SOMATIC SUBJECTS: 
THE PATHOLOGICAL PATH TO VICTORIAN WOMANHOOD

A Dissertation 
presented to 
the Faculty of the Graduate School 
at the University of Missouri

In Partial Fulfillment 
of the Requirements for the Degree 
Doctor of Philosophy

by 
ERIN WILSON

Dr. Nancy West, Dissertation Advisor

July 2012
The undersigned, appointed by the dean of the Graduate School, have examined the dissertation entitled

SOMATIC SUBJECTS:
THE PATHOLOGICAL PATH TO VICTORIAN WOMANHOOD

presented by Erin Wilson,
a candidate for the degree of doctor of philosophy,
and hereby certify that, in their opinion, it is worthy of acceptance.

____________________________
Professor Nancy West

____________________________
Professor Elizabeth Chang

____________________________
Professor Devoney Looser

____________________________
Professor Noah Heringman

____________________________
Professor Michael Yonan
For my amazingly supportive friends and family
Acknowledgements

This project would not have been possible without the support of faculty and colleagues at the University of Missouri. My utmost thanks goes to Nancy West for her encouragement, guidance, and enthusiasm for the project. I would also like to extend my highest gratitude to Elizabeth Chang. Her feedback was both supportive and challenging, and allowed the scope of the project to expand into critical terrain I hadn’t thought possible. My gratitude, too, is extended to Devoney Looser, Noah Heringman, and Michael Yonan for the care with which they treated my work. I’d like to acknowledge my fellow graduate students in the English department who let me work through ideas that seemed impossible to untangle, and who forced me to write on days when it felt as though the words would never form.
# Table of Contents

Acknowledgements..............................................................................................................ii

List of Images........................................................................................................................iv

Introduction  
   The Embodied Narrative and Victorian Women.........................................................1

Chapter 1  
   Bodies in Transition: Nerves and Pathological Sensibility.................................23

Chapter 2  
   An Exchange of Air: Consumption and Bonds Between Women in the Social-Problem Novel..............................................................64

Chapter 3  
   The Barbarian Within: Breast Cancer and the Writing Cure.............................105

Chapter 4  
   Fatally Feminine: Venereal Disease and the New Woman Novel.......................140

Conclusion  
   Do Diagnoses Matter?.........................................................................................182

Bibliography.......................................................................................................................190

Vita......................................................................................................................................201
List of Images

Figure 1: Melancholy by Constance Charpentier.................................11
Figure 2: She Never Told Her Love by Henry Peach Robinson...............28
Figure 3: Fading Away by Henry Peach Robinson..............................28
Figure 4: Detail of Ophelia by John Everett Millais..............................67
Figure 5: Lady of Shalott by John Waterhouse..................................68
Figure 6: “The Orgy” from William Hogarth’s A Rake’s Progress............151
Figure 7: Plate 3 from William Hogarth’s A Harlot’s Progress..............151
Figure 8: Frontispiece for August Barthélemy’s translation of Syphilis.....153
Introduction

The Embodied Narrative and Victorian Women

If Victorian novelists shared a cohesive narrative objective it was to explore the evolution of individual subjectivity within demanding social and cultural institutions. John Halperin declares, in *Egoism and Self-Discovery in the Victorian Novel* (1974), that the most common narrative path in Victorian fiction tracks a major protagonist through a state of underdeveloped or even fractured personhood that blossoms into a state of self-discovery, empathy, and eventual harmony through a series of what he calls “educational jolts” (2).\(^1\) It is a bold claim, but one difficult to refute. It is, after all, the course of canonical Victorian novels like *Jane Eyre* (1847) and *Great Expectations* (1860) among others. Gail Marshall implies that this narrative arc grows out of a collision of political and scientific discourses that generated an omnipresent anxiety of identity, particularly those discourses concerned with compartmentalizing the human and the subhuman, and consequently those preoccupied with codifying the borders between civilization and barbarism.\(^2\) The body occupies the axis of many of these discourses, as the relationship between corporeality and

\(^1\) For Halperin, the acquisition of empathy is what makes Victorian fiction distinct from eighteenth-century novels and narratives produced by Modernists. Harmony and closure are achieved both through the attainment of empathy and the subsequent ability to integrate into predefined social structures. Alternatively, if a character fails to assimilate, he or she often dies as in Eliot’s *The Mill on the Floss* (1860) or Hardy’s *Jude the Obscure* (1895).

\(^2\) Gail Marshall identifies Darwin’s theory of evolution, the birth of psychological inquiry, growing imperial tension, and shifts in gender politics as the discourses primarily responsible for generating these identity anxieties.
personhood is perpetually recognized and invoked. While the body might inhabit some volatile spaces in identity politics, it was, and perhaps continues to be, integrated into almost any conversation related to states of being. As Pamela Gilbert writes in *Disease, Desire and the Body in Victorian Women’s Popular Novels* (1997):

The body—despised, adorned, represented, medicated, ignored, dissected, and desired—is ineradicably entwined in subjectivity. What we do, feel, believe, know is as embodied beings. The body, uncertainly poised between nature and culture, practices and signifies identity. It is the fundamental trope of human experience.

While the body is a fundamental component in a multitude of ongoing Victorian debates, such as those related to empire and class, its centrality is particularly manifest where discourses of gender are concerned in the nineteenth century. As writers like Cynthia Russet and others have detailed, multiple modes of nineteenth-century academic and popular discourse adhered to the philosophical principle that men were the more cerebral of the sexes, with women living a more sensory, and thus purely bodily, existence. As Russett writes, “If men characteristically thought, women characteristically felt” (42). In other words, working from the principle of Cartesian dualism, woman is the “material” or “body” in the mind/body split. Thus, the fictive experience of “becoming” a woman would, for the Victorians, be an embodied one. As the novel becomes more and more fixated on detailing the path to personhood, the female *bildung*, consequently, reveals an interest in charting changes to the body as they relate to the emergent self. The resulting work, I propose, is a narrative fabric in which subjectivity, text, and body are interwoven—an embodied narrative.
It is my particular aim to examine nineteenth-century embodied narratives of women whose “educational jolts” are anchored in trials of disease and sickness. In the years following feminism’s second wave and the advent of “body theory,” much seminal work has been produced on the representative body in nineteenth-century fiction and art, particularly the gendered body, such as Helena Michie’s *The Flesh Made Word* (1987) and Ludmilla Jordanova’s *Sexual Visions* (1989). This project, though, takes the body beyond its representative capacity to an exploration of its narrative and epistemological power. Few critics have speculated about what the amalgamation of pathology and femininity means for a history of the nineteenth-century novel, aside from observing, frankly, that Victorian novels are rife with invalid women. This is, though, only part of the story. Certainly, disease is representational but it is also narratological. Like a novel, it has a beginning, a setting or series of settings, an apex, and an end. It has a cast of characters (symptoms), and an audience (both those predisposed to them and the doctors who treat patients). Foregrounding the body in a text, then, does more than present a symbol for sexual repression or “the female condition.” To embed the diseased body into a text is to introduce a micro-narrative into the superstructure that constitutes the novel. As the story of

3 Susan Bordo, with her seminal work *Unbearable Weight* (1994), and Elizabeth Grosz with *Volatile Bodies* (1994) applied a feminist methodology to discourse of corporeality. Both Grosz and Bordo argue that the body is a cultural construct, that theoretical work by psychoanalysts and poststructuralists have normalized the male body, and both call for critical examinations of corporeal experiences that are uniquely female.

4 Elaine Showalter makes such an argument in *The Female Malady* (1985) in her extensive discussion of constructions of madness throughout the nineteenth and twentieth centuries.
a body unfolds—it’s fluctuations, degenerations, and regenerations—it constitutes its own subplot or even shadow narrative that stalks the primary narrative, serving as the propeller of development for those in its milieu.

This project explores the role of disease in narratives of female development in the nineteenth century, particularly women’s novels with some additional attention to memoir, letters, poetry, and the visual arts. Specifically, I analyze the ways in which female subjectivities are formed in a relationship with illness, experienced either personally or by proxy. Bringing literary work into dialogue with gendered representations detailed in Romantic and Victorian medical treatises, I propose that certain diseases were uniquely adaptable to particular narrative paths and genres, and that the course of a female character’s growth within those genres depended on the nature of her pathology. In other words, there is no single “Victorian disease narrative.” Rather, there are multiple and sometimes incongruent subgenres of the embodied narrative sculpted to fit the semiotics of a particular malady. Each disease, therefore, constitutes its own genre with its own unique collection of formulas, conventions, and expectations. Consequently, as each disease adapts and shapes a distinct narrative, each disease also produces discrete Victorian femininities, such as “the rational woman,” “the angel in the house,” and the New Woman that become a part of their respective disease’s iconography. It is, ultimately, my conclusion that gendered representations of illness produced by biomedical discourse inform both the configuration of narrative structure and crystallization of subjectivity in the woman’s bildung. In other words, how a woman comes into being in the
course of a narrative depends not only on her experience of illness, but more specifically on how she experiences it.

Such a study is particularly rich in the nineteenth century because illness and invalidism are so ubiquitous in the narrative arts. As Athena Vrettos writes in *Somatic Fictions* (1995):

> It is difficult to find many Victorian novels that do not participate in a general dialogue about sickness and health, whether through sustained representations of physical affliction and exertion or passing metaphors of bodily sensitivity and threat (1).

The prevalence of such representations is tied to a whole host of cultural and institutional factors. In *Nineteenth-Century Narratives of Contagion* (2005), Allan Conrad Christensen details the spike in epidemic and plague that afflicted countless Victorians:

> The obvious material explanation of the fascination with contagion is the dramatic virulence of the series of epidemics during the middle third of the nineteenth century. In England these began in 1831-1832 when cholera, as a seemingly new and especially inexplicable disease, struck with terrifying unpredictability and claimed some 52,000 lives. Between 1836 and 1842 there occurred major epidemics of influenza, typhus, smallpox, measles, whooping cough, scarlet fever, and between 1846 and 1849 further epidemics of typhus, typhoid, and cholera. And the epidemic outbreaks continued while tuberculosis and venereal disease remained a constant cause of mortality as well (4).

In addition, or perhaps even because of this, the nineteenth century also witnessed the evolving professionalization of the physician, which included new processes for vetting doctors and surgeons, increasingly specialized fields of medicine, and the so-called “birth of the clinic.”

---

5 Foucault locates the proverbial birth of the clinic in the eighteenth century, even as he asserts that the clinic was always already a fixture in culture. In the
written medical materials among the populace was quite common, certainly when compared with today. Dr. William Buchan’s medical guide *Domestic Medicine* was, according to Charles Rosenberg, the most widely read nonreligious book in English during the half century following its initial publication in 1769, going into more than a dozen editions. In addition, lectures by prominent physicians like Thomas Trotter, Thomas Beddoes, William Hunter, and Weir Mitchell were widely attended not only by fellow physicians, but by members of the general public. Furthermore, the line between medical writing and fiction was often blurred as several physicians entered the literary marketplace as authors, the most famous example being Arthur Conan Doyle. Many of these texts, such as Dr. John Brown’s *Rab and his Friends* (1859), are fictionalized accounts of the doctor’s professional experiences.

With the changes in medical professionalization and discourse came many new theories of illness and embodiment, bringing with them profound discoveries and loud objections. The turn from miasma theory to germ theory to explain infectious diseases, for example, was highly contested until Robert Koch solidly verified germ theory in the 1870’s and 80’s.\(^6\) Arguably, the most

\[\text{nineteenth century, Foucault claims that the clinician came to replace the clergy as the primary source of human salvation. One might suggest, then, that while the clinic may have been born in the eighteenth century, it matured in the nineteenth.}\]

\[\text{\textsuperscript{6} Dr. John Snow is generally regarded as the father of germ theory. Before his *On the Mode of Communication of Cholera* (1849), the theory of communicability was dominated by the miasma model, which claimed diseases were transmitted via “bad air.” Snow’s insistence that germs carried in contaminated water were responsible for the cholera epidemics was rejected by public health officials, in spite of Snow’s overwhelming evidence. Robert Koch, in 1877, was able to isolate}\]
important theory of embodiment and identity to emerge from the Victorians is Charles Darwin’s theory of evolution through natural selection. As Cynthia Russett details, the publication of *On the Origin of Species* in 1859 generated new ways of understanding real and imagined relationships between disparate populations, innovations in disciplinary study, and eye-opening conceptions of defining humanity:

Evolution gave new meaning and an entire history to the particular facts of anatomy, morphology, and embryology. Biologists began to study organisms with an eye to their ancestral linkages and to their change and variation over time, as well as to their adaptive fitness in the present (4).

The findings of those studies were, as Sondra Archimedes notes, often conveyed in narrative terms. What she calls “the narrative of evolutionary biology” informs theoretical translations in other disciplines such as the narrative of, for example, psychological development or physical growth (2). The supremacy of “natural law” implicit in Darwinian theory informed other scientific disciplines aimed at uncovering the potential criminality and depravity of an individual by reading codes inscribed on the body, specifically phrenology, physiognomy, and forensic science. For proponents of phrenology and physiognomy, physiology was destiny, as the fate of individuals was thought to be governed by what was termed “the tyranny of their organization.” While phrenology largely fell out of fashion by the middle of the nineteenth century, its empirical emphasis became the linchpin in the burgeoning study of physical anthropology, as Russett explains:

---

the spore that causes anthrax. Later, in the 1880’s, he was able to isolate the bacteria that cause both tuberculosis and cholera.
Phrenology bequeathed to physical anthropology as well its faith in the biological basis of human capacity. Human beings were what they were because of the tilt of their faces and the shape of their skulls. To this contention physical anthropologists were able to add a great deal of anatomical and physiological data, but the message was the same: bodies determined minds (24).

If one’s interior was written on his or her exterior, it meant that the body, and thus the individual, was comprised of a network of signifiers that, if decoded by experts, could forecast behavior. The readability of the body was reinforced, also, by innovations in forensic science which, while undoubtedly life saving and instrumental in criminal detection, also allowed the Victorian body to be quantified, codified, standardized, and controlled. The discovery of unique bodily traits, such as blood types in 1818 and unique fingerprints, gave the body an unprecedented textuality. In *Detective Fiction and the Rise of Forensic Science* (1999), Ronald Thomas writes: “Each of these detective devices—fingerprint technology, forensic profiling, crime photography—is itself a nineteenth-century invention designed to convert the body into a text to be read” (4). Each of these innovation points to the conclusion that medicine is more than the means by which diagnoses and cures of diseases and injuries are made. It becomes one of the means by which we know who people are, what they are capable of, and who they will become.

As you might imagine, finding consensus and cohesion among such diverse voices in the nineteenth-century medical community can be taxing. One relatively uniform accord, though, is that women were more susceptible to nearly all maladies than men, and that virtually any affliction was more likely to result in fatality in “the more delicate of the sexes,” from influenza to tuberculosis to
“nervous shocks.” Thus, institutional systems of power that always already favor male privilege are fortified through the ethos of scientific authority. Cynthia Russett explains that the alleged predisposition to prolonged and fatal illness was connected to the perceived “lag” in women’s evolution that was viewed as somehow crucial to her ability to propagate the species:

The reason for woman’s arrested development was the need to preserve her energies for reproduction; she suffered a foreshortened maturation, but the race gained. And her weaknesses were actually strengths [...] Nature had decreed a secondary role for women. The great principle of division of labor was brought to bear: men produced, while women reproduced (11-12).

This “arrested development” made women, according to Russett, “fragilely attractive” (12). The most popular medical tracts produced from the middle of the eighteenth century to the final years of the nineteenth century reveal a broad tendency to imagine women, by virtue of their anatomy, as being in an almost perpetual state of weakness and illness. In *Domestic Medicine*, Dr. Buchan, even as he attempts to remain more equitable in his assessment of the sexes, reinforces this language. In a chapter called “Diseases of Women,” Dr. Buchan claims “nature has made them [women] less fit for the more active and laborious employments” (647). Furthermore, the “diseases” discussed in this chapter are often healthy functions of the reproductive system, including menstruation and menopause. The pathologization of normal bodily processes is indicative of broader attitudes about the nature of sickness in connections with constructions of womanhood. Barbara Ehrenreich and Deidre English explain that, because healthy processes were deemed pathological, there was effectively no way for a woman to ever be deemed healthy:
In fact, the theories which guided the doctor’s practice from the late nineteenth century to the early twentieth century held that woman’s normal state was to be sick. This was not advanced as an empirical observation, but as physiological fact. Medicine had “discovered” that female functions were inherently pathological. Menstruation, that perennial source of alarm to the male imagination, provided both the evidence and the explanation. Menstruation was a serious threat throughout life—so was the lack of it (121).

In other words, even a healthy woman was a sick woman in this paradigm. This seemingly unending cycle of infirmity meant, broadly, that illness would be closely aligned with femininity, an alignment that is quite evident in artistic and literary depictions of the sick. In *Invalidism and Identity in Nineteenth-Century Britain* *(2004)*, Maria Frawley notes that “artistic renderings tend to depict invalids as young and female” (13), and Mary Spongberg explains that such renderings fall in line, not only with popular assumptions about women, but also medical dictates about women’s bodies, “The male body was consistently represented as the healthy body, while the female body represented the diseased body” (2). Spongberg extends this representation, claiming not only that the female body is represented as diseased, but that women, by extension, signify disease itself. Thus, “invalidism” as a signifier of an identity is, inevitably, linked with femininity.

Naturally, the tendency to represent women and invalidism in this fashion has not gone unnoticed by critics, particularly feminist critics. A number of literary critics and feminist medical historians have proposed that biomedical discourse in the nineteenth century fabricated and perpetuated a representative female body that was always already diseased. By extension, illness itself would come to be seen as a womanly state with various maladies and diseases being
personified with female imagery or being described using feminine pronouns, such as in the image discussed at length in chapter four, in which syphilis is personified as a young woman, or in this painting by Constance Charpentier:

![Figure 1: Constance Charpentier, Melancholy (1801).](image)

In this painting, melancholy, pathologized in its own right, is represented as a young frail woman. Her rendering reinforces what Ehrenreich and English have described as “a morbid aesthetic” that arose in the nineteenth century “in which sickness was seen as a source of female beauty” (119). This doesn’t mean, of course, that men could not suffer from melancholy, or any other malady. It does

---

7 Ehrenreich and English go on to describe the disturbing and often detrimental ways in which nineteenth century fashion was tailored to belabor this aesthetic, including everything from wearing a corset to consuming vinegar or even arsenic.
indicate, though, that when a man suffers from such a disorder, he is suffering a feminine affliction.

This medicalization of the woman’s body and the subsequent feminization of disease was rooted in the conception of women’s reproductive anatomy as mysterious, unwieldy, and even potentially dangerous. Sondra Archimedes writes that the enigma of the female body led to the insistence among medical professionals that all female ailments could be traced back to a problem with the uterus:

The intra-uterine revelations that medical science afforded promised an answer to potentially all of women’s diseases; headaches, fatigue, and transitory discomforts now could be confidently assigned to the uterus and its environs (1-2).

Helena Michie agrees, and suggests that because of this perceived obscurity, the female body can only be a portent of turmoil. It could be presumed, then, that a Victorian novel’s harmonious ending is only achieved in spite of, or in defiance of, a female body. Michie writes, “they [women’s bodies] are themselves the unknowable, the unpenetrable mystery, they are not so much vehicles of epistemological consolation as they are sources of change, disruption, and complication” (7). While Michie is correct that the body is a source of disruption and change, she miscalculates when she asserts, consequently, that it cannot be a vehicle for knowledge. On the contrary, in the novels discussed in this dissertation, the body is able to change and cause disruption precisely because it is a host for epistemological consolation.

While the project covers a wide range of novels, maladies, and types of women, one constant is the insistence that the body is a forerunner of knowledge.
The body can, for example, be read like a novel, and thus information can be gleaned from it. In *The Heavenly Twins* (1893), Evadne learns that Menteith is monstrous because she “reads” it on his body. Alice James instinctively knows that she is a host for some abnormality years before her breast cancer diagnosis. In *Daniel Deronda* (1872), Mordecai’s visionary abilities seem to be connected to the consumption that is killing him. The body, for these writers, is not always a harbinger of chaos and disruption, although it certainly can be. What it consistently is, instead, is a place where knowledge is made and harvested.

Physicians like Rita Charon and Siddhartha Mukherjee, who each insist that the role of the physician is enhanced with an understanding of narrative, have readily recognized the value of a union between narrative studies and medicine. In her recent article in *Narrative*, “The Novelization of the Body, Or, How Medicine and Stories Need One Another” (2011), Dr. Charon writes that, like any narrative medium, “Illness exposes. It raises the veil on realities ordinarily hidden from view—family secrets, buried memories, personal regrets, unfulfilled ambitions, scars” (36). She goes on to assert that illness causes a disruption in the otherwise harmonious narrative of the human body, and that the physician can only fully treat a patient with a degree of narrative literacy:

The narrative thread of an ordinary life is interrupted by illness or even the threat of illness [...] Doctors enter these complex narrative situations having to imagine what the situation must be like from the inside. To do so requires, in addition to imagination, a fluency as a reader and receiver of accounts of others that is not taught in required courses in medical school (yet, anyway). In the absence of such fluency, the doctor is hapless, unable to fathom what in fact is occurring in the life of the patient, the life beyond the confines of the organs (37-38).
Dr. Mukherjee, too, understands that a disease, along with those afflicted with it, contains a narrative when he proposes to write a “biography” of cancer with his *Emperor of all Maladies* (2010), a book that is a history, a biography, and an ethnography all at once. Dr. Mukherjee asserts: “And beyond the biological commonality, there are deep cultural and political themes that run through the various incarnations of cancer to justify a unifying narrative” (xiii). The ability to understand pathology as a narrative, both Mukherjee and Charon imply, is vital to the treatment, perhaps even cure, of those diseases. Janis McLauren Caldwell, in her *Literature and Medicine in the Nineteenth Century* (2004), recognizes the power of narrative in a clinical setting when she calls the “history and physical” diagnostic tool “the most important development of nineteenth-century British medicine” (8). Miriam Bailin, too, seems to appreciate the narrative and epistemological power of disease in the nineteenth century when she calls sickroom scenes in Victorian novels “a conventional rite of passage issuing in personal, moral, or social recuperation” (5). However, neither Bailin nor Caldwell are interested in the gendering of this construction, even as Bailin concedes that “invalid” is a predominantly feminine signifier. An analysis of the gendered dimension of the illness narrative, though, is imperative for a thorough understanding of how narrative, sickness, and gender were all conceived in the nineteenth century, whether they be in league or independent of one another. No one could deny that a female character is far more likely to become ill in the course of a Victorian novel than a male character, despite the fact that the Victorians clearly recognized that men could, and did, become sick. The female invalid was so ubiquitous in Victorian novels because invalidism was one of the
ways in which the Victorians understood femininity. This was simply not the case for Victorian masculinity.

Furthermore, it is not only the fact that they get sick more often, but the significance of illness in identity formation, and the manner in which illness takes its course in the narrative that sets the female illness narrative apart from those of males. Consider, for example, novels in which both a female character and a male character die of the same affliction. Men, often, deteriorate rapidly from illness, and often their deaths occur outside the action of the novel. Women’s deaths, meanwhile, are often a lengthy spectacle. Mr. Clare in *Caleb Williams* (1794), for example, dies rather quickly of distemper, while Emily’s death of the same cause is much slower and more grueling. In *Wuthering Heights* (1847), Catherine Earnshaw’s decline takes multiple chapters and we are with her through most of her illness. Heathcliff, who succumbs to essentially the same malady (slow starvation) at the close of the novel, deteriorates much more rapidly; the sickness that claims him barely takes one chapter. In addition, the narrative of male illness often occurs ex-diegesis, when the man has been removed from the narrative world and placed in another, often foreign and exotic, domain such as Rawdon Crawley of Thackeray’s *Vanity Fair* (1847), Angel Clare of Hardy’s *Tess of the D’Urbervilles* (1891), or St. John Rivers of *Jane Eyre* (1847). In some instances where a man’s illness takes up pivotal space in the narrative, it often comes conspicuously at the time when his gender status is in flux or in contention, as in *Great Expectations* (1860).

There are many works of criticism devoted to the study of women and disease in the nineteenth century, such as the previously cited work of Pamela
Gilbert, Sondra Archimedes, Barbara Ehrenreich and Deidre English, and others. The work of *Somatic Subjects*, though, attempts to steer the scholarship in new directions. Pamela Gilbert’s book, *Disease, Desire, and the Novel*, focuses exclusively on the sensation novel, both because the invalid woman was a sensational figure and because the sensation novel was deemed a woman’s genre, often as a means of dismissing it. The invalid woman, though, takes up prominent space in the realist tradition, and I would argue that her place in the realm of realism, often cited by critics as the highest achievement of Victorian literature, is as pertinent and structurally transfixed as it is in narrative genres deemed excessive and unrealistic. *Somatic Subjects*, therefore, is heavily grounded in analyses of realist works. In addition, I’ve also decided to focus my readings almost entirely on women writers, with the exception of Ibsen and Zola in the final chapter. It would be easy to attribute the seemingly melodramatic and overwrought descriptions of invalid women to sexism when they appear in novels by men. It is more difficult to do so with the concession that women writers were just as likely as their male counterparts to adopt the trope and narrative trajectory of a sick girl to move their novels forward. If the novel was a means by which the Victorians both recorded and made sense of their world, my analysis reveals that women, often, understood that disease played a vital role in the unfolding of their paths.

At times, there is an unfortunate tendency, in the scholarship in this field, to treat such categories as “invalid” and “affliction” rather monolithically. There is little distinction granted, for example, between the bed-bound invalid and the self-proclaimed, yet highly functional, invalids of Austen’s novels. “Madness,”
too, becomes an umbrella term for a variety of pathologies. I contend, though, that not all afflictions were conceived of equally. All Victorian maladies carried unique symptoms, stereotypes, preconceptions, and associations. The idealized consumptive, for example, is certainly different from the loathed syphilitic. As such, the chapters in *Somatic Subjects* are divided by disease, rather than decade or author, in order to chart the patterns of representation threaded through novels across the nineteenth century, and to uncover the unique language characteristic of distinct pathologies. I begin with a chapter on “nerves” and “nervousness,” a category that serves, in some regard, as the thread through which the subsequent chapters are connected. In this chapter, I argue that bouts with nervousness, culminating in the inevitable nervous fever, function as points of redirection for female characters in states of romantic ambivalence, as they teeter between passion and reason. When the nervous body is stretched to its limit, the outmoded sensibility driving it must expire, paving the way for a Wollstonecraftian model of femininity—the rational woman. In the final decades of the eighteenth century, Thomas Trotter and other physicians codified the nervous body in their extensive treatises and tracts. This body is described consistently in terms of eighteenth-century “language of feeling,” suggesting that nerves are, essentially, pathologized sensibility. As a result, those traits formerly used to demarcate gentility and refinement in a young lady become symptoms of an underlying and potentially dangerous malady. To consider the narrative implications of this diagnosis, I turn to Jane Austen’s *Sense and Sensibility* (1811), Emily Brontë’s *Wuthering Heights* (1847), and Elizabeth Gaskell’s *Mary Barton* (1848) to explore the evolution of the nervous body from the late years of
Romanticism to height of Victorian Realism. In each case, the descriptions of female characters are remarkably aligned with the extensive sketches of female patients encased within the tracts of medical experts on nervousness. These novels, then, serve as extensive case studies for nervousness. In the examples of *Sense and Sensibility* and *Wuthering Heights*, excessive passion and sensibility are presented as chronic physiological disorders that develop into nervous fever. This fever becomes the pivotal moment of maturation for these women in that each emerges with a more tranquil sensibility, embodied in *Wuthering Heights* by the younger Catherine. *Mary Barton*, in contrast, mirrors changing mid-century discourse concerned with the lack of sensibility among the working class, specifically those of Edwin Chadwick and others who deemed the working-class body “insensible.” Thus, Mary emerges from her curious nervous collapse more passionate and sensitive, as opposed to less. Each heroine, whether she becomes more sensitive or less, adopts an identity akin to the “angel in the house,” suggesting both that the Victorian cult of domesticity is connected to the decline of sensibility, and that the nervous body is a precursor to the hysterical body that emerges later in the nineteenth century.

Since consumption was typically fatal in the nineteenth century, the protagonists I discuss in my second chapter do not suffer from it directly. Rather, they form intimacies with characters dying of debilitating lung diseases, forging a bond that precipitates an ideological transformation for the main character. The writers presented in this chapter—Charlotte Brontë, Elizabeth Gaskell, and George Eliot—engage with medically and artistically pervasive conceptions of the consumptive as spiritually superior and “too good for this world.” Moreover,
their novels come at a moment in medical history when the communicability of consumption is under examination. In other words, they write at a time when medical professionals begin describing consumption as contagious rather than congenital. Each of these writers draws on an aura of contagion to construct supporting characters whose sociopolitical affinities, like their common malady, are transmittable to the protagonist. Through a symbiotic relationship formed in the course of the novel, the subject of the *bildungsroman* adopts the essential qualities of the dying consumptive. Through her friendship with the angelic Helen Burns, Jane Eyre comes to understand the value of tempered emotions and civil disobedience. In her care for Bessy Higgins, *North and South*’s Margaret Hale (1855) learns of the hazardous working conditions of cotton mill workers, and gains empathy towards Milton’s working poor. The perpetually aimless Daniel Deronda finds his legacy and faith through the dying Mordecai. Jane Eyre, Margaret Hale, and Daniel Deronda become spiritual apprentices to consumptives who also serve as the voice of disenfranchisement and social iniquity. In the framework of these social problem novels, or at least novels hinting towards social problems, the consumptive serves as a divine vessel for social change as their mission is enlivened in the healthier body of the protagonist.

I expand the generic scope of the dissertation in my third chapter, which is concerned with breast cancer, as I seek to expound upon the often opaque and fragmented prose that marks its representations in memoir and epistolary writing. While consumption was sometimes characterized as a disease of excess—in regards to symptomology, traits of the sufferer, etc.—cancer was
consistently conceived of as a disease of implosion and inward decay. This chapter is predominantly occupied with personal narrative, in an attempt to understand the ways in which women suffering from breast cancer conceived of themselves, their bodies, and their femininity. I reflect on the role that cancer plays as a character in its own right, somewhat disembodied from the speaker, and the language invoked to render it as a villain, a foreign invader, or a criminal both in memoir and medical writing. The writers at the center of this chapter—Frances Burney, Sara Coleridge, and Alice James—use their writing to perform the healing work of trauma, as each attempts to give voice to unutterable pain and visibility to a malady defined by its invisibility. Their illness is persistently granted a malevolent agency and a personification not granted to the maladies discussed in the first two chapters. As the characters of the narrative become solidified, cancer emerges as the proverbial antagonist whose growth occurs in conflict with the body. In other words, while nerves and consumption come to define a body, cancer serves as the anti-body and breast cancer as the explicit enemy of femininity.

The final chapter explores syphilis narratives in late nineteenth-century novels, primarily two New Woman Novels—*The Heavenly Twins* by Sarah Grand and *A Superfluous Woman* (1894) by Emma Brooke. I begin the chapter with a sketch of the appearance of syphilis throughout nineteenth-century literary arts, visual art, and medical literature where it is predominantly and unfavorably connected with prostitution and vice. Medical writers asserted that women, particularly licentious women, were the carriers of sexually transmitted diseases while men were their victims. These charges effectively feminize venereal disease
and mark women’s bodies as inherently deviant and dangerous. Towards the end of the century, more sympathetic and complex portrayals of the syphilitic woman begin to emerge. Émile Zola’s Nana is a prostitute and, undoubtedly, she is a force of corruption and decay. However, Zola complicates the discourse that automatically equates prostitution with evil by outlining the ways in which Nana is constructed and controlled by depraved men. The women of Ibsen’s *Ghosts* (1881), *The Heavenly Twins*, and *A Superfluous Woman* are all victims of unfaithful spouses, shifting ownership of this disease from a female source to a male one. In addition to these literary manifestations, the work of late nineteenth-century obstetricians and gynecologists, and early feminist activists like Josephine Butler, helped change popular understanding of how syphilis was transmitted and women’s culpability in its spread in a historical moment when first-wave feminism was in its infancy. Venereal disease, then, adopts a political significance in the final decades of the nineteenth century as its dissemination is no longer a symptom of female vice, but rather becomes emblematic of the corruption of masculine dominance.

Implicit in *Somatic Subjects* is an insistence that the realms of medical discourse and the narrative arts are thoroughly interlocked, and that the two modes contribute to the invention of each other. Medical discourse contours the fictive body, and medical writing is shaped by narrative conventions. Moreover, in their mutual project of inventing the other, they each collaborate in the production of female paradigms. My project also builds on the work of body theorists and material feminists hoping to, in the words of Stacy Alaimo and Susan Hekman, “radically rethink materiality, the very ‘stuff’ of bodies and
natures.” In order to “radically rethink materiality,” I suggest that we reexamine mind/body discourse, and consider the narrative and formative work of a corporeal epistemology. Furthermore, this project has the potential to stretch the possibilities of genre and narrative studies in the overarching contention that the body in crisis, as much as the man or woman in crisis, is a vital narrative force.
Chapter 1

Bodies in Transition: Nerves and Pathological Sensibility

In the eighteenth century, it was often said that a good and decent young lady ought to possess a degree of sensibility. The delicacy of one’s body and its ability to fall prey to the senses was a marker of gentility and grace, as we see the noblest of eighteenth-century heroines growing pale or faint at the slightest distresses or dying from more severe traumas. The quality of sensibility, or “the capacity for living intensely that is demonstrated in a heightened sensitivity to one’s environment,” as Stephen Ahern writes, was the pervasive preoccupation of young ladies from the middle of the eighteenth century to the beginnings of Romanticism. In the age of revolution, in the turn from the eighteenth to the nineteenth century, “sensibility,” as a supposed virtue of refined young ladies, and a few men, underwent a fairly dramatic renovation as one’s ability to be greatly effected by surrounding stimuli became cause for concern for medical professionals like Thomas Trotter and William Buchan and writers committed to complicating traditional gender roles, most notably Mary Wollstonecraft.

Theorists of sensibility have largely attributed the changes in the discourse to

---

8 Stephen Ahern, in his Affected Sensibilities (2007), notes that a preoccupation with acquiring “the credit of proper sensibility” had “been a feature of British literature for generations” before peaking in the 1780’s (11). In Nerves and Narrative (1997), Peter Logan also explains the permutation of sensibility in the late eighteenth century from a province exclusively of the aristocracy to one of the growing middle class.

