in which he creates a character named Ezra Sandcraft who has spent his adult life being first one type of doctor and then another, while not actually providing quality treatment to his patients. Mitchell begins his story with an unrepentant Sandcraft explaining that he is dying of “Addison’s disease [...] this pleasing malady which causes me to be covered with large blotches of a dark mulatto tint” (2). Addison’s disease, also sometimes referred to as the “Bronze Disease,” is “a disorder caused by chronic deficiency of corticosteroid hormones resulting from disease affecting the adrenal glands, characterized by weight loss, weakness, increased pigmentation of the skin, and episodes of vomiting, diarrhoea, and abdominal pain” (“Addison’s disease”).¹⁴ It is clearly a painful and common disease that not only presents with more physical complications than hysteria, which allows Mitchell to focus on a male subject for his story. As a means of distraction for his patient, Sandcraft’s doctor has recommended the invalid “write out a plain account” of his life as it might interest readers (2). Audiences are left to marvel at the fact that the quack’s doctor is already a better caregiver than

¹³ Mitchell also wrote poetry. One of his most interesting poems, “Birth and Death of Pain,” seems informed by his wartime experiences as well as his work with soldiers and anesthesia. One of Mitchell’s most famous—during his lifetime—novels was *Hugh Wynne*, which “sold more than five hundred thousand copies within a decade of its publication and went through at least twenty-two editions” (Cervetti 221).

¹⁴ Erroneously, Addison’s disease has been put forth as a diagnosis for Jane Austen following her death.

Mitchell himself because he provides his patient with a useful diversion and a worthwhile endeavor.

As “Autobiography of a Quack” continues, we learn the full extent of Sandcraft’s duplicity and all the ways in which he took advantage of various patients in his positions as everything from a surgeon to a holistic physician. In addition to being a completely unreliable narrator who cheats his way through medical school, we realize he will scheme with anyone to increase his chances of successfully defrauding those who rely on him for medical advice. The instance of his professional duplicity on which I want to focus is particularly troublesome as it involves the health of a young woman held in her home in a manner similar to both Gilman and her narrator, Jane. Sandcraft played not only on the insecurities of this young woman but also on those of her family: “She was scared about her health, because she had a cough, and had lost a brother of consumption” (10). Ultimately, her family employed Sandcraft to calm the woman’s fears so she would be marriageable once again. Unfortunately, Sandcraft describes the young woman as “choke-full of emotions. I saw it would be easy to frighten her” (11) and so he does. Here we cannot fail to see the echoes of the ways in which Gilman herself was frightened by Mitchell’s diagnosis and records that fear in Jane, her narrator.

It seems that Sandcraft may have frightened the young woman too much, however. While he was paid to make her diagnosis serious—in fact the young woman’s uncle felt “it might have been put stronger” (11) even than Sandcraft did—however, he does it so convincingly that she elopes following “an attack of hysterics” (11). Sandcraft acknowledges after the fact that this elopement isn’t entirely surprising as “[h]uman nature plus hysteria will defy all knowledge of character” (10), once again creating a

narrative in which the hysterical woman is culpable for all of her actions, despite the questionable nature of her doctor. In Sandcraft's above rumination, we see an echo of Mitchell's own thoughts about hysteria as shared by Gilman when she writes that Mitchell believed her hysteria was caused by "self-conceit" (95), most likely as a result of being born to the famous Beecher family, of whom Mitchell also whole-heartedly disapproved. For both Sandcraft and Mitchell, then, hysteria is the result of the woman's character, not the environment into which society forces her.

Mitchell's stories—like his medicine—were not without critics. Cervetti explains that some readers complained his writing was not of "interest because of a want of vivid incident" (qtd. in Cervetti 161). In fact, we can see this lack clearly in the above anecdote as the woman's consultation, care, and elopement all take place outside the pages of the text, and yet, as a doctor, Mitchell should have felt himself more than capable of addressing at least the first two within his story. In response to well-earned critiques like this, Mitchell wrote angry letters and editorials. Cervetti explains that "unsigned reviews especially irritated [Mitchell], and he waged a small war by writing letters and an article condemning them" (161). Through their targeted dismissal of much of his work, Mitchell's literary critics reveal him to be an author lacking in talent, particularly with regard to knowledge of his patients.

