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The Politics and Poetics of Diagnosis in Nineteenth-Century American Literature and Medicine

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Abstract

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By Lindsey Grubbs

This dissertation explores the relationship between literature and diagnosis in the first hundred years of American psychiatry, beginning in the late eighteenth century. Drawing together recent scholarship on the relationship between literature and medicine in the nineteenth century and disability studies theorists' calls for a fuller accounting of the hazy margins of disability identity, it investigates "problem cases" of diagnosis. Specifically, it traces attempts to delineate categories of moral disorder, from Benjamin Rush's coining of "anomia" in 1786 to designate immorality as a medical condition, through hysteria, understood in the 1880s as a physical nervous disorder that both caused and was caused by immorality. These disorders are particularly interesting because of their liminal pathological status: their existence was so routinely contested that they sketch the moving outline of medical knowledge. Lacking clear biological markers, physicians relied upon narrative to systematize the medicine of the mind, drawing on the genres most familiar to them in popular culture, from the Gothic novel to the detective story to the Realist novel. This dissertation's four chapters demonstrate how literary genre and psychiatric diagnosis developed in tandem throughout the nineteenth century: the sensational gothic novel is paired with arguments for the medical management of personality, the birth of forensic psychiatry with early detective fiction, the introduction of clinical medicine to America with the objectivity-defying Romance, and the rise of Realism with new certainty about the medical value of patient testimony necessitated by early neurology. These chapters demonstrate the ways that nineteenth-century physicians drew on these genres—including stereotyped characters and sentimental plot devices—as they composed the case studies that built diagnostic knowledge in their young discipline. At the same time, they ask how literature served to process, simplify, disseminate, and ethically question new categories of moral disorder. Looking at the function of literary rhetoric in diagnosis and diagnostic rhetoric in literature, "The Politics and Poetics of Diagnosis" clarifies literature's role in medicalization, and medicine's impact on changing literary form throughout the nineteenth century—the period that saw the first several generations of both American psychiatry and a literature understanding itself as uniquely American.

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Table of Contents

The Politics and Poetics of Diagnosis in Nineteenth-Century American Literature and Medicine

Tabitha Gilman Tenney's 1801 novel *Female Quixotism* revolves around the adventures of Dorcasina Sheldon, who is "far gone with the novel-mania."[1] Her pathological obsession with novels has destroyed her ability to tell fantasy from truth and left her susceptible to manipulation by ill-meaning suitors. Representing Dorcasina's disordered relationship to reality, the narrator of this satirical novel makes clear the etiology of this mania (in inappropriate novel-reading) and clarifies its stakes. Dorcasina holds "the most extravagant" notions "that had ever yet entered the romantic imagination of a lovesick girl, and such as no lady, in her senses, would have attempted to execute, who was not blinded to all sense of propriety, and regard to reputation" (67). The preface to the text states that this lesson can provide women a path to "avoid the disgraces and disasters that so long rendered her despicable and miserable," simply by "observing [Novels and Romances'] baneful effects" on Dorcasina (iv). Inviting a diagnostic vision, the narrator trains the reader in healthy and unhealthy reading practices through judgement of Dorcasina's moral failures.

In the common fictionalizing gesture of the day, the "compiler" of the text rejects that it is a "mere romance, and Hogarthian caricatura, instead of a true picture of real life." Making clear the satirical thrust of the text, however, the writer compares it to "the most extravagant parts of the authentic history of the celebrated hero of La Mancha, the renowned Don Quixote" (iii-iv). Advertising the tongue-in-cheek manner in which the text should be read, the preface makes clear that this novel, at least, can be read without the fear of an infectious eroto-mania.

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[1] [Tabitha Gilman Tenney,] *Female Quixotism: Exhibited in the Romantic Opinions and Extravagant Adventures of Dorcasina Sheldon* (Boston: J.P. Peaslee, 1829), 1:67.

The "authentic history" of Quixote also played a role in American physician and so-called "Father of American Psychiatry" Benjamin Rush's early medicine of the mind. In an 1810 lecture, Rush used a literary example to establish the universality of his theory that even long-standing mental disorder could be cured: "Such cases must be common in all countries; or Cervantes, who copied all his characters from nature, would not have restored Don Quixote to the use of his reason in the close of his life of folly and madness."[2] In establishing medical jurisdiction over mental action, Rush drew on the same source material as Tenney. Taking Don Quixote seriously, Rush suggests that certain literary texts, while not precisely true, nevertheless represent truths about human character—by copying "from nature," the literary artist serves as the kind of observer of character required by the burgeoning medicine. Despite Tenney's joke about the "authentic history" of Don Quixote, her novel, too, takes for granted that the exaggerated characters and situations of fiction are able to reveal a truth about human development—that social isolation and excessive uncritical novel-reading can create an unhealthy credulity that she counteracts through satire, attempting to instill an ironic skepticism in her readers. For both, then, literature is able to capture some aspect of human behavior with sufficient authority to hone the medical gaze for both professional and lay audiences.

This dissertation explores the relationship between literature and diagnosis in the first hundred years of what we would now call American psychiatry, beginning in the late eighteenth century. Drawing together recent scholarship on the relationship between literature and medicine in the nineteenth century and disability studies theorists' calls for a fuller accounting of the hazy margins of disability identity, my work investigates "problem cases" of diagnosis. Specifically, I trace attempts to delineate categories of moral disorder, from Rush's coining of "anomia" in 1786 to

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[2] Benjamin Rush, "Lecture XVI. On the Study of Medical Jurisprudence. Delivered November 5th, 1810," in *Sixteen Introductory Lectures, to Courses of Lectures upon the Institutes and Practice of Medicine* (Philadelphia: Bradford and Innskeep, 1811), 374.

designate immorality as a medical condition, through hysteria, understood in the 1880s as a physical nervous disorder that both caused and was caused by immorality. These disorders are particularly interesting because of their liminal pathological status. Their existence was so routinely contested that they serve to draw the moving outline of medical knowledge: both the people arguing for and against them articulated what is necessary to verify medical knowledge. Lacking clear biological markers, physicians relied upon narrative to systematize the medicine of the mind, drawing on the genres most familiar to them in popular culture, from the Gothic novel to the detective story, the Romance, and the realist novel. I demonstrate the ways that nineteenth-century physicians drew on these genres—including stereotyped characters and sentimental plot devices—as they composed the case studies that built diagnostic knowledge in their young discipline. At the same time, I show how literature served to process, simplify, disseminate, and ethically question new categories of moral disorder.

The writers at the center of this dissertation are asking questions about the relationship between mind and society: What is the American mind? What is the diseased American mind? How do we know? And what does that knowledge ask of us? Diagnosis is a discursive practice with profound influences its subjects, in terms of medical treatment or institutionalization, on legal practice and incarceration, on political rights, on the education of women and people of color. Speaking broadly about the medicine of the mind and mental disorders, I stitch together what we would now call psychiatry, psychology, and neurology. The history of medicine in general offers important links between social institutions, but the history (and pre-history) of psychiatry and neurology are particularly interesting in their emphasis on questions of personality, selfhood, identity. Through controversial boundary cases of pathologization, I explore narrative negotiations of the liminal spaces between health and illness, mental and physical disorder, agency and compulsion, sickness and sin. Looking at the function of literary rhetoric in diagnosis and diagnostic

rhetoric in literature, I seek to clarify literature's role in medicalization, and medicine's impact on changing literary form throughout the nineteenth century—the period that saw the first several generations of both American psychiatry and a literature understanding itself as uniquely American.

Among my guiding questions are: How did writers, doctors, and patients negotiate the diagnostic boundaries between illness and health in the absence of biomarkers? What kinds of narratives responded to the medically unverifiable? How do narratives of diagnosis, medicine, or illness become legitimized? How were the rights of testimony differentially distributed? What counts as evidence of pathology? What roles do "doubt" and "suspicion" play in medical diagnosis, literary narrative, and the interplay between the two? How do different literary genres reify, challenge, or dovetail with diagnostic logics? Ultimately, the cultural history of diagnosis provides insight into medical epistemology, helps sketch the moving boundaries of the medical (and medico-legal) subject, and uncovers the ways in which readers are trained to forensically evaluate themselves and others. I argue that the narrative structure—and often fictional source material—grounding new diagnoses for ambiguous and invisible mental conditions renders literary analysis an indispensable tool in this project.

The Poetics of Diagnosis

Writers and physicians—two significantly overlapping categories—from the early republic to the late nineteenth century increasingly attempted to render invisible impairments and illnesses visible through new diagnostic schemas and descriptive practices. Wrestling with the suspicions occasioned by the impossibility of knowing the mind of the other, physicians argued for ever more specialized inquiry: by the time Isaac Ray wrote *Treatise on the Medical Jurisprudence of Insanity* in 1838, he could already argue that diagnosis of legitimate mental disorder (as well as the rooting out of

specious or feigned symptoms) required not just a physician but one who specialized in insanity. In contrast, several decades earlier, Benjamin Rush and a team of doctors tested a case of feigned insanity by checking a pulse.[3] Later still, from his position of post-bellum neurological expertise, George Beard referred to the antebellum period (including previous expert Isaac Ray) as the "paradise of non-experts."[4] Evolving notions of expertise, whether playing out in medical treatment, in court, or in welfare and pension hearings, shaped and were shaped by representation of illness in literary culture.

Beyond simply reflecting the changing ground for claims to authoritative diagnostic power, literature in the long nineteenth century *shaped* that authority, in part by defining the narrative possibilities for physicians attempting to articulate new schemas of mental pathology through case studies and their own fiction. Readers, in turn, were trained to internalize a diagnostic logic and employ a forensic gaze, constantly evaluating the normalcy and aberrance of others, and by extension of themselves. In recent years, literary historians including Justine Murison, Emily Ogden, Benjamin Reiss, and Jane Thrailkill have articulated the ways in which the science of the mind developed in conversation with literary experimentation in the nineteenth century, and Sari Altschuler has demonstrated that imaginative and literary genres in early America directly shaped medical theory and science.[5] Elsewhere, disability historians, literary and otherwise, including Susan Schweik, Ellen Samuels, Lennard Davis, and Rosemarie Garland-Thomson, and Susanna

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[3] Rush, "On the Study of Medical Jurisprudence," 369.
[4] Justine Murison, "'The Paradise of Non-Experts': The Neuroscientific Turn of the 1840s United States," in *The Neuroscientific Turn: Transdisciplinarity in the Age of the Brain*, ed. Jenell Johnson and Melissa M. Littlefield (Ann Arbor: University of Michigan Press, 2012).
[5] See, for example, Justine S. Murison, *The Politics of Anxiety in Nineteenth-Century American Literature* (Cambridge, England: Cambridge University Press, 2011); Emily Ogden, *Credulity: A Cultural History of US Mesmerism* (Chicago: University of Chicago Press, 2018); Benjamin Reiss, *Theaters of Madness: Insane Asylums & Nineteenth-Century American Culture* (Chicago: University of Chicago Press, 2008); Jane Thrailkill, *Affecting Fictions: Mind, Body, and Emotion in American Literary Realism* (Cambridge, Mass.: Harvard University Press, 2007); and Sari Altschuler, *The Medical Imagination: Literature and Health in the Early United States* (Philadelphia: University of Pennsylvania Press, 2018).

Blumenthal have described the ways in which social policy, legal theory, medical science, and literary representation worked together to cement ideas about normalcy and abnormality. [6] My own work draws together these strands, responding to an emerging focus within disability studies on mental and cognitive disabilities, which have often fallen through the cracks of more physically based conceptions of disability.[7] To illuminate the connections between medicine and lay culture, I draw from an eclectic blend of medical and literary texts: letters between physicians and authors, manuscript notes from medical lectures, printed asylum reports, newspaper accounts of madness and crime, and advertisements for medical treatments and facilities – as well as novels, stories, poems, and memoirs. In these texts, I read for two complementary features: what I think of as the literary logic of diagnosis and the diagnostic logic of literature.

To describe the former, I attend to those places in which texts build medical knowledge, proposing new diagnoses or treatments, by using features of literary narrative style or actual fictional case material. Sari Altschuler writes that, "Fiction allowed thinkers to test medical phenomena that would have been unethical to explore physically and also to work through complex problems without committing to a particular solution. Novelistic forays into the lives of others permitted doctors to examine experiences beyond what their individual embodiment would have otherwise allowed."[8] Bringing this argument to bear on the mental and moral sciences, I am interested in how this literary experimentation shaped the idea of a normative American mind. The medicine of the

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[6] See, for instance, Susan Schweik, *The Ugly Laws* (New York: New York University Press, 2009); Ellen Samuels, *Fantasies of Identification: Disability, Gender, Race* (New York: New York University Press, 2014); Lennard Davis, "Introduction: Disability, Normality, Power," in *The Disability Studies Reader*, ed. Lennard Davis, 4th ed. (New York: Routledge, 2013), 1–16; Rosemarie Garland-Thomson, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature* (New York: Columbia University Press, 1997); Susanna L. Blumenthal, "The Mind of a Moral Agent: Scottish Common Sense and the Problem of Responsibility in Nineteenth-Century American Law," *Law and History Review* 26, no. 1 (2008): 99–159.

[7] See Elizabeth Donaldson, "Revisiting the Corpus of the Madwoman," in *Feminist Disability Studies*, ed. Kim Q. Hall (Bloomington: Indiana University Press, 2011), 91–114; Margaret Price, *Mad at School* (Ann Arbor, Mich.: University of Michigan Press, 2011).

[8] Altschuler, *The Medical Imagination*, 11.

mind posed special epistemological challenges for physicians and laypeople. Wrestling with the problem of human opacity, writers attempted to render invisible impairments and illnesses visible through new diagnostic schemas and descriptive practices. Facing patients without clear biological markers of disease, physicians relied upon narratives of behavior to systematize the medicine of the mind, drawing on familiar characters, like Rush's Shakespeareans, and genres, like the Gothic, as they composed the case studies that shaped the boundaries of pathological and moral mental function, defining diagnostic boundaries imbued with moral import. As literature developed new narrative techniques to represent interiority, authenticity, and abnormality, physicians could employ these resources to articulate new schemas of mental pathology through case narration.

At the same time, literature relied on a reader's diagnostic gaze to develop characters and advance plots—what I am calling the "diagnostic logic of literature." Through literature, readers were trained to internalize a diagnostic logic and employ a forensic gaze, evaluating the normalcy and aberrance of characters and, by extension, themselves. Writing about the role of diagnosis in the British novel, Jason Tougaw writes that the "narrator-subject-reader triad creates a complex process of diagnosis and sympathy, each tied to the other. We read the signs or symptoms of the pathology and make a diagnosis. But we are also encouraged to react to pathos with sympathy."[9] The same is true in American literature, as readers of Charles Brockden Brown's *Wieland*, for example, are asked not just to assess the title character's alienating religious principles, but to diagnose him, attempting to identify the moment of his mental break, trace it to precipitating causes, imagine prognosis, and ultimately judge what bearing his pathology has on his responsibility for his acts and whether our sympathy should extend to his monstrous acts. In narrating Wieland's actions, Brown creates medical knowledge, using a story of pathology to provide the data for the invisible workings of the

[9] Jason Daniel Tougaw, *Strange Cases: The Medical Case History and the British Novel* (New York: Routledge, 2006), 12.

human mind, providing information inaccessible through post-mortem examinations. The fictional quality of these experiments also enables them to exceed the limits of medical science, claiming a kind of certainty that eludes the medical practitioner.[10]

Tracing the diagnostic logic of literature and the literary logic of diagnosis, I outline what I call the "poetics of diagnosis." In developing this term, I draw on Catherine Belling's study of the "poetics of contemporary hypochondria."[11] Belling argues that hypochondria is an outgrowth of our need to weave symptoms into a diagnostic narrative. Insisting upon illness that a physician does not see serves to position the "visceral authority" of the body against the authority of medicine (17)—but the kinds of narratives we develop from our symptoms are steeped in the medical narrative and cultural imagination. By investigating the "poetics" of these illness claims rather than their "facts," Belling hopes to move beyond the "truth" or "falsity" implied by medicalized narratives, instead holding analytic space for the unknown and highlighting "the existing discursiveness of medicine." As such, Belling's inquiry into hypochondria restores "the essential place of the methods and texts of the humanities—of reading, in the fullest sense—in the clinic and in medical education" (19). Where Belling brings her analysis to bear specifically on hypochondria, which she reads as a "place where medical knowledge is confronted by doubt" (1) and as a counter to modern medicine's positivist urge, my emphasis on disorders of morality across the nineteenth century will help reveal medicine's moving boundary throughout nineteenth-century America, focusing especially on the stakes of attempts to limn mental and physical disorder.

In addition to producing knowledge about medical epistemologies in nineteenth-century America, exploring the diagnostic logic of literature has repercussions for literary criticism more broadly. Introducing their call for early American disability studies in a recent special issue of *Early*

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[10] On this phenomenon, see Altschuler, *The Medical Imagination*.
[11] Catherine Belling, *A Condition of Doubt: The Meanings of Hypochondria* (Oxford: Oxford University Press, 2012), 20.

American Literature, Sari Altschuler and Cristobal Silva caution against the practice of retrospective diagnosis, which can be "a seductive tool" for critics working "to arrange signs and symptoms into a pattern that illuminates the logic of a text."[12] But rather than "resist[ing] the seduction that diagnosis offers," as they suggest, I examine its epistemological roots in the early national period. Indulging the diagnostic impulse is all but inevitable when reading *Wieland*, a novel in which Brown has intentionally engineered this seduction. One example of the fruits of this impulse might be seen in Christopher Looby's claim that the representation of "the disorders of paranoia, resentment, and recrimination … is meant to be understood as the equivalent, in this familial-national allegory, of the political catastrophe of the Revolution and the social and political uncertainties of its aftermath."[13] To diagnose the Wielands, for Looby and for others, is to diagnose the nation. In tracing these pathological and forensic narratives, I do not intend to perform diagnosis myself, but instead to trace the circulation of diagnostic logics and poetics between overlapping communities of medical professionals, writers, and readers.

Since at least the late eighteenth century, medical theorists have accepted the power of language over the body, and my dissertation examines what forms this language and its effects took across the nineteenth century. In the late eighteenth century, narrative served as more than a way to describe illness, for physicians, men of science, and laypeople believed that the imagination, fueled by the intake of stories, could produce physical symptoms. When a commission, including in its membership Benjamin Franklin, set out to debunk mesmerism in France, they concluded that mesmerism was not the powerful force that could create physical symptoms like fits in its objects—imagination was. But, as Emily Ogden clarifies, it was not simply that those mesmerized were tricked

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[12] Sari Altschuler and Cristobal Silva, "Early American Disability Studies," *Early American Literature* 52, no. 1 (2017): 13, https://doi.org/10.1353/eal.2017.0000.
[13] Christopher Looby, *Voicing America: Language, Literary Form, and the Origins of the United States* (Chicago: University of Chicago Press, 1996), 151.

into misperception, but rather that they truly experienced the symptoms.[14] Justine Murison also lays out the nineteenth-century belief that "fiction, whether moral or licentious, can infiltrate the reader—get beneath her very skin to shake her nerves and upset her physiology." The nerves, which could be influenced both by the external environment and internal thought are "poised at the vulnerable border between one's inner domains and the social landscape of the nineteenth century."[15] The study of the nineteenth-century mind was thus the study of narratives circulating between mind, body, and society.

More than a century later, foundational thinkers at the intersection of medicine and the humanities continued to articulate the power of language in the realm of illness. Medical anthropologist Arthur Kleinman writes that illness narratives are so powerful that they can shape the physical, social, and mental experience of symptoms. They "tell us about the way cultural values and social relations shape how we perceive and monitor our bodies, label and categorize bodily symptoms, interpret complaints in the particular context of our life situation; we express our distress through bodily idioms that are both peculiar to distinctive cultural worlds and constrained by our shared human condition."[16] Sociologist Arthur Frank writes that the ill learn about themselves "by hearing themselves tell their stories, absorbing others' reactions, and experiencing their stories being shared."[17] The structure of these stories, Frank writes, are shaped "by all the rhetorical expectations that the storyteller has been internalizing ever since he first heard some relative describe an illness, or she saw her first television commercial for a non-prescription remedy, or he was instructed to 'tell the doctor what hurts' and had to figure out *what* counted as the story the doctor wanted to hear"

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[14] Ogden, *Credulity*, 34.
[15] Justine S. Murison, *The Politics of Anxiety*, 51, 170.
[16] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1989), xiii.
[17] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics*, 2nd ed. (Chicago: University of Chicago Press, 2013), 1.

(3). Suggesting the power dynamics of the medical encounter, Frank writes that "illness becomes a *circulation of stories,* professional and lay, but not all stories are equal" (5). Among the aims of this dissertation is to look closely at the shape of the "rhetorical expectations" that shape the socially accepted illness narrative in the nineteenth century. By examining the circulation of a range of illness narratives about liminal diagnoses, from case study to diagnostic manual to newspaper reports of crime and fictional representations of illness, I trace this circulation, attending to its racial and gendered inequalities.