9 To draw on instances from only one author, Samuel Richardson’s eponymous heroines were notoriously afflicted with sensibility. His Pamela falls faint several times in her novel, and Clarissa famously dies from the emotional trauma of her rape.
both the rise of the middle class and the influence of medical knowledge.\textsuperscript{10} I would also like to suggest that the shifting discourse on sensibility, or what I would call sensibility’s pathological turn, is connected to a growing proto-feminist discourse interested in challenging the notion that the destiny of women is determined by a weak and frail anatomy. In this chapter, I argue that the body of work on “nerves” in the years preceding the Victorian era is indicative of the medicalization of sensibility, and that the shifting of sensibility from virtue to malady fundamentally alters the course of domestic fiction and the courtship novel as it enters the nineteenth century. Consequently, the “novel of sensibility” morphs into the “nervous novel” in the early years of the nineteenth century, generating a narrative path that charts the physical changes of a young lady whose struggles with romantic uncertainty lead to a physical and mental breakdown. This breakdown, the “nervous fever,” serves as the subjective crux in the young woman’s development. If she recovers, she is forever altered, physically and psychologically, by the event. Alternatively, her inability to recover almost certainly means literal or metaphorical fatality.

In this chapter, I discuss three very different nineteenth-century novels that, on one level or another, engage with the discourse of “nerves” in the construction of their female characters. Often, the course of nerves is not apparently critical to the novel’s primary narrative. It is fundamental, though, to character maturation, and its onset can, and often does, interrupt or alter the

\textsuperscript{10} Peter Logan, for example, proposes that complaints of nervous disorders came to “epidemic” proportions in the late Georgian years with the rise of the middle class and increased urbanization.
path of the dominant narrative. Each of these women suffers from an imbalanced sensibility that precipitates a physical and mental breakdown, which culminates in a nervous fever. Their sensibility is triggered, in each case, by a romantic predicament, linking their afflictions implicitly to love-sickness. In this way, love-sickness, sensibility, and the new category of nerves become conflated, and the courtship narrative that dominates literature about women in the nineteenth century can be seen to accommodate an exploration of the medical implications of forbidden, unrequited, and unfulfilled love.

While anyone can potentially suffer from either sensibility or nerves, it was commonly acknowledged that women were the primary carriers of this trait. This dominance was attributed, as has been widely discussed, to the perceived weakness of the female frame and the consequent fragility of women’s psyches. Thomas Trotter, author of the most comprehensive study on nerves in this time period, *A View of the Nervous Temperament* (1808), asserts that a propensity towards nervousness is exacerbated by environmental factors, but stems from biological destiny:

11 Ludmilla Jordanova references eighteenth-century French physician L.C.H. Macquart when she writes: “They [women] were taken to be highly ‘sensible’ (i.e. sensitive or even sensitized) like children, and more passionate than men. This was because of the ‘great mobility of their fibres, especially those in the uterus” (28). Athena Vrettos confirms this assertion, noting that the host of maladies attributed to “the emotional and mental state of the patient” reinforces “the idea that women’s emotions were more somatic, and their diseases more complicated by emotions, than men’s” (23).

12 The full title of this manuscript is *A View of the Nervous Temperament: Being a Practical Inquiry Into the Increasing Prevalence, Prevention, and Treatment of Those Diseases Commonly Called Nervous, Bilious, Stomach and Liver Complaints.*
The female constitution, therefore, furnished by nature with peculiar delicacy and feeling, soft in its muscle fibre, and easily acted upon by stimuli, has all its native tenderness increased by artificial refinements. Hence the diseases of which we now treat, are in a manner the inheritance of the fair sex (47).

Not only does Trotter give us an almost precise definition of sensibility in his assessment of nerves, he essentially argues that this affliction is, at its very core, female. While Dr. Buchan is more gender neutral in his *Domestic Medicine*, the chapter “Diseases of Women” implicitly engages with sensibility when he claims that women are more influenced by the passions than others belonging to “the animal economy” (526). He also acknowledges that women are more likely to suffer from “the whole train of nervous disorders,” although he connects this propensity for nerves to confinement rather than a natural delicacy (522).

As nerves have a tendency to favor women, the causes of these maladies also vary greatly between the genders. Trotter reports that nervous men suffer shocks, most often, because of what he terms “disappointments in public life, mostly financial and business” (87). On the other hand, women, as he discusses at length, inevitably suffer from nerves because of romantic disappointments or tragedies. We can see this difference at work in much of the literature and art of the nineteenth century, as we see both men and women contracting fevers following an emotional shock, but with the descriptions and underlying causes being disparate between the genders. Pip of Dickens’ *Great Expectations* (1861), for example, becomes both feverish and hysterical late in the novel. Corporeality

---

13 Scottish physician William Buchan published *Domestic Medicine* in 1769. It was exceedingly well-received, some critics say second only to the Bible in popularity, and went into multiple editions. These citations are taken from the eleventh edition, published in 1790.
is largely absent from the ruminations on his fever, as Dickens instead focuses on the psychological turmoil that accompanies it. Pip contends, “I often lost my reason,” and “I confounded impossible existences with my own identity.” The lack of physicality reinforces the biomedical position that women are the more corporeal of the sexes, and that men are the more psychologically inclined. Furthermore, the trigger of Pip’s affliction indicates an adherence to Trotter’s assertion that nerves manifest themselves in men because of socioeconomic turmoil. Pip’s malady comes not from his sorrow over Estella’s marriage, nor even after the trauma he experiences when he witnesses Miss Havisham die in a fire. Instead, it comes after the death of his benefactor, Magwitch, and with the fallout from his reckless financial undertakings. The moment he becomes virtually incapacitated, in fact, is immediately upon learning that he owes a sizable debt to a jeweler and that he’s to be arrested. He tells the collectors: “I would come with you if I could; but indeed I am quite unable. If you take me from here, I think I shall die by the way” (343). Pip’s psychological and physiological turmoil is triggered by an intense anxiety related to his socioeconomic station, not love.

In contrast, to draw from a visual source, Henry Peach Robinson’s photograph She Never Told Her Love (1858) illuminates the consequences of unrequited love in women. In the image, a young woman lies either dying or dead, a state she was driven to by unfulfilled desire. The severity of her malady is accentuated by another photograph by the same artist, Fading Away, which depicts a woman dying of consumption in the same dress and pose as the subject of She Never Told Her Love.
Figure 2: Henry Peach Robinson, *She Never Told Her Love*

Figure 3: Henry Peach Robinson, *Fading Away*
The similarities between the two photographs are indisputable. The dressing clothes, bedding, pose, and patient are nearly identical. The pairing of the two images gives a level of gravitas to the malady depicted in *She Never Told Her Love*, implying that love-sickness, or nervous fever, is potentially as lethal as consumption. The variances in the composition, too, seem connected to the ways in which nerves differ in conception and representation from other maladies.

The figure in *She Never Told Her Love* is entirely isolated; there is not even a frame of reference for the setting of the photograph, as opposed to *Fading Away* which is plainly set in a domestic sick-room with attendants. The indication is that one who is sick with love becomes increasingly withdrawn from society, retreating into a void, perhaps into one’s own depressed mind.

Despite the apparent severity of the affliction, and in spite of its pervasiveness in nineteenth-century fiction, nervous fever is seldom taken seriously in the growing body of critical work on medicine in nineteenth-century literature. Much of the critical attention it has received has treated it as a slippery metaphor for female sexual repression, and a melodramatic gesture that is contrary to realism. However, as scholars like Audrey Peterson have noted, nervous fever was much more than a useful aesthetic or narrative trope.\(^\text{15}\)

---

\(^{14}\) Stephen Eisenman suggests that the two figures are actually the same woman, and that the male figure in *Fading Away* is the cause of the romantic distress in *She Never Told Her Love*.

\(^{15}\) In her article “Brain Fever in Nineteenth-Century Literature: Fact and Fiction” (1976), Peterson declares herself to be concerned with “brain fever,” but the descriptions of her project are clearly connected to nervous discourse in the eighteenth and nineteenth centuries. This connection is made most explicit when
Respected medical professionals throughout the eighteenth and nineteenth centuries wrote lengthy treatises on nerves and nervousness, warning the populace about the physical dangers of mental strain and psychological shock. Most notably, Thomas Trotter’s aforementioned study on the subject, *A View of the Nervous Temperament*, carefully delineates the relationship between extreme emotional states and ill health as he outlines the various environmental and psychological hazards that will, inevitably, lead to a fatal “nervous fever,” such as polluted air, spicy or heavy foods, and “passions of the mind.” Trotter’s work, and the work of many of his contemporaries and predecessors, suggests a dialogue of sorts between medical discourse and the realm of artistic expression, as the nervous diagnosis bears striking similarities to descriptions of sensibility in novels of the eighteenth and early nineteenth centuries, and seems connected to writings on “hysteria” that flourish in the second half of the nineteenth century. Nerves, then, are the link between hysteria and sensibility in a sequence of bodily afflictions that came to define the female condition through the end of the nineteenth century.

**The End of Sensibility: Austen and the Nervous Body**

she references Alexander Tweedie’s 1833 discussion of brain fever and his claim that it originates with “a severe shock to the nervous system” (448).

16 Each danger receives extensive attention in Trotter’s third chapter, “Remote Causes of Nervous Diseases, &c.”

17 Buchan devotes an entire chapter to nervous fever in *Domestic Medicine*, and many of his predictions and conclusions are aligned with Trotter’s.
The literary paragon of problematic sensibility and nervous corporeality during this era is Marianne Dashwood of Jane Austen’s *Sense and Sensibility*. Scholarship on corporeal matters in Jane Austen’s novels is relatively scarce, but the scholarship that does exist is often concerned with this novel.\(^{18}\) Published in 1811, but composed and revised over the course of sixteen years, *Sense and Sensibility* is often characterized as Austen’s didactic attempt to illuminate the failings of sensibility, through Marianne, while simultaneously gesturing towards a new model of “rational” womanhood embodied by prudent and controlled Elinor.\(^{19}\) The failures of sensibility, according to critics of Austen like Marilyn Butler and Stephen Ahern, are primarily ideological. Butler, for example, asserts that Marianne’s sensibility promotes self-worship because of its insistence on an epistemology based on personal feeling and instinct being superior to the opinions of others, to the mores and customs of one’s family or community. More recent critics like G.J. Barker-Benfield and Ahern propose instead that the failure of sensibility lies in its distance from authenticity, that its reliance on a constructed fantasy realm as the basis for behavior and sentiment comes at the

---

\(^{18}\) One exception is John Wiltshire’s book-length study, *Jane Austen and the Body: “The Picture of Health,”* and even he acknowledges in his introduction: “And Jane Austen’s novels, I will admit, seem among the least likely texts on which to found a discussion of the body. Isn’t the body—absent, suspended, at best relegated to the interior position in the dyad of mind and body, as all agree is its position in our culture—virtually banished from her work?” (1).

\(^{19}\) In using the term “rational woman,” I’m drawing on Anne Mellor’s definition as outlined in her *Romanticism and Gender* (1993). In this book, Mellor writes that Austen was among a host of Romantic women novelists who “all wrote novels designed to advocate the revolutionary idea that women must think as well as feel, that they must act with prudence, avoid the pitfalls of sexual desire, and learn from their mistakes” (40).
expense of genuine relationships. To draw on the language of Jean Baudrillard, one might say that sensibility sufferers are too committed to the simulation of feeling, as they find themselves “substituting the signs of the real for the real” (2).

Essentially, women like Marianne feel only prescriptively insofar as their behavioral and emotional triggers are dictated by the degree to which the signifiers, in this case a romantic prospect, duplicate the fantasy of the real. In other words, because sensibility is a performative and affective mode, taking its cues from fictive visions, Marianne’s adherence to its creeds disassociate her from reality and allow her to become potential prey to a scoundrel simply because he “looks” and “feels” like a superior match. It is hard to argue with such assessments; these critiques of Marianne’s sensibility are most certainly valid. What is less evident in Austen scholarship, however, is attentiveness to the physical hazard that Marianne’s sensibility proves itself to be and what role that hazard plays in the narrative. Marianne’s sickness and near-death are very clearly connected to her sensibility, but because of its affective nature, the gravity of her physical plight is sometimes overlooked.

I propose, like John Wiltshire before me, that the problem with Marianne’s sensibility is less ideological than it is corporeal. By that I mean that while sensibility may be morally ambiguous it is, above all, a detriment to one’s physical welfare. I also expand Wiltshire’s reading of the novel to expound upon the various roles that Marianne’s body plays in her development and maturation. I connect her sensibility to Trotter’s diagnostics of the “nervous body,” and also propose that Marianne’s physical tribulations, while taxing, are necessary to her development and that the fever that marks the end of her suffering is a signal of
her maturation. In other words, her physical deterioration is a rite of passage, of sorts, in which she suffers through what Bill Wandless calls “the rites of sentimentality” (67) in order to emerge in recovery as a newly formed woman who is potentially prepared to evolve with the shifting gender paradigms.

While Wiltshire, in *Jane Austen and the Body*, sensibly discusses Marianne’s fever in connection with William Buchan’s descriptions of remitting fever, he rejects the notion that her condition is one of nerves, writing:

> Marianne is not suffering here a ‘hysterical’ or ‘nervous’ illness, but one authenticated by contemporary physicians and her author’s insistence on the clinical detail is a means of suggesting (not altogether successfully, since it occupies attention of itself too much) that ideas or convictions alone cannot bring about serious physical illness, not even an ideology so powerfully lived as sensibility (46).

Wiltshire’s claim, however, overlooks a few key points. To begin with, contemporary physicians, Buchan included, were perfectly comfortable authenticating nervous illnesses in their published works. Furthermore, while sensibility may not directly cause illness, in this novel sensibility is an illness. From its first reference in the novel, Marianne’s sensibility is persistently presented as a pathological concern, one that she apparently shares with her mother. A nervous disposition, according to both Buchan and Trotter, was typically inherited from one’s parent. Trotter, for example, declares that nerves generally originate “from hereditary predisposition” (169). Elinor, for whatever reason, seems to be born with an immunity to this malady: “Elinor saw, with great concern, the excess of her sister’s sensibility; but by Mrs. Dashwood is was

---

20 Buchan himself claimed that nervous fevers have been steadily increasing in the years leading up to his publication of *Domestic Medicine*. 
valued and cherished. They encouraged each other now in the violence of their affliction” (8). Austen, here, uses corporeal and perhaps even medically loaded language, choosing “affliction” as a descriptor for uncontrolled sensibility. The phrase is repeated later in the novel, with elevated concern after Willoughby’s departure. Elinor is often placed in the position of an observing physician charting symptoms, lulls, and improvements, like Buchan and Trotter, and as a nurse for Marianne when her sensibility overwhelms her, most profoundly at Cleveland when Marianne is near death. Before her sick-bed nursing, however, Elinor is called multiple times to physically care for a wilting Marianne. After publicly confronting Willoughby at a London party, Elinor ushers Marianne out of view, and treats her with lavender water to keep her from fainting when she become “dreadfully white” and is “unable to stand” (125). After Marianne learns of Willoughby’s engagement to Miss Grey, Elinor must physically restrain Marianne who has become hysterical: “…no attitude could give her ease; and in restless pain of mind and body she moved from one posture to another, till growing more and more hysterical, her sister could with difficulty keep her on the bed at all” (135). The persistent need for Elinor to care for Marianne in physical distress indicates that Marianne is suffering from a chronic physiological problem. Descriptions of Marianne in these moments, and others, seem lifted right out of the pages of Trotter and Buchan’s lists of symptoms, as do her aesthetic affinities, many of which Trotter expressly warns against.

Marianne’s admiration for music and her devotion to literature of feeling make her a prime candidate for a nervous disorder. While an attachment to
music merely predisposes one to harassment from nerves, Trotter sternly warns his readers about the undue influence of popular modern literature, particularly the novel which he calls “one of the great causes of nervous disorders.” His concern is in the potential abandonment of reason and reality, which he believes are expunged by the amoral and illusory world of modern fiction:

> It creates for itself an ideal world, on the loose descriptions of romantick love, that leave passion without any moral guide in the real occurrences of life. To the female mind in particular, as being endued with finer feeling, this species of literary poison has been often fatal; and some of the most unfortunate of the sex have imputed their ruin chiefly to reading novels (88).

Trotter speaks, here, to the ethical quandary of a sensibility like Marianne’s, a point reinforced by Barker-Benfield and Ahern, who each remark on her insistence on modeling her own feelings in accordance with fabricated narrative worlds. Her attraction to Willoughby is physical, clearly, but insofar as his “manly beauty” and “gallantry” are “equal to what her fancy had ever drawn for the hero of a favourite story” (33). While Marianne’s dominant aesthetic love is poetry, this passage indicates the power of narrative in shaping her perception. For Marianne, appreciation of literature necessitates the abandonment of reason and restraint in favor of the expression of one’s body. She points to her own body’s reactions as evidence of proper artistic appreciation, which she contrasts with Edward’s dry reading of Cowper: “I could hardly keep my seat. To hear those beautiful lines which have frequently almost driven me wild, pronounced with such impenetrable calmness, such dreadful indifference” (16). In

---

21 Trotter writes: “Persons much attached to musick, as being furnished with acute nerves, and nice sensibility, and of a sedentary turn, are often harassed by these diseases” (91).
Marianne’s estimation, authenticity and sincerity are expressed primarily physically, through gesture, through tears, and in an epistemology that is based in the body’s apparent ability to “know.” Marianne is sure of Willoughby’s virtues because, plainly, her body validates them. She “senses” his goodness, indicating that romantic attraction is somehow materially based, rather than spiritually, emotionally, or intellectually. The materiality of love and sentiment is accentuated by the lock of hair that she gives to Willoughby. This token, a romantic and implicitly intimate gesture, provides “proof” to all that the pair are engaged, and Willoughby’s acceptance of it is Marianne’s confirmation that her feelings are reciprocated. Through his acceptance of the lock of hair, their sentiments are materialized, as they are within Marianne’s body.

Marianne’s trust in her sensibility begins to quickly crumble when she is made aware of Willoughby’s true nature, and thus is confronted with the reality that her epistemological system, based on “feeling” truth, is faulty. The physiological dangers of sensibility are ignited almost immediately upon Willoughby’s sudden and mysterious departure. Wiltshire contends: “Austen does not accept the ideological premise that excessive sensibility, acting through the body’s heightened vulnerability, can of itself bring about destruction” (46). Wiltshire is quite right; it is much more complicated than that. Marianne’s sickness is caused by melancholy and excessive sensibility because they cause her to neglect her health, sometimes aggressively. Marianne’s sorrow is so great in the days of her separation from Willoughby that she is deprived of sleep and refuses to eat:
She was awake the whole night, and she wept the greatest part of it. She got up with a headache, was unable to talk, and unwilling to take any nourishment; giving pain every moment to her mothers and sisters, and forbidding all attempt at consolation from either. Her sensibility was potent enough (62).

While sickness is not precisely connected with excessive sensibility, Marianne’s “potent sensibility” is directly implicated in conduct that Trotter and Buchan guarantee will lead to nervous fever. Buchan writes, for example, that nervous fever is occasioned by depression and anxiety, coupled with want of appetite and lack of sleep. Trotter, too, connects melancholy with poor appetite, additionally claiming that dwelling in one’s melancholy will prove fatal, saying that sorrow is “corrosive.” Marianne’s refusal to accept consolation and her persistent refusal to discuss the nature of Willoughby’s departure are further cause for concern from a medical perspective. Trotter warns that disappointments in love can be fatal to those with “nice sensibility,” and that an inability to express love verbally aggravates a nervous body:

> It is this conflict between attachment and secrecy, that has often given birth to the emphatick expression ‘dying of a broken heart.’ But such afflications of mind commonly, sooner or later, produce some disease of the nervous system, which quickly draws into consent the digestive organs, and others of equally acute sensibility (86).

Trotter is speaking, here, about the relationship between psychological trauma and physical decline, and more broadly about the cyclical relationship between mind and body. Austen is exploring this relationship through Marianne, and developing upon its implications by making Marianne an active participant in her physical decline. Essentially, while Marianne is physically and psychically weakened by her interactions with Willoughby, she only becomes gravely ill when
she knowingly neglects her health. It is unclear what Marianne hoped to gain from this negligence, but the effects on the progression of the narrative are significant. Marianne must become sick, in a sense, to become well.

Marianne’s behavior goes against the advice of nearly every contemporary medical voice, both as she stews in her melancholy and exposes herself to environmental dangers listed by both Trotter and Buchan. Buchan, for example, warns against “keeping on wet clothes and “lying on the damp ground” (188). Just days before her climactic fever, Marianne takes several lengthy walks on the ground at Cleveland:

...not merely on dry gravel but all over the grounds, and especially in the most distant parts of them, where there was something more of wildness than in the rest, where the trees were the oldest, and the grass was the longest and wettest, had—assisted by the still greater imprudence of sitting in her wet shoes and stockings—given Marianne a cold so violent, as, though for a day or two trifled with was denied, would force itself by increasing ailments, on the concern of every body, and the notice of herself (216).

Austen also notes that Marianne, although admittedly and apparently ill, refuses medical intervention that could alleviate her suffering: “Prescriptions poured in from all quarters, and as usual, were all declined [...] it was with difficulty that Elinor prevailed on her, when she went to bed, to try one or two of the simplest of the remedies” (216-217). Here we see that Marianne is not a passive receptacle for stimuli, like some of the sentimental heroines who came before her. Rather, her own actions awaken her nervous collapse.

Upon her recovery, Marianne admits as much to Elinor: “My illness has made me think—it has given me leisure and calmness for serious recollection [...] My illness, I well know, had been entirely brought on by myself by such
negligence of my own health, as I had felt even at the time to be wrong” (244). She both acknowledges the role she played in the decline of her health, and rejoices at the transformation in sentiment that her illness initiates: “They [her feelings] shall no longer be governed and my temper improved. They shall no longer worry others, nor torture myself. I shall now live solely for my family” (245). It was only through this complete turn to the interior, refusing outward nourishment or care, that Marianne’s sensibility could, essentially, short-circuit. Moving out of that crisis, Marianne is able to appropriately turn outward.

As mind and body are thoroughly enmeshed in Marianne, her changed sentiments are signaled by an exterior alteration. Colonel Brandon is struck by her “altered looks” as she has moved from being “very brown” early in the novel to “pale” in the final third (241). The warmth with which she receives Brandon in this moment, through the physical gesture of “immediately extending her hand” signals the reader also to a revision of her romantic sentiments, as he will again “receive her hand,” this time in marriage. At the close of the novel, we find Marianne married to Colonel Brandon, reportedly content: “Marianne could never love by halves; and her whole heart became, in time, as much devoted to her husband, as it had once been to Willoughby” (268).

Some critics have questioned whether or not this match is satisfactory, or whether the marriage is designed to punish Marianne for her former flaws. Critics of the marriage propose that the union of Marianne and Brandon points to an Austen who is decidedly conservative and anti-feminist, that Austen has sublimated passion to pragmatism. Such a claim, though, presupposes that “passion,” implicitly of a sexual nature, is necessarily empowering. In the
estimation of the foremost voice on women’s rights during Austen’s lifetime, Mary Wollstonecraft, passion is actually the marker of an outdated and dangerous model of femininity, which is reinforced in sentimental literature. In her groundbreaking proto-feminist treatise, *A Vindication of the Rights of Woman* (1792), Wollstonecraft speaks repeatedly of modern womanhood in the language of sickness and pathology. To state it succinctly, in Wollstonecraft’s estimation, the state of womanhood is one of illness. She writes: “The conduct and manners of women, in fact, evidently prove that their minds are not in a healthy state; for, like the flowers which are planted in too rich soil, strength and usefulness are sacrificed to beauty” (7). This sacrifice distracts women from the pursuit of reason and rationality that are, according to Wollstonecraft, the highest of human affairs. If, in fact, we are willing to believe her hypothesis that women are collectively ill, the disorder that troubles them is sensibility. She describes those suffering from this malady: “Their senses are inflamed, and their understandings neglected, consequently they become the prey of their senses, delicately termed sensibility” (60) all of which leads to “overstretched feelings,” “libertine notions of beauty,” and most dangerously “sickly delicacy” (10). She derides sensibility and passion in young women and, like Trotter, points to popular literature as the cause of its perpetuation, asserting: “Novels, music, poetry, and gallantry, all tend to make women the creatures of sensation” (61). Instead of a marriage based on passion or even love, Wollstonecraft proposed that marriages ought to be based on friendship and mutual respect, if marriages are to be made at all: “Friendship is a serious affection; the most sublime of all affections, because it is founded on principle, and cemented by time. The very
reverse may be said of love” (73). Indeed, Marianne’s marriage to Brandon develops from a lengthy friendship rather than initial and magnetic attraction. The contrast between her relationship with Willoughby and her marriage to Brandon, and likewise Elinor’s marriage to Edward which also grew out of friendship, suggests Austen’s interest in Wollstonecraft’s new models of marriage and femininity that regard inflamed passions with skepticism. As a woman with reasoned senses, Elinor was already adequately prepared for a Wollstonecraftian womanhood. Marianne’s sensibility must run its logical course, like any fever, in order that Marianne be inoculated, in a sense, against sensibility.

The case of Marianne Dashwood is valuable to those of us who study Victorian fiction because she represents the shifting paradigm that will crop up again and again in the Victorian novel and narrative arts. Austen uses “nerves” again in an entirely different capacity in *Pride and Prejudice* (1813) and *Persuasion* (1818) as a comedic affect distressing women of the older, or at least out-dated, generation. In *Pride and Prejudice*, Mrs. Bennett’s nerves are referenced continually in relation to her apparent ridiculousness. Her hyperbolic reactions are even cited by Darcy as a contributing factor in his decision to steer Mr. Bingley away from a match with Jane Bennett. In *Persuasion*, Anne Eliot’s unhappily married sister Mary rarely leaves her home due to her aggravated nerves. Nervousness and nervous fever become agents for transformation, as they do in *Sense and Sensibility*, in novels well into the Victorian period. Often, the nervous fever breaks into the narrative at a moment of crisis and, as was the case in *Sense and Sensibility*, cause a profound alteration in the afflicted character as a “new self” emerges in the wake of the breakdown. In Emily
Brontë’s *Wuthering Heights*, this fissure in selfhood occurs in its most extreme manifestation, as Catherine’s essence is stretched across two bodies—her own and her daughter’s.

**Congenital Nerves: The Catheries of Wuthering Heights**

Emily Brontë’s *Wuthering Heights* is a novel existing in the temporal borderlands of English literary history. Its publication date denotes it as a Victorian novel, but its historical and geographical setting marks it as quasi-Romantic, along with its Gothic atmosphere, suggestions of supernaturalism, and multi-layered narrative structure. *Wuthering Heights* bridges late-Romantic and early-Victorian constructions of the nervous body. As it did in *Sense and Sensibility*, the fever that brings a lengthy turn of nervousness to its conclusion creates an opportunity for a new self to emerge. In *Wuthering Heights*, the event literally creates a new self with the younger Catherine, whose birth in the midst of her mother’s fatal bout with nervous fever signals the naissance of new ways of coming into womanhood.

Some recent critics of *Wuthering Heights* make the provocative claim that Brontë’s characters remain unchanged throughout her complicated narrative. Susan Gorsky, for example, proclaims, “all five [Edgar, Isabella, Heathcliff, Hindley, and Catherine] are essentially unchanged in nature” (179). Most recently, Beth Torgerson, following Gorsky’s lead, argues that Emily Brontë’s novel stands in “stark contrast” with those of her sister Charlotte because she denies the transformative power of illness that Charlotte embraced, “In fact, all of Emily Brontë’s characters remain psychologically unchanged, not just Lockwood.
The psychological essence of each is static in this highly tumultuous novel” (90). Such claims, however, neglect the complicated paradigm that Emily Brontë establishes throughout the novel, in which all aspects of material reality—land, homes, bodies, and possibly even souls—are mutable and transferrable through inheritance. Brontë relies on the logic of congenital transmission to extend the somatic subtext of “the nerves novel.” Thus, the transformative power of illness is omnipresent in *Wuthering Heights* as we consistently see transformation occur across bodies, most evidently between mother Catherine and daughter Cathy, allowing for what William Cohen calls “intersubjective contact” (11). Through her focus on the congenital aspects of nervousness, Brontë is able to retain its transformative power by suggesting that it can be both inherited and mutated across generations.

Like Marianne Dashwood, the original Catherine is propelled by uncontrolled senses and passions and an irresistible pull to another person, a drive similarly guided by self-worship. Marianne’s sensibility, if Marilyn Butler and others are to be believed, is a version of subjective idolatry, and this elevation of selfhood is both highlighted and complicated by Catherine. Catherine loves Heathcliff because they are, she claims, the same person. She famously proclaims “I *am* Heathcliff,” telling Nelly, “he’s more myself than I am” (63). She has taken the self-love that impels sensibility, and nerves by extension, to its most perverse extreme. If Catherine were to marry Heathcliff she would be, by her own logic, marrying herself. While Marianne’s nerves are triggered by a conflict between her idyllic vision of Willoughby and the reality of his nefarious deeds, Catherine’s is rooted in the struggle between her co-dependent
relationship with Heathcliff and the knowledge that a marriage to Edgar would be financially and socially prudent. The condition is made more severe by the acute and tortuous self-love that keeps Catherine tethered to Heathcliff.

The escalating battle between Catherine’s desire and her duty culminates in a physical collapse. Like Marianne Dashwood before her, the slow progression of nerves finds a climactic apex in fever, resulting in a moment where the self is split. Also like Marianne, Catherine destroys her body, implicitly because it is the sear of her desire, and we find Catherine engaging in the same high-risk behavior that Trotter and Buchan caution against. While Marianne is able to, for a brief time, express her affections for Willoughby, Catherine explicitly tells Nelly that Heathcliff, “shall never know how I love him” (63). While Marianne’s disease is prompted more from a separation from her beloved, rather than an inability to express love, Catherine’s destruction stems from a dangerous combination of the two. She represses her desires, triggering her nerves, and begins to deteriorate almost immediately after her marriage to Edgar and the disappearance of Heathcliff:

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, and take care she did not throw herself downstairs, or out of the window (69).

Just as Marianne exacerbates her already frail state with her long treks in the wet grass, Catherine’s actions initiate and hasten a physical collapse. Catherine’s pursuance, though, is more aggressive. While Marianne’s refusal to eat could be seen as an unhealthy appetite, Catherine patently starves herself. While Marianne “imprudently” sits in wet shoes and socks after her walk, Catherine is
prone to flinging open windows in the middle of wet and cold winds, and
demanding to be let out onto the moors in freezing temperatures. Marianne’s
neglect could be attributed to simple carelessness; it would be fair to say that
Catherine is slowly committing suicide. While Catherine does die, in a sense her
efforts are entirely unsuccessful because of the birth of Cathy.

Brontë continuously introduces the possibility that spirits are both
materially substantive and shareable. The most extensive extrapolation of this
concept occurs in Catherine’s statements about her relationship with Heathcliff.
She describes a comingling of souls and a shared essence that is at once physical
and metaphysical. She tells Nelly, “Whatever our souls are made of, his and mine
are the same” (63). As William Cohen notes, “…the idea that souls are ‘made of
something suggests that they have a substantial reality” (11). He explains this
point further, writing, “If ashes contain souls and ghosts can bleed then the
border between material and immaterial existence is thoroughly confounded”
(12). Indeed, nearly all borders are systematically blurred in Wuthering
Heights—material and immaterial, mind and body, self and other, and mother
and daughter. Just as Catherine “shares” matter with Heathcliff, she quite
literally shares matter with her daughter. Beyond that, she shares a name, i.e. an
identity, and she replicates, along with Linton and Hareton, the romantic triangle
of the first generation. Through the congenital paradigm that Brontë establishes
in the novel, Cathy can be understood as a distorted version of her mother. This
mutation, I submit, occurs when the two are quite literally of one body and
completes itself with the death of the mother and the birth of the daughter.
Brontë, if only briefly, acknowledges the ways in which illness has the potential to alter Catherine. First, she is physically transformed into a “lady” during her stay at Thrushcross Grange following an injury and brief illness. This transformation is only superficial, of course, as her romantic loyalties remain steadfast. This transformation, though, allows her to be a viable match for Edgar, which would have been nearly impossible before. Much later, during Catherine’s lengthy illness, Nelly reports to Heathcliff that Catherine seems on the mend, telling him:

> [...] she’ll never be like she was, but she is spared [...] I’ll inform you Catherine Linton is as different now from your old friend Catherine Earnshaw, as that young lady is different from me! Her appearance is changed greatly, her character much more so (116).

Nelly is both right and entirely wrong. Wrong because Catherine’s character has changed very little, and correct insofar as her words are, in sense, prophetic. Catherine Linton, daughter of the first, will be “changed greatly” from Catherine Earnshaw. The doubling that takes place in the naming of the two Catherines gestures towards the alteration that will inevitably occur with the death of the first Catherine and the birth of the second. The fever that claims the elder Catherine, as a rite of sentimentality, occurs while the two Catherines are, quite literally, of one body. The transformation that occurs as a result of a nervous collapse occurs across those joined bodies. Nerves kill the elder Catherine, but the younger carries the effects of its transformative power because she experiences the “rite of sentimentality” *in utero*. Brontë dramatizes the theory of congenital nervousness, while suggesting, by logical extension, that the transformative power of disease can occur through the line of succession making
the younger Catherine, in Lockwood’s terms, “a second edition of the mother” (121).

Mother/daughter dopplegängers are relatively common in novels at the turn of the century. Evelina, the eponymous heroine of Frances Burney’s first novel, bears a striking resemblance to her deceased mother, as does Matilda of Elizabeth Inchbald’s *A Simple Story* and another Mathilda, this time of Mary Shelley’s novella of the same name. While Brontë seems to be drawing on literary legacies of this type, Cathy is not a precise replica of her mother. Brontë qualifies their connection by saying that her name “formed to him [Edgar] a distinction from the mother, and yet a connection with her” (143). The implication is that the daughter, while literally separate from her mother, is always necessarily an extension of her. There is an acknowledged anxiety amongst the novels’ characters that the younger Catherine will inherit the undesirable traits of her mother, as in the aforementioned suggestion that she is Catherine’s “second edition.” Nelly hopes to form a distinction between them, pointing to the younger’s more temperate manner, “That capacity for intense attachments reminded me of her mother; still she did not resemble her, for she could be soft and mild as a dove and she had a gentle voice, and pensive expression” (146). The softening of Cathy’s intensity is reminiscent of Marianne’s own curbed sentimentality in the end of *Sense and Sensibility*. Marianne’s sensibility is not lost entirely, nor is Cathy’s. Rather, it is properly managed through a balance of good temper. Like Marianne, a physical alteration reifies the transformative power of disease, as Catherine and Cathy are not the nearly-identical physical specimens described in *Evelina* or *Mathilda*. Catherine is described as darker
than her daughter, who is “very fair” in comparison (9). This physical distinction, between light and dark, recalls Marianne’s own transformation from “brown” to “pale.” The lightening, in both cases, becomes the signifier for a tempered sensibility—one can certainly feel passion and emotion, but no longer narcissistically or dangerously.