Gilman's story—the fictitious one as influenced by her personal narrative—compared alongside Mitchell's, exposes the problematic nature of the nineteenth-century male-driven medical establishment. Gilman and Jane's experiences highlight doctors' inattention to what the female patient experiences, instead dismissing her complaints as weaknesses and nerves while her male counterparts are taken seriously. On the other

hand, Mitchell clearly reveals—undoubtedly unintentionally—the lengths to which some unscrupulous doctors will go to keep their female patients solidly in the domestic sphere, as evidenced by Sandcraft’s dramatizing his female patient’s illness. In each, we learn what happens when the female resists—as Gilman did by ignoring Mitchell’s advice; when the female submits—as Jane did in part in an effort to avoid direct contact with Mitchell; when the female patient forges a new path—as Sandcraft’s did. In all, though, we see the limited options the female has available to her as encouraged by a medical establishment unwilling or unaware of how to move past the assumptions of the previous centuries about the effects of illness on a woman’s mind and body.

One of the most unscrupulous stories told in “The Autobiography of a Quack” not only addresses gender disparities in nineteenth-century healthcare but also racial ones, and it is therefore the anecdote on which I choose to close this chapter. Sandcraft is called to the home of a woman of color and sets the scene as follows:

I blundered up an alley and into a back room, where I fell over somebody, and was cursed and told to lie down and keep easy, or somebody, meaning the man [I] stumbled over, would make me. At last I lit on a staircase which led into the alley, and, after much useless inquiry, got as high as the garret. People hereabout did not know one another, or did not want to know, so that it was of little avail to ask questions. At length I saw a light through the cracks in the attic door, and walked in. To my amazement, the first person I saw was a woman of about thirty-five, in pearl-gray Quaker dress—one of your quiet, good looking people. She was seated on a stool beside a straw mattress upon which lay a black woman. There were three

others crowded close around a small stove, which was red-hot—an unusual spectacle on this street. Altogether a most nasty den. (Mitchell 8)

The first notion which strikes anyone reading this depiction is the squalid nature of the place in which the woman resides. The fact that many nineteenth-century diseases spread in terrible tenements and back alleys like the one Mitchell describes meant care was hard to get for those forced to live in these places. Thus, they were left to the tender mercies of the newest doctors or the least sympathetic, as in the case of Sandcraft.¹⁵ The location in which this woman resides does not raise the only cause for concern in Mitchell's depiction. Equally troubling is the fact that Sandcraft spends more time describing his distaste for the room—"a most nasty den"—than he does studying or depicting his patient. Instead, he glances at her only after looking at the Quaker woman, whom he describes as good-looking in some detail.

Additionally, in this moment, Sandcraft seems to be indicating that not all is right with himself. He mentions the fact that when he is summoned to help this woman, he is already operating under preconceived notions about the location, wondering if he "should find a good patient or some dirty" person (8). Thus, we recognize that he has biases going into this call, and in fact is more worried about himself and whether or not he will be compensated for his night's work as "the locality did not look like pay" (8). Once he has decided to go and tend to her, he admits to finding her place by "blundering up an alley" where he presently "fell over somebody," indicating a turn of events that does not instill confidence in his ability to provide quality care as he at the very least cannot seem to

¹⁵ Today, unfortunately, health disparities still exist and are further impacted by race, as I address in the conclusion to this dissertation.

locate his patient and at the very worst is under the influence of something which Mitchell indicates through his choice of uncoordinated terminology.