Because the moral diagnoses I trace in the following pages proved resistant to the growth of clinical methods and instrumentation that hoped to link visible physical sign to hidden pathology, they provide particular insight into the role of narrative in a developing medical science. In *Birth of the Clinic*, Michel Foucault links the language of medicine to the development of the clinical perspective, arguing that in the late eighteenth and early nineteenth centuries the physician developed a "clinical gaze" that has "the paradoxical ability to *hear a language* as soon as it *perceives a spectacle.*"[18] In this "loquacious gaze" (xii) sits the root of a fantasy of diagnostic perfectionism, the belief that with time, "all pathological manifestations would speak a clear, ordered language" (94). For Foucault, it is "description, or, rather, the implicit labour of language in description, that authorizes the transformation of symptom into sign and the passage from patient to disease and from the individual to the conceptual" (114). Put most grimly, the case study is part of the project of pathologically dissecting the still-living patient—drawing "the dotted outline of the future autopsy" (162). For the liminal disorders I discuss here, this language sometimes works another way: attempting to pathologize behaviors that could not be validated postmortem (regardless of attempts to gather and compare skulls and search for diseased brain matter) the language remains unattached

[18] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage Books, 1994), 108.

to a palpable mass.

The language of diagnosis has profound implications for personal experience, medical science, legal standing, and social identity. Most practically, medical narratives attempt to render a complex and messy experience in a legible story for the purposes of treatment and education—to render illness into a comprehensible narrative that allows physicians, patients, and readers to imagine the arc of the disease. This comprehensibility requires diagnosis. Carolyn Smith-Morris, in the introduction to *Diagnostic Controversy*, writes, "Diagnosis is among the first responses to suffering, the one that initiates and organizes all others."[19] Yet Smith-Morris calls attention to the paradoxical double valence of the diagnostic gaze: "Diagnosis is a necessary and speculative tool for the identification of and response to suffering in any healing system. But it is also an expression and a vehicle of bio-medico-capitalist power" (19). This "bio-medico-capitalist power," drawing an increasingly wide range of patients into the scope of medical management, developed in significant ways throughout the nineteenth century in America. Physicians in ever more specialized fields gained professional capital as they created increasingly refined nosologies by drawing and redrawing lines around "authentic" disease categories, corralling anecdotal experience with symptom sets into clear diagnostic categories.

Psychiatrist and medical anthropologist Arthur Kleinman argues, "The recording of a case in the medical record, a seemingly innocuous means of description, is in fact a profound, ritual act of transformation through which illness is made over into disease, person becomes patient, and professional values are transferred from the practitioner to the 'case'."[20] Turning people into patients, diagnoses can carry both stigma and cachet: consider George Miller Beard's "American disease," neurasthenia, which was both pathology and point of pride, "a sign of either moral laxity or

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[19] Carolyn Smith-Morris, ed., *Diagnostic Controversy: Cultural Perspectives on Competing Knowledge in Healthcare* (New York: Routledge, 2015), 1–2.
[20] Kleinman, *The Illness Narratives*, 131.

extreme moral sensitivity," as the disease of the highly sensitive "brain-workers" whose neurology was challenged by the hectic pace of American life (specifically, by "steam power, the periodical press, the telegraph, the sciences, and the mental activity of women").[21] Diagnosis can be a useful tool, shaping an unruly set of symptoms into a clear constellation, enabling treatment, acceptance, or cure. In this latter sense, though, diagnosis does not serve a merely utilitarian purpose.

The role of diagnosis in histories of American psychiatry has been viewed as secondary to questions of treatment. In his influential social history of the medical profession in America, John Harley Warner argues that treatment was the primary role of the physician in the early nineteenth century and that "Diagnosis was of only secondary importance in determining appropriate treatment. To the extent to which the physician asserted control over a disease by naming and explaining it, diagnosis was of course an important part of managing a patient. Furthermore, it was a useful aid to prognosis, for it indicated a range of the most likely patterns and outcomes a particular case might take. Yet treatment was essentially symptomatic"[22] Here, Warner emphasizes the narrative qualities of diagnosis, with symptoms explained and futures predicted. By ultimately de-emphasizing diagnosis, though, he privileges the history of medical practice over the history of patient identity. While diagnosis may not always have impacted treatment, it was likely to impact social belonging and identity—whether one is labeled as immoral or mentally disordered shapes not only interaction with the medical system but with family, friends, and self-image.

Diagnostic Legitimacy, Diagnostic Hierarchies

[21] Tom Lutz, *American Nervousness, 1903: An Anecdotal History* (Ithaca, NY: Cornell University Press, 1991), 4, 6, 4.
[22] John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885* (Cambridge, Mass.: Harvard University Press, 1986), 92.

Clear diagnoses provide a kind of legitimacy and epistemic relief. Even when receiving a frightening or incurable diagnosis of physical disorder, patients who have long experienced symptoms may express relief in knowing that they aren't "crazy" and that it's not "all in their heads." Susan Wendell, for example, tells the story of a woman overjoyed to receive a diagnosis of Multiple Sclerosis, because the organic nature of the disease freed her from charges of neuroticism. Wendell says the relief was "the result of being rid of a terrible cognitive and social conflict—between how Gloria felt and what it was demanded that she believe about herself."[23] Wendell asks "But what of those who do not receive a diagnosis, either because they have not been to the right doctors, or because what is wrong with them is still unknown to medical science (a possibility that one rarely hears admitted in public)?" She says it would take enormous self-confidence and inner strength to "believe in one's sanity" after getting a diagnosis of "nothing wrong" for a condition that is already causing considerable suffering (125). Wendell's example reveals a perverse facet of some diagnoses, especially of contested or invisible conditions: a serious diagnosis can confer legitimacy upon an ailment, and a missed or withheld diagnosis can itself become a source of suffering or stigma. Also clear in this example is a hierarchy of complaints: to be told one is neurotic or somaticizing stress is to be told that one experiences illegitimate suffering, while to be diagnosed with Multiple Sclerosis is to be taken seriously. In this hierarchy, physical illnesses are more legitimate than mental illnesses, visible diseases more than invisible, clinically verifiable rather than phenomenological.[24]

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[23] Susan Wendell, *The Rejected Body* (New York: Routledge, 1996), 124–25.

[24] Wendell's ultimate point is that women's own testimony and knowledge of their bodies is not valued: the medical system, not ill women, hold the "cognitive authority," which she describes as "the authority to have one's descriptions of the world taken seriously, believed, or accepted general as the truth" (117). I agree with this assessment, but hope to interrogate the ways that neuroses and mental illnesses serve as the ultimate medical bogeyman. Although Wendell's book was written many years ago, this remains a common trope. In her 2018 book *Doing Harm,* Maya Dusenbery clearly articulates and unquestionably proves the devastating effects of medical sexism on women's health but does so in part by tapping into indignation towards psychological assessments of suffering (New York: Harper Collins Publishers. Belling's *A Condition of Doubt* addresses the way that the "legitimation" of diagnosis can be positive for hypochondriacs (6).

Mental illnesses, especially, face challenges to diagnostic legitimacy. Philosopher of science Ian Hacking writes, "People are not going to stop using the word *real* or its co-workers such as *true* in connection with controversial mental problems. Reasons for this range from finance to responsibility, from semantic theory to scientific metaphysics. Health insurance should pay only for real mental illnesses, right? Responsibility is the crux. We have a profoundly moral attitude to disease."[25] Making clear that such moral/ontological judgments are related to a perceived mind-body dualism, anthropologist Tanya Luhrman writes, "If something is in the body, an individual cannot be blamed; the body is always morally innocent. If something is in the mind, however, it can be controlled and mastered, and a person who fails to do so is morally at fault…[A] moral vision that treats the body as choiceless and nonresponsible and the mind as choice-making and responsible has significant consequences for a view of mental illness precariously perched between the two."[26] Across the nineteenth century, disorders of the mind navigated this division—medical practitioners and asylum superintendents frequently stressed the equivalence of manias and melancholies to more common physical ailments like colds, while popular representations like the stories of Poe obviously saved a unique kind of horror for stories of mental illness.

Across this period, I argue that literary narratives may be as influential in shaping beliefs about the reality of mental illnesses as medical ones, as they experimented with new styles of narration meant to represent thought more accurately. Looking at the rise of neurology and realism in the late nineteenth century, Jane Thrailkill suggests that "novelists were indeed instrumental in helping realize...a new way of seeing self," which she calls "the forensic self," as both neurology and literature privilege the disinterested and authoritative expert in the project of representing mental

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[25] Ian Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses* (Charlottesville, Va.: University of Virginia Press, 1998), 11.
[26] T. M Luhrmann, *Of Two Minds: An Anthropologist Looks at American Psychiatry* (New York: Vintage Books, 2001), 8.

interiors.[27] Demonstrating the diagnostic function of Realist narrative, she shows how a novel by Oliver Wendell Holmes drops clues that eventually reveal the "pathogenic secret" at the heart of the protagonist's strange set of hysterical symptoms (he was dropped as a child). She writes, "Narrative… is at once repudiated and installed as central to a physiological psychology. Here we encounter the enabling conditions for literary realism and its practitioners, who hover uncomfortably between fabricating events and mobilizing an apparatus of expertise to elicit the innermost secrets of persons and society."[28] Citing Realism and neurasthenia's dual interest in the "status of the individual,….the insistence on the importance of social environments to the understanding of individual motivation and action, the reliance on a …visualize positivism," Thomas Lutz notes the uncoincidental overlap in the growth of Realism and neurasthenia.[29] Beginning my investigation almost one hundred years prior to these investigations of Realism and neurology, I craft a lineage of lowercase-r realist gestures and a developing mental science: across the nineteenth century, physicians and literary authors alike worked to improve their ability to communicate mental states through language.

These realist narratives enabled not just medical diagnosis but social diagnosis, as accurate representations of mental states could clarify social bonds. According to Tougaw, "In the pages of a medical journal, the quest for knowledge is entangled with the need to tell a good story; in the pages of a novel, appeals to a reader's sympathy first require characters whose flaws, or diagnoses, are

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[27] Jane F. Thrailkill, "Railway Spine, Nervous Excess and the Forensic Self," in *Neurology and Modernity: A Cultural History of Nervous Systems, 1800-1950*, ed. Laura Salisbury and Andrew Shail (London: Palgrave Macmillan, 2010), 110, 107, 99.

[28] Thrailkill, "Railway Spine," 110. Aura Satz also examines the role of narrative in early postbellum neurology, as discourses of phantom limb and of spiritualism both worked to "map invisible forces, employing at times a similar rhetoric of substantiation" that relied upon the rhetoric of science—not asking for belief, but willingness to investigate, test, gather own evidence. (Satz, "'The Conviction of Its Existence': Silas Weir Mitchell, Phantom Limbs and Phantom Bodies in Neurology and Spiritualism," in Salisbury and Shail, *Neurology and Modernity*, 114–17.)

[29] Lutz, *American Nervousness, 1903*, 36.

severe enough to deserve it."[30] Early novels, he suggests, begin to feature an "almost diagnostic view of 'humanity'" while focused on individual characters (2). In a recent book, Maureen Tuthill argues that the question of health in early America was a profoundly social one revealing broader tensions between social cohesion and individual self-interest: what is my duty to the other? At what point does the object of my sympathetic attention forfeit that regard (through self-debasement, poor choices, etc.)? Early American novels, she argues, are working out the question of accountability and the limits of affection in the face of others' failures.[31] In both of these accounts, novels were one place where people investigated what kinds of pathology encouraged appropriate sympathy—a determination requiring the reader to approach the characters diagnostically. Given written descriptions of appearance and action, interiority and exteriority, the reader is asked to evaluate a character—are they worthy of censure, respect, sympathy, or hate? Are they erring or acting correctly? If erring, are their actions within their own control, or are they at the mercy of external forces, including the determining hand of disease or disorder? If the latter, how should we judge that behavior?

By examining the role of fiction in the creation and cultural dissemination of the diagnoses that shaped many people's experience of illness, I am not suggesting that those illnesses in themselves are fictional. Rather, I hope to articulate the many ways in which narratives of illness are formed, internalized, or questioned. As part of this project, I work to productively complicate the application of the "social construction of illness." Historian Edward Shorter has suggested that the expression of psychosomatic illness across the nineteenth century changed to match evolving categories of "legitimate" physical disorder.[32] Missing from his analysis, though, is a response to an

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[30] Tougaw, *Strange Cases*, 2.
[31] Maureen Tuthill, *Health and Sickness in the Early American Novel: Social Affection and Eighteenth-Century Medicine* (London: Palgrave Macmillan, 2016), 8.
[32] Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York: Free Press, 1993).

obvious counter: what became of those with poorly defined and untestable illnesses that were hardly regarded as legitimate? Although he writes about physicians' distaste for hysterical symptoms, for instance (125), his argument for patients' unconscious desire for diagnostic legitimacy does not account for the stigma such patients faced.

Overly simplistic accounts of social construction have been complicated by work in both the philosophy of science and disability studies. My understanding of the relationship between popular diagnostic narratives and the experience of illness veers from Shorter's and moves toward theories like those put forward by disability theorists. Elizabeth Donaldson, for instance, calls for a "feminist disability studies theory of mental illness that includes the body, one that theorizes bodies as 'material-semiotic generative nodes' and mental illness as physical impairments."[33] Tobin Siebers' theory of "complex embodiment" "theorizes the body and its representations as mutually transformative." Siebers notes that, "While identities are socially constructed, they are nevertheless meaningful and real precisely because they are complexly embodied."[34] Lennard Davis and David Morris's "The Biocultures Manifesto," suggests several "provocations" that unsettle the line between humanities and biomedical models, some of which are: "Pain is always in your head because your brain is….Embodiment is necessarily biological, and knowledge is always embodied….Bodies are always cultural and biological."[35]

By emphasizing narrative, I borrow from theorists like Roy Porter who wants to ignore the question of hysteria as a "real thing" and write instead "of hysteria experiences, that is, of people labeled as hysterical, or identifying themselves as suffering from the condition, and embodying it in their behavior; one taking into account all the intricate negotiations, denials, and contestations

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[33] Donaldson, "Revisiting the Corpus," 95.
[34] Tobin Siebers, *Disability Theory* (Ann Arbor: University of Michigan Press, 2008), 25, 30.
[35] Lennard J. Davis and David B. Morris, "Biocultures Manifesto," *New Literary History* 38, no. 3 (2007): 418.

bound to mediate such multifarious sickness presentations."[36] To complicate the thorny question of the "reality" of a given expression of mental disorder, philosopher Ian Hacking imagines historically contextualized "ecological niches" in which various disorders thrive, which are shaped by "framework of diagnosis, a taxonomy of illness" as well as "cultural polarity" and "observability."[37] The narrative quality of this cycle is emphasized by Frank, who writes, "disease can compel bodies, but how ill people are motivated to act depends on the imaginative conceptions of illness provided by storytellers" (187). In examining the genres and tropes that develop to describe moral disorder across the nineteenth century, I sketch the evolving literary ecology of moral disorder.

Moral Disorder and Disability Studies

My genealogy of contested moral disorders serves as a contribution to work in disability studies that focuses on mental, cognitive, and chronic disabilities, which have often fallen through the cracks of a more physically based conception of disability. Susan Schweik, Alison Kafer, Ellen Samuels, Tobin Siebers, Robert McRuer, Anna Mollow, and Elizabeth Donaldson have theorized the ways that invisible and chronic illnesses complicate the links between disability and group identity, suggesting ways that negotiating mental disability necessitates moving beyond an overly simplistic social model.[38] Susan Burch and Michael Rembis, in the introduction to a volume on disability history, acknowledge needing more histories that "involve historically marginalized groups

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[36] Roy Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," in *Hysteria beyond Freud*, ed. Sander L. Gilman (Berkeley: University of California Press, 1993), 226.
[37] Hacking, *Mad Travelers*, 2.
[38] See, for instance, Schweik, *The Ugly Laws*; Alison Kafer, *Feminist, Queer, Crip* (Bloomington, Indiana: Indiana University Press, 2013); Samuels, *Fantasies of Identification*; Siebers, *Disability Theory*; Robert McRuer and Anna Mollow, eds., *Sex and Disability* (Durham, NC: Duke University Press, 2012); and Donaldson, "Revisiting the Corpus of the Madwoman."

within disability communities."[39] I am particularly interested in examining how close attention to contested illnesses—especially ones sometimes read as psychological or psychosomatic in nature—and attempts to render them legible can highlight undertheorized topics in disability studies, the health humanities, and bioethics. These tensions reveal room for growth within discourses posing medical authority against identity politics. Writers and physicians in the nineteenth century, who sometimes imagined the relationship between the body and mind more capaciously than we do, and who engaged directly with the moral stakes of that relationship, can serve as a prime resource both for examining the foundations of these binaries, and for imagining worlds that destabilize them.

In returning to the social origins of professional mental diagnoses, I am offering historical ballast to the vision of a "crip future" offered by Alison Kafer. Kafer rejects both the medical and the social models of disability, offering instead a "hybrid political/relational model of disability" that sees disability as "assemblage" and "collective affinity" rather than fixed category.[40] She envisions an "expansive disability movement"—a crip future—which is better able to account for current disability studies' failures to theorize psychiatric, chronic, and cognitive disabilities and suggests that one way to pursue this future is to "trace the ways in which we have been forged as a group… but also trace the ways in which those forgings have been incomplete, or contested, or refused" (12). Kafer asks how space could be made within the disability community for those "who lack a 'proper' (read: medically acceptable, doctor-provided, and insurer-approved) diagnosis for their symptoms" (12).

This tension between verifiable physical ailments and unverifiable complaints was central throughout the nineteenth century. Schweik and Samuels have each documented anxiety about disability fraud in late nineteenth-century culture. Samuels writes that the nineteenth century was

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[39] Susan Burch and Michael Rembis, eds., *Disability Histories* (Urbana-Champaign: University of Illinois Press, 2014), 10.
[40] Kafer, *Feminist, Queer, Crip*, 11.

"occupied with the looming possibility that unknowable bodies in a newly mobile world provide unprecedented possibilities for deception," and inspired the fantasy of a "physician-detective" whose specialist knowledge could pierce to the truth. Expressing what she calls "fantasies of identification," nineteenth-century physicians, lawyers, and authors shared beliefs about objective markers of difference.[41] Schweik points to a doctor's handbook about how to identify fraud and to recognize the "faces of the neurasthenic" and the wrinkled brow of one thinking they are in pain rather than being so.[42] Robert McRuer and Anna Mollow write that, "For most people with impairments that manifest neither visible bodily differences nor abnormal test results, it is an ongoing struggle to obtain disability benefits, access employment accommodations, or persuade family members and friends that they really are disabled."[43] I intend my own contributions to the history of contested diagnoses to provide usable material for a larger crip project that challenges the boundaries of either medical or social definitions of disability.

In extending my inquiry from the late eighteenth to the late nineteenth century, I also press on the temporal boundaries of disability studies. As Altschuler and Silva recently noted, early American scholarship, wary of applying an anachronistic framework, has been slow to incorporate disability studies, and thus many influential disability historical works, like Ellen Samuel's *Fantasies of Identification* or Susan Schweik's *The Ugly Laws* consider only the mid- to late-nineteenth century. Turning to earlier periods, they argue, we can maintain historically specific representations of difference while bringing the methodological approach disability studies to bear on material from the period.[44] Among these approaches is a kind of ethical orientation to representations of mental difference that asks how representation shapes lived experience and how lived experience is

[41] Samuels, *Fantasies of Identification*, 1.
[42] Schweik, *The Ugly Laws*, 80.
[43] McRuer and Mollow, *Sex and Disability*, 11.
[44] Altschuler and Silva, "Early American Disability Studies."

communicated through text. Early American texts provide a particularly interesting site for enquiry into mental disorder, in part because mental disorder was conceived in such physical terms. Altschuler has previously argued that disability does not feature in the American novel before the war of 1815, but acknowledges that she is bracketing mental illness.[45] Interrogating this bracket offers lessons both for disability studies, which still struggles to theorize mental difference as thoroughly as physical difference, and for early American studies, to bring a new perspective to the prominence of madness and mental disability in early American texts.

The research underlying this investigation draws together disability, medical, and literary history. As argued by Beth Linker, the history of medicine and the history of disability have often remained at odds.[46] My own project demonstrates that histories of medicine, disability, and literature cannot be disambiguated, at least when it comes to mental health. Disability history carefully attends to intersections of health, power, and the lived experience of difference; medical history offers a rigorous historicism grounded in the archive; and literary history articulates the development of narrative technologies of representing the self and the other. Early psychiatry, especially, drew on narrative material to build knowledge, and thus the history of psychiatry is incomplete without a clear articulation of the influence of literature on both medical knowledge and style. Approaching my own literary-historical case studies as a disability history project, moreover, helps me foreground stigma, authority, and social identity. Ultimately, my dissertation will demonstrate how each approach serves as a supplement, and occasionally a corrective, to the others.

Narrating the American Mind

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[45] Sari Altschuler, "'Ain't One Limb Enough?' Historicizing Disability in the American Novel," *American Literature* 86, no. 2 (2014): 245–74.
[46] Beth Linker, "On the Borderland of Medical and Disability History: A Survey of the Fields," *Bulletin of the History of Medicine* 87, no. 4 (2013): 499–535.

Both the literary and medical writers in this dissertation were interested in narrating the interior of the uniquely American mind. In his formative history of psychiatry, Edward Shorter suggests that Americans followed the lead of European physicians without much innovation of their own until the 1930s.[47] In this dissertation I disagree: although the European influence is often clear for the figures that I discuss, many of whom received their medical training abroad, each practiced a medicine unique to the American setting. Early Americans, concerned with revolution, democracy, freedom, moral responsibility, and a uniquely national identity were beset by anxieties about physical vigor and healthy mindedness. From early claims that American democracy represented a development over degenerate Europe (Rush proposed the diagnoses "revolutiana" and "anarchia," for which the cure was democracy), to the fear in the 1830s that democratic freedoms could generate nervous Americans in need of asylums and moral management, to "the American disease" neurasthenia in the late 19th century, nationality has been linked to mental pathology.[48] In his popular medical text *Wear and Tear*, S. Weir Mitchell asks "how much our habits, our modes of work, and, haply, climatic peculiarities" might "sorely tax" "the nervous system of certain classes of Americans."[49] While these writers were not fundamentally practicing a different science than those abroad—indeed, claims about national illnesses and use of literary texts to ground medical science were international phenomena—their emphasis on the importance of their own national context bears closer scrutiny.