It is because of this transformation that the recycling of the romantic triangle can have a more harmonious outcome with the second generation. Cathy’s love for Linton is not self-love, nor is her eventual affection for Hareton. Indeed, her relationship with Hareton unfolds with a similar deliberation and care that Marianne’s love for Colonel Brandon’s possesses. While the level of intensity is nowhere near that of her mother, Cathy becomes convinced of her affection for Linton almost instantaneously, much like Marianne and Willoughby. To develop love for Hareton, on the other hand, requires a great deal of time and effort, like Marianne and Brandon. Naturally, this is not a perfect comparison. Cathy views Linton as a “pet” and views Hareton, initially, as a brute. The characterizations, like the atmosphere, are much more severe than in Sense and Sensibility. In its basic structure, though, the sets of relationships have much in common, particularly when considering the role of nerves at their core. Through their nervous trials, both Marianne and Cathy achieve a harmonious sensibility in which passion and reason can exist in equilibrium. The narrative of a nervous body, then, finds resolution broadly in the same manner that the Victorian novel, according to John Halperin, finds its conclusion. The affliction is cured, or the nervous narrative ends, when harmony is restored.
“The Pangs of her Anxiety”: Mary Barton’s Industrial Sensibility

Mary Barton, Elizabeth Gaskell’s novel of industrial hardship in Manchester, seems fundamentally different from novels like Sense and Sensibility and Wuthering Heights. Austen and Brontë, above all, are writing love stories, while critics of Gaskell generally agree that Mary Barton is a social problem novel, and that the marriage plot involving Mary, Jem Wilson, and Harry Carson is subordinate and inferior to the story of John Barton’s trials and struggles. I close this chapter with a reading of nervous fever in Mary Barton, however, because the events and physiological fluctuations leading up to Mary’s illness near the end of the novel share notable similarities with those of Marianne Dashwood and Catherine Earnshaw-Linton. The differences, though, indicate a shift in the ways in which nervousness was theorized and figured in the middle of the nineteenth century, particularly as it pertains to the laboring class.

In the years following Trotters’ treatise, the professional interest in nerves and sensibility waxed and waned in the medical community. With more communicable and lethal diseases claiming thousands of lives, specifically the cholera, influenza, and typhus outbreaks beginning in the 1830’s, nerves and nervous fever largely fell by the wayside in medical inquiry. Alexander Tweedie’s Clinical Illustrations on Fever (1830), for example, makes virtually no mention of nervous fever, and deals only sporadically with afflictions unique to women. Robert Gooch’s An Account of Some of the Most Important Diseases Particular to Women (1829), however, takes an approach to female nervousness that deviates slightly from the findings of Trotter and Buchan. Gooch’s descriptions of nervous symptomatology are relatively uniform to his predecessors:
The pulse is soft, and not much quicker than is natural; but it is easily quickened by the slightest emotion [...] A patient who was originally delicate, who has suffered long, and has used much depleting treatment, has been (as might reasonably be expected) the most reduced; she has grown thin, pale, weak, and nervous (313).

Gooch, though, shifts the etiological focus in a number of ways. To begin with, discussion of “nerves” is confined to his fifth chapter, called “Of the Irritable Uterus.” Dr. Gooch connects nervousness as a condition to female anatomy more explicitly than Buchan and Trotter do. In addition, while Buchan and Trotter encourage exercise and activity for those suffering from nerves, blaming a sedentary lifestyle for their onset and progression, Gooch calls for those made nervous with an irritable uterus to “abstain not only from foot and carriage exercise, but [from] the upright posture” (319). Gooch’s treatment plan predates Weir Mitchell’s famous “rest cure,” famously memorialized in Charlotte Perkins Gilman’s “The Yellow Wall-paper,” which treats nervous disorders with lengthy bed rest.22 While Gooch’s recommendations are not as extreme as Mitchell’s will be later in the century, his prescription moves women further into the home than was previously recommended.

A decade later, Edwin Chadwick produced his Report on the Sanitary Condition of the Labouring Population (1842), which as the title indicates is predominantly concerned with analyzing public health in relation to urban sanitation conditions. However, Chadwick makes a number of claims related to

22 Gilman, like the protagonist of her short story, was subjected to Mitchell’s “rest cure” after the birth of her daughter Katharine in 1884. Mitchell instructed Gilman to abandon writing, live “as domestic a life as possible,” and confine devotion to her “intellectual life” to a maximum of two hours a day.
the nervous body and the working poor that indicate a shift in nervous discourse. As Peter Logan explains in *Nerves and Narrative*, sensibility discourse underwent a substantial revision mid-century with the rise of an Industrial class and a concern with a gendered industrial body. Logan contends that Thomas Trotter, along with George Cheyne and John Burton, his eighteenth-century predecessors, believed that the body of an industrial laborer was less prone to nervous conditions because the urban working-class lacked the sensibility of the middle and upper classes. Logan, then, summarizes Chadwick’s theories on the matter as outlined in his report. Chadwick claimed, like those before him, that the working poor lacked sensibility, but contended that this lack was now the cause of nervous conditions, rather than the cure. Logan explains:

> Unlike the middle class, the Victorian working class is a body in need of sensibility. Thus, the new interest in the social problem posed by the industrial working class needs to be seen as a shift of focus away from the danger posed by too much sensibility, as in the late Georgian period, to the danger of too little (147).

“Too little” sensibility, Chadwick claimed, serves as a defense mechanism, as the laboring class is incessantly bombarded with loss. He reports, for example, that working class mothers are far less attached to their children than more genteel women, because the high infant mortality rate necessitates such detachment. Chadwick claims “the working-classes of a populous city are less awfully affected by the sight of death, from an unavoidable familiarity with it in their own homes”

---

23 Trotter, for example, asserts: “The diseases of a labouring and active peasantry, or those of any condition of mankind, exposed to the weather in all seasons, are almost confined to the inflammatory class; such as pleurisy, acute rheumatism, catarrh, cynanche, &c. These depend on a vigorous vital power, a rigid fibre, and a florid dense blood: they are a directly opposite state of the system to what predisposes to nervous diseases” (154).
Sensibility felt differently among the working class, plainly, because life and death are more intimately and pervasively experienced. Detachment of emotion, though, proves to have unintended side effects when the insensible is forced to confront strong emotion, as *Mary Barton* illustrates.

Disease, as a whole, is treated differently in *Mary Barton* than in either *Sense and Sensibility* or *Wuthering Heights*. Plague and illness are rendered much more explicitly and with more specificity, with Gaskell drawing direct ties between poor sanitation and living conditions and the typhoid epidemic that claims the lives of several minor characters early in the novel. As a whole, Gaskell’s novel is more affixed to a realist novel tradition than *Sense and Sensibility*, and certainly more than *Wuthering Heights*, and her use of typhoid early in the novel is indicative of a sensitivity to medical realism. Her introduction of typhoid takes on a language that is simultaneously graphic, even gritty, and recalls the language of public health specialists like Chadwick:

"The fever" was (as it usually is in Manchester) of a low, putrid, typhoid kind; brought on by miserable living, filthy neighborhood, and great depression of mind and body. It is virulent, malignant, and highly infectious. But the poor are fatalists with regard to infection; and well for them it is so, for in their crowded dwellings no invalid can be isolated (56).

In this paragraph, Gaskell sounds nearly identical to Chadwick, with a touch of Trotter and Buchan in the allusion to “depression of mind and body.” The somewhat detached language gives a level of authority to Gaskell’s realism, which seems to owe a debt to public health treatises like *Report on the Sanitary Conditions of the Labouring Population of Great Britain* in the construction of medical realism. However, the diseases that dominate the final chapters of the
novel, specifically John Barton’s monomania and Mary’s brain fever, are generally regarded as an abandonment of realism in favor of more sentimental treatments of the body as a part of what Jill Matus calls “the novelist’s repertoire of melodramatic devices” (32). However, while bodily matters can be melodramatic or sentimental, they are not definitively so. Mary’s physical trials have as much fidelity to medical case studies as those of the typhus sufferers. By including it in this novel, and by featuring it so prominently in the final stages of the narrative, Gaskell demonstrates that Mary’s health crisis is as alarming as the epidemics terrorizing those stricken with poverty. Insensibility, like poor sanitation and bad water, is a health risk.

Mary is the insensible woman that Chadwick and others write about. Her admission that she loves Jem, first privately and then publicly, causes her reticent sensibility to awaken. Her newly acquired sensibility, as it did for Marianne and Catherine, leads to a physical and mental breakdown, along with noticeable alterations to both mind and body. Mary Barton shows us how pathological sensibility evolves with changing socio-political landscape and gender politics. Despite the variations, the resulting femininity continues to be characterized by a tempered sensibility and romantic harmony.

The modes of female feeling described in Sense and Sensibility and Wuthering Heights are indicative of a Georgian discourse on sensibility, as both are set before Victoria’s rule, even though Wuthering Heights was published in 1847. Nerves, in these narratives, follow the patterns described by medical texts flourishing at the cusp of the nineteenth century, those of Trotter and Buchan. This manner of nervousness is not entirely lost in the Victorian industrial world
of *Mary Barton*, but it is specifically confined to the older generation. Mary’s mother, for example, suffers from Trotterian nervousness. It is not her own lovesickness that has led to her mental and physical decline. Instead, she is left in emotional shambles following the seduction and departure of her sister, Esther. The elder Mary’s corporeal troubles are not confined to times of crisis, however, as her husband remarks: “you are but a cranky sort of body at the best of times” (10). Her already fragile frame and implicitly delicate nerves are threatened on two fronts by the disgrace of her sister and, apparently, by her pregnancy: “She was far advanced in pregnancy, which perhaps occasioned the overpowering and hysterical nature of her grief” (9). The choice of “hysterical” as a modifier of nature ought to resonate powerfully for scholars of Victorian gender construction and body politics. “Hysterical” and “hysteria,” of course, find roots in the Greek “hystera” meaning womb, and “hysteria” as a powerful affliction of both body and mind became increasingly pervasive in the second half of the nineteenth century. The elder Mary is overpowered by both her grief and a “hysterical nature” which is, essentially, her female nature.

Like Catherine Earnshaw, the elder Mary Barton dies from a combination of complications stemming from childbirth and what her doctor calls “some shock to the system” (21). Esther too, it seems, suffers from a weakened constitution, made worse by her fallenness. Esther is clearly frail and vulnerable when John Barton sees her again, many years after her flight. His anger makes

---

24 Elaine Showalter extensively outlines the history of madness and hysteria in her seminal work *The Female Malady* in which she argues, amongst other things, that hysteria was both a decidedly female condition and *the* female condition.
“her face grow deadly pale around the vivid circle of paint,” and “with a feeble scream” Barton throws her “trembling, sinking, fainting” (111). Her apparent physical weakness is exacerbated by her apparent intoxication, which further marks her as a woman who is unable to control her body’s baser impulses, whose propensity for indulgence only makes her nervousness more clear to those who see her. The story of Esther’s seduction is remarkably similar to the elopement plots of many Austen novels, including Sense and Sensibility, as she tells Jem: “I always meant to send for her [Mary] to pay me a visit when I was married; for, mark you! he promised me marriage. They all do” (142). It seems Esther’s seduction was predicated on her belief in a romantic narrative, the promise of marriage and a happy ending, not unlike Marianne Dashwood. While Esther and John Barton clearly have a contentious relationship, they are of like-minds in their overwhelming apprehension that little Mary, of the novel’s title, will meet the same fate as her aunt. Esther claims her motivation for accosting both John Barton and Jem Wilson is in an effort to “save Mary (her dead sister’s only child, her own little pet in the days of her innocence) from following in the same downward path to vice” (140). John is also concerned, studying Mary for signs of similarity to her fallen aunt: “He often looked at Mary, and wished she were not so like her aunt, for the very bodily likeness seemed to suggest that the possibility of a similar likeness in their fate” (113). John Barton’s fear gestures to a theory of biological destiny, that an ill-fate is inscribed on and in the body. The bodies of Esther and the two Marys are linked together, indicating little Mary may have a

25 The Elizas of Sense and Sensibility are similarly seduced, as is Lydia of Pride and Prejudice and Maria in Mansfield Park (1814).
predisposition for nerves simply by virtue of looking like them, much like the Catherines of *Wuthering Heights*.

As the younger Mary develops throughout the novel, however, she demonstrates a stoicism and strength that neither her mother nor her aunt apparently possessed. In fact, Gaskell tells us quite early in the novel that Mary has not inherited the degree of nerves that her mother suffered from: “she was far superior in sense and spirit to the mother she mourned” (28). Faced with a traumatic event at a very young age, the death of her mother, Mary shows minimal distress, only a hint of the nerves from which her aunt and mother suffered: “her eyes were tearless, her face calm, though deadly pale, and uttering no sound, except when her teeth chattered for very nervousness” (20). While her body is clearly responding to the trauma, she remains relatively calm and unaffected. The young Mary embodies Chadwick’s predictions about the less affected and insensible working class. She maintains level-headedness throughout the novel in the face of unimaginable tragedy and hardship—the deaths of her mother and infant brother, physical abuse, a typhus outbreak that claims the lives of many people whom she knows, and even the death of her father towards the end of the novel. Mary’s “insensibility” is a more severe version of Catherine Linton’s gentle sensibility, and the controlled emotional state in which Marianne finds herself at the end of *Sense and Sensibility*. The evolution of nerves and sensibility from mother to daughter, and the amelioration of nervousness in its inheritance, indicates a generational divide in how nerves reveal themselves. Presumably, the nervousness of Esther and the elder Mary is an affliction of the older generation.
John Barton, too, possesses a Georgian nervous body. As Trotter predicts, Barton’s physical deterioration is triggered by professional failures, not by the loss of his wife. A failed trip to London initiates his physical and mental collapse:

> Then came a long period of bodily privation; of daily hunger after food; and though he tried to persuade himself he could bear want himself with stoical indifference, and did not care about it as little as most men, yet the body took its revenge for its uneasy feelings. The mind became sour and morose, and lost much of its equipoise (149).

The loss of “equipoise” points to an affliction of imbalance, like nerves or excess sensibility. As his monomania begins, Barton becomes singularly preoccupied, like Marianne or Catherine. He is, like his wife, ultimately unable to recover his balance.

When Mary’s nerves are finally triggered in the course of the novel, it occurs almost exclusively in matters pertaining to Jem Wilson, her eventual husband. So, while Mary may have a subdued sensibility in comparison with her mother and aunt, and while this sedation seems linked to her class position, “nerves” continue to be paired with both a hereditary predisposition and matters of the heart. Mary, like Marianne and especially Catherine, is faced with a romantic dilemma. Similar to Catherine’s awareness of the benefits of marrying Edgar, Mary recognizes the clear economic advantages of a marriage to Harry Carson over Jem. Unlike Catherine, however, Mary opts out of a marriage of economic convenience because of her realization that she loves Jem, “it had convinced her that she loved Jem above all persons or things” (117). This revelation follows her body’s violent reaction to his departure, after she reject his marriage proposal:
... now she lay half across the dresser, her head hidden in her hands, and every part of her body shaking with the violence of her sobs. She could not have told at first (if you had asked her, and she could not have commanded voice enough to answer) why she was in such agonised grief. [...] By and by her sorrow exhausted her body by its power, and she seemed to have no strength left for crying (116-117).

This is not the first time Jem has elicited an involuntary bodily reaction from Mary, and indeed her condition becomes progressively more severe the longer her feelings remain unarticulated. Watching Jem risk his life during the mill fire, Mary is the only person in a large crowd to outwardly react:

A sob, as if of excited women, was heard in the hush of the crowd. Another pressure like the former! Mary clung to Margaret’s arm with a pinching grasp, and longed to faint, and be insensible, to escape from the oppressing misery of her sensations (49).

The words “excited,” “insensible,” and “sensations” link the passage to nervous discourses, along with her longing to faint. It is as if her love for Jem is stored within her body before she is even cognizant of its existence. Mary is only made aware of her true feelings because of her body’s reaction to his perceived loss.

Despite the revelation, Mary quickly surmises that she cannot reveal her feelings to Jem: “She came to the unusual wisdom of resolving to do nothing, but strive to be patient, and improve circumstances as they might turn up. Surely, if Jem knew of her remaining unmarried, he would try his fortune again.” Almost immediately following these epiphanies, upon waking the next morning, Mary experiences the first signs of a nervous fever: “She wakened up shivery and chill in body, and sorrow—stricken in mind, though she could not at first rightly tell the cause of her depression” (118). These chills quickly subside, but the moment is reminiscent of others in Wuthering Heights and Sense and Sensibility wherein depression and physical discomfort are connected to the admission and
suppression of romantic sentiments. Mary’s condition is likely to deteriorate, if Trotter is to be believed, by the lack of a proper outlet for her feelings and by the containment of her desire.

Her physical and mental strength are further strained in her realization that her father is guilty of the murder for which Jem has been accused, and in her struggle to vindicate the latter without implicating the former: “Her head ached with dizzying violence; she must get quit of the pain or it would incapacitate her for thinking and planning [...] Then she sought for some water to bathe her throbbing temples, and quench her feverish thirst” (216). Mary’s worsening nerves come to a dramatic climax when she testifies at Jem’s trial, making her affections known to him in the most public of settings: “Suddenly she was roused, she knew not how or by what. She was conscious that all was real, that hundreds were looking at her, that true-sounding words were being extracted from her” (281). Mary, previously a figure of remarkable agency, is reduced to a pliable object under a scrutinizing gaze with her faculties becoming, apparently, beyond her control. The mental breakdown, with Mary’s internalized chant: “I must not go mad. I must not, indeed” coupled with a total physical collapse: “Oh, Jem! Jem! you’re saved; and I am mad—’ and was instantly seized with convulsions” (285). In this moment, the health of mind and body are merge, with falling prey to a fever and “going mad” becoming almost interchangeable. Mary falls into what Gaskell calls “the ghastly spectral of delirium,” gripped by a violent fever that makes her rant and rave in a manner similar to Catherine Earnshaw’s final days:
Hour after hour, day after day, she started up with passionate cries on her father to save Jem; or rose wildly, imploring the winds and waves, the pitiless winds and waves, to have mercy; and over and over again she exhausted her feverish fitful strength in these agonised entreaties, and fell back powerless, uttering only the wailing moans of despair (290).

These spells are notably similar to the antics of the dying Catherine Earnshaw, flailing and flinging open windows during a violent storm. Like Marianne Dashwood, Mary undergoes a physical alteration in her recovery, although she transitions from light to dark rather than Marianne’s “brown” to “pale”: “He was her sitting up in bed, her golden hair, dimmed with her one day’s illness, floating behind her, her head bound round with wetted cloths, her features all agitated, even to distortion, with the pangs of her anxiety” (292-293). Gaskell presents us, in the end, with a course of nervousness that is different from manifestations in older generations, but nonetheless continues to be triggered by a romantic quandary, along with a mental and physical break that leads to a physical, and presumably mental, alteration. Mary is, in many ways, a different Mary following her fever. However, while post-fever Marianne becomes more restrained and guarded about her feelings, post-fever Mary has the freedom to unburden herself of her suppressed feelings for Jem. Gaskell writes that her mind after her fever “was in the tender state of a lately-born infant’s” as she begins to experience her surroundings with almost hyperactive senses:

She was pleased with the gay but not dazzling colours of the paper; soothed by the subdued light; and quite sufficiently amused by looking at all the object in the room—the drawing of the ships, the festoons of the curtain, the bright flowers on the painted backs of the chairs—to care for any stronger excitement (301).
Because Mary initially presents with “too little” sensibility, as opposed to Marianne and Catherine’s abundance, she must be inflicted with a dose of nerves to compensate for this lack. While Mary Barton’s malady is different from Marianne’s or Catherine’s, in the end all three novels leave us with a similar resolution—a temperate sensibility, with nerves curbed by reason and maturity leads to a desirable outcome.

According to Elaine Showalter’s landmark work *The Female Malady*, “madness,” often characterized in the nineteenth century as “hysteria” became the chief medical concerns for women in the latter half of the nineteenth century:

Simultaneously [to the burgeoning feminist movements between 1870 and 1910], the female nervous disorders of anorexia nervosa, hysteria, and neurasthenia became epidemic; and the Darwinian “nerve specialist” arose to dictate proper feminine outside the asylum as well as in, to differentiate treatments for “nervous” women of various class backgrounds, and to oppose women’s efforts to change the condition of their lives (18).

The analyses I’ve provided indicate that the history of conceiving madness and hysteria as female maladies, even when as Showalter contends they are afflicting men, has its roots in discourses of nervousness coming out of Romantic medicine. As Showalter hints at, as class lines blur with the rise of the middle class, nerves and hysteria become more widespread.²⁶ It is the general consensus amongst feminist scholars and historians that hysteria discourse shackled women to restrictive domestic roles, with nearly all behaviors that deviate from a so-

²⁶ Showalter proposes that the reason for increased incidences of madness were connected to the common belief that insanity was a “disease of the highly civilized and industrialized,” citing Dr. Andrew Halliday’s observations on the lack of madness among “slaves of the West Indies,” “the contented peasantry of the Welsh mountains,” and “the wilds of Ireland” (24).
called “angel in the house” domesticity being labeled as potential evidence of a hysterical nature.

While I do argue that nervousness serves as a precursor to hysteria, and it’s hard to argue against the assertion that hysteria discourse was damaging to women, the restrictive element is less evident in instances of pure nerves earlier in the century. On the contrary, it seems that in the first half of the century, it was sensibility and nervousness that imprisoned women while their alleviation was liberating. Buchan and Trotter, as I previously stated, encouraged activity and movement for women suffering from nerves, and both worried that excessive domesticity would intensify their conditions. Each of the women in the novels I’ve discussed describes the experience of nervous fever as strikingly revelatory. Marianne speaks of the event as providing her with clarity, Mary Barton is made aware of her love, and is able to express it openly, because of her malady, and the younger Catherine finds a temperate balance that her mother was never able to achieve. It would be a mistake, though, to assume that these women are made docile and silent through their illness. Rather, each becomes a more tranquil version of their former self. Marianne continues to feel love, and we are led to believe that her love for Brandon is just as powerful as the love she felt for Willoughby. The elder Catherine has the same propensity for passion as her mother, but is granted a degree of softness her mother rarely exhibited. Finally, Mary Barton emerges from her bout not only with her love in tact, but with the chance at a new life as she and Jem relocate to Canada. Each of these disease narratives signals the coming of a new age of sensibility, with the excessive modes
of the eighteenth century and the Romantic era being phased out in favor of a restrained, but nonetheless sincere, Victorian sensibility.

Nerves are uniquely adaptable to the novel driven by a marriage plot because it was an affliction characterized so strongly with unfettered passion and inconsistent sentiments. As those sentiments change or vacillate between affection and disdain, the nervous disorder, and thus the narrative, must adapt accordingly. In the female bildung, which most often concludes with a marriage, coming into womanhood necessitates an abandonment of immature modes of expression in favor of progressive, moderated, and reasonable ones. For the marriage plot, it means selecting a well-suited match rather than and elopement with an attractive scoundrel. Therefore nerves, as they run their logical course, cast away the failures of the old generation and usher in new ways of being a woman.
Chapter 2

An Exchange of Air: Consumption and Bonds Between Women in the Social-Problem Novel

As an umbrella term encompassing essentially all pulmonary or lung diseases, most often tuberculosis, consumption is rampant in the Victorian literary canon. It fatally strikes down more characters than virtually any other affliction, claiming the likes of Isabel Vane of Ellen Wood’s *East Lynne* (1861), little Paul Dombey of Dickens’ *Dombey and Son* (1846), and poor Beth March of Alcott’s *Little Women* (1868). Consumption, in the view of many, was, like hysteria, the natural conclusion of overactive nerves. While hysteria, as consumption’s nervous cousin, produces a figurative death with the corruption of the faculties, consumption brings a literal death as it was, most often, fatal. In *The White Death: A History of Tuberculosis* (1999), author Thomas Dormandy reports fatality in 80% of cases (22), and, as Katharine Byrne remarks in her book *Tuberculosis and the Victorian Literary Imagination* (2011), consumption “remained throughout the Victorian era the biggest single killer of men and

---

27 While Alcott never makes this explicit, Beth’s physical characteristics coupled with the length of her physical decline and the description of her final moments indicate that Alcott, at the very least, was engaging was imagining something like a consumptive death.

28 Symptoms produced by nerves make one, supposedly, more vulnerable to consumption. Dr. Johann Zimmerman hypothesizes in his *Treatise on Experience in Physic* (1788), that a bout with nervousness which includes “a tremulous pulse, deep sighs, an alternate glow and paleness of cheeks, dejection, loss of appetite, a faultering speech, cold sweats, and watchfulness” will eventually “terminate in consumption” (288).
women in their physical and productive prime, or, more specifically of those aged between fifteen and thirty-five” (12).

Given its omnipresence in Victorian life, particularly amongst impoverished citizens, it is no surprise that it would be ubiquitous in the novel. In this chapter, I’m interested in exploring the particular occurrences of the consumptive in a supporting role in mid-century novels. Specifically, I’m interested in the role the consumptive plays in the social problem novel, or novels with a strong social agenda. In the novels included in this chapter—Charlotte Brontë’s *Jane Eyre*, Elizabeth Gaskell’s *North and South*, and George Eliot’s final novel *Daniel Deronda*—the consumptive serves in the role of what Vladimir Propp termed “the donor,” the character who imparts the hero or heroine with special knowledge or a magical gift. Rather than receiving an enchanted weapon or token, the formless gift bestowed on these characters is the gift of a heightened spiritual awareness that informs the political agendas of the novels. The growth of the protagonist into maturity, then, required the development of both a spiritual awakening and a political sensibility that is, almost entirely, dependent on the strength of the connection formed with the dying consumptive.

________________________________________________________________________________________

29 The social problem novel, as defined by Gail Marshall, used shocking detail and sensational stories to highlight the plight of marginalized groups, often the industrial poor. While *Jane Eyre* and *Daniel Deronda* are not social problem novels, portions of those novels mimic the style and implied political agenda of the traditional social problem novels of Dickens or Gaskell, specifically the Lowood sections of *Jane Eyre* and the London sections of *Daniel Deronda*.

30 In *Morphology of the Folktale* (1928), Propp describes the donor as the character encountered by the hero once he or she has left home. Also known as “the provider,” the donor is generally introduced to the character by chance meeting in a forest or on the road.
Through the bond created in the sickroom, in the “exchange of air,” the transmission of the consumptive’s spiritual and political essence is bestowed on the protagonist, inflecting the path that unfolds before them with a sense of social justice.

**Too Good to Live: Idealizing Consumption**

In the 1830’s and 40’s, the first decades of the Victorian era, discourse on consumption was in flux. As Katharine Byrne explains, medical writing on consumption tripled in the 1840’s, despite the fact that rates of infection and mortality were actually going down for the first time since the Industrial Revolution. Byrne claims that this surge:

> cannot be considered so much a reflection of the actual pathological importance of the disease, [but], as a reflection of its newly awakening, perceived social significance. These books, pamphlets and articles published are not only concerned with the numbers of people it consumes and destroys, but also with what it creates and produces: symbols and metaphors, political and eugenics fears, and the transfer of power and wealth (12).

Consumption’s newly perceived social significance is inextricable from what I can only call a fetishization of the consumptive as an individual whose professed moral and spiritual superiority marks itself on the body with an affliction characterized by a certain aesthetic beauty. As Clark Lawlor notes, in *Consumption and Literature: The Making of the Romantic Disease* (2006), the consumptive stereotype developed in the early years of Romanticism in what he

---

31 According to Katherine Byrne, the number of publications on consumption jumped from sixteen in the 1830’s to fifty in the 1840’s. The numbers continued to increase over the next three decades, and remained in the range of fifty to sixty publications per decade until the 1880’s.
calls “the glamorous sign of female beauty”—physical weakness, “a slender make,” a long neck, and a pallor coupled with flushed cheeks and red lips. Lawlor goes on to claim that consumption functioned as a “natural cosmetic,” whose aesthetic power was felt even by the healthiest women who sought to make themselves thinner and paler in an attempt to look consumptive. It is a cosmetic that translates vividly in the realm of Victorian art, particularly Pre-Raphaelite painting, where numerous literary icons are figured in the consumptive fashion, such as Ophelia and the Lady of Shalott:

Figure 4: Detail of Ophelia, John Everett Millais, 1852

32 The consumptive look could be achieved in a number of ways, some benign and others quite dangerous. Simple cosmetics could produce pale skin and red lips, while more extreme measures like corseting and semi-starvation were used to create the gaunt physique and labored breath.
In the above images, female literary figures, each regarded for their deaths, are rendered in the final moments of their lives, evoking consumptive aesthetics through the pale skin, flushed cheeks, and elongated necks. The depiction is particularly poignant in the case of the Millais painting, as its model, Elizabeth Siddal, reportedly contracted pneumonia and nearly died posing for several hours in an icy bathtub. Katharine Byrne proposes that the aesthetic allure of consumption was its reflection of dependence and passivity:

There was, therefore, a clear social investment in this advocacy of ill health, and one which can be held partially responsible for the prevalence of female illness in the nineteenth century. Invalidism became a way of life for women because it was a means of demonstrating the most desirable female characteristics, namely purity, passivity, and a willingness to sacrifice oneself for others, especially men. The invalid woman’s weakness of body meant that she was entirely and suitably dependent on others for physical, emotional and financial support, and yet her patient endurance of pain proved her strength of soul. Hence sickness came to signify virtue, and the sickly woman became the ideal woman (95).
Sickness, then, does more than signify femininity. In the case of consumption, it reflects an idealized femininity, through which strength of body is willingly forsaken in favor of masculine endeavors. Frailty, according to this logic, is a woman’s strength.

This rather broad assessment of what Bram Dijkstra calls “the cult of invalidism” that dominated the nineteenth century is amplified in the case of consumption because it was so strongly associated with heightened spirituality. Thomas Normandy identifies “its long association with childhood, innocence, and even holiness” (xiv) and Lawlor and Byrne agree that consumption is unique in representative discourses of disease because it was “aestheticized in a positive manner as a sign of passion, spirituality, and genius” (1-2). Consumption was more than likely granted this spiritualized status because it is, after all, a disease of air and breath, as Susan Sontag notes: “A disease of the lungs is, metaphorically, a disease of the soul” (17). That’s shouldn’t suggest that the soul itself is corrupt, but rather that a pure soul is most vulnerable to attack by wicked and corrupt bacterial forces, as if a clean soul is somehow too sterile to build an immunity. Sontag continues that “tuberculosis was thought to be an insidious, implacable theft of a life,” a life belonging to those who are “too good to live” (5).

Nearly all contemporary critics of consumption note the air of mythic tragedy that has surrounded the death of John Keats, for example, as encapsulated by Rene and Jean Dubos who write that Keats was “the fragile poet who fell victim to tuberculosis because his sensitive nature had been unable to withstand a crude world” (11). These persistent characterizations of the consumptive as possessing a soul too innocent for a world that is inherently corrupt and crude indicate an
assumption that a pure spirit is too grand for material containment, and that an earthly body will inevitably crumble and deteriorate from that spiritual weight.

Despite what Byrne alleges is an anxiety in the Victorian medical community over the symbolic power of consumption, this glorification of the consumptive was something that medical writers participated in and perpetuated. Moreover, even when the medical literature classifies the symptoms with gender neutrality, the adjective choices habitually feminize consumption and, consequently, those who suffer from it. As early as the eighteenth century, Dr. Buchan writes, in Domestic Medicine, that individuals most susceptible to consumption are those “betwixt the age of fifteen and thirty, of slender make, long neck, high shoulders, and flat breasts” (174). Dr. J. Hungerford Sealy, too, writes in his Medical Essays of 1837 that the consumptive possesses: “a peculiar delicacy of texture and colour of skin, a precocity of intellect, a clear brilliancy of eye and graceful tenuity of figure, forming in all the most attractive appearance of the human youth of both sexes” (92). Dr. Thomas Allinson concurs in 1853 when he writes that consumption is attacks “the talented, gifted and more beautiful more often than courser humanity” (1), and Edwin Alabone seems to be keeping these associations alive when he writes in 1880 that “it is a frequent thing for consumptive patients to be of a most refined nature...being remarkable for the gentleness of their disposition, the amiability of their character, and the great purity of their moral feeling” (24).

Dr. Thomas Beddoes, one of the most prominent voices on consumption in the earliest years of the nineteenth century, implicates the onset of female puberty in the pervasiveness of pulmonary infection among young women. In
Essays on the Causes, Early Signs, and Prevention of Pulmonary Consumption for the use of Parents and Preceptors (1799), Beddoes laments the process of becoming an acculturated lady, indicating his belief that female social and cultural development is complicit in women’s perceived ill-health:

It is not till after that unfortunate æra, when the girl is taken up to be manufactured into a lady, that everything conspires to prevent her organization, originally perhaps more feeble, from acquiring a healthy force of action. I have been sometimes tempted to think, that a period nearly equal to that if female education is required before the constitution can be undermined and the lungs thrown into a state of complete disease; and that this is one reason why consumption is so common about the age of puberty (120-121).

The implication of Beddoes’ assessment is that multiple facets of a young girl’s development—physiological, psychosexual, educational, etc.—fabricate a path in which aggregate health is almost certainly unachievable and in which consumption is likely to fester. Because the cause of consumption is so affixed to moments of maturation, it produces a semiotics that stretches this particular malady beyond its pathological makeup and symptomology into the space of identity politics. Unlike other maladies, consumption becomes the sum of the sufferer’s personhood; it is not a disease that you have, like cholera or smallpox; it is the entirety of who you are, particularly if you are a young woman.