Readers should be unsurprised, then, that when Sandcraft finally examines the patient he deems her below his notice. ““Good gracious,”” Sandcraft exclaims after “seeing how the creature was speckled. ‘I didn’t understand this, or I would not have come. I have important cases which I cannot subject to the risk of contagion. Best let her alone miss’” (5). In this moment, we witness four important (re)actions. First, Sandcraft finally acknowledges the ill woman, though he still chooses to speak to the Quaker instead of his former patient—a problematic commentary on his lack of interest in his engaging with those who most need his help. Secondly, Sandcraft promptly dismisses her, using his medical gaze to quickly hypothesize that she has smallpox, a highly contagious illness. Even later, when Sandcraft’s rival informs him that this was a misdiagnosis and the woman only had measles, he remains unrepentant. He tells his rival—the doctor who actually treated the patient and was promoted instead of Sandcraft to the Southwark Dispensary as a result—that he knew the patient was suffering from measles.¹⁶ He uses his substantial confidence in this moment to ask this rival, “you don’t think I was going in for dispensary trash, do you?” (9). His actions and reactions tell us that Dr. Sandcraft is a callous man, a victim of his own prejudices.

Further, Sandcraft compounds the first two insincerities by lying, saying he has other patients, which readers know through his own admission to be categorically untrue. Sandcraft has previously told us, “I waited a month without having been called upon by a

¹⁶ There are several similarities between smallpox and measles that might explain Sandcraft’s mistake, had it been prior to 1774, “when smallpox was first reported separately from measles” (Davenport et al 76). However, because this text takes place in the nineteenth century, no such benefit of the doubt can be given to Sandcraft and once again he proves his incapability.

single patient” (7). Finally, in perhaps the most distasteful moment we’ve seen so far from Sandcraft, he abandons the woman of color and the Quakers, choosing not to provide care. From a professional standpoint, this action is the most problematic. Cervetti explains that in this manner, Sandcraft departs from the doctor who created him, “[f]or many physicians, treating the poor and destitute was a necessary first step in establishing a successful medical practice. This was Mitchell’s experience” (92). Instead, Sandcraft abandons his patient, a terrible mistake as Cervetti explains, “[i]n the case of Sandcraft, after he fails to properly treat a poor black woman, news of his incompetence travels quickly and destroys his reputation” (92). However reprehensible his actions, they not only show us some glimmers of hope in terms of the expectations of doctors but they also allow us to examine the unvarnished history of not only gender biases in medicine but also racial ones.¹⁷

¹⁷ The afterward of this dissertation presented in the *Afterward* looks at the ties between the gender-specific medicine of the nineteenth century and modern-day racialized medicine to see where the roots of racialized medicine are and to consider how problematic it is to current diagnoses and medical disparities.

Afterward—A Long Way to Go

While modern readers would hope we have a better grasp on epidemiology and the impacts of gender on understandings of disease, we continue to struggle with

diagnoses not only as they are thought to be influenced by gender but also by race.

The accompanying artwork (*Figure 1*) by Paulina Siniatkina is a useful example.

Siniatkina painted this self-portrait, and

others like it in a series entitled “Hold

Your Breath,” while quarantined in a

tuberculosis hospital in Moscow, Russia.

Siniatkina explains that while undergoing

treatment for TB, she heard for the first time a stereotypes surrounding the disease today.

In particular:

I learned that there is a stigma surrounding this disease. People who are not infected react aggressively; they blame or avoid communications with those ill with TB. As a result, TB patients are afraid to speak out and they hide or lie about what is actually happening to them. In my experience my doctor advised me not to tell anyone I had TB, otherwise I would be branded for life. (Siniatkina “WHO: Hold Your Breath”).

While these stereotypes might arise from misconceptions about disease, they are hardly surprising when we consider both fears about infection as well as increasing knowledge



Figure 3: A self-portrait of Siniatkina. This untitled painting is the first in her series. To undergo her TB treatment, Paulina spent 6 months and 17 days in a TB clinic in 2015.

of epidemiology. Further, the need to lie, the requirement to quarantine patients, and the connections to other diseases are not new facets of TB; rather, these are glaring similarities to consumption diagnoses of the past that continue to be influenced by a patient's ability to pay for care as well as his or her social status.