In tracing the lineage of American psychiatry, we might begin with Benjamin Rush's 1786 lecture "An Inquiry into the Influence of Physical Causes upon the Moral Faculty." (The American

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[47] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: Wiley, 1997), 15.
[48] Murison, *The Politics of Anxiety*, 11.
[49] S. Weir Mitchell, *Wear and Tear, or Hints for the Overworked* (Philadelphia: J.B. Lippincott & Co., 1871), 7.

Psychiatric Association, at least, refers to Rush as the "Father of American Psychiatry."[50]) Claiming the care not just of madness but of moral health more broadly, Rush wrote, "Persons who labour under the derangement, or want, of these faculties of the mind, are considered very properly as subjects of medicine; and there are many cases upon record that prove that their diseases have yielded to the healing art."[51] Key among the cases that proved his physicalist understanding of mental disorder were Lear, Othello, and Cassius. Rush's rationalistic approach emphasized reason and theory over fallible observation and experimentation, and thus Rush reasoned his way to diagnostic conclusions from the source material of literary history.

In the 1820s and 30s, however, physicians began to reject rationalistic for empirical approaches to medicine.[52] Physicians like Isaac Ray were arguing for minute differences in mental states that were difficult to distinguish without the eye of an expert specifically trained in the care of the insane, as in "partial moral mania" and "concealed insanity."[53] While Shakespeare still provided important case material for Ray, his turn from rationalism to empiricism is exemplified in Ray's use not just of Rush's Shakespearean "types," but of extended passages arguing for the reality or counterfeit of specific aspects of Shakespeare's madmen, inveighing, for example, against those foolish readers who believed that Hamlet merely pretended to be mad. In his own case studies, too, he emphasized clues that a patient's state of mind may not be quite what it appeared.

By the 1850s, clinical methods had been wholeheartedly imported from Europe, and Oliver Wendell Holmes, the physician-professor-author of my third chapter, played an instrumental role in importing tools like the microscope and epistemologies like statistical thinking to American medical

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[50] Shorter, *A History of Psychiatry*, 15.
[51] Benjamin Rush, *An Inquiry into the Influence of Physical Causes upon the Moral Faculty : Delivered before the American Philosophical Society, Held in Philadelphia on the Twenty-Seventh of February, 1786* (Philadelphia: Haswell, Barrington, and Haswell, 1839), 3.
[52] Warner, *The Therapeutic Perspective*.
[53] Isaac Ray, *A Treatise on the Medical Jurisprudence of Insanity*, 3rd ed. (Boston: Little, Brown, and Co., 1853).

practice (although, as I will show, he understood the failure of those methods in the face of moral disorder and in the biased eye of the viewer).[54] The rise of clinical methods later in the century meant that more thorough physical examinations had to be done to rule out organic disorder, while the turn to statistics raised new questions about the status of the individual. Partaking of both objectivity-defying Romance and classificatory local color sketches, Holmes used literature to question advances in visualizing disorder.

Finally, in the early 1860s, the Civil War provided a vast and devastating laboratory for the study of mind and body. "Father of American Neurology" S. Weir Mitchell, known by many for his work with hysterical women, developed the practice of neurology by correlating the physical injuries to nerves with the testimony of soldiers who had been shot or otherwise injured. Murison writes that in this context, George Miller Beard understood that the role of the expert physician was justified by the unreliability of "human testimony."[55] Mitchell, too, was notoriously suspicious of his female patients' reports. Salisbury and Shail write that "neurology and modernity worked together to create narratives of legibility for previously occluded experiences and structures, registering as 'data' occurrences that had previously been either unnoticed or unavailable"[56] This put these doctors in a bind, though—the rise of neurology often meant dealing with injuries and illnesses that could not be seen or physically verified. Narratives, then, took on extraordinary power at the same time that those with illnesses were denied narrative authority. These changes in medical epistemology each required different narrative styles, from a rationalism requiring a kind of ideal case to an empiricism relying on observational data or statistical thought.

When comparing medical case studies with literary narratives, the first impulse is to put them

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[54] Oliver Wendell Holmes, *Currents and Counter-Currents in Medical Science with Other Addresses and Essays* (Boston: Ticknor and Fields, 1861).
[55] Murison, *The Politics of Anxiety*, 161.
[56] Laura Salisbury and Andrew Shail, eds., *Neurology and Modernity: A Cultural History of Nervous Systems* (London: Palgrave Macmillan UK, 2010), 8.

in opposition—one is reductive, the other is humanizing; one is particular, the other is universal; and so on. Such divisions cannot be supported as literature and medicine engage in a constant renegotiation of structures and authority. Murison suggests that this relationship changes with rising medical authority—that prior to the Civil War, fiction was often a site for experimenting with and imagining neurological concepts, whereas after the war it became a site of resistance to materialistic notions of subjectivity derived from neurology.[57] Elaine Showalter suggests that literary critics are well-positioned to track how hysteria has "moved from the clinic to the library, from the case study to the novel, from bodies to books, from page to stage and screen" developing its own narrative structures from "myth, popular culture, folklore, media reports, and literature."[58] Sari Altschuler and Justine Murison have shown how Oliver Wendell Holmes and S. Weir Mitchell used fiction to test ideas that went beyond existing medical science."[59]

Not only did literature and medicine borrow from each other, but the very distinction between medical and literary narratives of illness can be vague and often untenable. Literary works and medical case studies were sometimes written by the same people and occasionally employed similar language—and in many cases it is often unclear in which direction influence is moving. Tougaw claims some distinctions between writing in the two fields: "Novels are fiction; their characters don't exist; and their aims are aesthetic. Case histories tell true stories; their subjects are human beings who have lived and suffered; they are written as contributions to a vast body of accumulating medical knowledge."[60] These divisions are complicated in Tougaw's own examples, however, as his study presents a wealth of material characterized by a mixture of the genres, as physicians came to rely on purely fictional cases, and novelists drew on true stories.

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[57] Murison, *The Politics of Anxiety*, 6.
[58] Elaine Showalter, *Hystories* (New York: Columbia University Press, 1997), 6.
[59] Altschuler, *Medical Imagination;* Murison, *The Politics of Anxiety*, 5.
[60] Tougaw, *Strange Cases*, 14.

Literature's relationship to medicine was complicated, exceeding any attempt to align medicine with objectification and literature with relationality. While literature can "humanize" and encourage sympathy, it can also alienate, objectify, and judge. Poe's "The Tell-Tale Heart" is hardly a tale encouraging understanding and social networks. Nor is medicine uniformly objectifying, and physicians like Rush often argued for new diagnoses in order to enable networks of social support and improved empathy. Both literature and medicine played a role in solidifying psychiatric authority, as Ray's case studies justify the expansion of the asylum system, and Poe's tales forge stronger and more morally judgmental conclusions than medical narrative would support. Indeed, fiction may play a more important role in the dissemination of diagnostic logic and surveillance into everyday life.

Organization of Chapters

Fictional Illnesses consists of four chapters that demonstrate how literary genre and psychiatric diagnosis developed in tandem throughout the nineteenth century: I pair the sensational gothic novel with medical claims about the senses' power over thought and action, the birth of forensic psychiatry with early detective fiction, the introduction of clinical medicine to America with the objectivity-defying romance, and the rise of realism with new certainty about the medical value of patient testimony necessitated by early neurology. My first chapter, "'An Authentic Case': Benjamin Rush, Charles Brockden Brown, and the Physiology of Morality," draws together Rush's early psychiatric treatises with Brown's gothic novel *Wieland.* Both writers explore immoral behavior as medically and environmentally determined, and their works raise the question of what impact this determination should have on assessments of personal responsibility. In his 1786 "An Inquiry into the Influence of Physical Causes upon the Moral Faculty," Rush coins the terms *anomia* and

micronomia to designate pathological immorality, referencing literary characters like Hamlet and Othello, while Brown authorizes his fantastical Gothic novel as plausible and hence morally instructive by reference to medical case history. Both literature and medicine, in this early stage of professionalization, were negotiating their moral jurisdiction, and they rely on one another to do it, drawing on narrative methods to create new knowledge and style. Each relies on "authentic cases" to explore the bounds of human agency and culpability—but authenticity could arise as much from imaginative as from medical work. For Rush, literature can provide an accurate representation of human nature and medical knowledge, as testified by the marginal notes in his copy of *Journal of A Plague Year* and his citation of Don Quixote as irrefutable evidence that madness can pass. And Brown, by pressing various faculties to their limits, uses the aberrant mind to demonstrate the physiological and ecological grounding of all minds—a kind of fictional lesion study of the workings of the living brain, providing a kind of information that anatomists admitted they were unable to find in postmortem brain exams. While Karen Halttunen argues that gothic and medical genres transformed murderers from "common sinners" to "moral monsters" against which readers are asked to judge their own normality, I argue that the pathological vision articulated by Rush and Brown, of a human mind easily transformed by environmental insult and social contagion, instead called for personal identification and social reform.[61]

My second chapter, "Moral Insanity and Diagnostic Vision: Nat Turner, Isaac Ray, and Edgar Allan Poe," continues my examination of the expanding nosologies of mental disorder, particularly an increasing emphasis on the borders between madness and sanity. I turn to the rise of liminal diagnoses like "moral insanity" and "partial insanity" in legal practice, as the psychiatric jurisprudence of Isaac Ray and the detective fiction of Edgar Allan Poe both question how we can

[61] Karen Haltunnen, *Murder Most Foul: The Killer and the American Gothic Imagination* (Cambridge: Harvard University Press, 1998).

detect madness if someone attempts to hide it—or in the reverse, how we can detect sanity in cases of feigned madness. Here, I read Thomas Ruffin Gray's *The Confessions of Nat Turner* as a text establishing the exigence of diagnostic schemas capable of predicting violence without clear insanity. I read Turner's confessions against Isaac Ray's foundational work of medical jurisprudence, *Treatise on the Medical Jurisdiction of Insanity* (1838), which calls for expert diagnosis of liminal categories of madness, alongside Poe's short stories in the late '30s and early '40s, especially what I consider psychiatric detective stories, like "The Fall of the House of Usher." These texts take up Gray's exigence, calling for finely honed mental and moral diagnosis from the reader. Read together, these texts function as a kind of training manual, disseminating the logic of forensic psychiatry: Ray's emphasis on the borderlands of madness is paired with a call for specialization in the masterful detection of liminal cases—a reflection, too, of the increasing anxiety that the varieties of madness are so manifold that they can be undetectable, especially by the average person. Exceeding this medical work, though, the work of popular fiction writer Edgar Allan Poe encourages that diagnostic and forensic vision in the everyday reader. And the racial stakes of that inquiry indicate why the readers might need to be so trained, beyond the rare cases in which someone might claim the insanity defense in an act of murder. The questionably mad black mind becomes a tool for managing all black minds; the questionably mad white one spurs innovations in the science of adjudicating property disputes, wills, and other civil matters. Detecting hidden or partial mental derangement was a technology with broad social implications in a slave-holding society with a white propertied class in which physical characteristics plainly did not line up with normative assumptions about interior states.

Chapter Three, "Romantic Physiology and the "Physiological Romance": Narrating Diagnoses in Oliver Wendell Holmes's *Elsie Venner*," turns to medical professor and novelist Oliver Wendell Holmes, Sr., who employed the genre of the Romance in order to theorize the limits of the

objectivity he so often championed in the clinic. In his 1861 novel *Elsie Venner,* Holmes creates a fictional disorder and narrates the attempts of physicians and townspeople to diagnose its eponymous heroine. Holmes' medical philosophy, as articulated in *Currents and Counter-Currents,* a volume of medical essays published in the same year, is complex. While he has often been credited as an early proponent of the clinical method in America, he was highly pessimistic about the possibility of objective medical vision, detailing how easily it could be blurred by cultural forces and individual error. He dramatizes this anxiety in *Elsie Venner*. Ostensibly framed as a novel-length diagnostic investigation of the apparently amoral title character (whose malady is, in the end, pre-natal poisoning with rattlesnake venom), Holmes actually reveals the diagnostic conclusion to the reader early in the text, and so the majority of the novel is spent in reading about, and judging, the diagnostic failures of others. Like Poe, he encourages the reader's diagnostic powers, but by emphasizing the failures of other characters to diagnose accurately, he ultimately uses the novel to investigate the ethical response to ambiguous disorders of morality in the context of a developing science of heredity and environmental influence that placed moral agency beyond the individual's control.

In my final chapter, "'A Wasted Sympathy': Winifred Howells, the Illness Narrative, and Illness Poetics," I demonstrate the power of ingrained illness narratives to eclipse the individual's experience and to obscure the historical record. Winifred Howells, a rarely remembered poet and the daughter of famed Realist author William Dean Howells, died while being treated for hysteria by physician-novelist S. Weir Mitchell. Both Mitchell and Howells interpreted her illness through the lens of sentimental fiction that painted ill women as either angelic or manipulative. Unfortunately, while she lived, they often emphasized the latter. Following her early death under Mitchell's care, however, her father renarrated her life as one of blameless suffering through a memorial pamphlet. These competing narratives continue to impact critics writing about nineteenth-century ill women in

general, and about Winifred Howells in particular, and contemporary work that mentions her siloes her into one of the two tropes (passive sufferer or manipulative hypochondriac) without grappling with the full archival record. Concluding with readings of her own often neglected poetry, I demonstrate how she challenges such reductive narratives through poetic form. By illuminating the use of literary tropes in Mitchell's medical work and in Howells's memorial to his daughter, and their translation into contemporary scholarship on hysterical women in the late nineteenth century, I demonstrate the affective allure of narrative form, while I use her poetry to suggest other ways of engaging illness.

Ultimately, the dissertation is a cultural history of the limits of medical knowledge, which traces attempts to narratively conceptualize invisible illnesses and disabilities. I aim to provide useful context for our contemporary engagement with mysterious or invisible ailments, including psychiatric disorders, poorly understood chronic illnesses, and psychogenic disorders. In short, when faced with the medically unknown, what kind of narratives do we construct, medically and culturally, and what kinds of anxieties do these narratives produce? In my "Coda," I emphasize the ongoing relevance of the questions I've been posing to the present medico-cultural moment. Today as in the nineteenth century, the "legitimacy" of mental disability is heavily politicized, as patients, especially women, are regularly given diagnoses that are met with suspicion and doubt. I hope to clarify the sometimes dangerous power of narrative in defining marginalized identities. Stories, we can say, don't always contribute to healing: they can just as easily write off suffering as malingering, or encourage an objectifying and essentializing psychiatric gaze. In this final section, I look to memoirs and nonfiction essays by women that engage with the politics and poetics of diagnosis, arguing that the literary quality of diagnosis can form the basis for women to step in as authoritative narrators of their own disorder.

Chapter One

"An Authentic Case": Benjamin Rush, Charles Brockden Brown, and the Physiology of Morality

"*Most horrid murder!*—It falls very unfortunately to our lot to communicate one of the most barbarous and murderous acts ever committed by a monster in human shape." In these unlikely terms begins Benjamin Rush's medical notebook on "moral derangement." Between 1805 and 1812, Rush clipped out several sensationalistic newspaper articles detailing gruesome murders and pasted them into the volume, filling in the spaces around these columns with theories he would later publish in two essays at the intersection of medicine and law.[62] Drawing on the circumstances and even the language of these accounts, Rush compressed each into a case study for the medicalization of morality. Of what one newspaper calls a familicidal "monster in human shape," whose "sanguinary purpose… [was] equally callous to the feelings and inaccessible to the last cries of humanity," Rush notes, "He expiated his disease, for it cannot be called murder, upon the rack; the wheel of which came down eighteen times upon his neck, arms, and limbs." [63] Including details of the violence committed against the killer and excising those he perpetrated, Rush argues against capital punishment by displacing the crime of "murder" with the diagnosis of "disease."

With greater ambivalence, novelist Charles Brockden Brown relied on similar source material to confront parallel questions about disease, criminality, and culpability. Basing his 1798 novel *Wieland* on accounts of at least one notorious familicide, Brown expanded where Rush compressed, turning newspaper column to novel and fictionalizing Wieland's crime. Like Rush, though, he

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[62] Benjamin Rush, "Facts & Documents on Moral Derangement as exemplified chiefly in murder including newspaper but not containing Judges' Opinions," c.1804, volume 301, Rush Family Papers, 1748-1876, The Library Company of Philadelphia. Rush pulled much of this material into two texts: "Lecture XVI. On the Study of Medical Jurisprudence" in *Sixteen Introductory Lectures* and "On Derangement in the Will" in *Medical Inquiries and Observations, upon the Diseases of the Mind* (hereafter *MIODM*)

[63] Rush, "On the Study of Medical Jurisprudence," 384.

reframes a horrific act as more medical than monstrous or Satanic: his source material tended to spiritualize, rather than medicalize, the murders. According to a 1796 *New York Magazine* account of the Yates family murder, previously linked to the novel, such factors as "the equanimity of his temper, and the comfortable situation in which he was, and no visible circumstance operating to render him frantic" proved that the killer was not mad but "under a strong delusion of Satan."[64] Accounts from a second possible source, the Beadle familicide, dismissed insanity, citing devilish agency and positioning the murder as the natural outgrowth of Beadle's dangerous deistic theology. One report, though, introduced the problem of diagnosis that Brown would explore more fully. While concluding that Beadle "was of sound mind," the writer added: "It is difficult to determine where distraction begins. It is very evident he was rational on every other subject."[65] This "difficult" diagnostic question, of the line between "sound mind" and "distraction," lies at the heart of both Brown's novel and Rush's medical writing.

In this chapter, I examine the role of these narratives in the foundation of the new American science of the mind, building on Sari Altschuler's claim that "doctors and writers used literary form to experiment with health in the early United States," but extending it into the study of the mind, which takes narrative as its primary data.[66] These narratives, in which the particulars of a singular case become the basis for universalizing theory, arise from a medicine and a literature so closely twined as to be inseparable. This distinction between fiction and truth is not clear-cut for the figures I discuss. Brown argues for the truthful basis of his fictional tale, while Rush's rationalistic approach

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[64] "An Account of a Murder Committed by Mr. J---Y---, upon His Family, in December, A.D. 1781," *New-York Weekly Magazine; or Miscellaneous Repository*, July 20, 1796.

[65] Daniel Williams, "Writing Under the Influence: An Examination of Wieland's 'Well Authenticated Facts' and the Depiction of Murderous Fathers in Post-Revolutionary Print Culture," *Eighteenth-Century Fiction* 15, no. 3–4 (2003): 651, 653. While Brown's novel draws directly on the account of the Yates family murders, Williams argues that this account itself was likely at least partially fictionalized, drawing upon accounts of a more infamous murder, the Beadle familicide. For a careful comparison of Yates, Beadle, and *Wieland*, see Williams.

[66] Altschuler, *The Medical Imagination*, 11.

to medicine, which required generalizable idealized types more than actual patients, meant that imaginative literature was an important epistemological resource. Rush thus relies on narratives of pathological behavior—citing Shakespeare alongside Erasmus Darwin—to structure new diagnostic concepts, and asserts that these findings mandate social reforms like the abolition of capital punishment. For both, narrative—and fictional narrative in particular—was a major tool for navigating ambiguous and invisible pathological states. Michel Foucault suggests the appearance of medical progress and objectivity in the wake of the Enlightenment is "nothing more than a syntactical reorganization of disease in which the limits of the visible and invisible follow a new pattern."[67] For these early American medical theorists, that syntax echoed the interwoven generic conventions of story: biblical, clinical, and imaginative.

At the same time, literature relied on a reader's diagnostic gaze to develop characters and advance plots. The line between fiction and fact was muddy, with Rush citing Cervantes and Brown arguing for the truthful basis of his fictional tale. Including medical footnotes on the possibility of spontaneous human combustion, of biloquism, and of mania, Brown validates his novel, claiming the authenticity of its truth *value* if not its actual truth. Through literature, readers were trained to internalize a diagnostic logic and employ a forensic gaze, evaluating the normalcy and aberrance of characters and ultimately themselves. Brown asks his readers to identify the moment of Wieland's mental break, trace it to precipitating causes, imagine prognosis, and ultimately judge what bearing his pathology has on his responsibility for his acts. As much as Rush, Brown uses narrative to create medical knowledge, and for both, stories of pathology provide the data for the invisible workings of the human mind, providing information inaccessible through post-mortem examinations.

Rush and Brown, though, are not simply titillated by aberrance. Contrary to what previous scholarship suggests, Brown and Rush's figures are not moral aliens: their narratives are

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[67] Foucault, *The Birth of the Clinic*, 195.

interesting precisely because of what they allow the authors to claim about ordinary moral physiology.[68] It was only by making the case that the moral faculties could be diseased that Rush could establish the existence of a moral faculty at all. Brown's narrative of madness, too, works as a kind of fictional lesion study of the typical brain. What happens to the mind if we tamper with the auditory faculties? If we subject it to passion or love? If we introduce a diseased enthusiast as progenitor? *Wieland* thus serves as a narrative experiment in faculty psychology, creating medical knowledge and disseminating it to the reading public. Through case studies and fictional narratives, they frame moral monstrosity not as a deviation from ordinary psychology, but as the very evidence that psychology works on universal laws—a claim that can only be proven by demonstrating that even the extreme cases adhere to set principles.