The purported splendor of consumption, though, is not what sparked its resurgence in the medical literature of the 1840’s. Instead, as Katharine Byrne notes, it is the recurring debate over how this disease was acquired and transferred. She writes: “The single most important concern in the whole canon of medical writing on consumption was the debate over whether or not it was hereditary or infectious” (21). The bacilli that produce tuberculosis were not
discovered until the 1880’s, and so its precise cause remained a mystery, as did the answer to why, for example, one or two members of a household would be afflicted, while the others went unscathed. While the debate surrounding contagiousness was at its peak in the final decades of the nineteenth century, some work was done in the middle of the century by physicians who proposed that consumption was shared, for example, between married couples or parents and their children. Overall, though, British physicians remained convinced, until Koch’s discoveries, that either miasmic infection or hereditary transmission was at its foundation. Although though the means of acquisition were contested, it was widely agreed upon that consumption was distinct from maladies like nerves or cancer in its ability to be shared between individuals. Hence, the contraction of consumption implies some manner of bonding, regardless of whether or not it is inherited, contagious, or breathed through bad air. It is a malady characterized by mutual connection.

The mystery surrounding its communicability and the inability to map a strand of infection, according to Sontag, give an air of contagiousness to any disorder regardless of its pathological reality: “Any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious” (5-6). Continental physicians became convinced of its contagiousness in the nineteenth century, and accordingly took precautions to quarantine the sick, while most British and American writers maintained that while it may be transmissible, it is selectively so. In maintaining the notion that

---

33 In his tract *Is Consumption ever Contagious?* (1864), Henry Bowditch’s observations indicated that married couples often share consumption.
consumption afflicts the best among us—the most passionate and brilliant—medical and literary writers must underpin the aura of selectivity surrounding the condition. Thus, Bessy Higgins, Mordecai of Eliot's *Daniel Deronda*, and Helen Burns do not “catch” consumption, the way one acquires a cold or the flu; they are selected to receive it.

Just at the moment when consumption was under revived consideration in British medicine, the political significance of the novel was a growing source of critique and artistic energy. Gail Marshall writes that the growth of urbanization contributed to “a new form of fiction and fictional language which owe their birth in large part to the need to find ways of articulating new conditions.” That new form was the “social problem novel,” a narrative mode that shone a light on what Marshall calls “conditions which bring about official silence and omissions,” specifically, the conditions of the working poor, the industrial laborer, and the status of forgotten citizens like orphans, fallen women, and other social outcasts. As a political platform for social reformism, the social problem novel extracts the emotions of the reader by describing decent people living and working in squalor, consuming rotting food if they eat at all, and succumbing to early deaths all while maintaining steadfast work ethics and wholesome morals. Katharine Byrne claims that consumption is a “disease of individuals rather than the masses,” diseases of the masses being typhus or cholera, and thus concludes: “consumption is the perfect vehicle for the social problem novel” (16). I would take that assertion a step further, and claim that the consumptive is the ideal vessel for the political projects of the social problem novel, as we often find the consumptive character bringing a voice to the inequities that the novel is
designed to highlight. This is a role befitting consumption because those suffering from it are, as Susan Sontag writes: “an amalgam of two different fantasies: someone both passionate and repressed” (38). In the space of the social problem novel, the consumptive character becomes responsible for bestowing the wayward protagonist, and by extension the reader, with vital spiritual and political knowledge. In these novels, the magical gift donated to the protagonist is manifold yet intangible, literalizing Jacques Derrida’s assertion that what is truly given with any gift is “goodness itself.” For Jane Eyre, Margaret Hale, and Daniel Deronda, the goodness of the consumptive becomes their most valuable tool as they navigate the struggle to find a voice, a home, and an identity.

“Learn from Me...”: The Spiritual Apprenticeship of Jane Eyre

Charlotte Brontë’s Jane Eyre is a Frankensteinian creature of generic elements, harvesting parts from the bildungsroman, the spiritual autobiography, the Gothic novel, and the social problem novel, particularly in the sections set in Lowood, Jane’s boarding school. By the time it was published in 1847, its author had already lost a number of loved ones to consumption. Her sisters Maria and Elizabeth probably contracted it at the Clergy Daughters’ School at Cowan’s Bridge when the girls were children and, in the year following Jane Eyre’s publication, Emily, Anne, and Branwell Brontë all succumbed to tubercular consumption. Those who study Charlotte Brontë and her work agree that the novel is strongly autobiographical in nature, particularly in regards to the portion of the novel that takes place in a parish boarding school called Lowood and Jane’s work as a governess. Brontë’s contemporaries G.H. Lewes and Elizabeth Gaskell,
who would become her biographer, each saw the overlap between life and art in Brontë’s work, as Lucasta Miller explains:

As G.H. Lewes intuitively recognized, the novel contained elements taken from the author’s own life. Charlotte’s childhood misery at the Clergy Daughters’ School at Cowan Bridge was reworked in Jane Eyre’s Lowood; her elder sister Maria, who had died as a result of the school’s poor hygiene, bad food, and inhumane regime, was transformed into the poignant character Helen Burns.

Miller, here, references Lewes’ review of Jane Eyre that appeared in Fraser’s Magazine in December of 1847. In that review, Lewes praises Bronte saying: “Reality—deep, significant reality—is the great characteristic of the book. It is an autobiography,—not, perhaps in the naked facts and circumstances, but in the actual suffering and experience” (691). In The Life of Charlotte Brontë, Elizabeth Gaskell is somewhat guarded in detailing the “actual suffering and experience” with Brontë’s austerity, saying that the novel’s Lowood sections elicited an “over-strong impression upon the public mind by her vivid picture” (98). While Gaskell tries to remain diplomatic, giving textual space to the positives of the school at Cowan’s Bridge, she acknowledges that many of Brontë’s descriptions of Lowood match the testimonials of members of the staff at Cowan’s. To balance the scales, Gaskell proceeds, in a sense, to rewrite the Lowood sections of Jane Eyre, often using Brontë’s exact phrases, shifts in tone, and even opting to use Brontë’s character names rather than the names of real school personnel. Gaskell, in other words, is trying to give us a more balanced report of Brontë’s charity school than Brontë detailed in Jane Eyre, but even with that diplomacy Gaskell reports shocking details. While Gaskell treads cautiously, trying not to lodge accusations of abuse of neglect, she details claims of the staff that the children often went
hungry, when they were fed the food was rotten or unclean, and that the living quarters lent themselves to “the tendency to illness, both infectious and otherwise” (100).

These passages are written in a tone of notable objective distance, a tone that shifts markedly into one of sentimentality when she begins discussing Charlotte’s sister Maria. In the Cowan’s Bridge passages, Maria Brontë is the only fully realized figure. None of the other students are named, and the teachers are only distinguished by their counterparts in the novel. Gaskell reports: “She was far superior in mind to any of her playfellows and companions, and was lonely amongst them from that very cause.” While she might be guarded in drawing precise traces of Lowood over Cowan’s, Gaskell assures the reader that Maria served as the inspiration for Helen Burns, who is similarly “far superior” to the other students at Lowood: “I need hardly to say that Helen Burns is as exact a transcript of Maria Brontë as Charlotte’s wonderful power of reproducing character could give.” Despite Maria’s superiority, she was apparently “in constant disgrace with her teachers,” due to her “annoying faults” that remain unspecified by Gaskell (104). According to Gaskell, while the dying Maria was being beaten by the offending teacher, she apparently “hardly spoke, except to beg some of the more indignant girls to be calm” and the sufferings of her final days were “patiently borne” (105, 108). Gaskell’s description of Maria Brontë is rich with the signifiers of the glorified consumptive—superior, “delicate,” and calm in the face of certain death (108).

While Gaskell’s biography of Brontë and the chapter on Cowan Bridge touch on the stylistic mode of the social problem novel, a form which Gaskell
worked strongly in within her own fiction, Gaskell’s project with the *Life of Charlotte Brontë* is not reformism. While Charlotte Brontë may not have written *Jane Eyre* exclusively for political reasons, the sharpness of Brontë’s descriptions of Lowood and its conditions when compared with Gaskell’s more subdued record of events, indicate Charlotte Brontë’s more forceful engagement with a social platform.

Brontë uses the descriptive work of the social problem novel to heighten awareness, while her character work with Helen Burns elicits compassion. Jane’s record of Lowood is shocking in its detail, but lacks the personalization that would allow Jane to develop her own empathy, and by extension force readers to develop theirs. We are told, for instance, that the children must wash themselves each morning with freezing water, and are served a dinner consisting of “rancid fat,” and “strange shreds of rusty meat” (43). Brontë writes that the girls were required to congregate outdoors, in the damp and chilled Northern English air, saying: “the sundry pale and thin ones [girls] herded together for shelter and warmth in the verandah; and amongst these, as the dense mist penetrated to their shivering frames, I heard frequently the sound of a hollow cough” (40-41).

To this point, these neglected and abused girls are given no names and no faces. They are a mass of shivering frames and anonymous coughs. The source of the cough, really the lone voice in the mass of bodies, is soon identified when Jane meets Helen Burns, the “girl on the verandah,” who coughs as she quietly reads Samuel Johnson. From her first introduction, Helen is singled out from the mass and she has the only articulated voice. Her singularity is underscored again when Helen is also singled out for torment by the school’s staff. Jane reports Miss
Scatcherd’s relentless castigations of Helen Burns for offenses ranging from unclean fingernails to “slatternly habits” (47). However, even as the verbal assaults become more frequent and escalate into violence, Jane narrates that “Not a tear rose to Burns’ eye,” “not a feature of her face altered its ordinary expression,” and that Helen Burns presents Miss Scatcherd with the twigs that she is to be beaten with “with a respectful curtsy” (45).

Helen Burns, in a critical sense, is too good to live. She embodies what Katherine Byrne calls “the Christlike innocence of the child who dies because they are too pure for this world” and, accordingly, her death from consumption is befitting one of such greatness (16). In the early paragraphs of chapter nine, the chapter that concludes with Helen’s death, we are told that Lowood is under quarantine due to an outbreak of typhus, information given to us once again in the detached style of the social problem novel: “Semi-starvation and neglected colds had predisposed most of the pupils to receive infection: forty-five out of the eighty girls lay ill at one time” (65). Brontë describes this outbreak with the same depersonalization of the aforementioned bad meals and herded shivering bodies—no names, no faces, no voices. We learn, too, that Helen has taken to a sickbed, but is not suffering from typhus and is thus not amongst the huddled masses. Jane narrates: “She was not, I was told, in the hospital portion of the house, with the fever patients; for her complaint was consumption, not typhus” (66). This is a fictional moment that Bronte scholars can point to as a clear autobiographical instance. Like Lowood, Cowan’s Bridge had a typhus outbreak in 1825, which similarly afflicted approximately 40 of the students, according to Gaskell. 1825 was also the year that both Maria and Elizabeth Brontë were sent
back to Haworth after falling ill, and subsequently died. While it is likely that Maria Brontë died of consumption, it was never actually certain. Gaskell herself never claims it as a cause; in fact the word “consumption” appears nowhere in *The Life of Charlotte Brontë*. Consumption, though, is directly referenced in the novel, the fictionalized account of Maria Brontë’s short life and death. Brontë makes this explicit allusion, I would suggest, because of consumption’s symbolic weight. While it’s certainly true that the choice to give Helen consumption rather than typhus follows the autobiographical content of the novel to a degree, it’s more specific job is to make us see Helen as selected, both one of the sick and distinct from them. Put another way, Helen has consumption, the disease of exceptionalism, rather than typhus, the disease of the masses. In turning her sister Maria into Helen Burns, Charlotte Brontë sharpens the elements that would alert the reader to her honored status.

While Maria Brontë was exemplary, Gaskell reports that she occasionally, and understandably, complained of pain and fatigue, asked to be relieved of her chores and studies, etc. Helen, on the other hand, is unflinchingly stoic. She never cries, she never complains, and she never laments her situation, even on her death-bed. With Helen, Brontë is able to utilize the voice of the nobly suffering consumptive to promote the plight of the repressed. She truly is everything that the revered consumptive “type” is supposed to be. Jane describes her as “pale, wasted, but still composed.” She’s resigned to her fate, even smiling as she says to Jane: “You came to bid me good-bye.” While Jane is in great distress over Helen’s condition, it is Helen who serves the role of caregiver and soother, instructing Jane not to grieve for her:
I am very happy, Jane; and when you hear that I am dead, you must be sure and not grieve: there is nothing to grieve about [...] By dying young, I shall escape great sufferings. I had not qualities or talents to make my way very well in the world; I shall have been continually at fault.

Her death is a glorious one, as she tells Jane “the illness which is removing me is not painful; it is gentle and gradual: my mind is at rest” (69). In this moment, Helen reinforces the romanticized vision of consumption that constructs it as a “painless” and even beautiful death.

This silent suffering becomes a crucial element of the consumptive demise within the social problem context because it solidifies the notion that those suffering from consumption are divinely selected. Brontë draws on an esthetic model pulled from Christian martyrdom and mysticism, which essentially purports that great suffering is a marker of one’s grace before God. In a post-Enlightenment world, suffering for God is replaced by suffering for humanity itself. In Helen’s case, it’s both. Helen suffers because, she seems to believe, God needs her too. God needs her to suffer, by extension, because her suffering gives a voice to those who have none. If we can liken Lowood to a cloister or convent, and the descriptions of the school make this plausible, by logical extension we can see Helen existing in the tradition of early Christian mystics, many of them women, whose spiritual authority was drawn explicitly from their divinely inspired physical anguish.

Helen, of course, is often considered the spiritual voice of the novel, as her surname “Burns” is generally acknowledged by critics to be indicative of her passion for God, and likely further helps us see her as a martyred figure. If we think of Jane as Propp’s hero, and Helen as her donor, the most apparent and
arguably valuable gift that Helen bestows on Jane is the gift of Christian piety. According to Propp, a donor is needed to bestow a gift on the hero, a gift essential to complete his designated quest, “It is from him that the hero (both the seeker hero and the victim hero) obtains some agent (usually magical) which permits the eventual liquidation of misfortune.” Before the agent can be obtained, however, the hero must undergo a series of trials or “diverse actions” (39). In other words, the hero must suffer some level of pain in order to receive the gift. Jacques Derrida theorizes the complex politics of gifting in his *The Gift of Death* (1995), proposing that a gift inevitably represents a kind of death, “What is given—and this would also represent a kind of death—is not some thing, but goodness itself, a giving goodness, the act of giving or the donation of the gift” (41). In *Jane Eyre*, a literal death is required and, absent a totem to memorialize the event, the gift is simply goodness itself. More specifically, it is Helen’s goodness. In the weeks and months preceding her illness, Helen’s spiritual tutelage and sage-like wisdom inspire the lost and bitter Jane, who is understandably damaged due to the abuse inflicted on her at the Reeds’.

Before meeting Helen, Jane’s knowledge of God, really of any spiritual matters, is slim. She has read the Bible occasionally (only what she declares are the interesting parts), and does know that the wicked go to a pit of fire when they die, as she famously tells Mr. Brocklehurst that to avoid such a fate she must “keep in good health and not die” (27). Her tenure at Lowood is supposed to initiate her into God’s good graces and give her the discipline that Mrs. Reed says she needs. She attains both, but not in the manner that either Mrs. Reed or Mr. Brocklehurst intended. Instead, it is Helen who introduces her to an entirely
different manner of faith, and an altogether different form of discipline. Helen’s Christianity is largely divorced from institutional restrictions, prioritizing a deeply personal relationship with God. Furthermore, in Helen’s estimation, the corraling of one’s emotions and impulses is a vital element in one’s spiritual growth.

Their first encounter is one of a pupil being presented to a master, as Helen begins to educate Jane in the ways of God, patience, and endurance. Jane experiences “unavailing and impotent anger” as she watches Miss Scatcherd beating Helen. She tells Helen: “if I were in your place, I should dislike her; I should resist her, if she struck me with that rod, I should get it from her hand; I should break it under her nose” (46). Helen retorts that such a measure would get Jane expelled from Lowood, adding:

> It is far better to endure patiently a smart which nobody feels but yourself, than to commit a hasty action whose evil consequences will extend to all connected with you; and, besides, the Bible bids us return good for evil.

Helen continues that it is Jane’s duty to endure pain, indicating that pain is required to fulfill one’s destiny. When Jane says she could not bear to be publicly flogged, Helen says: “Yet it would be your duty to bear it, if you could not avoid it: it is weak and silly to say you cannot bear what it is your fate to be required to bear” (47). Bearing pain, and bearing it well, in Helen’s estimation, is a sign of strength. Vocalizing resistance, acting out, and certainly breaking a rod under Miss Scatcherd’s nose are each signs of weakness, a weakness that Jane must overcome. In being exposed to what Jane calls “this doctrine of endurance,” Jane is told to unburden herself of the anger she feels for John and Mrs. Reed, as
Helen is insistent that the pain she feels hurts only herself: “Would you not be happier if you tried to forget their severity, together with the passionate emotions it excited? Life appears to me too short to be spent in nursing animosity or registered wrongs” (49). She likewise instructs Jane to not dwell on Mr. Brocklehurst’s accusation that Jane is a liar, saying that Jane is too concerned with earthly attachments. In Helen’s catalogue of Jane’s flaws, she calls Jane too passionate, too impulsive, assuring her that violence is the mode of heathens, and that the path to righteousness is found in the New Testament: “Love your enemies; bless them that curse you; do good to them that hate you and despitefully use you” (49). It would be inaccurate to surmise that Helen simply cannot recognize that she is an object of abuse, that Miss Scatcherd and Mr. Brocklehurst are enemies, and that she, like all the girls at Lowood, are “despitefully used.” Helen’s distinctiveness stems from her insistence that forgiveness and endurance are not only stones in the path to God, but that they are, on some level, tools of resistance. When Jane tells Helen, “if I were you, I should resist,” she is failing to understand that Helen is resisting by refusing to devolve into reaction and anger. Through her example, Jane too learns to properly channel her own passions away from unproductive exercises like violence and into decidedly productive endeavors like painting, religious study, and the pursuit of knowledge.

This curbing of young Jane’s passionate nature is, of course, crucial to her development, even if we may bristle at the loss of some of her spunk. To see the potential consequences of unbridled passion in the novel, we need only look to Bertha Mason, Mr. Rochester’s mad wife whom he’s kept locked in an attic for 15
years, and whom Gilbert and Gubar have famously dubbed “Jane’s dark double.” In their landmark collaboration, _The Madwoman in the Attic_, Sandra Gilbert and Susan Gubar explore Bertha Mason’s role as a “version” of Jane writing: “But on a figurative and psychological level it seems suspiciously clear that the specter of Bertha is still another—indeed the most threatening—avatar of Jane” (359). They further characterize Jane’s confrontation with Bertha as the climactic moment in the _bildungsroman_ or, to borrow another phrase from Propp, the moment of “direct combat.” They write:

Most important, her confrontation, not with Rochester, but with Rochester’s mad wife Bertha, is the book’s central confrontation, an encounter not with her own sexuality but with her own imprisoned “hunger, rebellion, and rage,” a secret dialogue of self and soul on whose outcome the novel’s plot, Rochester’s fate, and Jane’s coming-of-age all depend (339).

When confronted by the personification of her own “hunger, rebellion, and rage,” Jane is unable to recognize it in the body of a person whom she refers to as “a beast,” “a lunatic,” and “the clothed hyena” (250). Without delving into the oft written about racial dimensions of Jane’s descriptors, I think it’s worth drawing parallels between these descriptions, and those used to describe Jane early in the novel—“bad animal,” “rat,” and “a mad cat.” Those impulses have been so long buried in Jane, that she instead copes with what is arguably one of the most shocking and traumatic moments in Victorian fiction not by lashing out at Bertha, or even at Rochester, but rather by forgiving his lies and deception, leaving Thornfield, and begging for death. In other words, Jane is in no danger of devolving into Bertha Mason because she has evolved into the person that Helen Burns was meant to be.
Returning to transmission, Brontë seems to be using Helen Burns’ illness and her relationship with Jane to act out the possible metaphorical implications of contagiousness and transmissibility. If consumption is the totality of the sufferer’s being, and if it is contagious, then it stands to reason that the essential qualities of the sufferer, the soul or spirit, would also be contagious. While conceptually this may seem far-fetched, the infectivity of Helen Burns is acted out in the subsequent pages of the narrative and in Jane’s immediate development.

At the moment of Helen’s death, she and Jane are in a tight embrace:

> She kissed me, and I her; and we both soon slumbered [...] I learned that Miss Temple, on returning to her own room at dawn, had found me laid in a little crib; my face against Helen Burns’s shoulder, my arms around her neck. I was asleep, and Helen was—dead (70).

In the subsequent pages, we find Jane behaving in a fashion and expressing sentiments that are curiously Helen Burns-like. We learn, for example, that Jane becomes the top of her class, as Helen was. She also brags that her once wild emotions are properly fastened:

> what seemed better regulated feelings had become the inmates of my mind. I had given in allegiance to duty and order; I was quiet; I believed I was content: to the eyes of others, usually even to my own, I appeared a disciplined and subdued character (71).

This is a passage with a lot of carefully chosen words and qualifiers. Jane herself hints at the untruth of her transformation, saying that she may merely appear disciplined and subdued, but in fact remains wild unruly and passionate. This admission, though, doesn’t separate her from Helen’s example. On the contrary, it reinforces her adherence to it. Helen herself tells Jane not to be fooled by appearances, and declares herself to be unruly and resistant to “systematic
arrangements.” Despite her inward resistance, and perhaps even an unarticulated desire to misbehave, Helen’s example thrives on a relentless focus on channeling that energy to a greater purpose, which is precisely the example that Jane follows. The spiritual and emotional strength that Helen models for her ultimately prove to be Jane’s most powerful coping mechanism in the days and years ahead. Because theirs is a bond solidified through illness, I suggest that Jane’s matured sensibility is not something she develops, but rather something that she contracts. Becoming Jane Eyre, essentially, means being infected with Helen Burns.

Helen’s position as the politicized voice of the social problem novel allows us to see both what Brontë wants to convey in regards to a political agenda and, perhaps more importantly, how she conveys it. A simple catalogue of atrocities, while valuable, it seems is inadequate. A message needs a face and a voice, and I conclude by contending that Bronte makes Helen definitively consumptive because the cultural and symbolic significance of that disease make the novels messages more poignant and resonant. Helen is both a representative of these forgotten and neglected children or, to borrow a phrase from Foucault, “other Victorians,” but she is also a model of what can only be called passive resistance. Her example—her refusal to show anger or sadness, her insistence on forgiveness—fly in the face of virtually everything that Mr. Brocklehurst, Miss Scatcherd, and the others declare about the “charity girls” inhabiting Lowood, specifically that they are inherently wicked, unclean, and in need of harsh discipline. Her death signals a marked turn in the novel, despite the fact that it comes relatively early. The “educational jolt” she experiences through her
exposure to Helen steers Jane onto the path through which she can attain harmony by educating young women, achieving spiritual fulfillment and serenity, and by making an egalitarian marriage. The same year of *Jane Eyre*’s publication, Brontë’s future biographer, Elizabeth Gaskell, will utilize a similar transmission formula with *North and South*, a novel more explicitly political than *Jane Eyre*, but one that is nevertheless insistent on blending spiritual devotion and politics through the voice of a consumptive character.

**A New Home: The Conversion of Margaret Hale**

Like her debut novel, *Mary Barton*, Elizabeth Gaskell’s *North and South* is a social-problem novel set in an industrial northern city. While it is not a *bildungsroman* in the tradition of *Jane Eyre* or *Great Expectations*, the emphasis on psychosocial development and identity transformation is striking as the novel traces Margaret Hale’s sudden move from the familiarity of her comfort in southern Helstone to the harsh and strange northern Milton which, initially, “represents all that is alien and repugnant to her” (Lansbury, 101). Through the course of the novel, as she becomes acclimated to the north, Margaret’s longing for her former life in Helstone gradually melts away until she becomes, essentially, a northern woman. In many ways, the advancement of her newfound northern-ness hinges on her friendship with Bessy Higgins, a young woman dying of consumption, or “fluff in the lungs” as she calls it. Margaret’s adaptability is dependent, largely, on her relationship with Bessy, much as Jane Eyre’s maturation is reliant on Helen Burns. As was the case with Helen Burns, consumption is used to signify Bessy’s special status in the novel as the bearer of
the critical knowledge that Margaret must acquire in order to come to northern womanhood, knowledge that is regional, religious, and political. As their friendship progresses, and as Margaret becomes Bessy’s sickroom support, Margaret’s identity as a northern lady takes shape, as she develops a middle-class femininity in which spirituality and class consciousness are conjoined.

Margaret and Bessy’s introduction unfolds much in the manner in which Propp would describe a typical hero/donor point of contact. As hero and donor are destined to meet, Margaret first encounters Bessy by chance, and on a road no less. Shortly after their arrival in Milton, Margaret ventures out to find “a nonpareil of a girl” to assist Dixon, the Hale’s housekeeper. This task, which begins to take several weeks, is described as “something of a trial” (65). The often lost and frightened Margaret happens upon Nicholas and Bessy Higgins, and Margaret is compelled to offer Bessy a gift, “The girl looked wistfully as the flowers, and, acting on a sudden impulse, Margaret offered them to her. Her pale blue eyes lightened up as she took them” (67). The giving of this gift initiates the hero/donor dynamic that will culminate in the receipt of Bessy’s “gift” to Margaret when a begrudging Nicholas invites her into the Higgins home. Margaret has found her “nonpareil of a girl,” just not in the manner she anticipated. Instead of finding a northern girl that she can incorporate into the Hale household, still southern in spirit, the southern girl is integrated into the northern home.

The Higgins house, for Margaret, functions as the gateway between the sanctuary of her familial home and Milton’s industrial economy. It is the space through which she can begin to see Milton not as a mass of unrefined and strange
characters, but rather as individuals similarly struggling with the changing economic climate of the north. Katherine Byrne remarks that:

What startles and alarms Margaret in Milton is the lack of deference in the workers who jostle past her on the street, the factory girls who stop to enquire about the cut of her gown and its cost, and the working men who pay an open compliment on her appearance (104).

What can only be classified as a disruptive culture shock is ameliorated through Bessy who functions as the mediator helping Margaret navigate her new environment. Bessy’s relationship with her father mirrors Margaret’s relationship to her own. Bessy’s sickroom replicates that of Mrs. Hale, and Bessy’s sister Mary becomes the equivalent of Dixon in the Hale household. The Higgins home, in a sense, is an alternative reality for Margaret through which she can see her own household dynamic replicated in a northern working-class environment. As Helen can be seen as a version of Jane, Bessy functions as a piece of Margaret’s subjectivity that Margaret must access and embrace in order to assimilate into northern life.

Incidentally, Bessy has much in common with Helen Burns. Like Helen, Bessy’s progressing illness runs parallel to the physical decline of another. Helen’s consumption sets her apart, literally and metaphorically, from the girls in Lowood succumbing to typhus. *North and South* tracks the nearly simultaneous illness narratives of Margaret’s two most important female influences—Bessy and her mother. The timeline of Bessy’s slow decline corresponds to the deterioration of Mrs. Hale; the declarations of their invalidism occur within in the same chapter, “A Soft Breeze in a Sultry Place,” and their deaths occur only two chapters apart. The debility and deaths of these two women, one representing
Margaret’s past and the other her future, are figured with enough striking distinction to indicate that Gaskell understood, as Charlotte Brontë did, that consumption is a distinctive end. The nature of Mrs. Hale’s mysterious malady, as detailed in a future chapter, is not disclosed to the reader. Bessy’s, on the other hand, is expressly articulated both through Bessy and through the detailed descriptions of the narrator. Bessy tells Margaret, “I began to work in a carding-room soon after, and the fluff got into my lungs, and poisoned me” (94). The reader also witnesses her disease running its grueling course, detailed through multiple episodes in which she gasps for air, fights to catch her breath, and in moments when she’s described as pale and perspiring from fever. Mrs. Hale, on the other hand, is barely seen once she takes to her sickbed. Bessy’s febrility adds an air of urgency and significance to her voice that is starkly different from that of Mrs. Hale, whose voice we rarely hear even before her illness. Returning to the comparison with *Jane Eyre*, Mrs. Hale’s presence is akin to the faceless and voiceless mass of sick girls at Lowood. Their deaths are tragic, but not in the way that Bessy’s or Helen’s are. Helen and Bessy are saintly sacrifices to unhealthy socioeconomic systems.

Bessy Higgins is not as blissfully resigned to her impending death as Helen, but expresses a similar dissatisfaction with the lot that the world has handed her. Helen told Jane, “I leave no one to regret me much: I have only a father and he is lately married, and will not miss me. By dying young, I shall escape great sufferings. I had not qualities or talents to make my way very well in the world,” indicating a belief that hers is a life not worth living, and that her continued existence would be burdensome to others, “I should have been
continually at fault” (106). Her insistence that she is bad is analgous to Bessy’s own assertion that she is “very wicked” (94). While Bessy is not as excessively self-deprecating as Helen, she does explain to Margaret that her life has simply become too hard to endure. When Margaret asks her if she wishes to die, Bessy replies:

If yo’d led the life I have, and getten as weary of it as I have, and thought at times, ‘maybe it’ll last for fifty or sixty years—it does wi’ some,’—and got dizzy and dazed, and sick, as each of them sixty years seemed to spin about me, and mock me with its length of hours and minutes, and endless bits o’ time—oh, wench! I tell thee thou’d been glad enough when th’ doctor said he feared thou’d never see another winter (82-83).

With these sentiments, Bessy enters into the tradition of the Keatsian consumptive who finds the world too cruel to tolerate, functioning as “a spokesperson for the sickness of her world” (Byrne, 64).

Like Helen, Bessy is afforded a degree of grace and beauty in her death that she was not granted in life. When Margaret ventures to the Higgins’ to pay her respects to the grieving family, she is brought to tears by the sight of Bessy’s dead body:

The face, often so weary with pain, so restless with troublous thoughts, had now the faint soft smile of eternal rest upon it. The slow tears had now gathered into Margaret’s eyes, but a deep calm entered into her soul. And that was death! It looked more peaceful than life (201).

In contrast, Mrs. Hale’s death is far from a peaceful event:

Before the night of that day, Dr. Donaldson’s opinion was proved to be too well founded. Convulsions came on; and when they ceased, Mrs. Hale was unconscious. Her husband might lie by her shaking the bed with his sobs; her son’s strong arms might lift her tenderly up into a comfortable position; her daughter’s hands might bathe her face; but she knew them not. She would never recognize them
again, till they met in Heaven. Before the morning came all was over (229).

Noticeably, Mrs. Hale is a present absence in the descriptions of her final moments; Gaskell focuses primarily on the movements of her husband and children in relation to her. She becomes a passive body unable to express anything, and her death does not seem “more peaceful than life.” Bessy, to use Katherine Byrne’s phrase, receives “a ‘good’ death” (16). Through this good death, she is marked as the conduit of grace in the novel.

Bessy’s sickness is more forcefully connected to a fiery temperament than Helen’s. In accordance with what Susan Sontag calls “the mythology of TB,” Bessy’s condition is aggravated at times by her passionate nature. Sontag describes the consumption’s passionate connotations:

> there is generally some passionate feeling which provokes, which expresses itself in, a bout of TB. But the passions must be thwarted, the hopes blighted. And the passion, although usually love, could be a political or moral passion (Sontag, 22).

Bessy, of course, is a woman of great moral and political passion. Following a lengthy rumination on her regrets and sorrows, Bessy “fell back completely worn out with her passion” (94). As we might view Helen through the lens of estheticism, we might imagine Bessy’s suffering in the tradition of Christian “passion” and spiritual ecstasy. It is through deprivation and discipline that Helen Burns is able to experience God, a track that culminates in disease. For Bessy, the painful experience of consumption, exacerbated by intense emotion, allows her to access God and testify to her unique experience of the divine.

Her spiritual testimony, often, intermingles with her political testimony, as the passionate speech that exhausts her is one in which she details the
numerous effects that her proximity to the mill has had on her body. She tells Margaret that the noise from the mill gives her headaches, and that her work has made her tired and tearful in addition to “poisoning” her (93). In *Jane Eyre*, the miasmic atmosphere that infiltrates Helen’s lungs is indicative of the poisonous manner in which the girls at Lowood have been treated; it is more of a metaphorical than literal hazard. In *North and South*, the air is quite literally poisoned by industry, and it is industrial labor and class disparity that kills Bessy, rather than neglect or Draconian parenting. In becoming “infected” with Helen Burns, Jane was tasked with repairing the structures that create the Helen Burns’ of the world. She does this by becoming an educator of women, the mistress of a household, and a mother. Margaret Hale receives a similar task when Bessy’s sensibility is transferred to her, as her journey to self-discovery culminates with her acquisition of the mill.

As Jane Eyre became more like Helen Burns following the death of the latter, Margaret Hale becomes more noticeably northern after Bessy’s death. Margaret’s most dramatic sea change occurs after the deaths of her parents, but her metamorphosis truly begins even before her mother dies. Bessy is particularly affected by the apocalyptic visions outlined in scripture, as she tells Margaret, “I believe, perhaps more than you do o’ what’s to come. I read the book o’ Revelations until I know it off by heart, and I never doubt when I’m waking and in my senses, of all the glory I’m to come to” (94). Immediately after Bessy’s death, Margaret’s thoughts are seized by scripture, referencing passages from *Isaiah, Psalms*, and Bessy’s beloved *Revelations*: “All beautiful scriptures came into her mind. ‘They rest from their labours.’ ‘The weary are at rest.’ ‘He
giveth His beloved sleep” (201). Shortly thereafter, she introduces Nicholas Higgins into her household and to her father, replaying her own introduction into the Higgins house earlier in the novel. Prior to this moment, The Hales, for the most part, opted to stay out of the political affairs of Milton, isolating themselves from the mill workers and their trials. After a lengthy conversation in which, once again, matters of labor politics blend with matters of religious faith with Mr. Hale’s concession that the Union “would be Christianity itself,” Mr. Hale, Margaret, and Nicholas Higgins share a prayer: “Margaret the Churchwoman, her father the Dissenter, Higgins the Infidel, knelt down together” (214, 215). In bringing Nicholas home to her father and in joining him in prayer, Margaret enacts Bessy’s coalescence of faith and social justice. Margaret demonstrates, in other words, that good Christians are committed to improving the conditions of the poor.