In this first piece in her series of paintings, we notice many tubercular symptoms a nineteenth-century audience would recognize. First, for example, look at the flushed cheeks of the men and women surrounding Siniatkina, and note a bit of color in the visible portion of her own cheeks. The fictional and real-life tubercular people focused on in *Chapters 2–4* of this dissertation also experienced a similar flush that colored their cheeks heightened the contrast in relation to the pallor of the rest of their face. This paleness is also noticeable in many of the other figures in the artwork, emphasized by the bags under their eyes and the hints of pale hands, brows, and jowls that make those who are seemingly tubercular stand out. In fact, most figures in the painting appear symptomatic for TB, perhaps as a commentary on the high infection rates throughout Russia, which have no consideration for age, gender, race, or social status, just as in the past.

Most clearly, however, in Siniatkina's self-portrait are the diversity of races pictured. Gone are the fainting, beautiful, high-class sickly females of the nineteenth century. They have been replaced with a much more holistic representation of the disease that includes the elderly and children, members of different races and genders, and, presumably, people of many social classes as evidenced by what they are wearing. Note, for example, the balding man in the bottom right corner wearing a greyed-out hoodie with the strings tightly bunched together. Compare him to the larger woman in the middle

on the left who seems to be wearing if not two nice coats, at least one with luxuriant scarf. Further, she is “put together” as evidenced by her makeup and accessories, implying she has the income and time to present herself thus. No doubt Siniatkina’s paintings represent the current status of TB in Russia where the disease continues to plague the population regardless of age, race, gender, or class. Peter Yablonskii, Alexandr Vizel, Vladimir Galkin, and Marina Shulgina studied the history of tuberculosis in Russia and note that it continues to infect the populace, causing particular problems in prisons and among those of lower socioeconomic statuses (374). However, they further articulate that the disease plagues children more now than in the past, and so the government has allotted much of the TB research and funding to tests identifying and treating tubercular children (Yablonskii et al. 375). This information shows us that while idealized reactions to TB in children of the past—as evidenced by the spiritual suffering of Eva St. Clare—were fairly common, nowadays more practical resources are being developed and designated for care of children before TB reaches its drug-resistant or full-blown disease stages.

TB continues to isolate patients in Russia, as well as other parts of the globe, both metaphorically and literally. In part due to the contagious nature of the disease, patients are sequestered while they undergo treatment. However, it is not just the disease itself that accounts for this separation: what it symbolizes as well as who it affects adds to the isolation. TB, according to the World Health Organization (WHO), disproportionately affects developing nations, as the above map (*Figure 2*) indicates. Furthermore, it affects those already facing health disparities even in developed countries.¹ In addition, the

¹ Facts and figures taken from their annual report (2019 edition) on TB.

connection TB now has to HIV in these developing areas the stigma around it persists.

The WHO explains, “TB is the most common presenting illness among people living



with HIV,
including among
those taking
antiretroviral
treatment, and it
is the major cause

Figure 4: This map is taken from the World Health Organization’s website and indicates the presence of TB throughout the world. Note that in particular drug-resistant infections are higher in developing nations.

of HIV-related deaths. Sub-Saharan Africa bears the brunt of the dual epidemic, accounting for approximately 86% of all deaths from HIV-associated TB in 2016” (WHO, “HIV and TB”). This brunt is not an easy one to bear, nor is it one many concern themselves with because of the location in which it manifested.

There is a long history that explains why developed nations like the United Kingdom and the United States are not as concerned about the outbreaks of TB in developing nations as they should be and it has to do with racialized medicine. While we now understand a lot more about an illness like TB than we did in the Romantic and Victorian eras, we still struggle to acknowledge the ways in which disease disproportionately affects women over men, people of color over white people, and people of advanced age. In other words, disease attacks minorities, but there are a lot of reasons for this fact including disparities in access to treatment, cost of treatment, and medical biases. Treatment, just like in the nineteenth-century, still privileges those with

money, access, power, and time. These disparities in wealth and illness have deep roots in the historical past.