Rush understood diagnosis as a rhetorical gesture with implications for law, education, and politics that justified the allocation of national resources and sympathies to protect individual and national moral wellbeing; the inevitability and the fallibility of diagnostic modes of thought animated Brown's novelistic investigation of moral agency and human error. In what follows, I analyze Rush's rhetorical deployment of two proposed diagnostic categories to describe maladies of the moral faculty—*anomia* and *micronomia*—in a bid for expanding medical jurisdiction into the moral, legal, and political realms. Through readings of his published and unpublished writings, I demonstrate his reliance on narrative structure in general and fictional works in particular as he writes into existence an American medicine of the mind. Rush granted fictional works like *King Lear*

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[68] Previous scholars have positioned moral monstrosity as increasingly distant from the ordinary. As the literature of murder transitioned in the mid-eighteenth century from execution sermons to first-person narratives, newspaper stories, and trial transcripts, Karen Haltunnen has argued, the murderer was cast as "moral alien"— no longer a reminder of universal sin, but a monstrous Other against which to mark communal normality. See Karen Haltunnen, *Murder Most Foul: The Killer and the American Gothic Imagination* (Cambridge, MA: Harvard University Press, 1998), chap. 2. In the British context, Jason Tougaw has argued that proliferating diagnostic categories served to "[explain] away the morbid and pathological—distancing it from the ordinary," Tougaw, *Strange Cases*, 9. Such claims position late-Enlightenment era moral alienation as a state of exception, yet Brown and Rush's familicides do the reverse.

and *Don Quixote* special epistemological status to capture universal human character and communicate typologies, and I argue that he uses such cases to support his rationalistic and universalizing medical theory by avoiding the problems of fallible and unreliable testimony. I close by indicating the instability underlying his paradoxical reliance on narrative's truth and his suspicion of patient testimony before turning to Brown's *Wieland*, which thematizes the failures of testimony that Rush attempts to paper over. The characters constantly evaluate and re-evaluate one another, and readers are asked to do the same, training our ability to judge pathology in part by demonstrating its limits—we leave *Wieland* unsure of any stable truth. Rush relies on literature for mimetic truth-value to clarify his medical position, using literature to fix and simplify extremity, whereas Brown presses extreme cases to the limits, undercutting Rush's attempts to stabilize knowledge through fiction at the same time that he encourages diagnostic discrimination. In different ways, I argue, these narratives became the foundation of the new American science of the mind.

Rush's Diagnostic Narratives

In an address to the American Philosophical Society in 1786, physician and Declaration of Independence signatory Benjamin Rush suggested an expansion of previous systems of medical diagnosis. Dramatically, he announced, "I am aware, that in venturing upon this subject I step upon untrodden ground. I feel as Æneas did, when he was about to enter the gates of Avernus, but without a Sybil to instruct me in the mysteries that are before me." He continues, "I shall begin with an attempt to supply the defects of nosological writers, by naming the partial or weakened action of

the moral faculty, MICRONOMIA. The total absence of this faculty I shall call ANOMIA."[69] By drawing analogies between his proposed moral faculty and accepted faculties—like memory, judgment, and imagination—Rush attempts to draw an anatomical line around another corner of the mind. Faculty psychology, which emphasized the need for cultivation through education or government, had important moral, social, and political consequences in the late eighteenth century.[70] Diagnosing moral action, Rush rebrands immorality as disease, replaces corrupt motive with pathological etiology, and punishment with cure: we should treat the "micronomic" not just with moral lectures, but through medical means like exercise and diet, through public health reforms, and through legislation geared toward these priorities, as in his conclusion to the essay: Pennsylvania needed public schools across the state.

Rush's address was immediately seen as an influential philosophical work, and it marked the beginning of the study of the mind that would preoccupy the so-called "Father of American Psychiatry" for much of the rest of his career.[71] In the first American textbook of psychiatry, Rush's 1812 *Medical Inquiries and Observations, on Diseases of the Mind*, he still pointed readers toward this early

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[69] Rush, *Inquiry*, 10. First published as *An Oration, Delivered before the America Philosophical Society, held in Philadelphia on the 27th of February, 1786; Containing an Enquiry into the Influence of Physical Causes upon the Moral Faculty (*Philadelphia: Printed by Charles Cist, 1786), the lecture was published in a second edition in both Philadelphia (Cist) and London (Dilly) in 1786. Another Philadelphia edition, the one I use here, was printed in 1839 with an introduction by George Combe. It is hereafter cited in text as *Inquiry*. It was also excerpted in the *American Museum* 5 (1789): 118-21, and Rush printed the full text as the first chapter of *Medical Inquiries and Observations, Volume II* (Philadelphia: T. Dobson, 1793). In this essay, I rely on the 1839 edition. For the publication history of this essay, and Rush's other work, see Fox, Miller, and Miller, *Benjamin Rush, M.D.: A Bibliographic Guide* (Westport, Conn.: Greenwood Press, 1996).

[70] Blumenthal, "The Mind of a Moral Agent," 116.

[71] Carl Binger, *Revolutionary Doctor: Benjamin Rush, 1746-1813* (New York: W. W. Norton & Company, 1966), 171-73. Rush's theory of moral derangement was a major contribution to psychiatric science, and would later be adapted to diagnoses like Prichard's "moral insanity" (277). Butterfield writes that this was his "most important philosophical paper and a landmark in the development of psychiatry as a science" (L. H Butterfield, ed., *Letters of Benjamin Rush* [Philadelphia: American Philosophical Society, 1951], 1:n378). The following year, Rush was given responsibility for all thirty-four maniacal patients in the Pennsylvania Hospital (Binger 177). The American Psychiatric Association branded him "father of American psychiatry" in 1965 Shorter, *A History of Psychiatry*, 15..

speech.[72] Throughout his career he maintained its focus on the physical basis of mental illness—a focus clarified in his later rejection of nosology for the theory of the "unity of disease," which cast all disease, physical and mental, as arising from debility and inflammation of the blood vessels.[73] His science of the mind rested on an ecological and embodied model of the human brain in which the moral faculty was shaped by and in constant contact with physical and social forces, including climate, sun, diet, education, and art.[74] Rush's psychiatry was a science with political implications, as the brain linked individual to nation.[75] As Justine Murison has shown, Rush understood moral faculties as "the metaphoric and literal bases of the nation," the grounds for what she calls "moral citizenship."[76]

Rush attended medical school in Scotland, where he was trained under William Cullen, ultimately coming home not just with medical training but with the republicanism and Common Sense philosophy of the Scottish Enlightenment. Reacting against speculative philosophies that questioned human perception and moral agency, Common Sense philosophers "relied upon introspection as they proceeded to elaborate universal 'laws of the mind' that dictated how human beings ought to act."[77] In the struggle to theorize consciousness, the liberal theological environment of Scotland, in particular, fostered an interest in the science of morals, and Cullen wrote that the

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[72] Benjamin Rush, *MIODM*, 357.

[73] On the national implications of Rush's assertion that the circulatory system, rather than the nervous system, united the body and dictated its health, see Sari Altschuler, "From Blood Vessels to Global Networks of Exchange: The Physiology of Benjamin Rush's Early Republic," *Journal of the Early Republic* 32, no. 2 (2012): 207-231.

[74] Edward Shorter suggests that since the late eighteenth century, psychiatry has shuttled between incompatible neuroscientific and psychosocial models, and places Rush in the former camp. Shorter, *A History of Psychiatry*, 29. Rush's organic understanding of diseases of the mind, though, incorporated psychosocial dynamics. Eric Carlson writes that though it first appears that Rush foregoes psychology for physiology, he actually develops a psychological theory (Eric T Carlson, Jeffrey L. Wollock, and Patricia S. Noel, eds., *Benjamin Rush's Lectures on the Mind*, Memoirs of the American Philosophical Society 144 [Philadelphia: American Philosophical Society, 1981)], 4). Here, I side with Carlson.

[75] Altschuler, "From Blood Vessels to Global Networks of Exchange," 221.

[76] Justine S. Murison, "The Tyranny of Sleep: Somnambulism, Moral Citizenship, and Charles Brockden Brown's Edgar Huntly," *Early American Literature* 44, no. 2 (2009): 251, 244.

[77] Blumenthal, "The Mind of a Moral Agent," 112, 101–2.

physician "must on occasion be the Moral Philosopher also."[78] As part of this fusion of philosophy and faculty psychology, physicians theorized new nosological systems that could explain the workings of the mind. If, as Christopher Looby argued of Thomas Jefferson, "neology was a ritual enactment of revolution,"[79] Rush's nosological neologies "anomia" and "micronomia" (and even more explicitly with his suggestions of "Revolutiana" and "Anarchia") began to revolutionize inherited medical knowledge by grafting American branches to his teacher Cullen's complex nosological tree.

In diagnosing individual maladies, then, Rush diagnoses national ones—most specifically, in this essay, the failure of its educational institutions, but elsewhere its jails and hospitals.[80] Maureen Tuthill suggests that discourses of health in early America pitted self-interest against social cohesion: what is my duty to the unhealthy other? At what point do the unhealthy forfeit that regard through self-destruction or poor citizenship?[81] Confronting the problem of human misbehavior and moral accountability, Rush's answer is that a physiological explanation for behavior should make us more generous to the failures of others. Of moral insanity he wrote, "all the light and knowledge of our science should be employed to oppose the usual punishment inflicted upon them. What should we

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[78] Quoted in George Makari, *Soul Machine: The Invention of the Modern Mind* (New York: W.W. Norton & Company, 2015), 171.
[79] Looby, *Voicing America*, 52.
[80] Although in some ways uniquely American, Rush's medicalization of moral agency was part of a broader Enlightenment investigation. In the struggle to theorize consciousness, the liberal theological environment of Scotland, in particular, fostered an interest in the science of morals, and Rush followed Cullen in fusing his duties as physician with his role as moral philosopher (Makari, *Soul Machine*, xiv, 171). On the relationship between medicine and law in assessing criminal and civic responsibility and its roots in the Scottish Common Sense philosophy, see Blumenthal, "The Mind of a Moral Agent." For more on Rush's European education, and for a medically oriented biography, see Binger, *Revolutionary Doctor*. For more recent work on Rush's medical philosophy, see Altschuler, "From Blood Vessels to Global Networks of Exchange"; Altschuler, *The Medical Imagination*; Don James McLaughlin, "Hyrdophobia's Doppelganger," *Literature and Medicine* (forthcoming); Eric Herschthal, "Antislavery Science in the Early Republic: The Case of Dr. Benjamin Rush," *Early American Studies: An Interdisciplinary Journal* 15, no. 2 (2017): 274-307; Richard Bell, "The Moral Thermometer: Rush, Republicanism, and Suicide," *Early American Studies: An Interdisciplinary Journal* 15, no. 2 (2017): 308–31; and Murison, "The Tyranny of Sleep."
[81] Tuthill, *Health and Sickness*, 8.

think of a surgeon, were we able to see him cut off an arm or a leg, because in its convulsive motions, it injured a toiler, or overset a teatable? It is equally absurd, and far more cruel, to inflict the punishment of death upon a fellow creature, for taking away a life under the influence of a deranged state of the will."[82] Immersed through his training with Cullen in the Scottish Enlightenment, Rush returned to America with an optimistic view of the perfectibility of citizens' faculties in a new national context and so made a medical case for institutions that could strengthen national morality.[83]

Rush's ecological model of the mind, though, did not simply mean that nobody was responsible for their actions, and a precise diagnosis relying on physician judgment remained necessary: diseases of some faculties or diseases of certain kinds precluded responsibility, others did not. Rush's schema also distinguishes between illness and vice, but suggests that vice can be understood through "analogy" to bodily disease.[84] Regardless, that immorality could be diagnosed, and that it could be cured, he asserts through reference to the "many cases upon record, that prove that their diseases have yielded to the healing art."[85] Ultimately, Rush understood an immoral act as part of a pathological narrative arc that enabled the medicalization of morality and intervention in education, law, and politics.

In a meaningful sense, his diagnostic approach to morality simply provided a new kind of evidence for his religious principles, enabling a campaign of medically-driven social reforms that squared with his personal theology. Rush's intellectual training under Cullen was fused with a brand

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[82] Rush, "On the Study of Medical Jurisprudence," 388. In this later publication, he calls the Philadelphia jail "this original and humane institution, in which science and religion have blended their resources together" and calls for a spread of "this christian system of criminal jurisprudence" (365–66). As this call suggests, paired with the benevolence at the center of his reformist impulse was a fantasy of control. On Rush's medical reforms and the extension of medical power to custodial authority, see Bell, "The Moral Thermometer."

[83] Blumenthal, "The Mind of a Moral Agent," 104–5.

[84] Rush, *MIODM*, 364.

[85] Rush, *Inquiry*, 3.

of theological optimism instilled by his upbringing in a sect of Presbyterianism preoccupied with grace and universal salvation and a later turn to Universalism that imagined salvation as "an inalienable right granted to all by a benevolent creator."[86] His blend of the European science of morals with Universalist theology resulted in a scientific case for social reform, with medicine taking the moral helm.[87] In 1786, the same year that Rush gave his speech on anomia and micronomia, he helped to found the Philadelphia Dispensary for the medical relief of the poor.[88] In addition to providing care for the impoverished, because "the flame of sympathy, instead of being extinguished in taxes, or expiring in a solitary blaze by a single contribution, may be kept alive by constant exercise. There is a necessary connection between animal sympathy and good morals."[89] Rush also campaigned for abolitionism, criminal justice reform, education, and temperance, and as physician for the mad at the Pennsylvania Hospital he was responsible for upgrades like installing heating as the American agent of the reformist tide sweeping through Europe as exemplified by Tuke's York Retreat and others advocating "moral treatment" rather than incarceration or family care.[90]

The foundation of Rush's diagnosis, upon which he placed so much humanitarian weight, was narrative. In the 1802 New York edition of the *Lexicon Phyico-Medicum,* John Quincy includes a familiar definition of nosology: "the arrangement of disorders, or distinguishing them into genera,

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[86] Bell, "The Moral Thermometer," 324–25. On Rush's blending of medicine and theology, see also Blumenthal, "The Mind of a Moral Agent," 105; Eric T Carlson, Jeffrey L. Wollock, and Patricia S. Noel, eds., *Benjamin Rush's Lectures on the Mind*, Memoirs of the American Philosophical Society 144 (Philadelphia: American Philosophical Society, 1981), 6.

[87] Although his mechanistic claims at times sound heretical, as in his claim that "religious melancholy and madness, in all their variety of species, yield with more facility to medicine, than simply to polemical discourses, or to casuistical advice," he sees human and divine agency as fully compatible. Attempting to bridge theological and medical inquiry he writes that those "in favour of the immortality of the soul have done that truth great injury, by connecting it necessarily with its immateriality" (*Inquiry,* 23, 9). Matter is as godly as anything else; Rush's moral faculty was endowed by God. Indeed, the "nomos" that he incorporates into his diagnostic terms is reference to St. Paul's "law of nature written in the human heart" (11), and thus his proposed diagnoses represent a fusion of taxonomic and theological principles.

[88] Fox, Miller, and Miller, eds., xxv.

[89] Rush, *Inquiry*, 22. On Rush's initial faith in the healing power of reading and his later belief that it would pervert readers' sympathy, see Bell, "The Moral Thermometer," 316-318.

[90] Binger, *Revolutionary Doctor*, 250–51.

species, &c, or examining their difference." But the first definition indicates the reliance of such clean, well-ordered systems on narratives of illness: nosology is "the history of disease, or a description of the causes, symptoms, and progress of disease."[91] To fill the diagnostic lacuna of moral disorder Rush presented histories, tying together the past, present, and future of moral action as etiology, symptom, and prognosis of disease. Establishing and naming moral disease, then, provides new avenues for perfectibility: "It is vain to attack these vices with lectures upon morality. They are only to be cured by medicine,—particularly by exercise,—the cold bath,—and by a cold or warm atmosphere."[92] Rush supports his novel medical theory through anecdotal evidence, narrating, for instance, the case of one woman who, as a result of illness, lost the capacity to tell the truth—evidence of the physical impact on moral capacity—but who was restored to verity by a cold snap.

The medicine of the mind, as Rush practiced it, required literary as much as medical skill, and he partook in what Altschuler has called "Imaginative experimentation," which "helped doctors and writers explore what could not be seen, draw novel conclusions from observation and experiment, and understand aspects of health that exceeded mechanistic paradigms."[93] Because the internal operations of the mind were not visible, the data he relied upon to build his diagnostic theories was necessarily behavioral, and narrative was the vehicle for conveying causal links. In sketching out the distinction between pathological lying and "exculpative, fraudulent and malicious lying," for instance, Rush writes that the difference is in pathological lying "being influenced by none of the motives of any of them.... That it is a corporeal disease, I infer from its sometimes

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[91] John Quincy, *Quincy's Lexicon Physico-Medicum Improved : Or, A Dictionary of the Terms Employed in Medicine, and in Such Departments of Chemistry, Natural Philosophy, Literature, and the Arts, as Are Connected Therewith : Containing Ample Explanations of the Etymology, Signification, and Use of Those Terms : From the 11th London Edition : With Many Amendments and Additions, Expressive of Discoveries Lately Made in Europe and America : Copy-Right Secured* (New York: Printed by T. & J. Swords, 1802), 465.

[92] Benjamin Rush, *Inquiry*, 13.

[93] Altschuler, *The Medical Imagination,* 13. On the challenges posed by physiological experimentation and the use of narrative to produce this knowledge, see 11–13.

appearing in mad people, who are remarkable for veracity in the healthy states of their minds."[94] Several things are necessary here, including a sense of motive and purpose and a stable sense of character from which divergences can be marked. Psychiatric literature, with little recourse to physical symptomology, requires the individual case to stand in as evidence for an entire category, with the imagination tasked with comparison. In laying out his new principles, he writes, "I shall only hint at a few cases, and have no doubt but that the ingenuity of my auditors will supply my silence, by applying the rest" (*Inquiry* 11). People are asked to infer from one case to many, and the anecdote becomes the basis for the universal.

Rush understood these pathological narratives to illustrate the mechanism underlying all minds rather than just pathological ones. Blumenthal suggests that Common Sense philosophers didn't account for insanity, and when they did they regarded the mad as "categorically different from the rest of humanity; in a self-evident sort of way, they were placed on the margins along with idiots, brutes, and children, where they served as foils against which human abilities and duties could be defined."[95] In contrast, Rush believed the particular features of a patient's madness could provide valuable information about the faculties and workings of the normal mind. The science of faculty psychology, for example, relied on cases in which a person behaved pathologically in one, and only one, particular way. Thus, if a patient had a damaged memory but otherwise operated normally, memory must be anatomically siloed from its neighbors. Such stories, Rush imagined, provided access to the vicissitudes of the working mind that were inaccessible to anatomists.

In drawing universal theories from singular narratives, Rush exemplified the rationalistic epistemology of his Scottish training, which emphasized system and theory over the clinical and empirical model that flourished in French hospitals.[96] The narrative genre of the case crossed

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[94] Benjamin Rush, *MIODM,* 265.
[95] Blumenthal, "The Mind of a Moral Agent," 118.
[96] Warner, *The Therapeutic Perspective*, 22.

national lines, as physicians and men of science communicated cases to one another across the Atlantic, working from the assumption that case material could form the stable base for medical philosophy. In their study of the history of objectivity, Lorraine Daston and Peter Galison trace scientific imaging, and particularly the atlas, as providing standard objects of inquiry for "collective empiricism."[97] For Rush and other early scientists of the mind this shared evidence existed largely in narrative form, fusing empiricism with the rationalistic methodology of Scottish medicine. Medical training in eighteenth-century Scotland required students to learn clinical genres, as they were assigned to copy patient case reports and their professors' lectures.[98] Medical journals like *Medical Observations and Inquiries* circulated in Edinburgh in the latter half of the eighteenth century, aiming to "revive the Hippocratic method of composing various narratives of particular cases, in which the nature of the disease, the manner of treating it, and the consequences are to be specified."[99] Sharing information from singular cases in a standard format, the case attempted to chip away at medical mysteries. Like other eminent physicians of his time, Rush, as a professor, relied more on reading than on experiment, and he drew on such circulating cases, keeping medical notebooks in which he transcribed quotations from other writers.[100]

Rush's narrative anatomization resolves what appears at first to be a contradiction between his early and late diagnostic philosophy. Although early in his career Rush added new diagnoses to the nosological systems of his forbearers Sydenham and Cullen (sometimes genuinely, sometimes ironically), he later became notorious for his rejection of taxonomic approaches to illness.[101] Hardly a

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[97] Lorraine Daston and Peter Galison, *Objectivity* (New York: Zone Books, 2007), 26.
[98] On the foundations of the case study genre in the Scottish Enlightenment, see Carol Berkenkotter, *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia, SC: University of South Carolina Press, 2008), chap. 1.
[99] Quoted on Berkenkotter, 23.
[100] Herschthal, "Antislavery Science in the Early Republic," 280.
[101] On Rush's nosology, and for readings of Rush's nosological satire, see Altschuler, "Global Networks," 209-210 and McLaughlin, "Hydrophobia's Doppelganger."

rejection of the diagnostic narrative, however, Rush's controversial doctrine of the unity of disease only increased the need for physician narrators; in other words, his rejection of nosology was linked to an embrace of diagnosis. In his lecture notes "On Nosology," for example, he utterly rejects the division of diseases "into Classes, Orders, Genera and Species after that manner of plants & animals," writing, "It is incompatible with all our knowledge in Anatomy and Physiology."[102] (Rather anticlimactically, he ends by acknowledging that nosology is unavoidable with the current state of knowledge and recommending that his students purchase Dr. Cullen's nosology and learn it.[103])

Despite its name, the unity of disease did not simplify the diagnostic process, but complicated it, requiring increased discrimination from a physician narrator. As McLaughlin writes, this unity was "more complex in its capacity for both interrelation and diversity than the discrete identities of nosology would imply."[104] Consider, for example, Rush's division of "intellectual derangement" in his work on medical jurisprudence: always originating in debility and inflammation, it can arise from acute inflammation (phrensy or phrenitis), chronic inflammation (mania, or madness), or delirium.[105] Madness, moreover, can be "partial" (on one subject) or "general." Each of these expressions of disease has different implications for jurisprudence and legal responsibility, and they can be told apart through behavior, a narrative of change over time, and the pulse. Rejecting nosology at the same time that he advocates for diagnostic groupings, Rush's system, as William Hedges has claimed, "perhaps largely semantic."[106]

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[102] Benjamin Rush, "Introduction to lectures on the practice of medicine, on nosology," [n.d.], volume 299, Rush Family Papers, 1748-1876, Library Company of Philadelphia, p. 2, p. 3v.
[103] Rush calls nosology "the ancient and universal tyrant," but sees it as natural and perhaps inevitable: "Mankind are by nature as much nosologist in medicine, as they are idolators in religion. In the present state of medical knowledge & prejudice therefore in the world,—it will be necessary not only to speak of disease in the plural number, but even to conform to habit as far as to name diseases" ("Introduction," p. 27r, 27v).
[104] McLaughlin, "Hyrdophobia's Doppelganger."
[105] Rush, "On the Study of Medical Jurisprudence," 366.
[106] William Hedges, "Benjamin Rush, Charles Brockden Brown, and the American Plague Year," *Early American Literature* 7, no. 3 (1973): 303–3.