Margaret also begins, apparently, to speak like a notherner after Bessy’s death. Her mother accuses her of, “having picked up a great deal of vulgarity since we came to Milton,” which the narrator indicates “referred purely to the use of local words” (218, 219). Mr. Bell reinforces the change when he calls Margaret “Miltonian” later in the novel (303). Because Gaskell’s use of objective point-of-view restricts the reader’s access to Margaret’s interiority, something we have unfettered access to in *Jane Eyre*, evidence of Margaret’s conversion must be expressed outwardly. She doesn’t need to monologue on her altered attitude in the way that Marianne Dashwood does in *Sense and Sensibility*. Her family, Mr. Bell and the reader sense her change because her manner of speaking, and thus her manner of thinking and knowing, has altered. Because language is the means
by which people make meaning, it would now seem that Margaret Hale understands her milieu, her purpose, and consequently herself in the manner that a northerner would.

Upon Margaret’s return to southern England in the final quarter of the novel, it is her old home that seems foreign and strange to her. Following an awkward day in Helstone with Mr. Bell, Margaret finds herself melancholic and her mind her spinning:

A sense of change, of individual nothingness, of perplexity and disappointment, overpowered Margaret. Nothing had been the same; and this slight, all-pervading instability, had given her greater pain than if all had been too entirely changed for her to recognise it.

She then begins to express sentiments that read strikingly like Bessy’s, “I begin to understand now what heaven must be [...] I am so tired—so tired of being whirled on through all these phases of my life” (363). Milton, Mr. Lennox insists, has altered Margaret. He remarks that, on her return to Helstone, “I had never seen any one so much changed” (389). The fatigue of “being whirled on through all these phases of my life” is alleviated with her reconciliation with Thornton, her rescue of the mill and the jobs of its workers, and with her implicit return to Milton. Early in the novel, Margaret’s comfortable existence is thrown into turmoil with her father’s crisis of faith, the move to Milton, and her mother’s illness. Through Bessy, Margaret’s faith, sense of home, and sense of self are restored, even if they are modified. More accurately, Bessy’s faith, sense of home, and sense of self are restored in Margaret. The transmission of Bessy Higgins’ essence to Margaret Hale has more complicated implications than the Helen to Jane transfer in *Jane Eyre*. Jane and Helen, in most respects, are alike. They are
neglected children living in a terrible environment. Becoming Helen is not a strain for Jane. Margaret’s education, affluence, and able body grant her a higher status than Bessy and, thus, grant her more responsibilities. At the point when Jane takes on Helen’s traits, she has no means of correcting the atrocities at Lowood. In fact, those atrocities are rectified without her. Margaret’s privileged positions, both monetarily and in physical ability, necessitate more aggressive action.

The Great Transmitters: or, Is Daniel Deronda a Social-Problem Novel?

Like Jane Eyre, George Eliot’s final novel, Daniel Deronda, is not a social-problem novel in a traditional sense. In fact, the sections of the novel devoted to Gwendolen contain nothing resembling the gritty realism of Gaskell’s descriptions of working-class life or the cast of pitiable derelicts you would encounter in the pages of Dickens. The portions of Daniel’s half of the narrative that take place in London, though, have much in common with the dank and grimy London described by Dickens in Bleak House or Oliver Twist, and the man at the center of his London excursions, Mordecai, has much in common with Helen Burns and Bessy Higgins. Like Helen and Bessy, Mordecai is suffering through the final stages of consumption, and he does so with the same peculiar mixture of ethos and pathos. Like Bessy, the gift that Mordecai has to bestow on Eliot’s protagonist is the gift of spiritual awakening united with an explicit political mission. In Daniel Deronda, as it was in North and South, the gift of the consumptive is the transfer of essence that is inextricably religious and social, as
Mordecai leads Daniel to the discovery of his Jewish heritage and paves the way for Daniel’s eventual journey to Palestine. Through Mordecai’s disease and death, Daniel Deronda is able to uncover his past, embrace his identity, and venture into his future.

When we meet Daniel, he exists in the background of his own life, and in the novel named for him, perhaps recalling little Jane Eyre hidden behind the red curtain. The opening lines are a swirl of questions that overtake Daniel’s mind as he watches Gwendolen Harleth gamble in a crowded room:

> Was she beautiful or not beautiful? And what was the secret of form or expression which gave the dynamic quality to her glance? Was the good or the evil genius dominant in those beams? Probably the evil; else why was the effect of that unrest rather than of undisturbed charm? Why was the wish to look again felt as coercion and not as a longing in which the whole being consents? (3).

The first moments of an eponymous narrative are occupied entirely with thoughts pertaining to another person. Daniel is a consummate observer; he spends most of the first chapter in surveillance, and even this action seems to be occurring without his control. Eliot writes that, “His attention was arrested,” by Gwendolen and that she raised the “inward debate” within him. This use of passive voice is repeated in his first encounter with Mirah as he is, “satisfied to go with the tide” (160). Women control his gaze and movements; Daniel controls very little on his own. As the novel becomes increasingly divided between the respective narratives of Daniel and Gwendolen, what stands out in Daniel’s is his persistent wondering and wandering. Daniel is a man of tremendous unease and aimlessness. He is unsure of his origins, has no rooted place to call home, and no discernable purpose. Once Daniel finally acquires an undertaking, helping Mirah
find her family in London, it is a task once again directed by a woman. Before meeting Mordecai, Daniel is much like Margaret Hale and Jane Eyre, being moved and directed by others. As a result, his personal growth is stunted. Daniel’s arrested development is amended by Mordecai, whose harmonizing strong sense of self and direction are physically arrested by his deteriorating physical state. In bridging Daniel’s able-body with Mordecai’s metaphysical intensity, the two men are able to form a singular body intended to advance advocacy for Zionism.

Truly, Daniel Deronda lacks the gritty texture of Gaskellian or Dickensian impoverished urban landscapes. In fact, exhaustive descriptions of any kind in Daniel Deronda are fairly limited; there are no smokestacks blackening the sky, nor are there starving children begging for alms or rotting food. Eliot is not interested in highlighting dangerous working conditions or the effects of abject poverty; her aims are more nonfigurative. Disregarding, for a moment, the formal aesthetics of the genre, the homogeneous objective of the social-problem novel is to give a voice to the voiceless masses by exposing injustices and buried crises. Daniel Deronda has that objective. The crisis that Eliot tackles is not socioeconomic inequity or unfair labor practices, but rather the historical injustice and bigotry directed at two disenfranchised entities—women and Jews.

To that end, Eliot is most attentive in describing the physical minutiae of individuals as opposed to settings, particularly the woman’s body and the consumptive body. Eliot, for example, is painstaking in describing the hands of various characters seen through Daniel’s eyes. Daniel observes the “white bejewelled fingers” (sic) of an English countess and their proximity to the “bony,
yellow, crab-like hand” of another gambler (4). He observes, also, “the arms and hands” and “taper fingers, delicately gloved in pale-grey” of Gwendolen, whom he calls “this problematic sylph” (5). Much later, he notes Mordecai’s “wasted yellow hands” (425). This repeated point of emphasis creates a link between Mordecai and the female characters comprising the Gwendolen thread. As they are objectified, Mordecai is objectified; as they are objects of disdain, he is. In both the Gwendolen and Daniel narrative threads, the bodies of the respective underclass—women and Jews, respectively—are emblematic of the systems that keep them subjugated. Gwendolen, as a beautiful marriageable woman, is continually objectified and, consequently, stripped of agency. Mordecai, on the other hand, is weakened by a disease that both beautifies him and marks him as sacred. Thus, the body, particularly Mordecai’s body, stands in the place of Milton or Lowood in Eliot’s novel. Mordecai’s body is the volatile space in which the injustices that the novel attempts to correct are underscored.

The course of Daniel and Mordecai’s friendship seems ideally suited for a Sedgwickian reading of male intimacy. In her landmark book, Between Men (1985), drawing on the work of Renè Girard, Eve Kosofsky Sedgwick explores the triangular desire that cements bonds between romantic male rivals:

And within the male-centered novelistic tradition of European high culture, the triangles Girard traces are most often those in which two males are rivals for a female; it is the bond between males that he most assiduously uncovers (21).

Daniel and Mordecai are not romantic rivals, but they do share a vested interest in the well-being of Mirah, who is revealed to be Mordecai’s sister. It is Daniel’s
search for her family that brings the two men together. Their encounters are often charged with a force that is likened to romantic desire. Eliot writes:

In ten minutes, the two men, with as intense a consciousness as if they had been two undeclared lovers, felt themselves alone in the small gas-lit book-shop and turned face to face, each baring his head from an instinctive feeling that they wished to see each other fully (424).

The lengthy description of Mordecai that follows recalls previous instances in which Daniel contemplates both Gwendolen and Mirah, and in which the women subsequently return his gaze, particularly the emphasis on Mordecai’s hands. Daniel observes:

...the face of a man little above thirty, but with that age upon it which belongs to time lengthened by suffering, the hair and beard still black throwing out the yellow pallor of the skin, the difficult breathing giving more decided marking to the mobile nostril, the wasted yellow hands conspicuous on the folded arms (424-425).

In describing Mordecai in this fashion, Eliot once again associates him with Gwendolen, implicitly positing that the plight of exiled Jews and the struggles of women are analogous. Consequently, Mordecai is constructed in a manner that grants him an erratic gender status, made more evident by the feminizing effects of consumption. It would seem, then, that if the social-problem consumptive figure is not explicitly female, he could not, nevertheless, be masculine. At the very least, the consumptive male in the social-problem novel must occupy a liminal gendered space that is decidedly not masculine. Eliot achieves this categorization through the obsession attention to Mordecai’s physicality, and through the characterization of his allure where Daniel is concerned.

Daniel’s attraction to Mordecai is a mixture of eroticism and reverence, a magnetism in which Mordecai’s state of ill-health is implicated. Upon meeting
him, it is immediately clear that Mordecai is dying of consumption, as he is identified as “the consumptive-looking Jew” (404). Eliot extrapolates the implications of Mordecai’s aesthetic later in the novel with a rumination that indicates that Mordecai’s religion is embroiled in his malady:

Imagine—we all of us can—the pathetic stamp of consumption with its brilliancy of glance to which the sharply-defined structure of features, reminding one of a forsaken temple, give already a far-off look as of one getting unwillingly out of reach; and imagine it on a Jewish face naturally accentuated for the expression of an eager mind (424).

Like Helen and Bessy, Mordecai’s inborn spiritual passion is, somehow, connected to his condition.

The knowledge traded between Mordecai to Daniel is, as in the cases of Helen and Bessy, based in spiritual affirmation. As was also the case on Jane Eyre and North and South, this knowledge is bound to a political initiative, specifically, the prejudicial views that typify the lives of Jews living in England, and the impetus to establish a nation for Jewish refugees in Palestine.34 Bernadette Waterman Ward calls Mordecai “a mystic” with “visions of a coming spiritual heir,” which he finds in Deronda (106). The two men bond quickly, forming a relationship that is likened both to a marriage and a parent-child structure, but the primary role this union plays is in the metaphysical awakening that Daniel must experience in order to accept his origins and his messianic

34 As many critics and historians have acknowledged, Eliot is quite ahead of her time with this proposed Jewish nation. The Zionist movement didn’t gain momentum until the late 1880’s, and the first tribunal of Jewish leaders proposing the establishment of Israel did not convene until 1890.
fate. Mordecai tells Daniel, “You cannot know what has guided me to you and brought us together at this moment. [...] You see some of the reasons why I needed you.” Mordecai indicates that their long-awaited union needed to be expedited because of his impending death, “The day is closing—the light is fading—soon we should not have been able to discern each other. But you have come in time,” subsequently asking, “How shall I save the life within me from being stifled with this stifled breath?” (425, 426). Ultimately, while his life cannot be saved, his purpose can be as it is transmitted to Daniel. Susan Meyer argues:

The novel expresses this idea of the surrender of self to a greater good also in terms of “transmission,” as when Mordecai speaks of “the great Transmitters” who passed down the great ideas of Jewish tradition, and when he wishes his own ideas of Jewish tradition, and when he wishes his own ideas to be treated by Daniel as if he were just a vessel (738). Again, the choice of words, this time “transmitter” and “transmission” makes the connection between spiritual influence and contagion palpable. Eliot, like Bronte and Gaskell before her, links pulmonary disease with divinity as she also suggests that Mordecai’s spirit is “transmittable” through the bond he’s formed with Daniel. At the end of Daniel Deronda, we find the quickly fading Mordecai literally adjoining Daniel and Mirah with his own frail body, as he is carried by the two of them, one on each side. Like the final embrace of Helen and Jane, the

35 Several critics have discussed the ways in which Eliot constructs Daniel as a messiah for proto-Zionism. Bernadette Waterman Ward, for example, writes that “Mordecai has visions and enunciates oracles which establish Daniel’s identity as a sort of messiah” (107), and Cynthia Scheinberg argues that Eliot creates explicit parallels between Daniel and Christ.
transmission of essence from Mordecai to Daniel is sealed in the sickroom.

Mordecai says to Daniel:

Death is coming to me as the divine kiss which is both parting and reunion—which takes me from your bodily eyes and gives me full presence in your soul. Where thou goest, Daniel, I shall go. Is it not begun? Have I not breathed my soul into you? We shall live together (695).

In the marriage between Daniel and Mirah, followed shortly after by Mordecai’s death, Mirah’s guardianship is transferred to Daniel and with her Mordecai’s unfulfilled legacy in what Daniel Novak calls “Mordecai’s re-embodiment in Deronda” (60). It is Daniel, accompanied by Mirah, who leaves England for Jerusalem, hoping to establish a nation for displaced Jews. Similar to the transfer of essence in Jane Eyre and North and South, after Mordecai’s death, Daniel is tasked with his faith, sister, and the future he was unable to complete.

*Jane Eyre, North and South,* and *Daniel Deronda* combine the developmental work of the *bildungsroman* with the political agenda of the social problem novel. Coming into maturity, in other words, means acquiring an appetite for correcting society’s ills. These parallel narrative projects are bridged through the consumptive as the embodiment of those ills. Consumption gives the bearer both a distinctive aesthetic and a distinctive voice. According to physicians like Beddoes and his colleagues, a nervous body stretched to its brink by excessive passion will, likely, produce consumption. If, as the logic goes, strength of spirit is offset by a weak body, a nervous frame distressed by two lines of passionate thought—religion and politics—is always already condemned. As the narrative of the nervous body indicates, balance must be achieved.
All is not lost, though, in the deaths of these figures. The transmission that occurs in the sickroom between sick donor and the hero means that the consumptive never really dies. Rather, she, specifically her spiritual and political fortitude, lives through the protagonist. Unable to withstand the human frame, the strong fervent spirit is memorialized in a healthy body. Jane, Margaret, and Daniel can withstand the passions of the consumptive because they are physically stalwart. Through them, harmony can be restored and injustice rectified.
Chapter 3

The Barbarian Within: Breast Cancer and the Writing Cure

Nineteenth-century representations of cancer, in many ways, stand in direct contrast with those of consumption, although the two maladies have much in common. While consumption is arguably the most omnipresent disease of nineteenth-century narrative, direct references to cancer are virtually absent. While there may be vague allusions to a “growth,” “malformation,” or even “income,”\(^{36}\) the words “tumor” and “cancer” are ghosts even in texts littered with references to other deadly afflictions like consumption, typhus, or cholera.

Consumption, as I detailed in the previous chapter, was written on the body through a set of unique signifiers—paleness mingled with flush and of course the expulsion of blood. Cancer, on the other hand, is generally defined by its invisibility and elusiveness. The deficiency in corporeal inscription translates into a code of silence that permeates both medical writing and the narrative arts. As Dr. Siddhartha Mukherjee writes in *The Emperor of All Maladies*: “If cancer existed in the interstices of those massive epidemics, it existed in silence, leaving no identifiable trace in the medical literature—or in any other literature” (41).

As such, there is little written about cancer in the field of Victorian literary scholarship, certainly when compared to the wealth of work on consumption or

---

\(^{36}\) As Erin O’Connor writes in *Raw Pathology: Producing Pathology in Victorian Culture* (2000), the word “ancome” was used in reference to “a swelling, a tumor, a growth” from the fourteenth until the late eighteenth century. In the early years of the nineteenth century, the word “ancome” was absorbed into “income,” and was defined both in the economic sense and as “a morbid affection of any part of the body, a swelling, impostume, tumour, or the like” (60).
hysteria. In this chapter, I’d like to examine those instances where the cancer-affected individual breaks the code of silence—in the memoirs, diaries and correspondence of three women suffering from breast cancer. Through personal narrative modes, I argue that Fanny Burney, Sara Coleridge, and Alice James write to textualize a self that is being systematically obliterated by a growing malignancy. This textualization, I subsequently argue, functions as the proverbial treatment for this particular affliction. First, I’ll begin by sketching and outlining the matter in which cancer was conceived of in medical writing of this period. I will, then, discuss the few instances in fiction where cancer is directly alluded to, or strongly implied. Finally, in moving into my close-readings of Burney, Coleridge, and James I will argue that the act of self-writing serves to combat the metaphorical effects of breast cancer, which is described not only as a villainous and autonomous force, but as one bent on obliterating its host.

From its earliest manifestations in medical writing, cancer has been enshrouded with obscurity. It is not only rarely spoken of, it is also difficult to detect and define, possessing a slippery set of signifiers, and a contested etiology.37 Until the development of radiation therapy in the early years of the

37 As Daniel Moulin details in *A Short History of Breast Cancer*, debates waged in the medical community well into the nineteenth century as related to the causes of cancer. In 1802, The London Society for Investigating the Nature and Cure of Cancer revived a long-standing controversy over whether or not cancer could be contagious, an issue that was not officially settled until 1820. Many French physicians like Philibert-Joseph Roux argued for a concept of diathesis, or something along the lines of an inborn predisposition. None of these assertions, however, proved to be consistently testable or verifiable.
twentieth century, there were also few agreed-upon courses of treatment. Dr. Mukherjee notes the stark bluntness with which cancer is treated in the medical writings of Imhotep, circa 2500 B.C. On the extensive papyrus scrolls that detail treatment plans for nearly every malady known to ancient man, Imhotep’s prescription for cancer reads simply: “There is none.” As an affliction that was overwhelmingly fatal, and definitively so without surgical intervention, uttering the diagnosis at all seemed to inject it with some sort of metaphysical force, as Susan Sontag writes: “The very names of such diseases are felt to have a magic power” (6).

The refusal to pronounce the words “tumor” or “cancer” might help us explain some of the more mysterious deaths in Victorian fiction, particularly those in which the author provides ideal and ample moments for revelation yet inexplicably withholds it. For instance, two notable characters in Elizabeth Gaskell’s work come to mind—Mrs. Hale of *North and South* and Mrs. Hamley of her final novel, *Wives and Daughters*. In *North and South*, Mrs. Hale falls gravely ill almost immediately upon the Hale family’s arrival in Milton. Mrs. Hale, we learn, was aware of her condition long before showing symptoms and before making her husband and daughter aware. In what seems like an opportune moment for Gaskell to inform her readers, when Dr. Donaldson explains his diagnosis to Margaret, we are told only that his findings are too

---

38 Each of the medical treatises cited in this chapter seems to present different suggestions for treating cancer. Compresses, both hot and cold, are sometimes recommended and certainly there were surgical options. Excision, though, proved to be a daunting prospect before anesthesia and antiseptics. Often, the surgery proved just as fatal as the disease.
horrible for words: “He spoke two short sentences in a low voice, watching her all the time; for the pupils of her eyes dilated into a black horror, and the whiteness of her complexion became livid” (116). We are told little else, aside from Margaret’s assertion that it is a “deadly disease” and that there is “no hope” (117). For a reader hungry for elucidation, this is a thoroughly frustrating moment. It seems, though, that Gaskell is telling us by, simply, not telling us. The silence, in other words, is the signal.

While the fatality of cancer is probably the most important reason for engulfing it in silence, it cannot be the only reason. Consumption, too, was as fatal as cancer, and Victorian writers were more than willing to make its uses explicit in their works. Cancer differs from consumption not in outcome, but rather in connotation. While consumption was a disorder that indicated some inherent beauty or divinity, cancer befalls those who are, for lack of a better term, cursed. Sontag writes that “it [cancer] is felt to be obscene—in the original meaning of the word: ill-omened, abominable, repugnant to the senses” (8). While consumption might reveal something spiritual, cancer according to Sontag “reveals that the body is, all too woefully, just the body” (17). She asserts, also, that having a tumor often produces a sense of shame, as it is notorious for “attacking parts of the body that are too embarrassing to acknowledge” (17).39 The sense of shame and embarrassment is both reinforced and decried by members of the medical community at various moments. In *Domestic Medicine*,

39 As Sontag notes, this is especially true of reproductive cancers and cancers of the digestive organs, but she adds that cancer of a thoracic organ like the lung is somehow less shameful than cervical or rectal cancer.
the generally diplomatic Dr. Buchan injects uncharacteristically pointed judgments against those likely to become afflicted with a tumor. He writes that women who lead an “indolent sedentary life” are most subject to any type of cancer, not just breast cancer. Furthermore, he adds:

This disease is often owing to suppressed evacuations; hence it proves so frequently fatal to women of a gross habit, particularly old maids and widows, about the time when the menstrual flux ceases. It may likewise be occasioned by excessive fear, grief, anger, religious melancholy, or any of the depressing passions. Hence the unfortunate, the choleric, and those persons who devote themselves to a religious life in convents or monasteries, are often afflicted with it. It may also be occasioned by the long-continued use of food that is too hard of digestion, or of an acrid nature; by barrenness; celibacy; indolence; cold; blows; friction; pressure; or the like (467).

The repeated insistence that those likely to become afflicted are the devotedly spiritual, incidentally, relates this affliction to consumption, in that the consumptive was seen as a spiritual figure. Cancer, it seems, is consumption’s dark double. The crucial difference, however, seems to lie in the manner of devotion and in the apparent difference between “spiritual” and “religious.” Being “religious,” naturally, implies an institutional affiliation that “spiritual” may not. According to Buchan, the institutional devotion is somehow connected to states of “excessive fear,” “grief,” and “the attributes of the choleric,” even possibly implying causation. The religiosity of the cancer sufferer, here, is seen as a depressant rather than a stimulant. This depressant, somehow, contributes to abnormal growth, as opposed to the febrile spirituality stimulated by
consumption. It is as if Buchan implies that a chasm in the body carved out by “the depressing senses” will inevitably be filled with some manner of malignancy.

Decades after Buchan’s assertions, French physician Dr. Alfred Velpeau attempts to counter those connotations in his *A Treatise on Cancer of the Breast and of the Mammary Region* (1856). He asserts that there is no evidence that a particular “moral condition” contributes to a predisposition towards cancers of any kind, indicating that “sadness, chagrin, distress of mind,” are each “blamed by the public and even certain observers,” implicitly fellow physicians and surgeons (118). The very strong indication is that cancer functions as some manner of judgment, a fate befalling those somehow deserving, a selectivity that functions in the opposite way that it does for consumption. The association with some sort of unfavorable morality might explain the use of breast cancer in constructions of the grotesque or carnivalesque in the eighteenth century. In *Gulliver's Travels*, for example, Gulliver encounters a beggar woman “with a Cancer in her Breast, swelled to a monstrous size, full of Holes, in two or three of which I could have easily crept, and covered my whole body” (93-94). This woman is a part of the crowd that Gulliver identifies as “[one of] the most horrible Spectacles that ever an *European* Eye beheld” (93).

To a less monstrous degree, Lady Delacour of Maria Edgeworth’s *Belinda* (1801) seems to have contracted cancer as a result of a transgressive act, and the

---

40 In *A History of the Breast* (1997), Marilyn Yalom credits Galen with initiating the notion that depression or melancholy can cause breast cancer in women, and notes that this belief is in keeping with contemporary speculations about the relationship between depression and cancer, for which researchers have found no link (209).
disease’s progress seems to be fueled by her persistent subversive activities. Early in the novel, Lady Delacour invites Belinda into her dressing room to privately reveal to her “a hideous spectacle.” Lady Delacour tells Belinda, “my mind is eaten away like my body, by incurable disease” (32). The initial wound was sustained while she and another woman, Harriet Freke, were engaged in a duel: a misfired pistol leading to a blow to the chest. The already transgressive act of a masculine display of violence is compounded by the fact that the two women were engaged in transvestism. As Susan Greenfield notes, Lady Delacour’s continued “sexual ambiguity and her general resistance to domesticity” apparently exacerbate her condition (214). Her condition is resolved, however, near the close of the novel when she decides to commit herself to her role as a wife and mother. Breast cancer, according to this logic, can be cured by adherence to traditional gender roles and commitment to femininity.

The depletion of youthful femininity, too, is implicated in the acquisition of breast cancer. While Velpeau rejects the notion that age is a contributing factor, and colleagues like John Birkett concur, many physicians declare the loss of menses to be the primary trigger for all reproductive cancers. There are, of

41 Edgeworth seems to draw on Samuel Taylor Coleridge’s “Christabel,” in which the title character is exposed to an unnamed horror on the bare breast of the mysterious Geraldine.

42 While this might seem far-fetched, many medical treatises list “a blow” or “a wound” as a possible initial cause for a malignant growth. Buchan lists “blows; friction; pressure” among possible causes, and while Velpeau seems skeptical of such sources, he does concede: “If many women recollect nothing as to the cause of their tumour, it does not follow that there may not have existed some pressure, some friction. A contusion, a pinch, are speedily forgotten, may thus become the source of diseases which show themselves long after” (113).
course, observably logical reasons for these assertions. Beyond the pathological reality, though, is a continued reinforcement that cancer stems from some manner of lack or loss. In this case, it is the loss of one’s ability to bear children and the loss of youth.

Cancer’s strongest symbolic weight is rooted in the understanding that is a disease characterized by multiplying abnormal cells that usurp the organs of an otherwise healthy body. With the advent of cellular pathology in the 1850’s, the medical community understood that tumors were cellular maladies, as opposed to viral or bacterial, that grew within the organs and tissue, presumably taking up the vacuous spaces created by diminished passions or fading youth. As writers like Mukherjee and Erin O’Connor have noted, the growth of cancer cells was often likened to urban overgrowth and population explosion. As such, modernity and its expansion were seen as contributors to the development and spread of cancer cells. Mukherjee writes that “Nineteenth-century doctors often linked cancer to civilization: cancer, they imagine, was caused by the rush and whirl of modern life, which somehow incited pathological growth in the body” (44). His point is corroborated by the claims of physicians like Willard Parker, who argued that cancer was, exclusively, a disease of the industrial West: “For—and this is an extremely significant circumstance,—it has been found that barbarous and semi-civilized peoples are comparatively free—some tribes, indeed, are perfectly free—from cancer” (36). Erin O’Connor concurs with Mukherjee’s assertion,

---

43 German physician Rudolph Virchow is credited with developing the most prominent theories of cellular pathology and comparative pathology which he codified in 1848 with his *Report on the Typhus Outbreak of Upper Silesia.*
additionally noting that breast cancer explicitly holds a special status in the regard because “it was a distinctly gendered form of the civilized disease” (65). As such, female reproductive cancers are often likened to a macabre exercise of reproduction, or, to quote Sontag “a demonic pregnancy” (13).

Yet, and most curiously, cancer is paradoxically described as a malady with an autonomous persona that is sourced outside of the body. In Raw Pathology, Erin O’Connor notes a curious linguistic shift at the turn of the nineteenth century: “A funny thing happened around 1800: the word ancome disappeared, and people began calling bodily tumors and growths incomes” (60). “Income,” she notes, points to cancer’s power as an economic metaphor. Moreover, “income” implies both growth and a degree of externality. After all, income can only be generated from outside of a system, in this case the body. Consumption was framed as biological destiny; in becoming afflicted with it, you become the person you were fated to be. It epitomized the sufferer’s identity, even when it snuffed out one’s life. Cancer, on the other hand, was considered a usurper of identity, figured as an invader even by physicians with a firm grasp of cellular pathology. Velpeau, for example, describes cancer as an endlessly duplicating parasite bent on the complete erasure of the host. He writes: “cancer plays in the organism the part of a parasite of an organic species, whose object is to substitute itself for others” (117). Parasite, like “income,” indicates an external source. It also, to a degree, implies a level of consciousness or cognition, a point Velpeau seems to reinforce when he calls cancer a “semi-individual” harbinger of death that replaces the hosts of life, the organs, with its own perverse display of procreation. Velpeau, here, echoes the encyclopedic writings of Novalis produced
in 1798 in which he describes tumors as “full-fledged parasites—they grow, are engendered, engender, have their structure, secrete, eat” (quoted in Sontag, 13).

Both Velpeau and Novalis grant cancer a degree of autonomy and agency that is conspicuously absent from the writings on other maladies like nervousness or consumption. As late as the 1880’s, long after the birth of cellular pathology, physicians like Thomas Bryant continue to describe cancer as a foreign entity that “attacks,” “invades,” and “infiltrates” organs and tissue. Logically, the pathological makeup of consumption and cancer would lend themselves to representations in quite the opposite vein. Consumption would be figured as an invader, as it is contagious and inhaled through the lungs, while cancer would be viewed as a growth that is in tandem with the body, and by extension the self. The rationale for such representations seems to be rooted in the elements that consumption possesses that cancer does not, specifically a seemingly concrete typology and visible semiotics. Cancer grows unbeknownst to the public, and often unbeknownst to its victim, allowing the carrier to be figured, essentially, as the dead walking among the living, often unaware that they are systematically being erased from inside out.

It is Dr. Velpeau’s assertion that cancer’s odious aim is to replace life with malignancy, or to substitute a true self with its own somehow unnatural self. Fanny Burney, Sara Coleridge, and Alice James each use their chosen forms—letters, memoirs, and diaries—to combat the mission of cancer. As each woman either recalls the trauma of dramatic intervention or finds themselves in the final

44 Bryant uses these terms in his 1887 treatise *The Diseases of the Breast*. 
grips of their writing attempts to solidify herself in defiance of her anti-self. In other words, scribbling a self is the most effective weapon against what Sontag terms “the barbarian within.”

“C’est moi, Monsieur!”: Fanny Burney’s Mastectomy Letter

In the spring of 1812, renowned novelist Frances Burney D’Arblay began crafting a letter to her sister Esther, a letter that would take three months to complete. The result was one of Burney’s most famous, if not infamous, works. Her so-called “Mastectomy Letter” graphically details the author’s radical mastectomy in a Parisian hospital in September of 1811. The letter, at times, seems written in multiple and competing voices. It is at once lucid and manic, fragmented and meticulously thorough. As Julia Epstein notes, Burney relies heavily on fictive tropes like “staging” and “persona-building,” making this letter a work that straddles the borders of surgical instruction and closet drama. As Epstein further notes:

The formal, stylized operation retold in Burney’s letter and her intimately encoded response constitute two approaches to the same timeless human need the need to avoid pain and suffering—and demonstrate the complex ways in which the act of writing, like the act of surgery, can be simultaneously wounding and therapeutic (131).

In the opening paragraph, Burney indicates a desire to have even the most tangential details of this ordeal locked in silence. Finding this impossible, Burney chooses to speak at length and in earnest, expressly stating that her hope

45 Burney explains in the early paragraph of the letter that rumors of her illness have already been disseminated in the circles of many of her acquaintances.
is that this document will serve as a warning for other women, and as an edifying
guide for those in desperate need of a corporeal education. In this way, Burney’s
letter serves a similar function as the medical treatise or case study, although
implicitly with a different outcome. The treatises of surgeons like Birkett or
Velpeau detail the minutiae of surgery as a tool of instruction for future surgeons.
Simply put, you would, ideally, learn how to perform a mastectomy or other
excision based on Birkett’s instructions. Burney, of course, has no interest in
tutoring her sister or nieces in surgical procedure. The aim, for Burney, is
prevention and general awareness.

Burney’s account, I further submit, enacts crucial healing work in that it
replays and replicates the surgery that she believes saved her life. In finally
articulating and reliving the trauma and pain of her surgery, Burney is able to, in
a sense, excise the event and freshly articulate a rejuvenated, if scarred, self. In
other words, composing the narrative of her breast cancer and its eradication
does a sort of psychological surgery, allowing a wholly healthy Burney to emerge.

The most substantial critical work on Burney’s mastectomy letter is Julia
Epstein’s article “Writing the Unspeakable: Fanny Burney’s Mastectomy and the
Fictive Body” (1986). In that piece, Epstein argues that Burney’s letter negotiates
both the wounding and therapeutic work of writing about pain, likening the act of
writing to the act of surgery. I would like to take this claim a bit further and
suggest that Burney’s letter is negotiating, also, the metaphorical connotations
that come attached to cancer in performing silence, in figuring her disease as at

46 A number of writers have speculated that, because her breast cancer never
relapsed, Burney’s growth was never malignant.
once intimate and alien, and in illustrating the ways in which reproductive cancer is somehow inevitably linked to the language of pregnancy and childbirth.

As Burney reports, she was not the only person in her circle insisting on secrecy. Most significantly, Burney’s own doctors, at times, treat her condition with silence. She describes how her doctor, following an examination:

“pronounced nothing—but uttered so many charges to me to be tranquil” (432). As we might understand Gaskell’s omission of a diagnosis in *North and South* as a confirmation of Mrs. Hale’s prognosis, we also find Burney, essentially, surmising her own fate because of her doctor’s refusal to deliver it. In discussing the “conventions of concealment” surrounding cancer, Susan Sontag describes the relatively standard practice of communicating the diagnosis to the patient’s family before the patient is made aware, saying “doctors consider that the truth will be intolerable to all but exceptionally mature and intelligent patients” (7). Sontag concedes that this practice is quickly vanishing, particularly in the United States, but as we see in Burney’s account of the events it was being practiced in her parlor. She states that the physician, M. Dubois, kept M. d’Arblay behind after her examination and that upon his reappearance, he too attempted to conceal the facts of the matter from her:

My alarm was encreased (sic) by the non-appearance of M. d’Arblay after his departure. They had remained together some time in the Book room, and M. d’Arblay did not return—till, unable to bear the suspense (sic), I begged him to come back. He, also, sought then to tranquilize me—but in words only; his looks were shocking! his features, his whole face displayed the bitterest woe. I had not, therefore, much difficulty in telling myself what he endeavoured to tell me (432).
Burney proceeds to describe the trials before her primarily in the language of the penal system, saying that a second opinion from M. Ribe “only corroborated the terrible judgment” and after yet another exam writes: “I was formally condemned to an operation by all Three” (433). She further speaks of the event as “the sentence” and remarks “I was in hourly expectation of a summons to execution” (437). The reliance on the language of criminal justice and penalty reinforce the notion that cancer brings with it a level of shame or anxiety relating to transgressive or troublesome deeds or feelings. What Burney may have done to warrant such shame is unclear. What is clear, however, is that Burney expresses feelings of being host to a formidable force that is at once inside and outside of her body.