An article about African Americans and tuberculosis—as well as insanity—taken from an 1896 newspaper provides historical evidence regarding deliberate ignorance of racialized minority health concerns. The author, Dr., argues that enslaved Africans and African Americans “up to 1860 enjoyed remarkable mental and physical health, and they were almost entirely exempt from certain diseases to which they are not only very susceptible, but are dying much more rapidly from these maladies than the whites; namely, insanity and consumption” (1185). This article also hints at a problematic justification for continuing slavery even though the practice had stopped nearly thirty years earlier as the implication goes that before emancipation, men and women of color were healthier, thus, they are better off enslaved. Here we read a blatant misunderstanding of historical contexts that supported slavery—as obviously men and women of color were ill before 1860 and undoubtedly contracted TB as a result of their cramped living quarters and its epidemic status throughout the nineteenth century. Furthermore, readers should be unsurprised to find that enslaved people often suffered from symptoms of insanity due to their mandated confinement. Harriet Washington, author of *Medical Apartheid* (2006) explains there were many “imaginary ‘black’ diseases, whose principal symptoms seemed to be a lack of enthusiasm for slavery” including, but not limited to “struma Africana,” a form of TB (36). However, as they did not receive proper care, health records were poor at best for the enslaved. Often, they

were presumed to be “faking” their illnesses.² Men and women of color were not believed when they presented as ill.

Additionally, because many enslaved men and women were presumed to be faking illness instead of presenting with real diseases and diagnoses, medical practitioners developed a habit of documenting their illnesses under other names, as in the case of *struma Africana*.³ Or, they viewed their illnesses as ways to avoid work or to rebel against their bewildered overseers. Susan Baur notes in *Hypochondria: Woeful Imaginings* (1988) that being continually fatigued, chronically ill, and in danger of an “imminent breakdown” were viewed as tactics used by enslaved Americans to rebel quietly (145-46). This idea of minorities feigning illness as a way to avoid dangerous, awkward, or otherwise unenjoyable situations continues today as a common misconception. Additionally, in *Gender, Race, Class, and Health* (2006), Amy Schulz and Leith Mullings focus on the far-reaching effects of this fallacy-laden phenomenon. They assert that “[a]lleged cultural traits, behaviors, or beliefs frequently implicitly or explicitly considered to be associated with racial groups, are often seen as constant, unchanging, and independent of historical and social processes” (Mullings and Schulz 4). Because of this mindset, downplaying illnesses manifesting in minorities continues today. Just as Harriet Beecher Stowe’s Marie St. Clare dismissed her slaves’ conditions and concerns as false over 150 years ago, some modern minds carry on the outrageous tradition with patients of color today.⁴

² For more on the problematic notion of feigned illness coinciding with incidences of enslavement, see also G. E. Berrios’s “Feelings of Fatigue” (1996) in *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century*.

³ *Chapter 4* mentions other illnesses that were particular to enslaved Africans and African Americans living in the United States before emancipation.

⁴ The scene I reference here and in *Chapter 4* is one in which St. Clare caustically disregards Mammy—one of the enslaved people living on their plantation—and her ailment. St. Clare tells her daughter Evangeline

It would be a grotesque mistake, therefore, to assume these racial, medical disparities ended when slavery did. We need look no further than the poet Paul Laurence Dunbar and his tragic death due to TB for proof of this fact. In *Lyrics of Sunshine and Shadow: The Tragic Courtship and Marriage of Paul Laurence Dunbar and Alice Ruth Moore* (2001), Eleanor Alexander writes that by the late nineteenth-century, “[a]cross the nation, people of color were viewed as lazy, improvident, childlike, irresponsible, chicken-stealing, crap-shooting, razor-toting, immoral, criminal beings” (15). In particular, “[c]lass added another important dimension to Paul’s formative years, for he grew up in dire poverty. He was also shaped by the gendered activities and attitudes of his environment and the psychological scars his parents and nation carried from slavery” (Alexander 15-16).⁵ Dunbar, who wrote beautiful poetry that seemed to speak to recently freed men and women, ended up contracting tuberculosis as a result of these dynamics. His poem “The Debt,” published in 1912—six years after his death—speaks to his experience:

This is the debt I pay
 Just for one riotous day,
 Years of regret and grief,

that slaves make “such a fuss about every little headache or finger-ache; it’ll never do to encourage it” (Stowe 263).

⁵ It is important to note that while Dunbar’s life and poetry are remarkable and useful for studying the history of racialized medicine, his treatment of his literary wife Alice Ruth Moore was not without problems. He was an abusive alcoholic, but this behavior in part is the result of the brutality his parents established as status quo in their punishment of their children. This brutality was born out of the treatment slaves such as Dunbar’s parents experienced at the hands of their owners and overseers (Alexander 21). Further, Dunbar was growing up when “late nineteenth-century America was gender rigid. Specific behaviors and responsibilities were attributed to men and women, with men as the superior, authoritative, dominant force” (Alexander 21). None of these points are meant to excuse Dunbar’s abusive behavior but rather to explain more of the underlying social and medical issues that further impacted the health of formerly enslaved Africans and African Americans.

Sorrow without relief.
 Pay it I will to the end—
 Until the grave, my friend,
 Gives me a true release—
 Gives me the clasp of peace.
 Slight was the thing I bought,
 Small was the debt I thought,
 Poor was the loan at best—
 God! but the interest!

Here, Dunbar could be referencing his TB diagnosis, his marital strife, his alcoholism, or his status as a second-class citizen simply because he is a minority. What is clear, however, is the haunting tone of his poem as he begs for relief from the situation in which he finds himself—and has been in for many years. Eerily, we note some of the praying for release that Keats expresses in his “Ode to a Nightingale” with a much more poignant focus as this poem was published following Dunbar’s death.

Dunbar, a clearly talented man who should have been afforded better opportunities, was left to die in squalor. In point of fact, he was rejected from many sanitoriums that were appearing throughout America to treat TB because he was African American. Alison Blank and Jim Murphy write in *The Invincible Microbe: Tuberculosis and the Never-Ending Search for a Cure* (2012), that Dunbar “was among the thousands of ‘outsiders’ who had difficulty finding proper medical care and eventually died of TB” (67). Dunbar’s case was not unusual; in fact, by the start of the twentieth century, African

Americans were still being denied treatment at all private sanitoriums and “[m]ost public sanitoriums followed the same exclusionary policies” (Murphy and Blank 66).

Today, however, the reverse is true, as men and women of color who are contagious for TB are, according to Washington, forced to undergo containment therapy (325). This containment is due in large part to the troubling and misguided notion that “blacks are also frequently presented as vectors of disease, posing a threat of infection to whites” meaning they must be contained (Washington 326). Thus, while we may have come some way in regards to gender-specific medicine, the advancements we have made are mostly for white, upper-class women.

As this project has shown, globally, we face problematic notions today about disease with regards to both gender and race that have their roots much earlier in literary and medical history. We need to be aware of the obstacles—cost, access, the medical gaze—many still face with regard to getting proper healthcare and also consider why these obstacles still exist. Empathy is a necessity in medical care and should be provided alongside holistic treatment of the patient but often is not.⁶ Rather, patients are reduced to their symptoms, exposed to stereotypes about their gender and/or race, and often the dynamics of the powerful doctor-meek patient may impede care. Therefore, it is up to us to study and then acknowledge the racist and sexist ideologies of the past and present and allow them no place in patient care.

⁶ For an excellent read on why empathy must have a place in medical care, see Dr. David Watt’s short article “The Cure for the Common Cold” (pg. 1184-1185) first published in *The New England Journal of Medicine* in 2012.

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