The centrality of narration to Rush's medical diagnosis is described usefully by a term coined by a posthumous reviewer. In an 1821 *Medical Repository* review of a work by J.L. Alibert, the reviewer, before turning to his main subject, writes

> Our illustrious countryman, Rush, inculcated on his pupils a very general disregard of nosology, which we think is greatly to be commended. … When the subject is considered dispassionately, it appears unwise not to study diseases after an arrangement of them convenient for the memory. Yet nosology is nothing more: the word has long ceased to convey its just etymological import, and might very properly be replaced by the term nosography, from which it is as widely different as geology is from geography."[107]

This etymological turn from *logos* to *graphos*—from inherent logical structure to descriptive practice—describes Rush's diagnostic practice as he sorted cases into rough categories that could be used to guide new medical knowledge. A reviewer of Rush's *Diseases of the Mind* writes that by releasing nosological preoccupation, Rush's text is "merely the history of his extensive experience among all the grades of mental maladies, which he has carefully differenced and classed, by the efforts in relation to thoughts and acts, by the predominance of certain bodily affections or symptoms, and by the similarity of treatment they required."[108] Rush's approach to disease is based in a complex negotiation of case material: diagnostic clusters are based on the similarity of the characters involved and their actions, and also retroactively based upon the outcome of their treatment. These cases were elevated to an artform, and the reviewer notes the "eloquence of the writer, of the originality and delicacy of his thoughts, of the versatility of genius by which a work of

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[107] "[Review of Alibert's Natural Nosology]," *The Medical Repository*, New Series (3), vol. 6 (1821): 198–99. The numbering of *The Medical Repository* becomes complicated due to new series. Counting from the first volume, this is the twenty-first.

[108] "[Review. Medical Inquiries and Observations upon the Diseases of the Mind]," *The Medical Repository*, New Series, vol. 1 (1813): 148. See previous note: this is the sixteenth volume from the journal's inception.

medical inquiry, is at once a metaphysical treatise on human understanding, a physiological theory of organic and thinking life, a code of pure morals and religion, a book of the best maxims to promote wisdom and happiness; in fine, an elegant collection of classical, polite, poetical and sacred literature."[109] The *graphos* of this new term was at the heart of Rush's medical style, as he called for physician judgment over memorization and classification: for Rush, the physician must read the illness in context, placing it in relation to its origins, its symptoms, and its prognosis.

In addition to Rush's attention to the narrative qualities of clinical cases, he also relied on fictional material to provide real-world information. On June 10, 1790, Benjamin Rush wrote in his copy of Journal of a Plague Year, "For the instruction, & entertainment I have received from this book, I am truly thankful to H.F."[110] Throughout, Rush folded page corners and annotated passages with tic marks alongside passages including one on people being frightened to death and another, both underlined and emphatically marked about a physician maintaining his health through the use of garlic, rue, tobacco and vinegar. In the final pages of the volume, Rush compiled an index that combined medical and social observations on topics such as "Origin of the plague," "State of morals after the plague," "The number who died of the plague & in what months," and "Effects of terror." Rush's rigorous annotating and indexing of this volume, despite probably knowing it was a work of fiction, highlights the kind of truth-value he believed fiction might hold.

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[109] "[Review. Medical Inquiries and Observations upon the Diseases of the Mind]," 148.

[110] Rush's copy of [Daniel Defoe], *A Journal of the Plague Year* (London: E. Nutt, 1722) is in the collections of The Library Company of Philadelphia. On Defoe and fictionality, see Catherine Gallagher, "The Rise of Fictionality," in *The Novel, Volume 1: History, Geography, and Culture*, ed. Franco Moretti (Princeton, N.J: Princeton University Press, 2007), 340. She writes that, "When Daniel Defoe published Robinson Crusoe in 1719, for example, he certainly intended to deceive the public, and he succeeded. A year later, in the preface to a sequel, Defoe, under pressure to admit that he had lied, still insisted on the historical accuracy of his tale but then, inconsistently alleged that each incident in the 'imaginary' story alluded to an episode in a 'real Story' (Defoe 1903: xi). He accordingly clung to particularity of reference, even as he shifted the grounds of his claim from literal truth to allegorical allusion" (339).

Literary material served a special epistemological purpose for Rush. In his 1786 lecture on moral illness, Othello is evidence that the dark of night negatively impacts morality ("Othello cannot murder Desdemona by candle-light" [*Inquiry* 17]), Caesar's trust in "'sleek-headed' Anthony and Dolabella" and suspicion of "slender Cassius" (3) is evidence that brain size and physiognomy correspond to moral capacity, and Hamlet is proof that habit improves the faculties, saying to his mother "Assume a virtue, if you have it not."[111] More than twenty years later, after he was well established as a physician for the mad, he still relies on literary evidence rather than his own, by then ample, cases. In his 1810 "On the Study of Medical Jurisprudence," Rush argues reason can return to the mad, writing, "Such cases must be common in all countries; or Cervantes, who copied all his characters from nature, would not have restored Don Quixote to the use of his reason in the close of his life of folly and madness."[112] To introduce the possibility of a complete loss of moral faculties, he introduces a supposedly truthful exemplar: "An epitome of all that has been recorded, or perhaps seen, of this derangement in the moral faculties has been given by Edgar of himself, in the tragedy of King Lear."[113] He takes for granted that at least some literary artists observe and report human nature with such clarity and truth that their characters are as effective as—if not more effective than—case histories in delineating new diagnostic groupings.

Rush's use of this imaginative material evinced a belief in verisimilitude in literature that allowed it to be placed alongside clinical cases, complicating the notion that novels exist in a fictive realm and case studies correspond more cleanly to reality. Following a literary case, Rush continues by noting that he has personally seen three similar cases. The literary case is thus a mechanism for clearly articulating that which has been personally seen—it provides a type alongside which to

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[111] Shakespeare was a particularly attractive source for early psychiatrists. On this phenomenon, see Reiss, chap. 3, and the second chapter of this dissertation.
[112] Rush, "On the Study of Medical Jurisprudence," 374.
[113] Rush, *MIODM*, 359.

position those personally encountered. The rationalistic system that predominated his approach was especially well-suited to fictional cases, as physicians were more interested in universal truths and kinds of patients than they may have been in actual patients themselves. Rush distinguished between imagination and fancy and dealt in realities grounded in experience rather than in absurdities.[114] Moreover, in the transatlantic market of medical cases, internationally known exemplars like Shakespeare, Milton, and Cervantes certified Rush as culturally knowledgeable and provided a stable base of material on which medical theory could be collaboratively built. Alongside the case studies circulating between early scientists of the mind, then, were a library composed by reliable observers of the human condition: the Bible, of course, provided valuable truths, but so did Shakespeare, Milton, Cervantes, and even, apparently, the scoundrel Defoe. As Daston and Park argue, in mid-eighteenth-century literature, "truth to fact" was subsumed by "verisimilitude—not truth itself, but the appearance of truth, which relied on conventions of plausibility, decorum, and seemliness."[115] The plausibility of literature was all that was required for the plausibility medical knowledge. Rush's use of literary material coheres with Scottish Enlightenment philosopher Lord Kames, who believed that fiction could impress the mind as strongly as experience. Indeed, fiction's emotional power could give it a stronger effect than history itself. Edward Cahill writes that in his logic, Kames "simultaneously affirms the truth of objective experience and declares fiction particularly well suited to representing it."[116] Through Rush, then, literary production is built into the fledgling field of American psychiatry, shaping its nosological codes.

Rush's use of literary figures recalls discussions of the role of pseudonymity in the print culture of the early republic. Although his medical writings were published under his own name,

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[114] Altschuler, *The Medical Imagination*, 22.
[115] Lorraine Daston and Katharine Park, *Wonders and the Order of Nature, 1150-1750* (New York: Zone Books, 1998), 212.
[116] Edward Cahill, *Liberty of the Imagination: Aesthetic Theory, Literary Form, and Politics in the Early United States* (Philadelphia, Penn.: University of Pennsylvania Press, 2012), 170.

Rush displays a different facet of what Warner calls the "distinct preference for fictitious personae" in early national culture.[117] By crafting pseudonymous patients rather than disguising his own authorship, though, Rush adapts this trope and so rather than claiming his own "depersonalization," and thus disinterestedness, as an author, he instead de-persons the patients on whom he bases new medical diagnoses. The exemplary patient behind a given diagnosis is not a patient at all, a fact that allows her to remain so exemplary. Lacking the messiness of real, embodied people, Rush's "fictitious personae" allowed him to fix diagnostic types without the problem of patients' individuality and attendant idiosyncrasies. In her rebuttal of Warner's reading of pseudonymous communication, Trish Loughran writes that anonymity was unsuccessful as a rhetoric of impartiality because "general readers did not need to know the precise details of a pseudonymous persona's identity in order to discern the *kind* of person who might be lurking beneath such a persona."[118] Altering this logic to fit the fictionalizing of patients rather than authors, the pseudonym can convey *kind*s of illness without the attendant problems of the individual ill person.

Whether grounded in imaginative literature, reported observations of other physicians, or unreliable patient testimony, Rush's epistemological certainty was a fiction. Murison has noted that mental science had a "fictional quality" as, in the end, "physicians and phrenologists theorized mental faculties but could not prove empirically their existence."[119] Rush is in some sense aware of this failure. In his lecture on anomia, Rush distinguishes between morality, which is associated with the will and can be observed through action, and conscience, based in the understanding, which is internal, and hence inscrutable and beyond his purview in the essay. With this distinction, Rush highlights the unreliability of testimony, particularly the testimony of one with indeterminate moral

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[117] Michael Warner, *The Letters of the Republic: Publication and the Public Sphere in Eighteenth-Century America* (Cambridge, Mass.: Harvard University Press, 1992), 43.
[118] Trish Loughran, *The Republic in Print: Print Culture in the Age of U.S. Nation Building, 1770-1870* (New York: Columbia University Press, 2007), 136.
[119] Murison, "The Tyranny of Sleep," 246.

faculties. However, later in the same essay he relies on this very unreliable testimony to ground a case: his diagnosis relies on storytelling, on motive, on trust in confession. Giving the example of a woman whose moral faculties are sound, except she can't help but steal, he writes, "As a proof that her judgment was not affected by this defect in her moral faculty, she would both confess and lament her crime, when detected in it" (*Inquiry* 7). Her confession, then, stands in as the "proof" that he needs to ground his medical theory, teetering on the edge of veracity.

Paradoxically, Rush's use of explicitly literary and even fictional material, like Don Quixote, may have seemed more stable than patient testimony. Fictional sources enabled the fantasy of legibility that Rush had to partially admit as fantasy when facing real patients. Daston and Park note that around the end of the seventeenth century, "intrinsic plausibility" became "a counterweight to testimony."[120] Equating "'verisimilitude' in art" with "'order' in nature," they note, "Verisimilitude defined what was plausible in a work of literature or the fine arts with reference not so much to historical or natural fact as to the opinions of the audience as to what was possible or proper" (358). It is not surprising, then, that Rush's evidence for the physiognomy of morality was drawn not from his own measurements, but in Shakespeare (*Inquiry* 3). Murison suggests that Rush's lectures "depended on a language of observation to explore the limitations of the mental faculties, a method that continually revealed the pitfalls of observation for the new medical science of psychology."[121] Rush's use of fictional material was a useful way around these "pitfalls of observation," though, and thus it was only the fictional source material that allowed the fictions of faculty psychology to attain the status of legitimate medical inquiry. Literary material allows him to imagine a fixed relationship between observation and truth—a fixity likely challenged by daily medical practice, but required by his agenda of reform. The instability lurking beneath Rush's reliance on such material would be

[120] Daston and Park, *Wonders*, 347.
[121] Murison, "The Tyranny of Sleep," 247.

taken to extremes by another theorist of the medicine of the mind: the novelist Charles Brockden Brown.

Brown's Authentic Case

Although no known correspondence between Rush and Brown exists, the men were familiar with one another personally and professionally. Most clearly, in 1803, Benjamin Rush replied to a request for a history of prison reform, saying, "Of course I must be excused from undertaking the work you have suggested to me. I shall mention it to Charles Brown. He possesses talents more than equal to it. The subject would glow under the eloquent strokes of his masterly pen."[122] (Somewhat mysteriously, a letter that Brown wrote to his brother James about the Yellow Fever outbreak in New York on 25 October 1796 is located in Benjamin Rush's archive at The Library Company.[123]) The men had several mutual acquaintances, most notably Elihu Hubbard Smith, Brown's close friend and roommate whom he met when Smith studied medicine in Philadelphia under Rush in 1790.[124] Smith was in regular contact with Rush while living with Brown, and ideas certainly trafficked between the men. For instance, the work of Erasmus Darwin, particularly *Zoonomia*,

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[122] Butterfield, *Letters of Benjamin Rush*, 2:874.

[123] Charles Brockden Brown to James Brown, 25 October 1796, box 14, folder 21, Rush Family Papers, 1748-1876, Library Company of Philadelphia. Although the provenance is unknown, possibly Smith thought the letter, which talked about rumor, imagination, and fear in the face of plague, would be of interest to his former teacher, with whom he corresponded about the fever, or perhaps Brown sent it to the physician himself. See also Charles Brockden Brown, *Collected Writings of Charles Brockden Brown*, ed. Philip Barnard, Elizabeth Hewitt, and Mark Kamrath, vol. 1 (Lewisburg, KY: Bucknell University Press, 2013), 373n2. .

[124] Brown, *Collected Writings*, 223. On at least one occasion, Smith was making visits in Philadelphia with Brown on the same day that he visited Rush, though it's unclear whether Brown accompanied him on that particular trip (*Collected Writings,* 320). They also had a mutual acquaintance in Walter Franklin, secretary of the Pennsylvania Abolition Society in 1794 while Rush was the president (*Collected Writings*, 99n4), and in William Dunlap, one of Brown's closest friends and Rush's fellow committee member on the first American Convention for Promoting the Abolition of Slavery (*Collected Writings,* 264n10).

published in America by Smith and Mitchill, was cited in Brown's authenticating footnotes and in Rush's medical journals.[125]

Brown's fiction emerged from what Bryan Waterman has called the "protodisciplinary knowledge culture" of the Friendly Club, of which Brown and Smith were a part.[126] This group, composed of men working in law, medicine, literature, commerce, and beyond, had a powerful role in establishing a national literature as well as helping to establish legal and medical publishing.[127] Club members Smith, Edward Miller, and Samuel Latham Mitchill founded the *Medical Repository*, and the club also started the *Monthly Magazine* in 1799, with the intention of including "every division of literature & while it comprehends, at once...letters & arts, customs & manners, the history of nations & the peculiarity of individuals,--it becomes alike the *Manual* of Science & of Conversation."[128] The Friendly Club's writers self-consciously crafted the genres that would shape much of American thought, but more than disciplinary models, they provided the cross-disciplinary fertilization in which *Wieland*, with its commentary on medicine, law, education, and politics, was grounded. Brown lived with Smith while he composed the novel in the summer of 1798, and the men exchanged both subject material and editorial advice as Smith attempted to compose a medical journal with "literary character" and Smith served as reader for Brown, writing in his journal, "Finished what Brown has written of 'Wieland.' Corrected a proof of Repository & one of Wieland."[129]

Like Rush, the club members understood themselves as moral diagnosticians. Bryan Waterman emphasizes the almost nosological mode of Smith's writing in his journal where he

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[125] For a detailed account on both the cross-fertilization between and the philosophical differences of Rush, Brown, and Smith, see Altschuler, *The Medical Imagination*, chaps. 1 and 2.
[126] Bryan Waterman, *Republic of Intellect: The Friendly Club of New York City and the Making of American Literature* (Baltimore, MD: Johns Hopkins University Press, 2007), 11.
[127] Waterman, 1.
[128] Quoted on Waterman, 46.
[129] Quoted on Altschuler, *The Medical Imagination*, 66.

"scrutinize[d] strangers' speech--just as physiognomists did faces--as a means of discerning character" and sorts conversations with "a pseudo-Linnaean vocabulary."[130] The *Medical Repository* makes explicit the belief that narratives of pathology generate new medical theory, opening with the history of the Plague of Athens as part of "The study of the histories of those wide-wasting diseases which pass under the name of Epidemics."[131] (This first issue also including a review of Rush's *Medical Inquiries and Observations, vol 4*.) The journal compiled cases, relating individual medical events in the service of universal theory. Correspondence from physicians is printed to similar purpose. The journal also contained cases, including many composed by Smith, meant to inspire broader theorization. One case written by Smith in 1797, "Case of Mania Successfully Treated by Mercury," illustrates his gestures toward new systems of knowledge. After a detailed case history, he articulates several hypotheses about the origins and character of the patient's illness, before closing, "The reader must determine which, or whether any of these conjectures deserve consideration."[132] Smith's close to this case, calling on the reader to exercise their own judgment to draw conclusions based solely on the narrative he himself has led them through, bears striking resemblance to the imperative in *Wieland*'s final paragraph: "I leave you to moralize on this tale."[133] Brown's fiction, too, engages in medical theory building as a basis for moral diagnosis.

Under the heading "Tales. passions pourtrayed," Brown's notebook includes medical categories like "Hallucination," "mimicry," "somnamb." alongside notes on "dissimulation" and "love of country." Slightly farther down the page, he includes a diagram where "moral" divided into "Self depravity" and "Another's depravity" and the word "physical" is split into "Direct" and

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[130] Waterman, *Republic of Intellect*, 34.
[131] Elihu Hubbard Smith, "Introduction," *The Medical Repository* 1, no. 1 (1797): 1.
[132] *The Medical Repository* 1, no. 2 (1797): 181.
[133] Charles Brockden Brown, *Wieland and Memoirs of Carwin the Biloquist* (New York: W. W. Norton & Company, 2011), 184.

"Indirect."[134] As Brown searched in his American gothic for something "more dignified and instructive than ruined castles, imaginary spectres, and the monkish fictions of modern romance," he landed on the medicine of the mind.[135] Grounded in the same physiognomic, associationist, and environmentalist theory as Rush and Smith's works, Brown's novel investigates the workings of the human mind through confessional narration, character description, and narrative cohesion (and its lack). Pointing to the popularity of Erasmus Darwin's mental case studies in *Zoonomia*, Edward Cahill writes that *Wieland* is "a contribution to the literary tradition of 'force of imagination' narratives" like the ones that claimed imagination could kill.[136] Rather than the voice of medical authority, though, we are placed firmly inside the narration of one of the patients.

Brown's novel takes the form of a letter written by Clara Wieland, who is relating the etiology of the trauma through which she narrates. She tells us of an idyllic country life with her brother, Theodore, his wife Catherine, and Catherine's brother (and object of Clara's affection), Henry. Members of the group begin hearing mysterious voices that sow discord, doubt, and anxiety among them. Eventually, Theodore heeds a supposed command from God to murder his beloved wife and children. In the end, we learn, the group was plagued not by a demon but by Carwin, a ventriloquist running "experiments" on them.[137] Carwin admits to it all—except for the final voice calling for familicide. A lingering question, then, is whether the command to kill means that Carwin is lying, or that Wieland was mad and hallucinating—a question calling for a diagnostic eye but thwarted by the opacity of the other. The form of the novel both thematizes this opacity and rejects it, providing us otherwise impossible access to the imagined inner moral life of our narrator, and, in

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[134] Charles Brockden Brown, "Notebook, 1801, n.d.," collection 84, volume 24, Brown Family Papers, Historical Society of Pennsylvania, Philadelphia.
[135]"Review, Wieland, or the Transformation. An American Tale," *The American Review, and Literary Journal* 1 (New York: T. & J. Swords, 1801), 333.
[136] Cahill, *Liberty of the Imagination*, 177, 193.
[137] Brown, *Wieland,* 230.

a sequel, to Carwin himself. While running experiments for his own interest, Carwin also runs experiments on behalf of the reader, who is given the material to theorize about human consciousness and will. What would happen if someone heard mysterious voices? If the testimony of their senses could not be made to fit their conception of reality? By incorporating long first-person confessions by Clarel, Wieland, and Carwin, Brown encourages us to sympathize with, and to evaluate diagnostically, an array of minds.