While Burney treats the events of her surgery with almost brutal detail, she writes of the affliction itself with obfuscation. As Sontag and Mukherjee predict, Burney shies away from much of the explicit terms of her illness, though she does mention “cancer” once when she writes “that the cancer was internally declared” (438). She refrains from using the word “tumor” or even “growth,” instead most often referring to the source of her trouble simply as “a small pain in my breast” (431). As her account proceeds, Burney more pointedly refers to her tumor as “the evil,” noting for instance “the evil was too far advanced for any remedy” (438). Evil, I would suggest, implies a degree of activity and consciousness. Burney, then, believes she is at the mercy of a calculating force. This force, at times, exists somehow outside of Burney’s body. In recounting her hesitation at proceeding with the surgery, Burney writes: “I knew not, positively, then, the immediate danger, but every thing convinced me danger was hovering
above me, and that this experiment could alone save me from its jaws” (441). In this passage, the difference between the doom of surgery and the doom of her diagnosis are nicely distinguished. “This experiment” will rescue her from death, figured here as hovering above her and possessing jaws. Burney renders malignancy as a disembodied entity and as something animalistic, perhaps even human, with jaws and presumably teeth.

In expressing her dismay that surgery is required to alleviate her disease, Burney also writes: “the poor breast was no where discoloured, and not much larger than its healthy neighbor. Yet I felt the evil to be deep, so deep, that I often thought if it could not be dissolved, it could only with life be extirpated” (435). Burney surmises that her affliction can be relieved “with life,” life which she indicates surgery is incapable of accomplishing. The mastectomy, in Burney’s view, is analogous to the cancer itself. At times in the course of the letter, it is difficult to detect whether or not Burney speaks of her affliction or of its prescribed treatment as “the sentence,” “the judgment” or “that most frightful of deaths.” On the other hand, both Burney and her doctors also liken the procedure to childbirth, affirming Sontag’s contention that cancer is “a fetus with its own will” or “a demonic pregnancy.”

The connection between Burney’s surgery and the act of childbirth is, remarkably, introduced by Burney’s physicians in what is the first of a whole host of metaphors implicated in the growth of Burney’s tumor. The anxiety over confronting a patient’s pain was wholly felt by surgeons before the development of anesthesia. In Dr. Lorenz Heister’s instructions for fellow physicians on how to proceed with a mastectomy cautions surgeons:
Many females can stand the operation with the greatest courage and without hardly moaning at all. Others, however, make such a clamor that they may dishearten even the most undaunted surgeon and hinder the operation. To perform the operation the surgeon should be steadfast and not allow themselves to be discomforted by the cries of the patient” (quoted in Mukherjee, 49).

Burney’s physicians seem incredibly anxious not about the potential failure of the procedure, but rather about her ability to withstand the pain. She writes that M. Moreau “enquired whether I had cried or screamed at the birth of Alexander.” When she responds that she, of course, had, Moreau seems relieved, saying “Oh then, there is no fear” (436). Burney’s physician is not only creating a comparison in the level of pain, but implicitly in the manner of pain she is to experience.

Moreau’s assumption may be rooted in the pervasive understanding that all female reproductive organs, the breasts included, were trussed together in operation and a phenomenon called “sympathy.” As Moulin writes, physician Philibert-Joseph Roux, a proponent of the theory of diathesis, explained that cancer spreads via “sympathy” between two organs:

In his view ‘diathesis’ was a result rather than a cause. Spreading would occur under ‘sympathetic influence’; Roux did not believe in the existence of a cancer virus that might attack other organs via the circulating blood. ‘Sympathy’ was a mysterious associate that might exist between two or more separate organs” (54).

Without using the term, Moreau seems to be drawing upon the concept of sympathy in constructing a gauge of pain for Burney. Knowing, of course, that the occupation of the womb affects the breasts, insofar as childbirth produces

[Mukherjee takes his passage from Heister’s A General System of Surgery in Three Parts (1750).]
lactation for example, it stands to reason that the excision of a breast mass would somehow be borne similarly as the birth of a baby. Thus, Moreau establishes the mastectomy as a version, in a sense, of childbirth.

Julie Epstein makes much of the adjudicatory language of Burney’s letter, drawing evidence for this claim both from Burney’s word choices like “trial,” “sentence,” and “judgment,” and Burney’s description of the surgical events themselves. Burney writes that “7 Men in black” deliver her to the operating theater and that she her eyes were veiled for the procedure, just as criminals might be blindfolded for their executions. While this evidence is compelling, I would also suggest that Burney’s account also draws on the language of ritual and even exorcism in relaying the event. The ritualization of the mastectomy, as Mukherjee mentions, was not unusual in Burney’s time as he reports that Dr. Heister “once described a mastectomy in his clinic as if it were a sacrificial ritual” (49). If we think of Burney’s “7 Men in black” not as executioners but rather as exorcists, what we find on the subsequent pages is a highly stylized ritual that conflates the spiritual with the medical.

Burney is brought first to the hospital by Dr. Aumont, whom she refers to as “the Messenger and terrible Herald” (438). Burney begins to convulse upon seeing the tools of the medical ritual, in this case the “glitter of polished Steel” (441). Following her veiling, M. Dubois uses his finger to trace “a straight line from top to bottom of the breast, secondly a Cross, and thirdly a circle.” The gesture required repeating later in the paragraph when Burney writes: “I saw the fatal finger describe the Cross—and the circle” (441). Burney’s use of the word “Cross” inevitably conjures up images of Christian ritual, particularly those in
which the body is crossed by one with divine authority, compounded by Burney’s insistence on referring to her tumor as “the evil.”

The ensuing passages are wrought with ellipses and fragments as Burney details the steps of the procedure: “Yet—when the dreadful steel was plunged into the breast—cutting through veins—arteries—flesh—nerves—I needed no injunctions not to restrain my cries” (442). Burney’s language, here, mimics the surgical act itself, as the ellipses stand in for the incisions that demarcate Burney’s afflicted tissue from the healthy tissue. Burney also draws on military language not to describe the disorder itself, but rather to describe the manner in which her physicians proceed. She writes that “M. Dubois now tried to issue his commands en militaire” and that he “acted as Commander in Chief” (440). This metaphorical move serves a few valuable functions. First, it reinforces the notion that Burney’s body has been subject to an invasion of some sort, and that the combatant is both foreign “hovering about me” and hostile. It also allows us to see Burney, momentarily, not as a subject but rather as a setting in the story of the mastectomy. Burney’s body is reified as a topographical landscape, with the effected tissue marked as the site of conquest.

In the midst of these layered and sometimes competing metaphors, Burney seems to slip in and out of presence, as if the work of the narrative is also duplicating the erasure that cancer is thought to perform. She reports being “re-animated” when M. Dubois commanded the women to leave the operating room, moments later reporting a “horrible suspension” in which “I did not breathe—and M. Duvois tried vainly to find any pulse” (441). Shortly after, when Dr. Larry asks of the attending physicians “Qui me tiendra ce sein?” Burney responds “this
aroused me from my passively submissive state [...] I started up, threw off my veil, and, in answer to the demand ‘Qui me tiendra ce sein?’ cried ‘C’est moi, Monsieur!’ (441). In this instance, Burney delivers what I would call the “defiant definition.” Up to this point, Burney has struggled with the crushing silence of her doctors, conflicting prognoses, and seen her attempts at resistance rejected repeatedly. Moreover, she is afflicted with a disease that seeks to replace her with itself. In declaring “C’est moi” or “It’s me,” Burney uses her only available tool, her voice, as her last means of resistance against the forces that seem bent on destroying her. Burney’s body becomes a mosaic of competing metaphors—criminality, military, exorcism, birth—that allow her to frame and reframe her ordeal.

Decades after Burney’s letter, Scottish physician Dr. John Brown wrote a short story titled *Rab and his Friends* (1859), a piece that is difficult to read without imagining Burney in the margins. Brown draws on his surgical apprenticeship to James Syme and his personal experiences as a surgeon to write the story of Rab, a mastiff, and his owner Ailie who suffers from breast cancer. A mastectomy is ordered, which Ailie survives only to succumb shortly thereafter to a fatal infection. Brown’s tale, in a sense, recontextualizes Burney’s mastectomy from the perspective of the physician and the resulting text bears striking similarities. Brown’s descriptions of Ailie and her disorder, in addition, participate in the broader discourse relating to the malevolent nature of the malady. Brown examines Ailie’s complaint: “a trouble in her breest—some kind o’ an income we’re thinkin’” and concludes:
What could I say? there is was, that had once been so soft, so shapely, so white, so gracious and bountiful, so “full of all blessed conditions,”—hard as a stone, a centre of horrid pain, making that pale face, with its gray, lucid, reasonable eyes, and its sweet resolved mouth, express the full measure of suffering overcome. Why was that gentle, modest, sweet woman, clean and loveable, condemned by God to bear such a burden? (15).

Brown here draws on the language of usurpation to describe the pathological nature of this disorder. It renders hard what was once soft, replacing life with necrosis. In addition, he substantiates Sontag’s assertion that those afflicted with cancer are “condemned by God.” Brown confirms another of Sontag’s theses, as Burney did, that the tumor serves a fetal role. Becoming septic following her mastectomy, feverish and delirious Ailie begins treating a bundled nightgown as a suckling child:

Suddenly she sat up in bed, and taking a bedgown which was lying on it rolled up, she held it eagerly to her breast,—to the right side. [...] She held it as a woman holds her suckling child; opening out her nightgown impatiently, and holding it close, and brooding over it, and murmuring foolish little words, as over one whom his mother comforteth, and who sucks and is satisfied.

Brown continues that “the pain in the breast telling its urgent story to a bewildered, ruined brain, was misread and mistaken” (25). Brown, here, is detailing the phenomenological relationship of sympathy between the organs. Womb, breast, and now brain are each linked together in Ailie’s declining frame; as one is taken by the disease, the others follow suit. Ailie, for all purposes, has been erased. Brown writes:

The body and the soul—companions for sixty years—were being sundered, and taking leave. She was walking, alone, through the valley of that shadow, into which one day we must all enter,—and yet she was not alone, for we know whose rod and staff were comforting her (24).
As Burney had, Brown relies on Christian ritual drawing on excerpts from the 23rd Psalm as he outlines her physical deterioration. The strategy is repeated when the character of James, likewise a physician, includes reading the Psalms to Ailie as part of her recovery treatment.

Much is made, in both Burney and Brown, about the conduct of the patient and the capacity of the sufferer to handle the proceedings well. In the final paragraph of her letter, Burney insists to Esther: “I bore it with all the courage I could exert, and never moved, nor stopt him, not resisted, nor remonstrated, nor spoke” (443). Somehow, in Burney’s view, the assurance that the event was well-borne ameliorates the horror transcribed in the preceding pages. By the time Brown crafts Ailie in the 1850’s, patients now have the benefit of chloroform,48 but Brown takes time nonetheless to detail the ways in which Ailie is an exemplary surgical subject. He writes:

The pale face showed its pain, but was still and silent [...] It is over: she is dressed, steps gently and decently down from the table, looks for James; then, turning to the surgeon and the students, she curtsies,—and in a low, clear voice, begs their pardon if she has behaved ill (20).

This emphasis on the “good behavior” of the patient links these two pieces together in the establishment of an ethics of suffering that is foregrounded by stoicism. I wouldn’t suggest that Brown is drawing on Burney in the construction of Ailie. Rather, I would propose that both Brown and Burney are engaged in the production of the “good patient.” The good patient bears unbearable pain and terror with a dignified silence, maintaining the code of invisibility and erasing the

48 James Young Simpson began administering chloroform as an anesthetic in 1847, primarily as relief for the pain of childbirth.
event through an almost immediate return to normalcy, or at least a performance of normalcy. The aesthetics of the “good patient” are lurking in the pages of Sara Coleridge’s letters and memoir, too, as her preoccupation with constructing her pain and suffering in compliance with these ethical boundaries borders on fanaticism.

**The Frail House of Clay: Sara Coleridge’s Poetics of Cancer**

In a sense, Sara Coleridge’s entire life was defined by ill-health. The only daughter of Samuel Taylor Coleridge and his wife Sarah Fricker witnessed the lengthy debilitation of her father from chronic illness and opium addiction, was widowed in her early forties, and was herself a self-confirmed lifelong invalid. Throughout her life, Sara Coleridge suffered from various ailments, but it was her final illness that drove her to produce a memoir. That illness was breast cancer, a malady that had begun to pain her late in 1849. Two years later, she wrote her daughter Edith a letter, which she said would provide “a little sketch of my life” (33). While her breast cancer diagnosis and the bleak prognosis for recovery was undoubtedly the impetus for writing her memoir, Sara Coleridge’s memoir and collected epistles reflects the pervasive hesitancy to write disease into being. In the extensive collection, the word “tumor” never appears, nor does “cancer,” “malignancy,” nor even the more innocuous “income.” As Katherine Meiner writes:

> The course of Sara’s final years might be described as an attempt to bury the terrifying connotation of cancer underneath the familiar, acceptable symptoms of a far less dire state: her life-long and deeply examined nervousness (54).
In spite of the attempts to bury her disease in the language of nerves, the uniqueness of cancer and its murky clues are imbedded and imprinted in her work. Coleridge, it would seem, has much in common with Burney. In linking their trials, we find a representative pattern of breast cancer emerging that concerns itself primarily with rendering the tumor as the anti-body.

When directly referencing her present affliction, Coleridge obfuscates allusions or symptoms opting instead to opaquely reference her dwindling time. She writes to Edith: “I have long wished to give you a little sketch of my life. I once intended to have given it with much particularity, but now times presses—my horizon has contracted of late” (33). What follows, in all reality, is primarily a biographical sketch of her father rather than Sara herself. In particular, Sara Coleridge ruminates extensively on the illnesses and death of her father, which she links to her own ill-health. In speaking of her father’s death, she writes:

His frail house of clay was so illumined that its decaying condition was the less imperceptible [...] for the last thirty-six hours of his existence he did not suffer severely. When he knew that his time was come, he said that he hoped by the manner of his death to testify the sincerity of his faith (98).

Coleridge seems to be engaging with the aesthetics of a “good death” which is explicitly tied to some sort of spiritual surrender. Incidentally, her father died of heart failure, likely exacerbated by a pulmonary condition and years of drug abuse. In my discussion of consumption in the previous chapter, I argued that consumption was marked as a “good death” for the spiritual elite. Sara Coleridge, here, carves out a new parameter for good death that is still tied to a degree of spiritualism, but indicates that disease itself is no longer necessarily the marker
of “the sincerity of his faith.” The manner of his death, in this case, is no longer the pathology itself, but rather the dignity with which one suffers death.

These new borders prove important as Coleridge utilizes them to render her own relationship to sickness and death. Sara’s history of illness, in her view, is an inherited legacy, as she writes: “I inherited that uneasy health of his [her father]” (34). Just as she omits the details of her own failing health, she chooses not to reveal the cause of her father’s:

His body was opened, according to his own earnest request—the causes of his death were sufficiently manifest in the state of the vital parts; but that internal pain from which he suffered more or less during his whole life was not to be explained, or only by that which medical men call nervous sympathy (99).

Sara Coleridge, in this passage, is juggling the work of both revealing and disguising. She reveals that he received an autopsy, and does so rather crudely. She also strips Coleridge’s body of its humanity, saying that his body was examined rather than Coleridge himself. “The causes,” multiple, were manifest in “the vital parts,” which undoubtedly refers to the organs. While Samuel Taylor Coleridge did not die of cancer, Sara draws on a linguistics of malignancy in the vague descriptions of the examiner’s findings, a language invoked again with the use of the word “sympathy” in the final clause. Of course, she never says what those manifestations are. What she gives us, instead, is a glance at a private reading practice, in which she has access to the textuality of Coleridge’s interior, but what precisely was read remains in the shadows.

Sara Coleridge treats her own illness with a similar level of mystery. When she does speak of it, she constructs her malady with a markedly similar disembodiment that Burney treated her tumor. Like Burney, Coleridge sees her
cancer as a malevolent force that threatens her from outside of her body. She writes to Aubrey de Vere in 1851: “There is a torpor ever hanging over me, like a cloud overspreading the sky, only rent here and there by some special force; and my eyes have a heavy, deathy look” (526-527). It is a curious choice of words. Burney's cancer had jaws and teeth as it hovered above her in that operating room. The torpor implicated in Coleridge’s death is almost devoid of a material presence, likened to a cloud overspreading the sky. Coleridge tells de Vere that she grows weaker with every passing day and the growing “deathy” look overtaking her eyes reminds one of Burney's devolution into passive states at intervals during her ordeal.

Shortly before succumbing to her disease, Sara Coleridge makes two textual defining declarations, much like Burney’s “C'est moi.” She writes a letter to de Vere, the last in the collection edited by her daughter Edith, in which she proclaims:

I am now an invalid, confined to my own room and the adjoining apartment, with little prospect of restoration, though I am not entirely hopeless. My malady, which had been threatening me ever since the summer before last, did not come into activity till a few months ago. What my course and the event may be perhaps no physician can tell to a certainty. I endeavor not to speculate, to make the most of each day as it comes, making use of what powers remain to me, and feeling assured that strength will be supplied, if it be sought from above, to bear any trial which my Father in heaven may think fit to send. I do not suffer pain (528).
Here again, she refuses to tell Aubrey de Vere, apparently her closest confidante,\(^49\) the nature of her illness. Instead, she places emphasis on how she is coping with her rapidly failing health, just as she did with the description of her father’s death. In his biography of Sara Coleridge, Bradford Mudge writes that in her final months she was driven to articulate and assert a self as she had neglected to do in years past:

> No longer was she simply ‘Coleridge’s daughter,’ and during her September crisis it suddenly became imperative to discover who in fact she was. It became necessary to unravel the various roles she had adopted and order them as neatly as she had her father’s works (162).

In unraveling those roles, she sets herself definitively in a role that is tightly bound to her present body, and that bonds her to her father’s legacy. She stresses her lack of pain and resignation, similar to Helen’s almost overjoyed deathbed declarations in *Jane Eyre*. The important difference, though, is that Coleridge continues to stand in defiance of her disorder, even confessing to having “the sense of sinking and depression” as her health declines. Unlike Helen’s consumption, Sara’s cancer reveals nothing about the state of her soul. Her insistence on maintaining assurance in defiance of her body and in voicing the self make her an adversary to her malady.

This adversarial relationship comes through strongly when she writes a poem titled “Doggrel Charm,” a direct address to her tumor on March 29\(^{th}\) of 1852, just over a month before her death. This was not the first time Sara had

\(^{49}\) As Bradford Mudge points out, the vast majority of the correspondence in the Coleridge collection exists between Sara Coleridge and de Vere. Mudge even contents that rumors persisted that the two were romantically involved.
constructed a poem about illness. In her childbearing years, she wrote several including “Sickness,” “Written in my Illness at Hampstead during Edith’s Infancy,” and “Verses Written in Sickness 1833, before the Birth of Berkeley and Florence.” The tone and structure of these poems in relation to “Doggrel Charm,” though, is strikingly different. “Sickness” has twenty-eight lines, and holds only two sentences. “Written in my Illness at Hampstead” has forty lines, composed of ten sentences, approximately one per stanza, similar to the structure of “Verses Written in Sickness 1833,” which also has forty lines of eight sentences, likewise one per stanza. “Doggrel Charm” has only twelve lines and three stanzas, but includes seven sentences, four appearing in the first stanza alone. Unlike the first three “sickness poems” “Doggrel” is virtually stripped of metaphor or metaphysical rumination. “Sickness” and “illness” are constructed as perpetual states of being, states in which one’s identity becomes enwrapped. In these poems, Coleridge is conceptualizing chronic illnesses. They have no agency, nor the “activity” that she ascribes to her cancer in her final letter to de Vere, nor are they addressed as entities. In “Doggrel” she bestows an identity upon her tumour, referring to it as “ye,” “thee” and you” and addresses it as you would if it were an individual. The first four lines are exclamatory imperative sentences in rapid secession:

Split away, split away, split away, split!
Plague of my life, delay pretermit!
Rapidly, rapidly, rapidly, go!
Haste ye to mitigate trouble and woe!

In conceiving of this poem as a “charm,” implicitly to ward off her cancer, Coleridge is, like Burney, relying on ritualism to combat the effects of her disease.
In a sense, she’s performing the opposite of a classical “invocation of the Muse.” Rather than calling on a force to work through her, she attempts to use language to expel it from her. Not having the hope of a literal excision, Coleridge uses the final stanza of the poem to create a division between herself and her cancer, instructing it: “Crack away, tumour, I pray thee to crack.” The division is solidified as an opposition when she writes in the penultimate line: “But if you’re in the wrong, right let me be.”

Surgical intervention was never an option for Sara Coleridge. As Mudge writes, her physician Dr. Edward Newton assured her repeatedly that the tumor was benign and would not grow. Once Newton realized that her condition was worsening, it was too late. The mass was too great, and the danger of an operation too severe. Faced with certain death, her only defense is in the creation of a life, her own in the pages of her memoir, correspondence, and final poem. Burney declared that her only defense against cancer, the epitome of death, was life. The memoir, as a declaration of life, is a version of that cure. As Epstein argued that Burney’s writing serves a surgical function, Coleridge’s writing invokes a healing function using many of the same tools as Burney—ritual, de-figuring the malady, and in a declaration of the self.

**Pathologic Vanity: Alice James and Pain Relief**
Like Sara Coleridge, Alice James was a lifelong invalid suffering from ailments ranging from spinal neurosis to rheumatic gout of the stomach. Labeled a hypochondriac, the younger sister of William and Henry James spent the majority of her maturity bedridden, suffering from her various nagging pains, or in conflict with family members and physicians who maintained that there was little wrong with her aside from melancholia and chronic paranoia. In 1891, James proved her critics wrong when she was diagnosed with breast cancer, which she succumbed to in 1892. Alice James’ diary, which she began several years before her death, outlines the details of a life lived in almost constant, and invalidated, emotional and physical pain. While her physical pain multiplies exponentially, her emotional pain is alleviated with her diagnosis because it brings her validation. In Alice James’ view, her diagnosis confirms for skeptics what she has always known; she is, as a confirmed invalid, an expert on pain. Her diary is a testimony to that expertise.

The compilation of Sara Coleridge’s life and letters was initiated, in part, by the strong desire to inscribe a subject in a textual space as a means of resisting the progression of her disease. Alice James writes with a similar biological drive, but with variant aims. James’ cancer diagnosis comes at the end of her text, as opposed to Coleridge’s which occurs ex-diegesis. The composition of Alice James’ diary, however, was initiated by an unnamed force, but a force that she

50 Alice James was the youngest of the James children, and was the family’s only daughter. In her teens, she began suffering from “neuralgia,” which would lead to subsequent nervous breakdowns in the 1860’s and 70’s. Until her diagnosis with breast cancer in 1891, her physicians attributed the majority of her physical and mental tribulations to overactive nerves and possible hysteria.
nonetheless locates within her body. In her first entry, dated May 31st of 1889, she writes:

I shall at leave 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).

Without knowing that she has a malignant growth inside her, James invokes the act of writing as a prescription for health. To continue the surgical metaphor established with Burney, James’ diary does the work of excision and pain relief. In what seems like a series of prophetic statements, Alice James asserts in multiple instances long before her diagnosis that her body hosts a destructive force. In addition to the aforementioned allusion to “that geyser of emotions,” she further writes: “I shall cork myself up again before long and return to my state of ‘bottled lightning’ as Wm. [William James] calls it” (60). Later, she references “a sprite within me” (75). The first two metaphors—a geyser and lightning—suggest a degree of organic inevitability. Just as the military language of Burney’s letter turns Burney’s body into an atlas, the language of natural phenomena give James’ interior mechanics a topographical landscape. This landscape comes equipped with a “sprite,” again suggesting an entity with a will and purpose, much like Burney’s hovering danger.

What startles in the climax of this body’s narrative is the joyousness with which her diagnosis is pronounced. On May 31st of 1891, exactly two years after she began her diary, James writes that “a lump in my breast which has given me a great deal of pain, is a tumour, that nothing can be done for me but to alleviate pain” (207). This announcement is preceded by statements of jubilation and
glee, as she begins that entry by proclaiming: “To him who waits, all things come! My aspirations may have been eccentric, but I cannot complain now, that they have not been brilliantly fulfilled” (206). She goes on to describe a union with her condition that is unlike that of Burney or Coleridge. She writes:

To any one who has not been there, it will be hard to understand the enormous relief of Sir A.C.’s uncompromising verdict, lifting us out of the formless vague and setting us within the very heart of the sustaining concrete (207).

James chooses to pluralize the possessive pronouns in this sentence, suggesting an alliance between herself and her malady. While cancer is rendered as a villain in the work of Burney and Coleridge, James sees her tumor as a comrade in the unstated project of the diary. In doing so, the lines of division between self and disease are blurred as James pits herself consistently against those who misread and misdiagnose pain, while she constructs her cancer as something of an ally in her quest for validation. It is not an enemy of selfhood. On the contrary, it is the proof of her identity.

James’ writing is persistently preoccupied with constructing oppositional relationships that are driven, primarily, through her corporeal epistemology. In the introduction to her diary, Linda Simons writes of:

...the struggle that Alice James enacted throughout her life to assert her identity in the face of persistent misinterpretation by most persons who knew her, including, of course, her parents and four brothers. She became most aware of that misinterpretation when she was ill; and she was ill frequently, from the time she reached puberty until she died (xi).

Throughout her diary, James declares herself to be a specialist in all matters related to pain and suffering, and a gatekeeper of appropriate ways in which to
know and express pain in text. James lambasts George Eliot, for example, for her ineffectiveness in construing pain. She writes:

> What a lifeless, diseased, self-conscious being she must have been! [...] What an abject coward she seems to have been about physical pain, as if it weren’t degrading eno [ugh] to have head-aches, without jotting them down in a row to stare at one for all time, thereby defeating the beneficent law which provides that physical pain is forgotten (41).

The implication is clear; George Eliot’s experience of pain is unsound, and thus her definitions of suffering are invalid. It is James’ contention that Eliot never knew “true pain,” and thus that only those who have experienced such pain can properly convey it. Much later, she establishes a boundary between the realm of the well and the realm of the sick when she writes: “This is the sort of thing that well people are always saying to the weak and they have no conception of their cruelty” (77). In James’ view, the ill possess an entire worldview that is inaccessible to those outside of it. Even those who understand pain on an intellectual level, specifically physicians, have a habit of misreading it in practice. As she rejoices her diagnosis, James writes:

> I was always driven back to stagger alone under the monstrous mass of subjective sensations, which that sympathetic being “the medical man” had no longer higher inspiration than to assure me I was personally responsible for, washing his hands with a graceful complacency under my very nose (206-207).

The “medical man,” it seems, is in the business of invalidating James’ subjectivity, a sense of self that she explicitly ties to her experiences with bodily pain. Her relationship to her malady, as a result, is conciliatory as it is a tool with which she can arm herself against her critics, medical and otherwise. Moreover, its particular power, for James, lies in its palpability. She writes: “I have longed
and longed for some palpable disease, no matter how conventionally dreadful a label it might have been” (206). The power of palpability lies in its unique ability to be felt, and thus “read,” by those who doubted her. As a woman who struggled perpetually from misinterpretation, the palpable tumor voids the possibility of further mis-readings. Simply put, her critics have no further reason to doubt her authority.

As Burney’s letter and Coleridge’s memoir and collected letters did, James’ diary functions as a testimonial of the self and a totem that memorializes her trauma. Writing in regards to James’ letters, Joanne Jacobson contends that Alice James “learned to exploit her consignment to a marginalized form, to rewrite her own narrative in her letters and to make herself central in it” (366). To expand this contention into the scope of the diary, I would further suggest that James’ desire to centralize herself in this text is driven by a complex relationship with her faultering body in which the fractured self is fused through pain and the recognition of that pain. While Alice James seems less invested in an aesthetics of “good suffering” than Sara Coleridge, she is developing an invalid identity that subverts the commonly objectified position of the patient, particularly when that patient is female. Kristin Boudreau writes: “Resigned to an inescapable invalidism, James manipulates the position commonly understood as impotent but sensitive in order to establish a clear-sighted subject position” (53). Burney’s attempts to establish a subject position that is not beholden to her body. Coleridge’s declaration “I am now an invalid” grudgingly surrenders to the body’s role in writing personhood. Alice James’ willingly and happily unites body and self. In doing so, she renders a model of authorship that is drawn from one’s
relationship with pain, establishing a system of signifiers that is created and accessed exclusively by those who know true pain. Each text creates an “us versus them” conflict. For Burney, she and her physicians are in league against her tumor. Coleridge’s memoir places herself and her daughter in a race against her decline. For Alice James, “they” are virtually anyone else—her brothers, her doctors, etc. The “we,” on the other hand, is James and her tumor.

The three women discussed at length in this chapter—Burney, Coleridge, and James—demonstrate that the written word holds an uncanny power. While the body may not literally be saved through writing, subjectivity is salvaged in writing through the trauma of cancer. The text, or collection of texts, stand in place of a body, hosting the makeup of the author’s essence. If the self is to be erased by a metastasizing mass that systematically overtakes the organs, the act of writing the self in the arguably indestructible and material form of a text effectively reverses the work of cancer.

The writings of Burney, Coleridge, and James remove the self from the frame of the dying body and situate it on the written page. The page, then, takes the place of the vital organs and the composite parts comprise an alternate body. In each case, while the experience of cancer may vary, the text itself mimics the course of the disease. The ellipses dotting the pages of Burney’s letter replicate surgical incisions. The absence of a diagnosis in Coleridge’s memoir and letters gestures towards cancer’s invisibility. Finally, in detailing her decline, James does her best to codify a semiotics of pain that is distinguished from the benign pain of those around her. The act of composition, then, serves a mimetic function not only in duplicating the self, but in the reproduction of a body invaded by its
own uncanny perversion of mimicry. Through the resulting text, and its
subsequent consumption by readers, the writer has, in a sense, cured cancer.
Chapter 4

Fatally Feminine51: Venereal Disease and the New Woman Novel

To describe someone or something as Victorian is, typically, to deliver a mild insult. It is a term often used to describe outmoded social ideas, outdated scientific principles, and woefully repressed codes of moral and sexual conduct. It conjures up images of a Dickensian domestic scene with a cordial man and wife keeping a respectable distance from one another, uniting only in the hopes of producing future generations of upstanding English citizens. As Michel Foucault affirms in “We Other Victorians”:

...twilight soon fell upon this bright day, followed by the monotonous nights of the Victorian bourgeoisie. Sexuality was carefully confined; it moved into the house. The conjugal family took custody of it and absorbed it into the serious function of reproduction. On the subject of sex, silence became the rule (3).

Yet, lurking in the shadows of that Victorian bourgeois paradise were the poor, the fallen, the orphaned, and the sick, those unfortunate creatures constituting the ranks of Foucault’s “other Victorians.” In the deepest recesses of the crowd of forgotten citizens are the venereally diseased, those who so flouted the conventions of polite society that they were stricken with a disfiguring and deadly malady, most often syphilis. Unlike the idealized consumptive or the invisible cancer patient, the mere existence of syphilitics disturbs a hegemonic model of Victorian civilization by demonstrating, and visually displaying, that decadence

---

51 The phrase “fatally feminine” is used by Dr. Cornerstone in Brooke’s A Superfluous Woman to describe Jessamine Halliday in his clinical assessment of her initial condition.
and depravity hold positions of power, even in the locus of civilization. The syphilitic, one might say, is the ultimate “other Victorian.”

The climbing rates of venereal infection throughout the nineteenth century were a direct affront to the conventional, if informal, consensus on what sex and sexuality were and were not in the Victorian social order. Unwaveringly high rates of venereal disease meant that sexuality, in actuality, was not at all confined. Rather, it was a public matter in which even those at the peak of civilization, men of means, were implicated. The unshakeable propagation of diseases like syphilis and gonorrhea necessitated revisions of an already heavily gendered biomedical discourse that insisted, from the end of the eighteenth century onward, that “public women” were responsible for the origins and dissemination of venereal disease. Sander Gilman notes that, for the majority of syphilis’ history, depictions of those suffering from it were fairly equally represented between the sexes, even proposing that males were more often associated with the disease as “active” sufferers as opposed to “the passive suffering of the female” (250). He then writes that this gender neutrality changes in the eighteenth century during the Age of Reason: “Only in the Enlightenment does the image of the syphilitic patient shift from male to female, but then only

\[52\] Mary Spongberg notes that “The female body came to be treated as the organic cause of the disease,” further claiming that it was consistently taken for granted in nineteenth-century that the female body was the source of infection. Any subsequent discussion in this regard was concerned, almost solely, with surmising what unique properties of the female body caused such infections to ferment (3).
with the female as the image of the source of infection” (252-254). He continues, “By the eighteenth century, the image of the patient, the individual bearing the signs and stigmata of syphilis becomes that of the corrupt female” (254-255).

This image persisted throughout most of the nineteenth century, as venereal diseases were overwhelmingly associated, both in the medical and popular imagination, with the prostitute and other “public women.” According to the writings of the forefathers of modern gynecology, particularly the lauded William Acton, the woman’s body is where you find both the formation and the force of infection, a claim expressed most ardently through discourses related to the prostitute’s body. The vast majority of the case studies outlined in the medical literature of the early to mid-nineteenth century chart the tale of an unsuspecting man whose tryst with a public woman leads to his infection and death while she, upon inspection, is shown to have no signs of infection whatsoever. Thus, policies were enforced, first in France then in Great Britain, to protect men from such women. In a marriage of medicine and the law, the

53 Buchan’s *Domestic Medicine*, an Enlightenment-era text, makes no mention of prostitutes in his most extensive chapter on venereal disease, “Of Chancres.” He only distinguishes the sexes when outlining the distinct symptoms that manifest between men and women and refers almost unilaterally to the venereally afflicted as, simply, “the patient.”

54 The euphemisms vary, even in the clinical literature, but include “woman of the town,” “opera-dancer,” “grisette,” etc.

55 Acton provides an extensive outline of the theoretical etiological history of venereal disease, detailing the claims that the disease was born out of men copulating with livestock, Neopolitan women, and the native women of the colonies.
Contagious Diseases Acts sanctioned a medical and narrative logic that begins with a depraved woman and ends with a dying man. According to the micro-narratives that comprise the case studies of Acton and others, the woman’s body is the space of venereal contact and transmission by virtue of her anatomical design and nature; she is not a patient any more than a virus or a tumor can be a patient. She is the nexus of contagion, a trap into which unsuspecting and unknowledgeable men fall.