In his novel, Brown invites an evaluation of his fiction on the basis of laws of plausibility or facticity. Despite Gallagher's claim that fictionality "seems to have been but faintly understood in the infant United States at the end of the eighteenth century," *Wieland's* complex impact on the reader relies upon it. For Gallagher, "the reader is trained in an attitude of disbelief, which is flattered as superior discernment. The readers of these early novels were encouraged to anticipate problems, make suppositional predictions, and see possible outcomes and alternative interpretations. In short, the reader, unlike the character, occupies the lofty position of one who speculates on the action, entertaining various hypotheses about it."[138] Although Brown's characters do their fair share of speculating within the narrative, this dynamic describes the "lofty position" of readers with access to authenticating medical testimony who are thus able to disregard certain of the characters' divine fears.[139] Of the change in discourses of fictionality across the eighteenth century, Gallagher writes, "What Fielding had that Defoe lacked was not an excuse for fictionality but a use for it as a special way of shaping knowledge through the fabrication of particulars."[140] The fictionality of the novel is in this sense not far afield from that of the case study, in which the particulars selected by the writer are shaped into a narrative meant to stand in as representative, despite the singularity of its case. The

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[138] Gallagher, "The Rise of Fictionality," 345, 346.
[139] Thomas Koenigs, "'Whatever May Be the Merit of My Book as a Fiction': *Wieland*'s Instructional Fictionality," *ELH* 79, no. 3 (2012): 730.
[140] Gallagher, "The Rise of Fictionality," 344.

cases that Smith contained within the covers of his magazine—narrative offerings to a communal growth of medical knowledge—escape their margins in Brown's fiction.

Recalling the "plausibility" required for both moral literature and medical cases, Brown's "Advertisement" for *Wieland* shows him navigating anxieties about the immorality of fictional work by asserting the probability of his outlandish novel. He invites an evaluation of his fiction on the basis of the same laws of plausibility—medical expertise or historical precedent—that ground the case study.[141] He acknowledges how unlikely some of the occurrences sound, but appeals to "intelligent readers" to see how it fits in with actual natural principles: "The power which the principal person is said to possess can scarcely be denied to be real" and has "strength of historical evidence." As it does in the case studies that built diagnostic schemas, the plausible tale enables "the illustration of some important branches of the moral constitution of man." Reversing Rush's reliance on the plausibility of fiction, Brown's novel depends on the medical plausibility of madness:

> Some readers may think the conduct of the younger Wieland impossible. In support of its possibility the Writer must appeal to Physicians and to men conversant with the latent springs and occasional perversions of the human mind. It will not be objected that the instances of similar cases are rare, because it is the business of moral painters to exhibit their subject in its most instructive and memorable forms. If history furnishes one parallel fact, it is a sufficient vindication of the Writer; but most readers will probably recollect an authentic case, remarkably similar to that of Wieland.[142]

With this introduction, Brown not only verifies his text's grounding in the historical and medical record, but also makes a claim for the author as "moral painter": one whose descriptions of the

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[141] Koenigs, "Whatever May Be the Merit of My Book as a Fiction," 728.
[142] Brown, *Wieland,* 4.

"perversions of the human mind" can instruct the reader. Brown here relies on the logic of the case study, in which a singular case (in *Wieland,* very singular) can provide the ground for theorizing aspects of the human mind.

Despite its horrific trappings, then, the novel encourages identification with rather than alienation from Wieland's state of mind: the breakdown of the characters' minds and capacity for moral action occurs through attacks on the normal workings of the mind, and they model normalcy under duress, not aberrance. An anonymous reviewer of Brown's work, who articulates this feeling, noted that in describing a single character, an author "gives us much knowledge of the state of society at the time, and what is still higher, an increased and nearer knowledge of mankind." By representing peculiarities, we are informed not by their difference, "but because they resemble us in every thing except that distinguishing character and those prevailing tastes which are ascribable to the peculiar circumstances in which they are placed."[143] He continues that Brown portrays minds "strangely gifted or influenced, as if for the pleasure of exploring some secret principles of our nature … as if he had discovered springs of action which could not be understood in the usual way, by our observation of their effects, but only from a minute, philosophical discussion of impulses and motives by the parties concerned, after a cool, thorough self-inspection" (70). The characters engage in self-study, not "that they may grow better, or give us a moral lesson; they are perfectly satisfied with the study, and succeed in engaging us to watch them" (72). *Wieland* draws on extraordinary circumstances in order to show the operation of the mind: what follows of disturbing this or that human faculty, most notably by disturbing sensation through ventriloquy, but also through religion or love? By pressing various faculties to their limits, Brown uses the aberrant mind to demonstrate the physiological and ecological grounding of all minds.

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[143] "[Review. The Life of Charles Brockden Brown by William Dunlap]," *North American Review* 24 (June 1819), 65.

The singular events that befall the Wieland family are, through a kind of case logic, meant to provide readers with universal information about mental function. Although Wieland's act is horrific on its face, it is an exaggeration of normal behavior rather than a negation of it: narratively, his misperception is aligned with more typical circumstances, as when Clara's love of Pleyel overcomes her capacity to control her thought and actions. The strange closing chapter suggests the way in which the novel was meant to train our powers of discernment: having narratively experienced the extreme circumstances of the Wieland family murders, we are given the opportunity to practice picking up similar dynamics in a more typical story, of a woman being tricked by a seducer. By the time readers reach this more anodyne example, the limits and failures of human faculties have been dramatically anatomized. Brown's unfinished sequel, written in Carwin's voice, extends the mental ecology back farther, demonstrating how Carwin became both physically and mentally habituated to ventriloquy. The "habit" of deceptively ventriloquizing is built explicitly from his environment, as he trained this physical "faculty" by experimenting with echoes called into a rocky canyon.[144] Having developed this faculty, he writes that "my character had been, in some degree, modelled by the faculty which I possessed" (223). The consistent use of the word "faculty" in Carwin's speech, and the narrative of its physical and ecological basis, allow this ventriloquy to stand in for something like Rush's moral faculty. How does this faculty, grounded in his body and in his literal environment, and which he fostered but lost control of, dictate his behavior?

Brown's narrative also invites readers to judge and sort characters at a second level: we, along with Clara, attempt to determine whether the things her friends hear are pathological hallucinations; but we, above Clara, attempt to determine whether her representations of those hallucinations are well-ordered and healthy. As Looby points out, ultimately Clara's diagnostic vision

[144] Brown, *Wieland*, 188.

fails: Wieland was not mad or hallucinating.[145] Our readerly diagnostics, then, are accurate only if they detected her own disorder rather than his. Through manipulating our attention to pathological details through a pathological narration, Brown, like Carwin, experiments with our capacity to accurately know the other.

Brown's invitation to read diagnostically comes before introducing us to the major storyline, as Clara narrates the mysterious death of her father, a religious zealot, by spontaneous human combustion. This event is often read as an allegory of the dangers of enthusiasm and mysticism and as foreshadowing the murderous religious mania of Wieland Jr. However, Brown here includes an infamous authenticating footnote. He writes: "A case, in its symptoms exactly parallel to this, is published in one of the Journals of Florence. See, likewise, similar cases reported by Messrs. Merille and Muraire, in the "Journal de Medicine," for February and May, 1783. The researches of Maffei and Fontana have thrown some light upon this subject."[146] More than just allegory or nod to conventions of fictionality, he is establishing the possibility of such an event, encouraging the reader to think in medical terms and to decide whether the senior Wieland is a subject for medical or spiritual inquiry.

The downfall of Wieland Sr. aligns with Rush's description of physico-moral decline shaped by environment. Brown reports that he was raised in a gloomy environment with bland food that altered his temperament: his "heart gradually contracted a habit of morose and gloomy reflection" (9). His upbringing turns him into a religious separatist who comes to America to proselytize. His failure to win converts damages his health, and he becomes morbidly obsessed with the certainty of an early and awful death. This anxiety impacts him physically, and he claims that his "brain was scorched to cinders" and falls into fits. His brother-in-law, a surgeon, does a physical evaluation.

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[145] Looby, *Voicing America,* 190.
[146] Brown, *Wieland*, 18.

Clara writes, "My uncle perceived, by his pulse, that he was indisposed, but in no alarming degree, and ascribed appearances chiefly to the workings of his mind" (14). Although this exam suggests that the "workings of his mind" are not "alarming," shortly after, Wieland goes to pray at an altar and is consumed in a mysterious fire. He returns home scorched, and we get a description of his wounds as observed by his surgeon brother—whose physical exam had apparently overlooked the possible literal conflagration originating in a cinder-scorched brain. By discounting the relationship between mind and body, our surgeon inadequately foreshadows the physical risks Wieland faces. It is not just the physical exam that fails. The surgeon uncle asks for Wieland's testimony—that he felt a blow, that he saw the flame—and is not believed: "There was somewhat in his manner that indicated an imperfect tale. My uncle was inclined to believe that half the truth had been suppressed. Meanwhile, the disease thus wonderfully generated, betrayed more terrible symptoms" (17). But partial testimony and alarming symptoms cannot provide sufficient grounds for proper diagnosis of the case – much less a plan for treatment -- and he ends up dying in a strange accelerated putrefaction. Clara writes, "Such was the end of my father. None surely was ever more mysterious" (18).

Surely. The novel never gives the reader tools to make sense of this occurrence, which may take the honor of most mysterious mystery in *Wieland*. We are foiled by the same limited testimony and unrecognizable tally of physical symptoms that bar the surgeon. Tellingly, the medical cases Brown references are significantly less ambivalent, as he notes that "modern physiologists" have clearly proven the possibility of such an event.[147] In the cases he cites, the object of medical mystery,

[147] These cases were published in English in the April 1792 issue of *American Museum, or, Universal Magazine* ("Letter respecting an Italian priest"). Although many details in the novel are drawn directly from this source, Brown makes notable changes. The source ignores the possibility of divine rage and documents the symptoms in more detail ("sphacelous" and maggot-filled). The writer theorizes "these people had perished by their whole substance spontaneously taking fire, the principal feat of which had been the entrails or the epigastric viscera, and that the exciting cause was naturally found in the phlogiston of the animal humours, called forth by that of the spirituous liquors combined with the latter" (148).

a combustible priest, is given a diagnosis, strange as it may be, of what we might call auto-electrification, by correspondence to a category of people with similar symptoms. Brown's friend and biographer William Dunlap accepted this combustion as a "wonderful phenomena of the moral and physical world …vouched for by unquestionable authorities." Self-combustion--though "easily explained to the philosopher" is still so rare and wonderful that it surpasses the capacity of understanding of the "mass of readers."[148]

But within *Wieland*, this case history generates only one of many possible hypotheses (Clara tweaks it, making it circulatory rather than electrical, evoking Rush). It is up to us to decide, though we lack the tools to do so. And this failure of knowledge brings with it a tangle of metaphysical implications. The unclassifiability of this event leaves our narrator (and us with her) powerless to sort through the complicated implications of this event:

> Was this the penalty of disobedience? this the stroke of a vindictive and invisible hand? Is it a fresh proof that the Divine Ruler interferes in human affairs, meditates an end, selects and commissions his agents, and enforces, by unequivocal sanctions, submission to his will? Or, was it merely the irregular expansion of the fluid that imparts warmth to our heart and our blood, caused by the fatigue of the preceding day, or flowing, by established laws, from the condition of his thoughts? (18)

In short, is this a divine problem, or a medical one? For Clara, it matters—because if the latter, the event becomes less morally charged—it is more fluke than righteous rage from the deity. If divine, she must wrestle with responsibility, agency, the truth of divinity, and fate—while the latter is "merely" governed by anxiety and "fatigue" working "by established laws." The former sounds

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[148] William Dunlap, *The Life of Charles Brockden Brown: Together with Selections from the Rarest of His Printed Works, from His Letters and from His Manuscripts Before Unpublished* (Philadelphia: J.P. Parke, 1815), 12.

significant, weighty, the latter is almost arbitrary. In contrast to the physiological certainty of his source material, Brown reintroduces doubt, engaging his readers in a diagnostic project and asking them to theorize what "established laws" could create such a dramatic connection between mind and body—one that would be applicable not just to combustion but to more mundane bodily functions.[149]

The combustion mystery sets up a major theme of the novel: witnesses have a bank of facts and perceptions, drawn both from the testimony of others and from personal sensory experiences, but are unable to craft a stable narrative from them even with expert testimony. Clara asks, "What is the inference to be drawn from these facts? Their truth cannot be doubted. My uncle's testimony is particularly worthy of credit, because no man's temper is more sceptical, and his belief is unalterably attached to natural causes" (18). Contrast this with Rush, whose work of medical jurisprudence suggests that in difficult cases, testing the pulse will clarify ambiguity. By beginning the novel with a medical mystery and never giving us the tools to solve it, Brown foregrounds the failures of knowledge. But at the same time, this move draws attention to our desire for that impossible narration. Clara and her brother often note hints of things occurring in their own lives that may be related to the death of their father—though they don't seem to be right. They watch for glimmers and fires that will be the symptoms revealing their own fiery prognoses, and so do we.

The characters within the novel are constantly diagnosing one another. After the mystery of the disembodied voice, Clara thinks of her brother, "I could not bear to think that his senses should be the victims of such delusion. It argued a diseased condition of his frame, which might show itself hereafter in more dangerous symptoms" (30). Although she is wrong at the time, eventually, her

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[149]According to both Koenigs and Waterman, it is clear that Brown means for his readers to incline toward the medical explanation. Waterman writes that "Brown suggests that the elder Wieland's predisposition to religious delusion—and his spontaneous combustion—may both have medical explanations. When he stumbled onto the fateful pamphlet, his 'mind was in a state peculiarly fitted for the reception of devotional sentiments' (that is, he was young, poor, and depressed)" (*Republic of* Intellect, 81).

early diagnostic attention proves to be correct, at least in some sense, and her fear of dangerous "symptoms" bears fruit when she sees him, mad, toward the end of the novel, at which point the word is repeated several times: "His hands were clasped with a force that left the print of his nails in his flesh. His eyes were fixed on my feet. His brain seemed to swell beyond its continent. He did not cease to breathe, but his breath was stifled into groans" and she is "transfixed with inexplicable horror by the symptoms which I now beheld" (116). In a more everyday experience, Pleyel misreads the symptoms of Clara's feelings for Carwin, as he "scrutinized the sentiments and deportment of this man with ceaseless vigilance" and "watched your words and your looks when he was present" and thus wrongly "extracted cause for the deepest inquietudes" (95). His diagnosis, that Clara is in love with Carwin, is false, and is the basis for a terrible misunderstanding that almost ruins their relationship.

The novel eventually demonstrates the futility of diagnostic approaches to the other, as Clara pronounces, "Let that man who shall purpose to assign motives to the actions of another, blush at his folly and forbear. Not more presumptuous would it be to attempt the classification of all nature, and the scanning of supreme intelligence" (111). Brown's inclusion of a physician in the plot demonstrates fully that this diagnostic failure impacts medical practitioners as well, and he consistently makes errors: first in missing Wieland Sr.'s danger, and later, almost killing Clara by giving her information she could not handle, because "he had wrongly estimated the strength of my body or of my mind. This new shock brought me once more to the brink of the grave, and my malady was much more difficult to subdue than at first" (131). The doctor so routinely misreads peoples' physical and mental state that readers have cause to mistrust his classification of Wieland's madness as "reducible to one class"—and here the footnote directing readers to "Mania Mutabilis. See Darwin's Zoonomia, vol. ii, Class III. 1. 2.—with those he saw in the German Army (134).

Our own narrator's testimony, too, is suspect. She presents her own physical symptoms when thinking of Carwin: "My blood is congealed: and my fingers are palsied when I call up his image" (41). Our diagnosis of her terror lends credence to his dangerousness, but also begins to hint at her own instability, which she will later make explicit: "My narrative may be invaded by inaccuracy and confusion; but if I live no longer, I will, at least, live to complete it. What but ambiguities, abruptnesses, and dark transitions, can be expected from the historian who is, at the same time, the sufferer of these disasters?" (112). The narrative instability that Rush attempts to ignore, then, is placed at the center of Clara's confession. She explicitly invokes the reader's judgment, as when she speaks to whether she has a "passion" for Carwin, writing "I shall not controvert the reasonableness of the suspicion, but leave you at liberty to draw, from my narrative, what conclusions you please" (45). We constantly accompany Clara as she attempts to discriminate between reality and misperception, intention and effect, madness and monstrosity, but are unsure of the value of her own testimony. She fails even in self-knowledge as she writes of her impending death--"my existence will terminate with my tale" (164)—and then picks up the pen again years later to wrap up loose ends.

Paradoxically, the trappings of Brown's fiction produce a diagnostic desire in the reader, allowing us to imagine we have the power to read the opaque minds of others even in a novel so focused on failures of credibility and insight. While we view Brown's characters diagnostically, judging their actions and their capacity to discriminate the true from the false, that diagnostic vision is also turned inward: the reader participates in the process of discrimination, lacking the information to make judgments any more clear than those of the characters. This fiction, then, works differently from Rush's literary material. To explain Wieland's familicide, we are given competing narratives: Wieland claims divine inspiration, his uncle claims mania, Clara initially blames Carwin, and the reader is confronted with confusion. The reader is given no tools to make sense of a

spontaneous combustion or a mysterious voice either, and thus are implicated in, or at least sympathetic to, the confusion that arises. And we never know whether Carwin called Wieland to murder, because that final piece relies on Carwin's testimony. Ironically, Clara herself is convinced, after all of deception that has passed, by his physical demeanor when expressing his confusion.[150] By inhabiting Clara during madness, we experience and diagnose simultaneously, and like her, we alternate between suspicion and credulity. As a *Blackwood*'s reviewer noted, Wieland leaves you "in a tense—a sort of uncomfortable, fidgeting, angry perplexity."[151]

The perplexity of the reader emerges in part from the denial of clear attributions of blameworthiness. In a recent article, David Zimmerman suggests that the central theme of Brown's novels is the "the conundrum of moral complicity"—the problem of who, ultimately, is responsible for an action. Zimmerman draws on legal theory to examine what he calls Brown's Gothic "complicity studies," that privilege sociological networks and "reject the individual as the central unit of social, moral, and literary analysis."[152] Law also grounds the novel for Laura Korobkin, who argues that *Wieland* is a "highly forensic novel" asking readers to act as "a juror at whose 'bar' evidence of crime is presented for judgment."[153] In Korobkin's legal reading, Carwin is unquestionably guilty, while Wieland is fully excused due to insanity. But the evaluations we are asked to make in *Wieland* are more finely grained than a binary sane-mad, and indeed push the reader to consider whether madness excuses wrongdoing in the first place. Brown's complex portrait of

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[150] A similar pattern holds in other, less obviously medicalized, fiction from the period. Reading Hannah Webster Foster's *The Coquette*'s narrator as a "mechanical being," Ogden suggests that "in conceiving of interiority for the mechanical subject, this novel also writes the inner life--the social and moral life--of the scientific fact." (Emily Ogden, "Mesmer's Demon: Fiction, Falsehood, and the Mechanical Imagination," *Early American Literature* 47, no. 1 [2012]: 147.)

[151] Anonymous [John Neal,] "American Writers. No. II," *Blackwood's Edinburgh Magazine* (October 1824), 425.

[152] David Zimmerman, "Charles Brockden Brown and the Conundrum of Complicity," *American Literature* 88, no. 4 (2016): 665, 667.

[153] Laura Korobkin, "Murder by Madman: Criminal Responsibility, Law, and Judgment in Wieland," *American Literature* 72, no. 4 (2000): 723.

diffused moral complicity and the threat of environmental insult in some ways reinforces Rush's view, but also pushes the idea of pathological morality to its limits—if everyone is a product of their environment, we are left unable to hold people accountable. Moreover, universal limitations on the power of perception muddy the water still farther. The moral certainty of Rush's physiological argument is complicated through Brown's novel, which extends rather than compresses the sensationalistic source material into a lengthy morality study, whose physician character is no less able to step outside of the limits of his own environmentally conditioned brain as anyone else.

Fictionalizing Theories of Mind

For both Rush and Brown, literature provides medical information about the faculties of the human mind, and for both it allows an exploration of questions of moral responsibility. Exploring boundary cases of pathologization, they narratively negotiate the boundaries of moral disorder. But Rush writes with certainty that the medicalization of morality justifies a reworking of criminal and social responsibility. For him, the physician's knowledge, grounded in narrative histories and even fiction, provides unambiguous insight into the proper treatment of wrongdoing. He relates, for instance, a case in which he "proved" that a traitorous man was actually mad, and hence innocent, by taking his pulse and saving him from the death penalty—a fantasy of medical legibility validated only through its narration.[154] Brown, in contrast, highlights the liability of the brain of the man of science to the same pressures that impair those they observe. In the opening pages of *Wieland*, a physician taking a pulse gets useless information, as the man he has just verified as physically healthy spontaneously combusts. When this same physician weighs in on Wieland's madness at the end of the novel, arguing that the ventriloquism of Carwin predisposed Wieland to disorder, it is no longer

[154] Rush, "On the Study of Medical Jurisprudence," 369.

clear that it matters. In the end, Clara refuses to diagnose or speculate, since neither could mitigate the horror.

Brown begins and ends the novel by asking the reader to "moralize on this tale,"[155] and has encouraged us to do so through Clara's eyes all along. Foregoing Rush's pronouncements, Brown invites the reader to participate in this theorization, providing ample opportunities for the reader to exercise a diagnostic eye and assess moral responsibility. Most obviously, of course, when does Theodore Wieland become mad? Which utterances are hallucinations and which the accurately perceived voice of Carwin? But also, to what extent does Clara's trauma distort her capacity to relate her narrative? And, especially with the subsequent publication of Carwin's "memoirs," should we understand him as at the mercy of a body and mind formed to commit fraud? These stories of illness enable physician, author, and reader to explore the social implications of that knowledge—but their irresolution points to the readers' implication in the idea that a flawed brain (their own) can exemplify universal laws.

Brown's novel thus theorizes the medicine of the mind and invites readers to hone their diagnostic skills, while also demonstrating the fallibility of diagnosis and questioning its authority to legislate evil. While Rush relied on the mimetic value of literature to make a medical claim that he could translate into legal imperative, Brown's novel both claims that mimetic value and exceeds it, using literature to experiment upon workings of the mind, but recognizing that the results of those experiments invalidate, rather than support, certainty. Rush, though, never fully incorporated this skepticism into his philosophy, reading literature for verisimilitude, and mistaking verisimilitude for truth.

Each illustrates the power of both physical and social environment on the mind, showing how external forces distort individual agency and suggesting aberrance is not monstrosity, but

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[155] Brown, *Wieland*, 181.

normalcy under duress. Rush, for example, relates cases of moral disorder not just to better understand pathology, but to prove that in all persons, morality is grounded in physical, and thus medical, principles: if a fever can turn a moral woman into a liar, then we must all have a moral faculty subject to disease. Although Brown emphasizes the horror of his murderer's violent mania, he, too, grounds this pathology in a physical and social context, crafting a narrative of environmental and external agency in which madness is continuous with normalcy: Wieland is not a monster, he is in possession of faculties more susceptible (for seemingly heredity reasons) to the corrupting influences of Carwin, whose tricks impact the mental state of each character—and, through extension, each confused reader.

Whereas Rush believes that new classifications have the power to positively shape our relationships with one another—to sympathize with rather than judge the micronomic, for instance, or to help us improve their capacities through diet and exercise—Brown rejects that logic. If Rush's fantasy is to narrate immorality in such a way that it is medically recognizable and manageable, then Brown's response is to shatter the tidiness of narrative as resolution. While Rush argued that moral pathology invalidates capital punishment, Brown's novel is more ambivalent, closing by invoking the reader's moral judgment rather than attempting to legislate it. Either way, though, the authors' narratives of illness acknowledge not the monstrosity but the mundanity of immoral action—the faculties of the human mind are universal and inevitably open to insult. Ultimately, both Rush and Brown narrate extreme cases of aberrance to produce knowledge not just of pathology but of the ordinary brain. Thus, literature, and fiction in particular, provides the narrative basis of the fledgling field of psychiatry, both by building the knowledge base for a somatic and ecological model of the human mind and by encouraging readers to question what that model can and can't tell us. Contravening the division between humanizing fiction and objectifying medicine, the uses to which Rush and Brown put fictional narratives reveal the need for a more complex model of the

relationship between literature and psychiatry. Fictional narratives provide the basis for Rush's physiological reductionism, but also for his humanitarian pursuit. Brown's novel asks us to hone our objectifying medical gaze and, in grappling with our inability to perfect it, to medically evaluate our own minds and their failures.

Chapter Two

Moral Insanity and Diagnostic Vision: Nat Turner, Isaac Ray, and Edgar Allan Poe

In April 1840, Edgar Allan Poe published a brief article on "The Trial of James Wood" in which he castigates lawyers for omitting a "very material argument" for the defendant's insanity. The man displayed "entire self-possession—a remarkable calmness—an evenness of manner altogether foreign to his usual nervous habit."[156] Wood's appearance of sanity, Poe suggests, was his clearest sign of madness. Referring to the "cunning of the maniac," Poe suggest such duplicity was well-known to "those who have made the subject of mania their study." Here, Poe makes a crucial diagnostic error: Woods' frightening calmness aligns more closely with a new diagnosis, "moral insanity," proposed by British ethnologist James Cowles Prichard and advocated for by American asylum physician Isaac Ray in his influential 1838 *Treatise on the Medical Jurisprudence of Insanity.* The medicine of the mind in the 1830s was preoccupied with outlining such liminal states of sanity—like moral insanity, concealed insanity, and simulated insanity—that suggested pathology could be hidden beneath a "normal" appearance or that a sane person could successful feign disorder. Claiming the authority to differentiate between such disorders, Ray and his peers justified the rise of the psychiatric expert.

Building on Rush's earlier work on moral disorder, 1830s asylum physicians more fully developed the concept of a form of madness that left all or some of the reasoning powers intact.[157] Prichard established "moral insanity," which was elaborated in turn by Ray.[158] As Jodie Boyer has argued, though, "moral insanity" was a remarkably broad description of behavior, functioning "more

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[156] [Edgar Allan Poe,] "The Trial of James Wood," *Alexander's Weekly Messenger* 4, no. 14 (April 1, 1840): 2.
[157] Dan Shen, "Edgar Allan Poe's Aesthetic Theory, the Insanity Debate, and the Ethically Oriented Dynamics of 'The Tell-Tale Heart,'" *Nineteenth-Century Literature* 63, no. 3 (December 2008): 340–41.
[158] Haltunnen, *Murder Most Foul,* 216.

as a cipher than as a distinct diagnosis."[159] The group of behaviors that fell under the umbrella of moral insanity became of crucial medico-legal concern when, with the rise of asylums in the 1820s, mental physicians entered more and more courtrooms as expert witnesses. Ray's 1838 treatise on the jurisprudence of insanity was a major development, and Ray became a popular expert witness as he argued for a move beyond the dualism of the "wild beast" test, under which a ruling of insanity only prevented legal guilt when the defendant was totally alienated from reason.[160] In opposition to earlier physicians who had been called to court to make statements about injury and death, Ray and his colleagues claimed jurisdiction over moral responsibility.[161]

Ray, believing the legal application of psychiatry to be lagging far behind clinical understanding, articulates the diagnostic crux of the problem. He writes, "The only difficulty, or diversity of opinion, consists in determining who are really insane, in the meaning of the law, which has been content with merely laying down some general principles, and leaving their application to the discretion of the judicial authorities."[162] According to Ray, because the mad were isolated in asylums, not even general medical practitioners, let alone agents of the law, had enough experience with the insane to have accurate judgment. Relating cases that could demonstrate the lines between true and false illness, determine when a sane person feigned madness, and when a mad person passed as sane, Ray worked to a solve a tangle of medical, legal, and social problems that required a conception of madness more fine-grained than total alienation from reason.

This chapter examines the narrative practices undergirding this rise of forensic psychiatry in the early nineteenth century. By 1838, no longer satisfied with clear physiological signs of madness like Rush's pulse test, Ray's faith in such clear pathological signs had waned. Although the pulse

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[159] Jodie Boyer, "Religion, 'Moral Insanity,' and Psychology in Nineteenth-Century America," *Religion and American Culture: A Journal of Interpretation* 24, no. 1 (2014): 72.
[160] Ray, *A Treatise on the Medical Jurisprudence of Insanity*, ix.
[161] Haltunnen, *Murder Most Foul*, 217.
[162] Ray, *A Treatise on the Medical Jurisprudence of Insanity*, 3.

could still provide "collateral proof," the delineation of true insanity relied on the less tangible knowledge of an expert in the medicine of the mind. The invisibility of these new species of disorder meant that physicians had to rely on narrative, as much as medical, expertise, and as a result, texts like Prichard and Ray's relied on popular and literary genres to establish the lines between normalcy and madness.

In what follows, I find precedents for Ray's narrative method in Thomas Ruffin Gray's "Confessions of Nat Turner" and further experimentation in the popular fiction of Edgar Allan Poe. Gray's publication of Turner's confessions exemplifies the popular demand for narratives of the ambiguously mad mind. Ray's emphasis on the borderlands of madness is paired with a call for specialization in the masterful detection of liminal cases—a reflection, too, of the increasing anxiety that the varieties of madness are so manifold that they can be undetectable, especially by the average person. The work of popular fiction writer Edgar Allan Poe, however, encourages that diagnostic and forensic vision in the everyday reader. Spanning the 1830s, these texts each narrate the lines between rationality and madness, each encouraging a forensic style of reading designed to overcome the inscrutability of the mind of the other. Looking at the role of such literary forensics and their often racial components in the growth of psychiatric jurisprudence, I argue for the importance of literary study in the history of psychiatry. Although psychiatrists like Ray did not draw their methods directly from the literary texts I discuss here, referring more directly, as Rush did, to Shakespeare (and, secondarily, Sir Walter Scott), I argue that popular and literary practices for narrating liminal mental states provided the exigence and logic of the growth of a psychiatric jurisprudence designed to make hidden interiors legible. Put another way, while Ray's source material was Shakespearean, his own medical genre was Gothic.

In a society increasingly concerned about the frightening disjuncture between appearance and character, the Gothic, in particular, provided generic elements that dramatized attempts to read

interior character from external signs. Haltunnen cites the 1830s as an important period in the transition between religious narratives to secular, gothic narratives of individual "moral aliens," disseminated by the profusion of literatures beyond the execution sermon.[163] As new genres of writing developed to describe crime, the role of the individual exposing a private mind is heightened, and cases become individualized and extraordinary.[164] By asking how Gothic tropes travelled between popular, medical, and literary texts to imagine mental interiors, I intend to bridge previous readings of the Gothic as a psychological and a social genre. Teresa Goddu argues that the American gothic has been too often psychologized rather than historicized: "Because of America's seeming lack of history and its Puritan heritage, the American gothic, it has been argued, takes a turn inward, away from society and toward the psyche and the hidden blackness of the American soul."[165] Rejecting such readings, Goddu contextualizes the gothic's relationship to race and slavery, arguing that such a reading reveals that "the American gothic is haunted by race."[166] Tracing the role of the Gothic in Turner's confessions, Ray's diagnostic thought, and Poe's tales of psychological detection, I aim not for a psychological reading of the Gothic, but rather for an analysis that historicizes this psychology, tracing the racialized narratives and tropes that created and disseminated new medical beliefs about frighteningly liminal minds.

The relationship between the medical study of the mind and race were changing in the years between Rush and Ray. Racist thought permeated the intersection of medicine and law, and the earliest treatise of American medical jurisprudence, Thomas Cooper's 1819 *Tracts on Medical Jursiprudence* took for granted that blacks were "an inferior variety of the human species," and thus

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163 Haltunnen, *Murder Most Foul*, 2.
164 Haltunnen, 38-41.
165 Teresa Goddu, *Gothic America: Narrative, History, and Nation* (New York: Columbia University Press, 1997), 9.
166 Goddu, 7.

not as amenable to rehabilitation.[167] Sander Gilman outlines a long history of what he calls the "Nexus of Blackness and Madness,"[168] and Jeannine DeLombard argues that while insanity had once been linked to "blackness and wildness," American mental health professionals in this period began to point to white "civilization" as the root of mental dysfunction. Physicians like Ray argued that the pressures of democratic citizenship had a detrimental effect on American mental health and thus black Americans were simultaneously distanced from and associated with mental illness: protected from madness by their "uncivilized" status, they were vulnerable to mental collapse in the face of integration.[169]

The biological psychiatry of the period fantasized a mind made legible by race, gender, and craniometry, but this fantasy could be fulfilled only in the text of circulating medical and literary narratives. Chris Lukasik writes that "as an emergent technology of surveillance, physiognomy was frequently discussed as a weapon against dissimulation." This technology, however, was less based on "practice," than on the "logic… of physiognomic distinction" which "offered a means to establish moral character."[170] This logic, more discursive than pragmatic, took narrative forms: "Reading faces and reading novels were indistinguishable practices for discerning character during the period" (16). Gray, Ray, and Poe each constructed a fantasy that aberrant behavior could be read on the body or face but can sustain that fantasy only through narration.

In tracing the role of narrative in conceptualizing liminal diagnoses like "moral insanity" and "partial insanity" in psychiatry and law,[171] I begin with a consideration of Thomas Ruffin Gray's

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[167] Quoted on Jeannine Marie DeLombard, *In the Shadow of the Gallows: Race, Crime, and American Civic Identity* (Philadelphia: University of Pennsylvania Press, 2012), 226.
[168] Sander Gilman, "On the Nexus of Blackness and Madness," in *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness* (Ithaca, NY: Cornell University Press, 1985): 132-149. See also Reiss, chapter 2.
[169] DeLombard, 226.
[170] Christopher J. Lukasik, *Discerning Characters: The Culture of Appearance in Early America* (Philadelphia: University of Pennsylvania Press, 2010), 12.
[171] In 1853 Ray republished the work with a third preface that indicates the explosion of interest in psychiatric jurisprudence beginning in the 1830s: "For the last twenty years, no part of Medical Jurisprudence has

"Confessions of Nat Turner." Newsprint narratives of the Southampton rebellion pinned the violence of the event to one individual whose mind defied easy categorization. Within a single article, or even a single sentence, these accounts vacillated between attributing Turner's rebellion to madness, canny manipulation, religious fanaticism, animality, intelligence, and stupidity. In crafting a clear expression of motive that would ease white Southern fears, Thomas Ruffin Gray presents Turner as a Gothic villain whose first-person narrative can provide the insight necessary to see under the calm "surface of society" to see "the recesses of his own dark, bewildered, and overwrought mind."[172]

Psychological histories like the one Gray offered formed the basis of the psychiatric jurisprudence of Ray and his colleagues, the most fundamental concerns of which were also how to differentiate between states of madness and sanity. Ray argues that there is no "severer exercise of a physician's knowledge and tact, than a case of simulated insanity."[173] Associating madness with whiteness and the dangers of "civilization," Ray's jurisprudence was typically geared toward questions of property. Moral insanity, in which the head of a family may sound perfectly reasonable in front of a court but behave destructively, was a threat to white property and family order. Unlike narratives of Turner's mind, which asked one individual to produce knowledge about an entire race, these stories of idiosyncratic property holders were geared toward discrimination within white communities. Ray's text relied upon narrative to solidify new diagnostic categories that would impact beliefs about motive, morality, and guilt. To establish the literary stakes of such a project, I read the textbook alongside Ray's 1847 "Shakespeare's Delineations of Insanity" to demonstrate how literary discrimination was established as the key to differentiating between states of sanity and madness.

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received so much attention, in one way and another, as that which relates to Insanity" (*A Treatise on the Medical Jurisprudence of Insanity,* xi).

[172] Thomas Ruffin Gray, *The Confessions of Nat Turner, the Leader of the Late Insurrection in Southampton, VA.* (Baltimore, MD: Thomas R. Gray, Lucas & Deaver, print., 1831), 4.

[173] Ray, *A Treatise on the Medical Jurisprudence of Insanity*, 350.

Having established the role of literary narrative in establishing psychiatric diagnoses, I argue that popular literature played a vital role in disseminating new ideas about the mind and encouraging a diagnostic vision in the wider population. The tales of Edgar Allan Poe in the latter half of the 1830s reflect his knowledge of and interest in the relationship between mind, medicine, and law.[174] I look at those tales that I think of as his "psychological detective fiction," especially the "Fall of the House of Usher," with its portrait of a pathologically overwrought white landholder, which predate his marked turn toward legal questions in his later detective fiction. By looking at those tales predating Poe's turn to detective fiction in 1841, I emphasize the detection and diagnosis of non-normative minds, rather than the more explicitly forensic turn of his later works.

Compilers of crime literature like Gray, alienists like Ray, and writers of literary fiction like Poe each participated in the project of developing a narrative style that could capture mysterious mental interiors. The traffic in Gothicized narratives and detective genres moved in all directions between them: Gray relied upon Gothic tropes to capture Turner's motive and mind; Ray responded to the demand for fuller accounts of the mind with narrative vignettes resembling popular literature and read literature with a diagnostic eye; Poe relied on the disjuncture between interior and exterior to build horror and mystery that allowed him to create reader investment by encouraging diagnostic detection. Together, these texts call for a finely honed mental and moral diagnosis from the reader, functioning as a kind of training manual, disseminating the logic of forensic psychiatry. And the racial stakes of that inquiry indicate why the readers might need to be so trained, beyond the rare cases in which someone might claim the insanity defense in an act of murder. The questionably mad black mind becomes a tool for managing all black minds; the questionably mad white one spurs

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[174] John Cleman, "Irresistible Impulses: Edgar Allan Poe and the Insanity Defense," *American Literature* 63, no. 4 (December 1991): 623–40. Cleman writes, "Poe's familiarity with the scientific/medical accounts of insanity in his day has been well-established, and his awareness of the issues of the insanity-defense controversy can be linked to two specific cases in which the defense was employed, both occurring in the environs of Philadelphia where Poe resided between 1838 and 1844" (626).

innovations in the science of adjudicating property disputes, wills, and other civil matters. Detecting hidden or partial mental derangement was a technology with broad social implications in a slave-holding society with a white propertied class in which physical characteristics plainly did not line up with normative assumptions about interior states. For this training, medical jurisprudence of insanity borrowed from literature, and literature in turn disseminated the newly formalized techniques.

Diagnosing Motive in Turner's Rebellion

"Nat Turner's Rebellion" began on August 21, 1831, as a group of enslaved people from Southampton County, Virginia, began killing members of white slaveholding families. Turner eluded capture until October 30, was found guilty on November 5, and executed on November 11, 1831. In the interval between the "insurrection" and his capture, many black Virginians were killed in retaliation.[175] Articles and pamphlets about the rebellion display a diagnostic logic: Turner's mind must be classified and pathologized to understand the rebellion, whether in the eyes of a southern audience who required a motive other than slavery to maintain social order or in those of northern abolitionists diagnosing a social ill. Narratives of the rebellion attempt to develop this pathological motive.

Although ostensibly focused on black madness and criminality, public discourse in the aftermath of the rebellion was driven by fears of the disordered white mind. One article reported "women and children half-distracted by their fears" in North Carolina,[176] while another woman

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[175] On the use of the name "Nat Turner," see Kenneth S. Greenberg, "Name, Face, Body," in *Nat Turner: A Slave Rebellion in History and Memory* (Oxford, UK: Oxford University Press, 2003), 10.

[176] *The Niles' Register,* September 24, 1831 in Henry Irving Tragle, *The Southampton Slave Revolt of 1831: A Compilation of Source Material* (Amherst: University of Massachusetts Press, 1971), 89. Tragle's old but extensive collection of primary source documents provides newspaper stories, trial records, and accounts of the crime from 1831 on.

wrote, "Some have died, others have become deranged from the apprehension since the South Hampton affair."[177] The best-known narrator of Turner's rebellion, the lawyer Thomas Ruffin Gray, also emphasized the impact of the rebellion on the white mind. On September 26, 1831, *The Constitutional Whig* of Richmond published an anonymous letter from a local man, which David Allmendinger has convincingly argued was Gray.[178] Relating his experience surveying the damage in the wake of the attacks, Gray writes, "In visiting each house, the mind became sick, and its sensibilities destroyed."[179] The first and last lines of Gray's preface to *The Confessions of Nat Turner,* too, refer not to Turner's madness, but to effects of the insurrection on the "public mind" which was "greatly excited," resulting in the spread of rumor and untruth."[180] The confession is offered as a "narrative" capable of "removing doubts and conjectures from the public mind which otherwise must have remained" (5). White mental disorder, then, provides the exigence for diagnostic assessments of Gray's pamphlet.

Soothing these minds hinged on Gray's ability to clarify Turner's motive. In the immediate aftermath of the rebellion, newspapers circulated rumor about the event, quickly proliferating explanations for the violence. Greed, fanaticism, revenge, trickery, and madness are all posited as possible motives, with confusion as to motive a common theme.[181] An article published shortly after the rebellion in *The Constitutional Whig,* however, contains both a denial of any motive and a clear expression of one: "If there was any ulterior purpose, [Turner] probably alone knows it. For our

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177 Quoted on Stephen Howard Browne, "'This Unparalleled and Inhuman Massacre': The Gothic, the Sacred, and the Meaning of Nat Turner," *Rhetoric & Public Affairs* 3, no. 3 (2000): 310–11.
178 David F. Allmendinger, "The Construction of The Confessions of Nat Turner," in Greenberg, *Nat Turner*, 24–42.
179 Tragle, *The Southampton Slave Revolt*, 97.
180 Gray, *The Confessions of Nat Turner*, 3.
181 Richmond's *The Constitutional Whig* cites "a spirit of plunder and rapine" (Tragle 36), while *The Richmond Compiler* writers on August 31 of men "mad--infatuated--deceived by some artful knaves, or stimulated by their own miscalculating passions" (37). *The Richmond Compiler* wrote on August 27 that "Their ultimate object, as well as the means they took to perpetrate so many murders, whence they came, and whither any of them is going, are circumstances not yet explained" (49).

own part, we still believe there was none." This claim of bewilderment is followed immediately by such a statement of "ulterior purpose": "We therefore incline to the belief that he acted upon no higher principle than the impulse of revenge against the whites, as the enslavers of himself and his race."[182] Freedom, the obvious motive, was incompatible with the explanatory models of these white narrators.