The medical and lay conversations on venereal disease remained focused on the policing and monitoring of women, as a means of protecting men, until the final decades of the nineteenth century when the discourse takes a notable shift from public spaces of infection to private ones. The emphasis turns from the danger of the streets to the danger of one’s own marriage bed, as more and more physicians vocalized and textualized their concerns over rates of congenital syphilis and its role in the degeneration of the nation. This redirected discourse materializes at nearly the same moment as the surfacing of the New Woman and the New Woman Novel. Several critics have noted the collision of these two discourses, but none have explored the ways in which the biomedical discourse

56 Spongberg claims that the repeal of the CD Acts brought renewed interest in the dangers of congenital syphilis, with physicians like Alfred Fournier producing tracts written for the public that cautioned women against making bad marriages and provided warning signs for women to observe in potential spouses.

57 Typically associated with the work of writers like Olive Schreiner, Henrik Ibsen, Sarah Grand, George Egerton, Mona Caird, et al., the “New Woman Novel” emerged as a form in the late-nineteenth-century with narratives focused on female protagonists who challenge conventional gender roles by, for example, refusing to marry, openly expressing sexual desire, working towards enfranchisement, engaging in transvestism, etc.
informs and shapes the structure of the “disease story” that plays a prominent role in numerous New Woman narratives.

In this final chapter, I’d like to propose, first, that the disease plots of Sarah Grand’s *The Heavenly Twins* and Emma Frances Brooke’s *A Superfluous Woman* are not only modeled on biomedical case studies, but also that the transmutation of their core narrative architecture highlights and deconstructs the atrocities of institutional patriarchy. Furthermore, it is my contention that the reconstruction of the venereal disease narrative in the New Woman novel serves as a means through which the author establishes the defining features of the New Woman, in that her desire to question masculine dominance, her autonomy, and her consumption of knowledge can, ideally, exempt her from infection.

A discussion of these novels, and this particular malady, necessitate a broadening of scope to an international terrain. To begin with, Grand and Brooke engage either implicitly or explicitly with national literary traditions that are decidedly not British in the crafting of their work, particularly in Grand’s case as her novel is rife with allusions to French naturalist fiction. Secondly, and perhaps more importantly, syphilis is a disease characterized by international and intercontinental contact, certainly more than nerves, consumption, or cancer. The acquisition of syphilis is evidence, if nothing else, of some manner of intimate contact. It demonstrates a macabre connectivity between individuals at the micro-level, between sexual partners or offspring, and on the macro-level, as the most consistent “origin stories” related to syphilis trace its origins to invading
nations or colonized natives. The Heavenly Twins and A Superfluous Woman mimic this international contact through continued allusions to non-British materials, mostly French fiction, and by drawing from medical source material that is, again, predominantly French. In a sense, then, we might say that the novels themselves are infected.

The Narrative Map of Syphilis

There is no doubt that venereal disease was a major public health concern throughout the nineteenth century. Judith Walkowitz reports that the increased number of cases in the military were the greatest cause for alarm, as she indicates: “By 1864, one out of every three sick cases in the army were venereal in origin, whereas admissions into hospitals for gonorrhea and syphilis reached 290.7 per 1,000 of total troop strength” (49). A.N. Wilson writes that numbers amongst the general population were similarly staggering:

Among the surgical outpatients at Bartholomew’s Hospital in London, one half had venereal diseases, mostly the deadly syphilis—at Guy’s it was 43 per cent. At Moorfield’s Eye Hospital and at the Throat Hospital in Golden Square, one fifth of patients admitted were suffering from venereal or contagious diseases, VD or CD, as they were called (308).

In major cities, the situation was most dire. According to Marilyn French, 45% of city-dwelling men had syphilis (155). In England and on the continent, panicked doctors and government officials argued that civilization itself was on the brink of

58 One of the most popular theories is the so-called “Columbia hypothesis,” which claims that syphilis came to Europe through Columbus’ voyages to the New World. Italians, on the other hand, claim that the first recorded syphilis outbreak in Naples in the late fifteenth century was brought on by invading French troops.
destruction from this epidemic or, as Elaine Showalter writes, “doctors predicted the unavoidable ‘syphilisation’ of the Western world” (188).59

As rates continued to climb, government officials took legislative measures, in the hope that potential infectivity could be avoided or at least decelerated. In 1864, British Parliament passed the Contagious Diseases Acts with the intention of improving the health of military personnel.60 The Acts subjected those suspected of being infected to a physical examination. However, as many have noted, only women were subject to their enforcement. As Frank Mort explains, “it was women who were defined as the human agents of infection, threatening national health and security and challenging the social order by their active and autonomous sexuality” (76). Officers of the law were focused exclusively on prostitutes and suspected prostitutes and not, as Barbara Caine writes, on the men who paid for their services:

In accordance with them [the Acts], any woman who was identified as a common prostitute by a member of the metropolitan police was required to undergo medical examination. If found to be venereally diseased, she could be detained before a magistrate and then bound by his orders to submit. Hence the Acts established a system of supervision and surveillance of prostitutes in specific areas (170).

Such legislation meant, ostensibly, that women’s bodies could be analgous to a water reservoir or a public housing complex in the language of sanitation discourse. As long as the body remained untainted, public health is not in

59 Showalter takes the term “syphilisation” from Alain Corbin who uses it in his “Le périle vénérien au début du siècle...” (1977).

60 As such, the acts were only enforced in garrisons and naval ports.
jeopardy. Once contaminated, however, measures must be taken to halt the spread of further corruption.

Naturally, the Acts had their share of critics and opponents, one of the most vocal being Josephine Butler. The examinations were seen as invasive, often humiliating, and according to some even violent. In her “Appeal on Prostitution,” Butler calls the exams “torture” (166), and others regarded the pelvic exam as “instrumental rape” by a “steel penis” (Mahood, 128). Butler, incidentally, made it her mission to eradicate the CD Acts, as she repeatedly charged that the acts “secured the enslavement of women,” referring to them often as “the slave code” (Caine, 170). Butler would insist that those who sought to regulate prostitution were operating under the faulty presumption that men were “naturally unchaste,” and that those who become infected with deadly venereal disease had been manipulated, even ensnared, by seductresses (Caine, 167). As Butler asserts:

They continually speak as though there were but two sets of persons to be considered—fallen and contagious women on the one hand, and pure women and children on the other. It is curious to observe how often they ignore in their arguments the existence of that intermediate class, who convey contagion from the one to the other (167).

To return to the analogy linking women’s bodies to water supplies and public housing, it would seem that it would be impossible to view men’s bodies in this way. Instead, infected men are equivalent to unsuspecting citizens who

\[61\] James Marion Sims invented the steel vaginal speculum in the 1840’s, for use in vaginal surgery. With the passage of the C.D. Acts, law enforcement officials and the physicians who worked in collaboration with them began using the instrument as a means for examination rather than care.
becoming choleric from contaminated water. They are never culpable for drinking tainted water. After all, the need for water is a biological drive that must be quenched, like the drive for men to have sex with women.

In focusing efforts solely on women, the authorities effectively othered women who desire, in any way, to negotiate public life. Women’s attempt to enter the public domain contaminates the masculine hegemonic order that genders public and private space. In other words, men only become infected because women are trafficking in spaces that they do not belong. They have invaded a restricted domain, just as bacteria invade the body.

It is easy to understand why the legislative and law enforcement communities would be more concerned with policing women than men, even if they did so with a level of corruption that is to be deplored. The obsession with women’s bodies, as opposed to diseased male bodies, indicates a concordance with the edicts of medical professionals, as Mary Spongberg writes: “Men were consistently represented as the victims of disease, women as its source. For the most part, medical advice was written for the male sufferer, with women being confined to the role of contaminator” (3). The very name “venereal,” or “of Venus,” implies an origin that is not only carnal, but feminine. While it is certainly acknowledged in the medical literature that men’s proclivity for prostitutes is the cause of their disease, the “means of transmission” is almost always the female body, as meticulously detailed in William Acton’s extensive A

---

62 According to Barbara Caine, Josephine Butler’s investigations into the CD Acts uncovered the collusion between the police, medical practitioners, and brothelkeepers aimed at keeping the CD Acts in tact (155).
Complete Practical Treatise on Venereal Diseases, and Their Immediate and Remote Consequences (1848):

The vagina may become a means of transmission of the virus; this frequently happens in prostitutes. An individual suffering under chancres has connexion (sic) with a girl; a quantity of virus is left in the vagina, but produces no action, as the mucus membrane is covered with a secretion. Should a second individual have connexion with this female under these circumstances, the virus may affect him and no local disease be discovered on her genital organs, even after the most minute examination (185).

The woman’s body, here, serves as the conduit through which disease is traded between unwary men. Freeman Bumstead confirms that such logic was the norm when he writes that many physicians were led “to believe in the possibility of ‘mediate contagion,’ or the transport of virulent pus from one person to another by the genital organs of a third, which merely serve as a vehicle and are not themselves inoculated.” The precise reason she is not inoculated is rarely articulated, but is implicitly founded in a perceived perpetual state of corporeal turmoil, imbalance, and lack of hygiene among women, as Mary Spongberg notes: “The female body came to be treated as the organic cause of the disease” (3). Acton cites French professor of medicine Jean Astruc when he attributes the “immediate source” to “the nature of the diet, to immoderate promiscuous intercourse, and the virulent acrimony of the menstrual flux” (25). Phillippe Ricord notes: “If women were only more attentive to cleanliness, and took more care of themselves, venereal complaints would be less common” (206-207).

---

63 Jean Astruc’s A Treatise of the Venereal Disease... (1737) is widely considered to be the first significant medical treatise on the subject.

64 Ricord is quoted, here, in Acton’s Treatise.
This discourse of hygiene and cleanliness is reinforced by Acton when he describes the penis as “a sponge” that “cleans the vagina” (185). The implication is quite evident. Women, specifically prostitutes, serve the role of contaminator and their bodies constitute “the space where disease could and did fester” (Spongberg, 35). They don’t succumb to disease because they already embody it.

Until the 1870’s and 1880’s, approximately, the discourse continued in this vein. Legislation and medical tenets were entirely focused on policing confirmed prostitutes and on the identification of potential prostitutes through what Spongberg calls “clear signs of degeneracy” that were believed to be inscribed on the bodies of certain women. As she writes:

...medical authorities in Great Britain began to suggest that it was possible to distinguish likely carriers of syphilis and other venereal diseases by the way they looked; that is, that such women’s bodies were inscribed with clear signs of degeneracy and subsequently these women could be shown to have an aptitude for prostitution and a capacity for disease (1).

Thus prostitution, embodied by the women who committed it, was a virus unto itself. The perceived textuality of the degenerate woman’s body and the ability to “read” it accordingly became the fixation.

This task was complicated, though, by the purported suppressive architecture of the female anatomy, which allowed obvious symptoms to remain hidden. In the eighteenth century, reading the body for signs of disease was as simple as identifying external symptoms like facial lesions and chancrees. The presence of sores, a sign of primary syphilis, was an indication of infection and signaled to onlookers that the bearer was both a participant in and the embodiment of vice. Such lesions mark the faces of numerous Hogarthian
prostitutes, such as those seen in *A Rake’s Progress* (1732-1733) and the subject of *A Harlot’s Progress* (1732):

Figure 6: Hogarth’s *A Rake’s Progress*. Plate 3: “The Orgy.”

Figure 7: *A Harlot’s Progress*, Plate 3
In each of these images, women alone bear the marks of disease. The signs are noticeable and instructive, but the men soliciting their services either refuse or are unable to read them.

As they entered the nineteenth century, physicians became insistent that the syphilitic woman can no longer be identified merely by scrutinizing her face, but rather through meticulous and professional inspection of her most intimate regions. Most women, they now argued, may not show any outward signs of disease if they become infected. As Mary Spongberg asserts: “It was accepted both within popular culture and medical discourse that women could be exempt from the disease while passing it on to men” (3). Acton and others express this position frequently in their writing, as in the aforementioned passage where Acton refers to a case in which the woman acts as the vessel for transmission between an infected to an uninfected man, all while she remains apparently healthy. The danger, then, is no longer alleviated upon the inspection of the woman. On the contrary, the body absent of signs merely means she is concealing the affliction from unsuspecting men, as encapsulated in this frontispiece for an 1840 French edition of Fracastoro’s sixteenth-century poem *Syphilis*:

---

65 Girolamo Fracastoro was an Italian physician and poet, whose “spore theory” of disease transmission was the standard theory for infectious disease until the advent of germ theory in the nineteenth century. His three-volume poem, *Syphilis or The French Disease* (1530), tells the story of a shepherd named Syphilus who contracts a lethal disease after insulting a Haitian god. With the publication of this work, Fracastoro is credited with creating the word “syphilis.” In 1840, August Barthélemy translated the poem into French from Fracastoro’s original Latin.
Figure 8: Frontispiece for Syphilis (1851)

In this image, a credulous young man sees the beautiful veneer of a woman who conceals the decaying skeletal face of syphilis beneath. Behind the body of the young lady hangs a scythe in black draping, identifying her as the Grim Reaper. The source of syphilis remains female, as it was with Hogarth. What has changed, though, is that the ability to decipher the text of the body is now much more intricate. This young man is unseasoned and untrained; he looks, but sees merely a beautiful woman. “Inspection” and “examination” become professionalized enterprises. Women, more specifically their bodies, became subject not only to a sexualized male gaze, but a scrutinizing medical gaze.
Renewed interest in the dangers of congenital syphilis proliferated after the repeal of the Contagious Diseases Acts in 1886. Mary Spongberg claims that the anxiety of racial degeneracy led eugenicists to investigate the effects of congenital syphilis in the final decades of the nineteenth century. The list of potential effects, by that time, was extensive:

By the end of the nineteenth century, it was generally assumed that both syphilis and congenital syphilis were responsible for numerous dystrophic afflictions, malformations of the body, arrest or retardation of physical and intellectual development, infantilism, dwarfism, inborn lack of vitality, cachexia, rickets, hydrocephalus, meningitis, certain forms of epilepsy, tabes, and general paralysis. The syphilitic body was set to become the quintessential degenerate's body (Spongberg, 159).

While it was recognized that an infected mother could, and did, pass syphilis on to a child, it was debated in the medical community whether or not the infection of the father could be inherited by his offspring. For the better half of a century, the respected and accepted opinions of John Hunter and Dr. Ballard were that syphilis, in fact, was not congenital, and was certainly not transmissible through paternity. In 1861, Dr. Freeman Bumstead was among the first to include in his treatise, *The Pathology and Treatment of Venereal Disease*, the case of a man who infects his wife and unborn child:

Since then he has had several attacks of constitutional syphilis, and his wife, who was in the fifth month of pregnancy, contracted an indurated chancre, had a syphilitic eruption, alopecia, iritis, etc., and gave birth to an infected child at term, which, under homeopathic treatment, died at the age of one month (371).

Dr. John Hutchinson was among the first to insist openly, in 1876, that fathers could infect their children directly, perhaps even bypassing the mother in the incubation of the womb. In 1881, Dr. Alfred Fournier gave a series of lectures at
St. Louis Hospital in Paris called *Syphilis and Marriage*, in which he provides graphic details of the symptoms and stages of syphilis, with the hopes that his cautions would act, essentially, as a prophylaxis against imprudent marriages.

Many, though, remained defiant in the face of the evidence. Admitting that syphilis was not only congenital, but that men could be the source of a familial outbreak, meant acknowledging difficult realities. First, it meant recognizing that venereal disease had invaded the bourgeois domestic realm, the space explicitly constructed as a refuge for decent women from the ills of public life. It also meant that any woman, not just those deemed unsavory, could become infected. Consequently, it also meant considering the possibility that men, not women, were accountable. The debate and the reality behind conjugal and congenital infection shined a light on the dark spaces that guarded male privilege and the maintenance of male dominance throughout the nineteenth century, and arguably beyond. The discourse that insisted that women were safe in their homes, that their husbands and fathers protected them from the dangers of public life, and that good women were safe from the deaths that befell “bad women” could no longer go unchecked.

It is in this moment that the New Woman emerges as a challenge to those increasingly unsteady discourses at the turn of the century. Loralee MacPike explains how the mere existence of the New Woman threatened to shake the foundation of hegemony:

In the century preceding 1880, medicine, science, and derivatives of the idea of evolution, both social and biological, had all contributed to a normative, or prescriptive, theory about the nature of women-in-relation-to-society, which structured a discourse about women that controlled women’s actual experiences—the ways they could
live their lives. The emergence of the New Woman in the 1880’s and 1890’s both made possible and required a restructuring of that discourse as women’s lives began visibly to contradict the theory (369).

As the apparent distance between theory and reality in gynecological discourse became evident, New Woman writers were able to seize on its contradictions in order to construct narratives that expose masculine corruption, uncover systemic corruption and ineffectiveness, and offer New Womanhood as an alternative discourse for women entering modernity.

The Decay of the Nation: Zola and Grand

Emile Zola’s description of his eponymous heroine’s demise in the final paragraphs of Nana (1880) is among the most graphic and revolting in literary history. Nana was the ninth novel in Zola’s Les Rougon-Macquart series, which Zola envisioned as an extensive naturalist portrait of France’s Second Empire. Nana is the tale of a young woman’s sexual exploits and their role in her rise and subsequent fall, not unlike Hogarth’s A Harlot’s Progress. As the novel opens, Nana is an untalented actress and singer and a very popular sexual companion. She is an enchanting physical specimen with an “overpowering sex-appeal that intoxicated the audience” and an “irresistible power” (19, 25). Zola also likens her to “an animal in heat,” and a “man-eater” with a sexuality “powerful enough to destroy all these people and remain unscathed” (26, 25, 27).

66 Les Rougon-Macquart was Zola’s twenty-volume collection of novels, published between 1871 and 1893. Nana was published after Une Page d’amour and before Pot-Bouille. Nana’s first appearance as a character in the series, though, occurs in L’Assommoir, the novel published immediately prior to Une Page d’amour.
Indeed, Nana’s allure is a destructive force. She financially ruins three men, drives one to crime, and two men to violent suicide. In the end, Nana dies alone in the Grand Hotel, quarantined with smallpox. Upon her death, Zola describes the scene:

Now Nana was left alone, lying face upwards in the light of the candle, a pile of blood and pus dumped on a pillow, a shovelful of rotten flesh ready for the bone-yard, her whole face covered in festering sores, one touching the other, all puckered and subsiding into a shapeless, slushy grey pulp, already looking like a compost heap. Her features were no longer distinguishable, her left eye entirely submerged in discharging ulcers, the other one a sunken, fly-blown black hole. A thick yellowish fluid was still oozing from her nose. Starting from the left cheek, a reddish crust had overrun the mouth, pulling it into a ghastly grin. And on this horrible and grotesque death-mask, her hair, her lovely hair, still flamed like a glorious golden stream of sunlight (425).

As Nana was a woman of low moral character, her demise seems entirely in accordance with the narrative of disease outlined by Acton and others. While the stated cause is smallpox, Zola’s subsequent remarks link her affliction to her life of sexual debasement. He writes:

Venus was decomposing; the germs which she had picked up from the carrion people allowed to moulder in the gutter, the ferment which had infected a whole society, seemed to have come to the surface of her face and rotted it (425).

Zola’s reference to “the gutter,” “ruisseaux” in Zola’s original French, links the passage to an earlier description of Nana, in which “the gutter” is related to Nana’s public display of her sexuality: “With her hand on her hip, she was really

---

<sup>67</sup> Incidentally, smallpox and syphilis were often confused for one another, as the lesions produced by syphilis were likened often to both cow and smallpox. Thus, smallpox had a taint of depravity associated with it, both because of its similarities to syphilis and because it was associated with the lower rungs of society and urban decay.
at home with her Venus—in the gutter and all set to walk the streets” (20).

“Ruisseaux,” or “the gutter,” is the place in which disease is trafficked; it is the home of “her Venus” and the “carrion people” who trade germs. Even though the manner of her death is not venereal, Zola highlights the transmissibility of her disease in the final moments of the novel, connecting it both to the unsavory characters she makes contact with and implying that the responsible contact was sexual.

Nana, it would seem, receives the death she “deserves,” not only as a prostitute, but as an ensnarer of men. Zola, though, is painstaking in his complication of the moral values ascribed to Nana’s demise as he details Nana’s path over the course of both this novel and *L’Assommoir*. Near the end of *L’Assommoir*, we learn that Nana’s father is an abusive alcoholic who drives her to a life on the streets. Nana, not unlike Daniel Deronda, exists in the periphery of her own novel in the opening pages of the narrative. Many men speak of her and describe her, but she is not a physical presence until she appears onstage in the last third of the first chapter. Even then, we don’t hear her speak. The first chapter is dominated by acts of looking, gaze acts that both inform how the reader perceives Nana and establish the hyper-visuality that pervades the rest of the novel. All aspects of Nana’s identity, aside from her sexuality, are rendered as a burlesque. Her voice is likened to a “cackling hen” and she sings out of tune (18). The novel does not even record Nana’s voice until the second chapter. She only becomes an arresting presence when she removes her clothing onstage:

> A murmur spread through the house like a rising wind. A few people clapped and every opera-glass was focused on Venus.
Gradually Nana had asserted her domination over the audience and now she held every man at her mercy (26).

Nana’s domination over the men in the audience, and indeed all the men she encounters, is generated entirely by her physicality, as it is the only piece of her identity that anyone cares to acknowledge. Nana, in other words, is all body. Zola establishes a value system, in *Nana*, that is based entirely on the aesthetics of the body, first through a sexual gaze and, in the final paragraphs, in a clinical gaze. This is not unusual, of course. In many ways, the narrative of literary history is one which women are valued and devalued based on the purported beauty of their bodies, or lack thereof. However, once we consider Zola’s particular aesthetic obsessions alongside the economics of the gaze that venereal disease discourses formulate, culpability and agency in *Nana* becomes much more layered.

Nana is a constant object of a masculine and often erotic male gaze, a gaze that is textually replicated through Zola’s detailed descriptions. The novel is buttressed, as Peter Brooks notes, with “a mise-en-scene for Nana’s body,” first in its glorious rise and finally in its subsequent decay (2). In that sense, Nana is more setting than character in the novel. She is the locus of action, interaction, and transmission, not unlike Dickens’ London or Brontë’s Yorkshire moors. As she performs the operetta, the on-looking men are seduced by surface, and are unable to see the interior or what lies behind, as in the frontispiece from the Barthélemy’s *Syphilis*. Zola, though, problematizes this paradigm by fleshing out Nana’s path to corruption. The story of Nana begins, as previously indicated, not with Nana herself, but rather with the men who “made” her—her father and
Bordenave. We are made very keenly aware that, if Nana is a monster of some sort, like the woman from the Fracastoro frontispiece, she is fashioned and cast on the world through the abuse of her father and the pandering of a greedy pimp. In other words, she is a weapon against men that is crafted by men.

Truly, the men left in her wake suffer greatly from her ill-treatment. The story does not end, though, with the men, as it does in the clinical narratives of Acton and others. Rather, the story ends with the horrific suffering of Nana, giving a face to the woman that clinicians had insisted could not suffer from such a malady. Zola’s novel replicates and draws out the clinical narratives put forth by Acton, Ricord, and others in which two men trade an infection through a seductive third party. He complicates this narrative, though, by equalizing the active suffering of the “infected” parties—Nana’s victims and eventually Nana herself—while demonstrating that the sources of monstrosity, her father and pimp, are free from suffering.

Many critics have surmised that Nana’s decomposing corpse at the close of the novel serves as a metaphor for a decaying France at the close of the century. While it’s a compelling reading, less criticism has been devoted to the role that contagious disease plays in the reification of “Frenchness” through the body of Nana, and what that role means for representing French fin-de-siècle masculinity. Peter Brooks calls Nana’s sex, as it works through her body, “the source of stories, the motor of narrative, the place from which emanates the narrative dynamic” (32). It is a narrative that ends with the almost total destruction of the narrative world, with the implosion of its masculine bastions and the decomposition of its center. Nana reveals that, while femininity might be
the instrument through which masculinity crumbles, women are not the architects of that course. On the contrary, it is a course carved out for men by other men; women like Nana are only the moveable pawns.

_Nana_ haunts the pages of Sarah Grand’s _The Heavenly Twins_ (1893). At the very least, it is a text that Grand clearly held in her mind as she composed her narrative. It is mentioned several times in the novel, and the name itself may be a reference to a line from Zola’s novel, in which Bordenave refers to Rose Mignon and Steiner as “the heavenly twins” (5). Grand’s work evokes a Freudian “three-casket” model, following the lives of three young women—Evadne, Angelica, and Edith—a structure that invites the reader to surmise that, in the end, one woman will find happiness and success while the other two will either die or fall. Grand writes disease narratives into the marriages of both Evadne and Edith. Evadne avoids infection by refusing to consummate her first marriage to Colonel Colquhoun, a man with a sordid past. Edith, on the other hand, is not so lucky. She rejects the love of the decent but socially unacceptable Diavolo, instead marrying the wealthy but dastardly Sir Mosley Menteith. In the end, Edith and her son succumb to syphilis, while Menteith escapes with only a broken nose.69

68 Freud explored this model in his “The Theme of the Three Caskets” (1913). In that essay, Freud analyzes the recurring narrative that culminates with a man choosing between three women, his primary examples being _King Lear_ and _The Merchant of Venice_. It was Freud’s conclusion that the chosen woman is, inevitably, set apart from the other two by her muteness.

69 When Menteith tries to enter his home during Edith’s final days, Angelica banishes him from the house, throws a Bible at his face, and breaks his nose.
Sarah Grand holds a distinctive position in the formulation of New Woman fiction and in defining the characteristics of New Womanhood. Grand claimed invention of the term “New Woman” in 1894, which she described as “one who, while retaining all the grace of manner and feminine charm, had thrown off all the silliness and hysterical feebleness of her sex” (Richardson, 228). In addition to her novels like *The Heavenly Twins* and *The Beth Book* (1897)\(^7\), Grand wrote numerous essays on the subject of women’s changing roles including “The Modern Woman” and “Aspects of the New Woman,” in which she expounds upon the parameters of New Womanhood. She asserts in the latter that “Women were awaking from their long apathy, and, as they awoke, like healthy hungry children unable to articulate, they began to whimper for they knew not what” (“Aspects,” 271). The New Woman, she claims, is a hostage of an epistemological crisis, thirsty for the knowledge that has been denied to her by those invested in maintaining the current systems of power. She writes:

> We have allowed him to arrange the whole social system and manage or mismanage it all these ages without ever seriously examining his work with a view to considering whether his abilities and his motives were sufficiently good to qualify him for the task. We have listened without a smile to his preachments, about our place in life and all we are good for, on the text that “there is no understanding a woman.” We have endured most poignant misery for his sins, and screened him when we should have exposed him and had him punished. We have allowed him to exact all things of us, and have been content to accept the little he grudgingly gave us in return. We have meekly bowed our heads when he called us bad names instead of demanding proofs of the superiority which alone would give him a right to do so (271-272).

\(^7\) *The Beth Book*, like *The Heavenly Twins*, concerns a woman whose limited options lead her into an unhappy marriage to an objectionable man. The novel is a sequel, of sorts, to *The Heavenly Twins*, as Angelica returns to serve a supporting role as a friend of the protagonist, Beth Caldwell.
All that allowance, meekness, and endurance, according to Grand’s “The Modern Woman,” only forces a woman “to face disease and death as the chattel of her husband” (708).

With *The Heavenly Twins*, Grand narrativizes the bleak consequences of blind obedience and wanton ignorance. The novel opens and concludes with Evadne, the first thing we learn about her being “She wanted to know” (13). She consumes every morsel of information that she is able to acquire, reading French novels like *Nana* and anatomy textbooks, among other texts. Her hunt for knowledge is no small feat considering her father’s resistance to her education. Grand tells us that Evadne’s father “was one of those men who believed emphatically that a woman should hold no opinion which is not of masculine origin,” who assures his daughter that excessive study and knowledge acquisition will only bring “confusion” and suffering unto her. The sentiments of Evadne’s father are akin to those expressed by Buchan and Trotter in the eighteenth century, as they claimed that mental stress and excessive study could trigger a nervous temperament. Evadne’s father stands not only as the voice of the “bigoted Conservative” who is “ignorant of the moral progress of the world,” but also recalls the diagnostic voice of older generations of physicians who, often, held that the key to a woman’s health was restraint—in desire, in emotion, and in intellectual endeavors (15).

While Evadne’s scholarly rigor and thirst for knowledge is a focal point of the first chapters of the novel, we learn that Edith, apparently, knows nothing of the ills of the world. Edith is described as the Beales’ “only daughter, their white
child, their pearl; and certainly she was a lovely specimen of a well-bred English girl” (137). In her attentiveness to Edith’s physicality, Grand generates a “mise-en-scene” of the body that recalls Zola’s descriptions of Nana, down to the highlighted details. The flawlessness of her body is tightly bound to our ability to read her in contrast with Evadne and Angelica, the first having almost no physical descriptions and the second being set apart physically through her transvestism. While Nana’s body makes us aware of an indulgent sexual appetite, through Edith’s descriptions we are made aware of her overwhelming purity:

Her warm bright hair, partly loosened from one thick braid into which it had been plaited, fell from off the pillow to the floor on her right, and the sun, looking in, lit it up and made it sparkle. She left that window with the blind undrawn so that he might arouse her every morning; and now, as the first pale ray gleamed over her face, her eyelids quivered, and half opened (137).

The meticulous attention to detail, and in particular the extended description of Edith’s hair, recall the closing description of Nana’s decomposing body, sprawled across the bed, with lit-up hair. Anna Maria Jones notes that the similarities between Edith and Nana force us to predict Edith’s eventual destruction: “Edith’s similarity to Nana begins with an eroticized bodily description and ends with physicality turned corrupt: the beautiful girl—all sleepy sensuality—becomes, in both novels, the horrifying diseased body” (227). In Nana’s case, though, the beauty of the girl was dissolute to begin with. Nana’s depravity becomes a bodily inscription at the close of the novel, but the depravity that wrote it always existed within her. Nana is the monstrous creation of careless men, like Frankenstein’s creature. She is always already a corrupt body. Edith, on the other hand, is thoroughly untainted. Edith’s parents, we learn, have strategically kept her
cloistered not only from any evil but even from the knowledge of evil, in order that she remain “pure-minded”:

They seemed to think that by ignoring the existence of sin, by refusing to obtain any knowledge of it, they somehow helped to check it; and they could not have conceived that their attitude made it safe to sin, so that, when they refused to know and to resist, they were actually countenancing evil and encouraging it. The kind of Christian charity from which they suffered was a vice in itself. To keep their own minds pure was the great object of their lives, which really meant to save themselves from the horror and pain of knowing. Edith, by descent, by teaching, by association, and in virtue of the complete ignorance in which she had been kept, was essentially one of that set (137-138).

Edith consistently and insistently ignores signs of trouble, even when they are sent to her from her own subconscious. Before her marriage to Menteith, Edith has a prophetic dream in which Lord Dawne hands her a sore-ridden infant:

He held the child out to her. She took it from him, smiling, raised its little velvet cheek to hers, and then drew back to look at it, but was horrified because it was not beautiful at all as it had been the moment before, but deformed, and its poor little body was covered with sores (138).

Upon waking, a shaken Edith begs God to “keep me from all knowledge of unholy things,’—by which she meant sights and circumstances that were unlovely, and horrifying” (139). Her vision materializes the following morning, when she encounters a beggar-woman and her child lying across the road. Rather than, as the narrator says, “take the poor dusty disgraced tramp into their carriage, and restore her to 'life and use and name and fame’,” Edith and Mrs. Beale proceed to the house to receive Sir Menteith (142). Edith’s commitment to educational abstinence precludes her from interacting with “the tramp,” something that, incidentally, might have reshaped her own fate. The girl, as it turns out, was a mistress of Sir Menteith; the child is theirs. Edith, in spite of her training, seems
to recognize, if only briefly, that her vision and the incident on the road are
connected: “she recollected her horrible dream, and began involuntarily to piece
the vision of the morning to the incident of the afternoon in order to find some
faint foreshadowing for her guidance of the one event in the other” (149).
Nonetheless, Mrs. Beale, Edward, and Edith “dismissed the whole matter from
her mind,” journeys to Malta with Menteith, thus solidifying her fate. The
entirety of Edith’s righteousness is predicated on her maintaining a curiosity
void, a deficiency which is meant to guarantee her future success and happiness
in marriage. Moreover, it would secure her health. Grand demonstrates, through
Edith’s subsequent tragedy, that fidelity to conservative gender mores and
outdated medical recommendations are not only insufficient but, ultimately,
lethal.

Edith’s undeveloped senses preclude her from “reading” Menteith’s
wickedness, which is plainly read by the vastly more knowledgeable Evadne.
Evadne’s frequent proselytizing throughout the novel mimics Grand’s own voice
as expressed in her essays. To her aunt, for example, Evadne charges:

You set a detestably bad example. So long as women like you will
forgive anything, men will do anything. You have it in your power
to set up a high standard of excellence for men to reach in order to
have the privilege of associating with you (75).

She expresses shock and anger when the Beales agree to marry Edith to Menteith,
calling him “that dreadful man” and describing him as “bad—thoroughly bad.”
Her primary evidence for his deviance, aside from a few hints dropped by Colonel
Colquhoun, is that she simply does not like the way Menteith looks at her (201).
Upon their first meeting, Evadne is bothered by Menteith’s physicality, in spite of
the fact that Edith and Mrs. Beale find him alluring: “She noticed something repellent about the expression of Sir Mosley’s mouth. She acknowledged that his nose was good, but his eyes were small, peery, and too close together, and his head shelved backward like an ape’s” (155-156). Evadne’s expertise allow her to perform a physiognomic reading of Menteith’s body and, seeing atavistic and animalistic traits, she is convinced of his immorality. Edith and her mother, on the other hand, see only “a good-looking young man” (142). Grand’s narrator takes a moment, in the sentences following Edith’s initial impression, to assess Menteith’s character vis-à-vis his face:

...he had a face which some people called empty because of the singular immobility of every feature except his eyes; but whether the set expression was worn as a mask, or whether he really had nothing in him, was a question which could only be decided on intimate acquaintance (142).

Grand’s choice to liken his face to a mask recalls the Frascatoro frontispiece, in which a lifelike mask covers the deadly truth. Evadne performs the role, in this novel, as the proverbial expert. The knowledge of anatomy, human nature, and the evils of male dominance gleaned from her extensive reading practices grants Evadne the power to “read” Menteith’s various features as an index of depravity. Like the physician, her expert examination of Menteith reveals his deeply hidden truths.

While Menteith continues to be unreadable to all but Evadne, Edith’s infection and the infection of her son become exceedingly obvious to all but Edith herself. According to the narrator, Edith and her family anticipated that the birth of her son would alleviate the suffering that her marital life has fostered. Instead, his arrival compounds it:
But Edith’s child, which arrived pretty promptly, only proved to be another scourge for her. Although of an unmistakable type, he was apparently healthy when he was born, but had rapidly degenerated, and Edith herself was a wreck (236).

Despite her efforts to give no signs of her interior turmoil and degeneration, Edith’s body and the body of her son have been textualized by syphilis, and nearly all who encounter them are able to read their condition. The Bishop expresses concern about Edith’s changed face, asking Mrs. Beale: “Have you noticed her face? I don’t like the look of it at all; not at all” (241). Unlike Menteith, Edith and her child haven’t the luxury of pretense once their infections take hold. All who encounter her son are shocked by his appearance. Grand writes of the child: “he was old, old already, and exhausted from suffering, and as his gaze wandered from one to the other it was easy to believe that he was asking each dumbly why he had ever been born?” (245). Menteith’s child by the French girl, too, has noticeable disfigurements: “Edith looked at the child. It should have been running about by that time, but it was small and rickety, with bones that bent beneath its weight, slight as it was” (246). Unable to maintain denial any longer, Edith’s mental and physical health collapse almost instantaneously. She becomes gripped by madness, spending her last weeks hysterically ranting. Her demise constitutes what Anna Maria Jones calls “a spectacle of suffering,” somewhat akin to the macabre display of Nana’s corpse (225). The spectacle of Edith’s death, though, is removed from her body and placed within the voice of the hysteric who, paradoxically, serves as a voice of truth. She lashes out at Menteith, sounding like Evadne when she declares him “that dreadful man,” admitting in one instance “I want to kill that monstrous child” (255, 258). The voice of the
“emancipated” woman and the voice of the hysteric are conflated, as both Edith and Evadne speak truths through subversive speech. Both Edith and the French girl are doomed due to their naivety and their apparent inability to read Menteith who, unlike the women, is essentially free of overt signs of degeneracy, excepting those that can only be discerned by expertise and careful scrutiny.

What Grand does in constructing this outbreak is to mutate the medical model of infectivity, which places the woman’s body as the nexus of infection that binds together two men. In the medical literature, it is the men who “actively” suffer through the manifestation of symptoms, while the woman suffer passively, if at all, as her infection lies dormant. In this case, it is the women who suffer, while the man who bridges their conditions silently hides disease within him.

While few critics have taken up Grand’s novel for analysis, those who have speak at length about the ways in which the novel draws on the language of eugenics and professes a fear of racial degeneracy. One such critic is Meegan Kennedy, who recently criticized what she perceives to be the novel’s squeamishness regarding clinical descriptions of the disease, particularly as they pertain to men:

...while foregrounding its desire to “break” the silence around male sexual promiscuity, which condemns innocent women and children to terrible syphilitic deaths, the novel also maintains that silence by retaining a kind of decorous reserve around the decaying body of the syphilitic male (262).

What is overlooked in this assessment, though, is an understanding that the absence of what Kennedy calls “the stigmata of tertiary syphilis” in Menteith reinforces the revision of the disease narrative that Grand’s novel is trying to accomplish. Through the Edith narrative, Grand rewrites the venereal case study by placing a man, an aristocrat no less, at the center of transmission and, thus,
the degeneration of civilization. What this means, then, is that bourgeois Victorianism and the pressing future of Englishness are at risk of collapse not from “other Victorians,” but instead from the citizenry on which the current system is built and maintained—the male aristocracy. A woman’s only protection from this dire forecast is, essentially, to become literate. Grand’s proposed cure is enacted through the Evadne narrative, as she refuses to consummate her marriage both for fear of her own health and the health of potential offspring. While I argued in the previous chapter that the metaphorical “cure” for cancer is self-writing practices, in the case of venereal disease, where prevention is paramount, the key to survival is in the strengthening of both textual and visual literacy.

**Infection and Inheritance: Ibsen and Brooke**

Ibsen’s *Ghosts* was only performed once in England during his lifetime, but its premiere caused quite a stir.  

71 Clement Scott called it “a wretched, deplorable, loathsome history” in his review in *The Daily Telegraph* and another critics declared it a “loathsome production,” describing it as “revoltingly suggestive and blasphemous.”  

72 Its subject matter was considered too shocking

71 The performance occurred on March 13th of 1891 at the Royalty Theatre in London.

72 Clement Scott’s review appeared in *The Daily Telegraph* on March 14, 1891. The latter remarks come from a review in *The Daily Chronicle*, also from March 14th.
and indecent for most audiences, particularly women; critics and audiences were simultaneously fascinated and appalled. The play concerns a series of revelations about a recently deceased man of society, Captain Alving, whose wife, Mrs. Helen Alving, must divulge the nature of his depravity to their ailing son, Oswald. As the play opens, it is Mrs. Alving who is perceived to be the fringe figure, particularly by Pastor Manders, for having sent her son away and attempting to abandon her marriage. Rather than pass her husband’s fortune to their son, Mrs. Alving uses the inheritance to build an orphanage, as she fears Oswald will be tainted by the legacy of his father if he inherits the money. Despite her efforts, an inheritance of some sort is unavoidable. Oswald is suffering from congenital syphilis, discovers that the object of his affection is, in fact, his illegitimate half-sister, and subsequently commits suicide in order to alleviate his suffering and sever the line of succession.

Mrs. Alving has much in common with Grand’s Evadne. She, too, is the bearer of privileged knowledge, as she is the harbor for her husband’s secrets. Like Evadne, also, she is a fan of subversive literature as her ownership of certain unspecified novels scandalizes Pastor Manders. Like Evadne, Mrs. Alving breaks

73 Many of the reviews the play received noted the number of women in attendance that evening. In the aforementioned review by Scott, he notes: “But, strange to say, women were present in goodly numbers; women of education, women of refinement, no doubt women of curiosity, who will take away to afternoon teas and social gatherings, the news of the sensation play that deals with subjects that hitherto have been to most men horrible and to all pure women loathsome.” Likewise, the review in The Daily Chronicle expresses some surprise at the large attendance of women at the play.

74 The plot of Kate Chopin’s “Mrs. Mobry’s Reason” (1891) is quite similar, except that the child in question is a young woman hoping to marry.
away from marital conventions with the hope of saving herself and her son from a grim fate. Evadne does this by refusing to consummate her marriage, and Mrs. Alving attempts to do so by fleeing the marriage altogether. Mrs. Alving, thus, serves as the expert in a tale of innuendo, veiled mystery, and gossip; it becomes her duty to uncover and reveal hidden truths. Her son Oswald takes the place of Grand’s Edith, blissfully unaware of the wickedness of his legacy until it is far too late to save him. Once his own health begins to decline he must rely on his mother’s knowledge to decipher the decay of his own body. The truth of his body—his disease, his desire for Regina, etc.—becomes the reality of inheritance, a reality that his mother had tried desperately to protect him from. Meaning is made for the man, in other words, through the subversive woman.

Oswald’s father, Captain Alving, as many reviewers declared him, was a “bad man,” though no one suspected this aside from his wife. Like Mosley Menteith, Captain Alving is able to mask his licentiousness and, by extension, his affliction because he is privileged both with a pleasing physique and an admirable family name and fortune. His youth was spent, apparently, engaging in lustful indulgence and, as Mrs. Alving reveals to Pastor Manders, his appetite was not quelled following their union. On the contrary, his lust seems to have been exacerbated in marriage. Mrs. Alving tells Pastor Manders that her husband lived, “After nineteen years of marriage, as dissolute—in his desires at any rate—as he was before you married us” (34). His inability, or lack of desire, to control his sexual impulses led him to partake in prostitution and, most horrifically, to rape a servant-maid, an event which resulted in a child, Regina. His lust for Regina’s mother is rerun through Oswald’s desire for Regina, a replication with a
heightened sense of taboo because the two are siblings. Thus, it would seem, pathological sexuality is not only congenital, like syphilis, but each generational mutation brings a brand of sexual depravity more horrific than the first.75

While the precise cause of Captain Alving’s death is somewhat murky, Oswald’s decay is most certainly a result of the disease, a reification of his father’s legacy of depravity. He tells his mother that his disease is his “birthright” and notes that the disease has now extended from “down there” to his brain (86). The infection has spread, literally, from the sex organs to the brain and, more importantly, his words indicate that the corruption of the body has bled into identity. Sexual depravity and biological decay, in Ghosts, is represented categorically as masculine, despite the fact that neither Mrs. Alving nor Regina are paragons of female purity. Moreover, as each generation of males has the potential to be worse than the last, the only antidote is the rupture of the family unit and severing the ties of corrupt lineage.

Because Oswald’s disease is inherited from his father through the body of his mother, who appears to be free of infection, one could argue that Ibsen has employed the traditional paradigm in which disease is traded between men through women. In other words, the woman continues to be the nexus. However, Helen Alving’s body is not the space from which disease festers and grows. On the contrary, all seeds of contamination of the play, both literal and figurative, can be traced back to Captain Alving. Incidentally, Mrs. Alving takes on the role of the proverbial mask of infection, as illustrated in the Frascatoro

75 Mary Spongberg uses the term “pathological sexuality” to describe both Captain Alving and Oswald (162).
etching. Her life’s work, she tells Pastor Manders, was in concealing her husband’s dealings. In what she calls her “ceaseless struggle,” Mrs. Alving tells Manders that her primary duty as a wife was in the compulsive masking of her husband’s “dissolute living”:

After Oswald’s birth, I thought Alving seemed to be a little better. But it did not last long. And then I had to struggle twice as hard, fighting for life or death, so that nobody should know what sort of a man my child’s father was (34-35).

Her extensive efforts in concealing her husband’s business come, eventually, at the expense of her own happiness and peace of mind. Thus, the suffering which syphilis brings is displaced from the body of the carrier to the body of the woman condemned to bear his secrets. Mrs. Alving is the active sufferer.

Ibsen also strongly implies, like Grand, that Mrs. Alving’s subversive knowledge and commitment to what Pastor Manders calls her “pestilent spirit of self-will” inoculate her, in a sense, from infection (45). Her actions that Manders describes as monstrous—her estrangement from Alving and the abandonment of her son—prove to be her only defense against infection. Ibsen, then, goes beyond the somewhat conservative solutions of Grand who, as Meegan Kennedy surmises, “wishes to reform marriage, not do away with it” (263). In the world of *The Heavenly Twins*, marriage is possible and even favorable with carefully structured boundaries. In *Ghosts*, the institution is not salvageable. Pastor Manders fails to see this when he forces Mrs. Alving to return to her husband forces her to resume “the path to duty” (33). Just as social and cultural illiteracy leads to Edith’s misery and destruction, Mrs. Alving’s adherence, although reluctantly, to womanly duty, effectively, mean death for her son and her own
unending suffering. Marriage as an institution, in Ibsen’s view, only promulgates a system that is, at its heart, corrupt and iniquitous, reified through the viral transmission of disease.

Emma Frances Brooke’s novel *A Superfluous Woman* is likewise preoccupied with inheritance, similarly symbolized by references to “ghosts.” In the opening of the novel, Jessamine Halliday inhabits Dr. Cornerstone’s ward afflicted, as he diagnoses her, “with a splenetic seizure brought on by ennui and excessive high breeding.” Dr. Cornerstone insists that she has no disease, but that her sickness is instead “A fantasy, a mere pose. Her imagination had been touched by the picturesque interest of mortal decay upon aesthetic furniture,” the only cure for which, as he declares, is “Reality” (11). Upon her release from the hospital, Jessamine abandons society life, writing to Dr. Cornerstone that she now seeks “to work and to live simply” (34). Despite her best efforts, and in spite of finding love and affection with a simple but sincere Highland farmer, Jessamine returns to London to marry Lord Heriot, thus fulfilling her womanly obligations and her Aunt Arabella’s wishes. Like Grand’s Edith and Ibsen’s Mrs. Alving, the choice to perform one’s conjugal duties only brings tragedy. She bears multiple children who are afflicted with congenital syphilis leaving, as Brooke writes late in the novel, the once vivacious Jessamine, merely, “the ghost of Jessamine” (259). She, like Edith, dies in a maddened feverish state.

Jessamine Halliday, in many ways, harkens back to Marianne Dashwood. Like Marianne, Jessamine is plagued by a nervous body, the condition of which is kindled, according to her doctor, by a precarious combination of fantastical thinking and a weak physique. Unlike Marianne, though, Jessamine’s stunning
beauty seems to be uniquely problematic. In describing her in the opening chapter, bedridden in a sanitarium, Brooke, just as Grand did in *The Heavenly Twins*, seems to be channeling Zola’s *Nana*:

> She lay there as beautiful and still as a marble statue. Her dark hair fell upon the pillow and over the edge towards the carpet; her dark lashes rested on her cheek; her features were small, and there was a dimple near her mouth, and a dent in her chin; her eyebrows were wide and beautiful as a bird’s wing (6).

While the parameters of beauty outlined in this passage are conventional, the contextual placement of the description, the sickroom, moves the moment from eroticization to a clinical assessment. Beauty, in other words, becomes part of symptomatology. This pathologization of female aesthetics is solidified when Dr. Cornerstone is struck by her physique but sees it, curiously, as a symptom of her underlying complaint. He tells Carteret: “I never saw a creature so fatally feminine. She was just a pretty piece of sexuality. She never thought of herself save as a dainty bit of flesh which some great man could buy” (12). Cornerstone is of the Buchanian or Trotterian school of nervous disorders, prescribing courses of fresh air and training in reality. Cornerstone argues that Jessamine’s condition marks her as a dangerous figure, and is particularly fearful that her potential marriage to Lord Heriot could mean ruin for him. He remarks to Cateret: “But before my mind had pictured the Paradise around this modern Eve, I saw already the snake lurking in the grass—fatal and horrible” (21). Her fiancé, on the other hand, is described by Cornerstone as “the greatest catch in Europe” (22). Cornerstone, of course, has completely misdiagnosed these bodies just as legislators and physicians had misjudged the cause and nature of venereal
infection. Like Mrs. Alving, Jessamine attempts to flee her unfulfilling society life and, again like Mrs. Alving, duty and the lure of orthodoxy bring her back.

However, the marriage she makes to “the greatest catch in Europe” is, as Cornerstone is forced to admit, “a degradation” (262). Like Mosely Menteith of *The Heavenly Twins*, Heriot’s handsomeness masks a deplorable family legacy that he has both inherited and, apparently, perpetuated. To Dr. Cornerstone, a bedraggled Heriot praises Jessamine’s commitment to their marriage saying,

> Lady Heriot has been a good wife, doctor. [...] I’ve nothing to say against her. I wouldn’t have anything happen to her for half my fortune. When I married her she was a pack of whims; but I like that. It’s wonderful how she changed after. Steadied, you know. Well, I don’t mind telling you she set herself to reform me (280).

For all her former flaws, Jessamine, now Lady Heriot, has been tamed by matrimony. Her transformation from flighty girl to domestic angel would, in a different sort of novel, provide the example for what a recovery from nervousness or hysteria ought to look like. This, though, is a New Woman novel. As such, Lady Heriot will not be rewarded for surrendering to the old ways of womanhood. Like Edith, another ideal of the old ways of womanhood, the promise of domestic tranquility is disrupted by the misdeeds of her husband and the birth of children who serve as evidence of his contamination. Dr. Cornerstone, called to examine the couple’s ailing children, is shocked to discover each of them in various stages of physical deterioration:

> He passed with rapid scrutiny and a horror-stricken heart from one to the other. On those frail, tiny forms lay heavily the heritage of the fathers. The beaten brows, the suffering eyes, expiated in themselves the crimes and debauchery of generations (271).
Unlike Mosley Menteith, Heriot has inherited a legacy of depravity, indicated by his own syphilis. Cornerstone observes:

...Lord Heriot’s past was a long one; it did not begin with himself. There had been a sameness in the history of the Heriots for generations; it was varied only by the differences in manifestations caused by the different tastes and fashions of the time. The lines of the resulting contour cut deep. Violence and excessive animation in the first instance—the unabashed and muscular tiger who founded the family—had, in the inevitable processes of time, degenerated into meanness, irritation, and vice in such members as did not reap their heritage in insanity, disease, and shocking malformation.

The “natural extinction” of this degenerating line was only prevented, apparently, by their wealth and titles (277). The story of venereal infection, in *A Superfluous Woman*, becomes more than the story of predatory men preying on unsuspecting innocent girls. Its presence in the Heriot household points to an enduring systemic blight that men, regardless of the consequences, will work to maintain. Disregarding the obvious physical and mental handicaps of his children, his wife’s declining health, and despite the fact that Lord Heriot is aware of his role in their conditions, he begs Cornerstone to “set her on her legs again, and give me my heir” (284). Heriot asserts, also, that the fate of their future offspring “rests on her” (280). Like Mrs. Alving’s secret-keeping, the future of the Heriot race is a burden that Jessamine, literally, has to carry. It is also, as it was in *Ghosts*, a burden that is impossible to overcome.

In her letter to Dr. Cornerstone, Jessamine laments: “I am so sick of shadows). The sentiment recalls the familiar line from Tennyson’s “Lady of Shalott: “I am half-sick of shadows.” In Tennyson’s poem, the Lady of Shalott’s desire and curiosity ignite a curse. The Lady of Shalott, in looking out her window at Lancelot, disobeyed the instructions given to her upon her
incarceration in her tower, the punishment for which is a depleting death. In *A Superfluous Woman*, Jessamine Halliday, sick of shadows, likewise disobeys the rules, venturing out of society and into the Highlands. Death only comes to her upon being brought back to the realm of shadows, as it were. *A Superfluous Woman* demonstrates, as *The Heavenly Twins* did, that the codes established with the pretense of protecting women, in fact, will ultimately lead to their destruction. The story of Jessamine Halliday, in a sense, is a mutated version of Austen’s *Sense and Sensibility*. Both Jessamine and Marianne Dashwood open their narratives in physical shakiness, brought on by a devotion to fantasy. While becoming “steadied” saves Marianne, it means death for Jessamine. While Grand leaves her readers with a modicum of optimism, with “revisions” of traditional marriage through Evadne’s second and Angelica’s first, Brooke’s vision for the future is unrelentingly cynical. Marriage, the family, and the aristocracy, in their current states, cannot be salvaged. Brooke’s implicit argument is, for women, to forego convention completely by abandoning the system, allowing it to self-destruct.

The New Woman novel proposes new avenues for advancement for women in the turn to modernity. At the end of a long legacy of narratives predicated on a “good” marriage making a woman’s future happiness, the New Woman writer charges that a woman’s only hope in a rapidly deteriorating civilization is to amend or reject the old modes of womanhood. In Grand’s more conservative model, it is the path of education, which allows you to make sound marriages and pragmatic choices regarding the integrity of one’s body and personhood. In the more nihilistic work of Emma Frances Brooke, working
within the current system is unacceptable. Divorcing oneself from a system that is, inevitably, degenerating is the only solution. In placing venereal disease at the center of their novels, Grand and Brooke make the case that the physical and mental breakdown that typifies narratives of bad women is now displaced on the actions of bad men and the ignorance of the women associated with them. Edith and Jessamine are sacrifices, as Mary Spongberg writes, “on the altar of male lust” (164). In a larger sense, though, they are sacrifices on the altar of compulsory patriarchy. In shifting the place of the woman in the infection narrative from center to end, and in highlighting the suffering of women within that narrative, Grand and Brooke are both revising the venereal disease map and, more poignantly, rewriting the definition of womanhood through its relationship to embodiment.

The venereal disease narrative is, likely, particularly fruitful for the political project of the New Woman novel because it encapsulates the endemic failures of institutional patriarchy—in marriage, in the law, and in the clinic. In rejecting the gyno-centric diagram of venereal disease that precipitated the C.D. Acts, and in building their narratives around a congenital infection schematic, writers like Grand and Brooke draft a gendered plot centered on regeneration. As Angelique Richardson writes of Grand’s narrative strategy: “Thus, degeneration was a masculine narrative, while regeneration was feminine” (240). For all its pessimism, A Superfluous Woman even suggests that regeneration is possible through the retelling of Jessamine’s narrative by Cornerstone, and in the reexamination of his evaluation of her through that storytelling. The novel ends when Dr. Cornerstone travels to the Highlands to find Colin Macgillvray, the
farmhand Jessamine loved but chose not to marry. In the final pages of the narrative, the two men declare Jessamine, the formerly declared “fatally feminine creature,” “true as steel” (335). Incidentally, both *A Superfluous Woman* and *The Heavenly Twins* end with the perspective of a physician, Dr. Cornerstone and Evadne’s second husband Dr. Galbraith, respectively. The voice of the syphilitic woman being snuffed out, both Grand and Brooke rely on the voice of the physician to conclude her story. Thus, in an exercise of irony, the physician, previously complicit in the narrative of degeneration, becomes the woman’s advocate in the regeneration narrative.

In the same way that the consumptive is the “perfect vessel for the social problem novel,” the syphilitic woman may be the perfect figure for the New Woman novel. As the consummate “other Victorian,” not unlike the New Woman herself, she possesses a dual signification as a social pariah and a victim of civilization. In the New Woman novel she becomes, like the consumptive, the voice of injustice. Through her disease and her dying declarations, she amplifies the dire consequences of unchecked institutional patriarchy. In other words, her narrative does much of the political work of the New Woman novel. Hers is a cautionary tale, in the vein of the “fallen woman” narrative. Through her story, though, we do not learn about the dangers of succumbing to temptation or lust. Instead, through her tragic example, we learn of the potentially life-saving value of an education, of instinctual knowledge, and of challenging authority. The syphilitic woman, thus, is the herald of a new era of feminist thought.
Conclusion

Do Diagnoses Matter?

Last summer, my students and I earnestly tried to diagnose Tiny Tim’s affliction. As a group, we used the tools at our disposal, everything from experiential knowledge to cursory searches on Web MD, to pinpoint the precise malady would strike both the lungs and legs of a small child and could, apparently, be cured through access to a sizeable amount of money. After several minutes of moderately heated discussion, I asked the group: “Does it matter?” There was momentary silence before a particularly impassioned student declared, “Of course it matters!” There was a longer pause after I queried, “Why?” After considerable silence and prolonged agony, I asked, “What would it mean for A Christmas Carol if Tiny Tim’s affliction was caused by his own negligence, rather than something genetic? What if Tiny Tim’s limp and bad lungs are caused by congenital syphilis? What if he had something Scrooge couldn’t fix? What if he wasn’t sick at all? What if he was a healthy, albeit impoverished, child? Would it change things?” After some consideration, the consensus was, “Yes.” It would change the way we see Tiny Tim; it would change the degree of onus we place on Scrooge to use his fortune to help him; it would fundamentally change the story.

Diagnoses do matter. They matter because they can cement or alter a reader’s sense of affection or disgust for a character, because they have the power to map and reroute the terrain of the narrative, and because their distinctive qualities and acuteness can shape the conception of the self. Marianne Dashwood cannot fall out of love with Willoughby and into love with Brandon
until nervous fever short-circuits her sensibility. Nervous fever makes Marianne who she is; no other malady could do so. Similarly, Helen Burns could die of nothing other than consumption. Dying of typhus, like the other sick girls in Lowood, would diminish our ability to see her as a martyr for social justice and would deprive Jane of the opportunity to adopt her essence in the sickroom. Jane Eyre cannot become Jane Eyre unless Helen dies of consumption. She would become an altogether different, perhaps even unrecognizable, Jane.

If we grant that the Victorian novel details the forging of identities, we must also acknowledge that nineteenth-century writers recognized and utilized the transformative capacity of the body within that venture. Undoubtedly, disease is omnipresent in Victorian fiction because sickness and death were prevalent in the daily lives of Victorians, but it is also because it has the power to make and unmake identities. It is no coincidence, in Dickens’ *Bleak House* (1852), that Esther Summerson’s disfiguring disease brings with it the discovery of her parental legacy, for example. Esther’s physicality is radically altered in her illness, an alteration that triggers a ripple effect through the other aspects of her existence. Likewise, Caroline Helstone’s illness in Charlotte Brontë’s *Shirley* (1849), forces her mother to, at last, reveal herself to the daughter she abandoned. Illness, in both cases, proves to be the stimulus for identity reconciliation.

Sickness, for better or worse, is at the core of being, particularly when the underlying malady or injury is enduring, debilitating, or incurable. Disease narratives housed within Victorian novels allow a distinct mode of being to take shape. Not every example of illness, though, is necessarily transformative and
revelatory in nineteenth-century fiction. Jane Bennett falls ill early in *Pride and Prejudice*, for example, with nothing particularly catastrophic or remarkable occurring as a result.\(^\text{76}\) Instances like this, which appear substantially in Victorian novels, are not “disease narratives.” They are flashes in the sickroom, like a photograph or a sketch, but they are not necessarily imbedded in the architecture of the narrative. Jane Bennett’s sense of self, and the reader’s sense of her, is not constructed around her health, or lack of it. That is not the case for the women described in this project. “Getting sick,” as Jane Bennett does, is fundamentally different from “being an invalid,” in the way that Sara Coleridge or Harriet Martineau declare themselves in their writings.\(^\text{77}\) The first is a temporary and often innocuous impediment; the latter is an interminable state of being. For the most part, the women described in this project are chronically ill. They can each claim the invalid status, even if that identity does not carry them to the grave. It is an identity category that is as significant, in Victorian fiction, as being a member of the aristocracy, being an orphan, or being English.

The writers discussed in this project, from Burney to Brooke, consistently grant that the body is at the center of identity politics and, thus, it must be prominent in the foundation of a developmental narrative. Burney clutches her own breast while declaring “C’est moi, monsieur.” Emily Brontë’s novel posits

\(^\text{76}\) It’s worth acknowledging, though, that this event gives her long-term access to the Bingley home, and Bingley himself, which helps strengthen his early affections for her.

\(^\text{77}\) Harriet Martineau became bedridden after being diagnosed with a tumor in her uterus in 1839. Her autobiography, *Life in the Sick-room* (1844), chronicles her experience with chronic illness.
that the soul is a part of material reality; spirit and body are not distinct. The congenital infection that marks the children of Captain Alving and Heriot allow the world to see who their parents are and, thus, who they are. The attempts of Heriot and Mrs. Alving to hide the secrets of an odious familial history are futile; those legacies are written on and in the body. In these narratives, biology is destiny. This particular destiny, unfairly or not, is most expressly felt in narratives of female development because of the ingrained belief that women’s faculties were more beholden to the whims of a fluctuating physiology, dominated by an unstable reproductive system. Thus, the story of a Victorian woman is, almost inevitably, also the story of a body.

The body, too, is readily recognized in these narratives a means of gaining knowledge—through the reading of one’s own body or through the bodies of others. Alice James both “knows” and “feels” that something is growing inside of her before it can be detected by experts. The inability for Catherine Earnshaw to express what she both feels and knows, that Heathcliff is her one true love, ultimately leads to her death. “Feeling” and “knowing” consistently become conflated, even when the body provides misinformation, as in the case of Sense and Sensibility. It is not, in Austen’s case, that body knowledge is always wrong. New information can alter feeling, and vice versa; there is a symbiosis between reason and sense. In fact, a refusal to rely on the body’s knowledge often leads to disaster. In The Heavenly Twins, Edith’s life could have been spared, had she not ignored the knowledge that her body possessed regarding her future fiancé. The same is true for Jessamine Halliday. The body’s knowledge, in many cases, trumps the assertions of so-called “experts.” Embracing embodiment allows the
women in these narratives to construct their own dominion of expertise and put their own unique body of knowledge into practice.

This ability to feel knowledge within one’s body seems, in the works discussed in this project, to be an almost exclusively feminine aptitude. Masculine-dominated expertise, even medical expertise, is often not the source of the most accurate information. The disconnect between expertise and instinct is, arguably, most famously exemplified in Gilman’s “The Yellow Wall-paper.” The protagonist, a fictional stand-in for Gilman herself, is at the mercy of doctors, including her own husband, who set her on precisely the wrong course for a cure. Dr. Cornerstone severely misunderstands Jessamine Halliday and the impending “disaster” of her marriage. He believes a woman so severely afflicted with nerves would be an unsuitable spouse. Ironically, it is Jessamine’s instinctive distaste for Heriot that is validated in the end. The authoritarian Mr. Brocklehurst is not an expert on God, or much of anything, in *Jane Eyre*. Instead, it is the dying Helen Burns who holds the keys to that knowledge, a status that is reinforced by her malady. While the writers in this project, often, reinscribe the idea that women are beholden to their bodies, a notion often decried by feminist critics, each one also implicitly proposes that the workings of the body are, almost invariably, superior to the oft extolled knowledge that years of medical training or intense study can bring. Ultimately, it would seem, there is no adequate substitute for “gut feeling.”

A holistic understanding of Victorian narrative is incomplete without a consideration of the body’s narrative strength. Many literary critics have explained that narrative can be written on the body—through scars, wounds, or
tattoos, for example—but there has been less consideration for the ways in which bodies write narratives and, further, how corporeality combined with narratology shapes subjectivity. Peter Brooks recognizes both in his *Body Work: Objects of Desire in Modern Narrative* (1993) when he describes the body as, “an object and motive of narrative writing—as a primary, driving concern of the life of the imagination” (xi). He goes on to explain that this power is derived from our own complicated relationship to embodiment:

Our bodies are with us, though we have always had trouble saying exactly how. We are, in various conceptions or metaphors, in our body, or having a body, or at one with our body, or alienated from it. The body is both ourselves and other, and as such the object of emotions from love to disgust (1).

Victorian writers, particularly women writers, consistently grapple with these paradoxes. The conflicts, both internal and external, which accompany embodied experience drive these narratives much in the same way that the conflict between “self and culture” or “man and nature” drive other narratives. These novels are the “working through” of selfhood, in which the body, and thus the subject, must become acclimated to its world to achieve harmony. The text, therefore, follows the body through its trials and triumphs. When driven by disease, the text has no choice but to follow the natural course that the pathology maps.

Diseases come with their own narrative and representative makeup and, like any literary or film genre, they generally have a relatively predictable course and outcome. A case of nerves can take many paths, depending on degree, cause, and outlet. Too little or bottled passion can, apparently, cause cancer. Too much can lead to a nervous breakdown and fever. Passion for spiritualism can lead to consumption, and passion for carnal affairs can lead to venereal disease. The
initial germ, inharmonious passion, carries a variety of consequences. There is predictability, though, based on what we can ascertain based on its etiology and its objective. That predictable course results in the production of generic conventions and formulas. Frenzied girls like Marianne will deteriorate gradually before collapsing in fever. The angelic religious devotee will develop a cough and a pale pallor. The early instances of bodily disharmony can, thus, allow us to predict the fate of its host and, furthermore, allow us to ascertain what sort of narrative we have before us.

It is worth considering, then, the ways in which diseases function as genres and, moreover, how they subsequently inform pre-established generic conventions in Victorian fiction. Consumption’s particular cause and course is well suited to the social problem novel, a genre in need of a tragic voice to herald its political project. Venereal disease is adaptable to the New Woman Novel because it is a disease fiercely, and typically unfairly, associated with wayward and dangerous women. The diseases selected by these writers are not random accidents. They were selected with calculation based on the particular assumptions and unique directions that come with them. Changing the malady, I would ultimately submit, could mean an altogether different novel, in the same way that changing the setting from, for example, an industrial city to the countryside could mean the difference between a pastoral romance and a gritty realist novel. A different disease means a different path, and a different path means a different genre. If we believe that the final product of a Victorian novel is a harmonious subject, it is reasonable to assume that a different disease would produce an altogether different sort of identity in the end. Personhood, then,
often dependent on the stability or instability of the body in Victorian narrative.

If the Victorian novel is formed around the uncertainty of identity, this project, ultimately, asks that we examine how that anxiety is fueled and resolved by an unstable body. What we often discover is that the body resides at the center of subjectivity. Narrative harmony, then, might mean coming to terms not only with the constraints of society or the limits of desire but with the inescapability of embodied existence.
Bibliography


National Library of Medicine, Bathesda, MD. *Sexual Visions Images of
Gender in Science and Medicine between the Eighteenth and Twentieth
Centuries*. 82. Print.

Baudrillard, Jean. *Simulacra and Simulation*. Ann Arbor: University of

Beddoes, Thomas. *Essay on the Causes, Early Signs, and Prevention of
Pulmonary Consumption for the Use of Parents and Preceptor*. Bristol:

Birkett, John. *The Diseases of the Breast, and Their Treatment*. London:

Print.

Boudreau, Kristin. “A Barnum Monstrosity’: Alice James and the Spectacle of

Bowditch, Henry Ingersoll. *Is Consumption Ever Contagious, or Communicated
by One Person to Another? A Paper Prepared for the Boston Society for


Brontë, Emily and Richard J. Dunn. *Wuthering Heights: The 1847 Text,


Brooks, Peter. *Body Work: Objects of Desire in Modern Narrative*. Cambridge:

------. “Storied Bodies, or Nana at Last Unveil’d.” *Critical Inquiry*, 16.1 (Autumn,


----- and Angus Easson. *Wives and Daughters*. Oxford: Oxford University Press,


------. *She Never Told Her Love*. 1858. Photograph. George Eastman House Collection, Rochester.


Scheinberg, Cynthia. “‘The beloved ideas made flesh’: *Daniel Deronda* and Jewish Poetics.” *ELH*. 77:3, Fall 2010, 813-839. Print.


Shelley, Mary, Betty T. Bennett, and Charles E. Robinson. *Mathilda*. *The Mary*


Vita

Erin Wilson grew up in Tulsa, Oklahoma, the daughter of James and Ellen Gore. She earned her Bachelor of Arts from the University of Tulsa in 2005, with a certificate in Women’s Studies. She stayed at the University of Tulsa for her Master of Arts, which she received in 2007. While in the graduate program at Tulsa, she received an award for Excellence in Teaching. She entered the Ph.D. program at the University of Missouri in August of 2007 as a G. Ellsworth Huggins Fellow. While at Missouri, she also pursued the graduate minor in Women’s and Gender Studies. Her research interests include 19th-Century British Literature, film studies, genre studies, and body theory. In the fall of 2012, she will become a Postdoctoral Fellow for the Honors College at the University of Missouri.