To deny slavery as motive, white southerners had to seat the motive in a single deviant mind—the mind of Nat Turner.[183] Thus, a diagnostic assessment of Turner was critical.[184] If Turner was uniquely mad, southerners need not worry about future rebellions or the possible revolt of their own slaves. If his mind was "warped" by environmental causes, they needed to restrict black peoples' access to education and religion. After the rebellion, Patrick Breen notes, most whites emphasized stories of the loyalty of their slaves, suggesting that the rebels were outliers rejected by

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[182] *The Constitutional Whig,* September 3, 1831 in Tragle*,* 70.

[183] Somewhat paradoxically, given his focus on centering the rebellion in Turner's mind, Gray was one of the first writers to cite slavery as a major cause. Agreeing with others who cited fanaticism and terrorism as motive, he mentions a beating that Turner received from his master, and clearly expresses Turner's desire for freedom. (Allmendinger, "The Construction of The Confessions of Nat Turner," 31–34). In some sense, his claims are at odds: on the one hand, Turner is an idiosyncratic figure whose deluded motives for rebellion should ease white minds about the convictions of the enslaved generally; on the other, slavery and its attendant violence formed a powerful motive that would likely be shared by all those enslaved. The solution to this conflict was partnering Turner's seemingly exceptional mind with a statement on the general mental disability of the black population: Gray's letter rejected fears of a broader conspiracy, writing, "Is it possible for men debased, degraded as they are, ever to concert effective measures?"

[184] Diagnoses of Turner's mental state also compel contemporary scholarly research. Douglas Egerton traces the lineage of "allegations of insanity, or at least rhetorical hints of instability," citing news articles contemporary to the rebellion that claimed that Turner was himself unstable—his religiosity evidence of disorder—and that claimed he was a mastermind manipulating others. Arguing against those who see Turner as an unstable figure, Egerton compares his rebellion with others across the hemisphere around the same time to argue that Turner was actually in possession of reason: "If Turner was indeed an unsound, messianic crusader, he found ample company in his madness among hundreds of potential liberators throughout the western hemisphere." (Douglas Egerton, "Nat Turner in a Hemispheric Context," in Greenberg, *Nat Turner*, 135, 138.) For Egerton, diagnosing Turner's true mental status answers questions about history. Scales, too, rejects the "dominant historical assessment" of Turner "hallucinatory, fanatical, warped, 'enthusiastic,' and egocentric" because "these accounts strip him of rationality and subjectivity" ("Narrative Revolutions," 216) Ashley Byock challenges such accounts that "figure… the resistant slave as a singular, will-driven, rational being who undermines the demeaning typology of essentializing hierarchical logics of racial difference." (Ashley Byock, "Dark Matters: Race and the Antebellum Logic of Decorporation," *Symploke* 24, no. 1 (2016): 51) Removing Turner's will from the equation, she writes, "Far from the agentic individualism of the Enlightenment, or Locke's 'liberty,' this revolution emerged from an alien, non-incorporated willfulness" (61).

the larger black community.[185] As Browne argues, depicting Turner as an intelligent, persuasive, ultimately evil--and, crucially, executable—madman "functions to reassign the origins of rebellion from slavery as a system to the perverse machinations of a fanatic."[186] Is the problem individual or systemic? The tendency in much Southern literature on Turner was to root the violence in some force foreign to the southern plantation, including very often abolitionist print material.[187] The pathologization of Turner was another way to externalize the cause: the more Turner turned into a symbol of black madness, the more rebellion could serve as a symptom of an individual's pathology—one that could be managed through surveillance. In carrying out a psychological investigation, Gray offers suggestions for the community: the authorities must "keep a watchful eye over all."[188]

Problematically for those attempting to understand Turner's motive, his mind seemed to defy categorization. Was Turner mad, fanatic, or fraud? There is clear confusion around the lines between these categories: In the *Richmond Enquirer* he is "a fanatic preacher," "artful, impudent, and vindicative"; in *The Constitutional Whig* he is "stimulated exclusively by fanatical revenge, and perhaps misled by some hallucination of his imagined spirit of prophecy"; while in *The Richmond Compiler* he is a man "of the deepest cunning, who for years has been endevouring to acquire an influence over the minds of these deluded wretches."[189] Even within one sentence, reports cannot settle whether Turner believed himself a prophet or simply manipulated those around him. Gray's anonymous letter written before Turner's capture fuses depictions of Turner as deluded fanatic and master manipulator: Turner used trickery to establish his role as prophet, for instance, by making marks on

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[185] Patrick H. Breen, "A Prophet in His Own Land: Support for Nat Turner and His Rebellion within Southampton's Black Community," in Greenberg, *Nat Turner,* 104.
[186] Browne, "This Unparalleled and Inhuman Massacre," 319.
[187] Browne, 317–18.
[188] Gray, *The Confessions of Nat Turner*, 5.
[189] Tragle, *The Southampton Slave Revolt*, 44, 52, 60.

leaves in the woods, leaving them out, and then "prophesizing" their existence to "some ignorant black" who would go find them, but at the same time "an imagination like Nat's" was particularly susceptible to supernatural beliefs.[190] Even in *The Confessions*, after Gray has spoken to Turner at length, he demurs: "He is a complete fanatic, or plays his part most admirably. On other subjects he possesses an uncommon share of intelligence, with a mind capable of attaining any thing; but warped and perverted by the influence of early impressions."[191]

The "fanaticism" with which Turner was so frequently charged worked as a racialized diagnosis. John Mac Kilgore reads accounts of Turner's "fanaticism" as allied to "enthusiasm," which had been "crystallized into an Enlightenment diagnosis of psychophysiological excess" by the middle of the eighteenth century.[192] Enthusiasm could denote a neutral or positive desire for equality and was linked to freedom struggles across Europe, and thus Turner's pathological fanaticism is explicitly a racial diagnosis: it "represented an instance of familiar democratic revolt inadmissibly applied by black people" (1350). While Kilgore suggests that "*enthusiasm* should be detached from any supposed pathological condition of the private individual (i.e., Turner)" to focus on circulating narratives of insurrection (1350), this "pathological condition" of the mind is not so easily dismissed in Turner's case. An account in the *Norfolk Herald* writes, "His profanity in comparing his pretended prophecies with passages in the Holy Scriptures should not be mentioned, if it did not afford proof of his insanity."[193] Turner's "fanatical" prophecies serve as diagnostic material for white southerners attempting to contain the threat of his insurrection.

Learning to identify the signs of Turner's too-well-concealed fanatical madness became of utmost importance. Among the earliest responses to the rebellion is a call for increased

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[190] Tragle, 92–93.
[191] Gray, *The Confessions of Nat Turner*, 18–19.
[192] John Mac Kilgore, "Nat Turner and the Work of Enthusiasm," *PMLA* 130, no. 5 (2015): 1347.
[193] *Norfolk Herald*, November 4, 1831, in Tragle, *The Southampton Slave Revolt*, 134.

"surveillance" until "tranquility shall be restored to the infected district."[194] Southern whites considered ways to discover whether there were "other Nat Turners lurking within the population they had enslaved" and legislated increased oversight and restrictions on gathering and education. Even abolition was debated as a possible solution.[195] One writer argues that enslaved people must not travel between plantations or assemble on Sundays "(as they have been in the habit of doing for some time past, at the numerous grog-shops which infest our land) by which their [*] are depraved, and their morals corrupted."[196] The draft of a bill in the 1831 Virginia legislature responds to the insurrection by proposing that no black person be able to preach, hold assemblies, or buy or sell alcohol. Print circulation, too, was targeted.[197] One report wrote that as far as Connecticut, a proposal for a black college was rejected because it presented "an unwarrantable and dangerous interference with the internal concerns of other States, and ought to be discouraged."[198]

Northern abolitionists, too, approached Turner's insurrection with a diagnostic logic: if he manifested an entirely natural, sane reaction to enslavement, then it was that institution that needed to be remedied. These writers were driven not to diagnose not Turner, the individual, as the Southern papers attempted to do, but the institution of slavery. The revolt itself is read as a symptom of a larger social problem, while the motive of liberation is an exculpatory one. One writer asks "For what object" the rebels killed: "Plunder? No--there is no evidence that such was their object. On the contrary, almost all the accounts concur in stating that they expected to emancipate themselves, and they no doubt thought that their only hope of doing so was to put to death, indiscriminately, the whole race of those who held them in bondage. If such were their impressions,

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[194] *Richmond Compiler*, August 24, in Tragle, 37.
[195] Kenneth S. Greenberg, "Blood and Public Curiosity," *Reviews in American History* 44, no. 1 (March 14, 2016): 112.
[196] *The Richmond Enquirer,* November 25, 1831, in Tragle, *The Southampton Slave Revolt*, 150.
[197] Tragle, 460.
[198] Tragle, 103.

were they not justifiable in doing so? Undoubtedly they were." Although the writer agrees the plan was delusional, hampered by poor education and mandated ignorance, but though "They were deluded, but their *cause* was *just*."[199] On September 17, *The Liberator* uses an extended illness metaphor to reject claims that the publication itself had caused the rebellion: "The truth is that men are too ready to ascribe sudden and violent eruptions of evil to the operation of temporary causes. Everyone is more ready to charge any sickness under which he may be suffering to some accident, rather than to a decaying constitution; he is willing to flatter himself that his malady is not deeply rooted in his frame."[200]

Both for those invested in the maintenance of slavery and for those who worked against it, Turner provided a unique problem. As DeLombard has argued, the criminal confession represented the earliest first-person expression of black personhood in early America. Denied legal personhood unless being held criminally responsible, the black persona was developed, she suggests, not through the narratives of slavery and freedom often cited as originating African American literature, but with confessions like Turner's, which represented a generic step between the slave as property and the individual writing an account as a member of print culture. Regardless of political motive, then, accounts that removed agency from those criminals—whether through racist science or the environmentalist claims of abolitionists who blamed the institution of slavery—contributed to attacks on black personhood. Attempts to reassign blame from the black criminal to the slaveholding society inadvertently destroyed the seeds of black personhood: "By sundering the black persona from the criminality in which recognized legal personhood had so long inhered, the abolitionist tactic of reassigning culpability to the white American citizen could also fortify the "average racism" fostered by a fabulist like Edgar Allan Poe, to say nothing of the scientific racism

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[199] *The Sentinel*, [n.d.,] reprint in *The Liberator*, October 1, 1831 in Tragle, 104, 105.
[200] Tragle, 81.

being developed by proslavery professionals like Dr. Samuel A. Cartwright."[201] Diagnoses of madness to some extent enabled this "sundering," and ultimately, Turner is dehumanized both by southern papers, as in *The Richmond Enquirer's* claim that the rebels are "inhuman monsters,"[202] and by abolitionist writings that liken the rebellion to a force of nature rather than a human act, as in *The Liberator*'s account on of the rebellion as "The first step of the earthquake, which is ultimately to shake down the fabric of oppression."[203]

As is clear from the distinction between southern and northern diagnoses of the rebellion, Gray and Turner's confessions do not provide a single explanatory model. For white southerners, Turner's biography furnishes ample symptoms that evidence pathological mental and moral function, isolating Turner's mind as aberrant but also representative, providing insights into the proper "care" of the black mind—namely, refusing education and congregation. For abolitionists, Turner's aberrations are themselves symptoms of a broader social disease: the conditions of slavery, the failures of education, and the madness of southern slaveholders produced violence.[204] These competing interpretations are due in part to the dual voices of the *Confessions*.[205] Critics have

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[201] DeLombard, *In the Shadow of the Gallows*, 166–67.
[202] *The Richmond Enquirer,* September 12, in Tragle, *The Southampton Slave Revolt*, 77.
[203]*The Liberator*, September 3, 1831 in Tragle, 63.
[204] Browne clarifies distinctions within the northern position on slavery: "Romantic racialists like Thomas Wentworth Higginson could point to the revolt as proof positive that enslaved Africans possessed powerful impulses toward freedom and the courage to act on them. Antislavery conservatives like Harriet Beecher Stowe were reminded of how important it was to move slowly, lest servile insurrection erupt throughout the South. Immediate abolitionists like William Lloyd Garrison found it difficult not to crow in the faces of those too obdurate to see the import of the Southampton revolt. Far from controlling the 'meaning' of Nat Turner, then, the text rather calls out for different and competing interpretations." (Browne, "This Unparalleled and Inhuman Massacre," 325).
[205] Allmendinger, "The Construction of The Confessions of Nat Turner," 40. By comparing the information in Gray's letter to that in the *Confessions*, Allmendinger argues that the information about Turner's visions and interior states is authentic to the enslaved man. Counting at least 116 pieces of information provided in the pamphlet which appear to be new to Gray, Allmendinger writes, "The coherence of his personal history with existing timelines compiled by those like Gray who studied the rebellion means that to compose a narrative of Turner's interior, Gray needed either to contrive a fiction with incredible care or—more simply—to obtain the authentic account by the one source whose memory had stored a lifetime of animosity against those who had stood in the way of freedom" (40). I am not particularly interested in parsing the distinct features and effects of Gray and Turner's voices, sharing DeLombard's suspicion of attempts to detect "an authentic black

previously suggested that these two voices offer what Browne calls "two fundamental logics for the interpretation of violence—the Gothic and the Sacred."[206] Gray represents "the rebel as unique, alien, mad, local, and containable; Turner's text presents a tropological figure of universal significance."[207] For Kilgore, too, Gray portrays "a gothic villain with literary cultural capital" while Turner "resist[s] that stock characterization through a kind of prophetic bildungsroman."[208] I argue, though, that Gray's logic ultimately dominates, given his editorial role and his emphasis on inviting pathologizing readings. Ultimately, the reader only encounters Turner's "Sacred" logic through Gray's Gothic, skeptical, and medicalizing lens. For example, the "marks" that assured Turner's family he was a prophet are reframed through a parenthetical calling them "a parcel of excrescences which I believe are not at all uncommon, particularly among negroes, as I have seen several with the same. In this case he has either cut them off or they have nearly disappeared."[209]

Still, in giving voice to Turner's sacred narrative within his own Gothic one, Gray inadvertently establishes Turner's (contingent) personhood. Although ostensibly arguing against the education of blacks, Gray's pamphlet also demonstrates the incompatibility of an intelligent black mind with the institution of slavery. Looking at an earlier confession by Pomp, a mad black murderer, Andrea Stone demonstrates how the same text that offers a "sensationalistic account of his fits and murderous hallucinations" and brands Pomp as a national threat also provides Pomp the opportunity to share a catalog of the abuses suffered at the hands of his master and white society.[210] "Turner's" voice within the pamphlet serves a similar function: His intellect and manners as a child

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voice" by remembering that "prosopopoeia is in fact the parlor trick performed by all autobiography" (*In the Shadow of the Gallows*, 36).

[206] Browne, "This Unparalleled and Inhuman Massacre," 310.

[207] Browne, 329.

[208] Kilgore, "Nat Turner and the Work of Enthusiasm," 1355.

[209] Gray, *The Confessions of Nat Turner,* 7.

[210] Andrea Stone, "Lunacy and Liberation: Black Crime, Disability, and the Production and Eradication of the Early National Enemy," *Early American Literature* 52, no. 1 (2017): 110–11, 114, 119.

are a crucial point in the story: his master noticed his "singularity of…manners" and "uncommon intelligence for a child" and declared that he had "too much sense to be raised" and that "if I was, I would never be of any service to any one as a slave."[211] His mind, he says, was "restless, inquisitive and observant of every thing that was passing" (8). He learns to read without being taught, as "one day, when a book was shewn me to keep me from crying, I began spelling the names of different objects—this was a source of wonder to all in the neighborhood, particularly the blacks—and this learning was constantly improved at all opportunities" (8). His learning was quick and his imagination was "fertile" (8-9). Of course, these marks of intelligence and cleverness are pathological exclusively because Turner was a black child rather than a white one. So, like Pomp's, Turner's confession clarifies the abuses that drove his revolt. He reports that "it had been said of me in my childhood by those by whom I had been taught to pray, both white and black, and in whom I had the greatest confidence, that I had too much sense to be raised, and if I was, I would never be of any use to any one as a slave" (9). Repeating the language of his enslaver for the second time about having "too much sense to be raised," Turner emphasizes the incompatibility of intelligence with enslavement. The language recurs again on the following page, but reframed through fellow slaves who told him that "if they had my sense they would not serve any master in the world" (10).

In order to counter the dangerous message of Turner's intelligence, Gray's Gothic framing explicitly medicalizes Turner's mind. Establishing the pathological origins of the "gloomy fanatic," and of the "dark, bewildered, and overwrought mind" produced when fanaticism is "acting upon materials but too well prepared for such impressions."[212] This phrase, emphasizing the materiality of Turner's mind as an object that can be "acted upon," and the individual rather than communal basis of the murder, suggests biological rather than societal problems. Turner's confession is not simply

[211] Gray, 8.
[212] Gray, 5.

an admission of actions: it is an intellectual and psychological biography. Gray presents the account not just as explanation, but as "an awful….and useful lesson" in psychology, showing the "operations of a mind like his, endeavoring to grapple with things beyond its reach" (4). He gives not just Turner's history, but explicitly that of his mind: "How *it* first became bewildered and confounded, and finally corrupted and led to the conception and perpetration of the most atrocious and heart-rending deeds" (4-5, emphasis mine).

Turner's susceptibility to madness is explicitly racial, linking black body to fanatical mind. The longer Turner remained undiscovered after the rebellion, publications seemed to darken his skin: according to Greenberg, one of the earliest newspapers described Turner as having a "bright" complexion, though he was not a "mulatto." Over time, though, descriptions—including those by historians with access to this description—began to describe him as a dark black man.[213] An article published by *The Richmond Enquirer* upon his capture includes an assessment that explicitly links physical appearance and mental state: "He answers exactly the description annexed to the Governer's Proclamation, except that he is of a darker hue, and his eyes, though large, are not prominent.--they are very long, deeply seated in his head, and have rather a sinister expression. A more gloomy fanatic you have never heard of. He gave, apparantly [sic] with great candour, a history of the operations of his mind for many years past; of the signs he saw; the spirits he conversed with; of his prayers, fastings and watchings, and of his supernatural powers and gifts, in curing diseases, controlling the weather, etc."[214] In keeping with this belief that visual cues could help scrutinize Turner's mind, the *Confessions* were originally meant to have been published with a lithographed portrait of Turner.[215]

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[213] Greenberg, "Blood and Public Curiosity," 16.
[214] *Richmond Enquirer,* November 8, 1831 in Tragle, *The Southampton Slave Revolt*, 137.
[215] *The Norfolk Herald*, November 14 in Tragle, 140.

The quantity of narratives circulating about the fate of Turner's body suggests how much the black body was believed to produce medical knowledge about the workings of the black mind. Although the fate of his body is not clearly known, it is generally believed that his body was given to physicians for dissection, both as a posthumous punishment and to fill the need for cadavers in regional medical schools. Greenberg traces stories of the fate of Turner's body, including that his skull wound up in Wooster, Ohio, where it was used in anatomy lectures, that it stayed in Southampton, or that his skin was turned to purse.[216] As late as the early twentieth century, a historian spoke of Turner's skull as looking like "the head of a sheep, and at least three-quarters of an inch thick" and a newspaper claimed that it was "a large skull, of fine contour, of well developed brain, of a man 34 years old."[217] Such claims demonstrate the fantasy that Turner's qualities of mind could be linked to his physical brain, relying on his body as medical evidence that might help advance the science of detecting dangerous men.

Beliefs about the medical evidence of Turner's body, though, required corroboration with his testimony. Gray takes great pains to mark Turner's confessions as "authentic," an authenticity vouched for by the triple prefaces preceding the account: one by Gray, one by the "Members of the Court Convened at Jerusalem" which vouches that the confessions were agreed upon by Turner, and finally one by James Rochelle, Clerk of the County Court of Southampton, which vouches for the status of those members of the court who vouched for the confession.[218] The rhetoric of

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[216] Greenberg, "Blood and Public Curiosity," 18–20.

[217] Quoted on Greenberg, 21.

[218] These markers of authenticity were only partially effective at the time, as a November 25, 1831 review in *The Richmond Enquirer* complains: "The confession of the culprit is given, as it were, from his own lips--(and when read to him, he admitted its statements to be correct)--but the language is far superior to what Nat Turner could have employed--Portions of it are even eloquently and classically expressed.--This is calculated to case some shade of doubt over the authenticity of the narrative, and to give the Bandit a character for intelligence which he does not deserve, and ought not to have received.--In all other respects, the confession appears to have been faithful and true. The whole pamphlet is deeply interesting!--It ought to warn Garrison and the other fanatics of the North how they meddle with these weak wretches" (Tragle, *The Southampton Slave Revolt,* 143).

authenticity fantasizes a possible clarification of Turner's mental state.[219] In Gray's publication of Turner's confessions, "motive" alone is insufficient, and instead the "history of the motives" must be given (7). He relates not just his feelings on the insurrection or on slavery, but how his mind came to take the form that allowed them: he speaks of a childhood experience "which made an indelible impression on my mind, and laid the ground work of that enthusiasm, which has terminated so fatally to many, both white and black" (7).

Belying the supposedly authentic and realist depiction of Turner's mind, Gray couches the confession with gothic rhetoric.[220] In the tone and vocabulary of a gothic novelist, Gray writes:

> I shall not attempt to describe the effect of his narrative, as told and commented on by himself, in the condemned hole of the prison. The calm, deliberate composure with which he spoke of his late deeds and intentions, the expression of his fiend-like face when excited by enthusiasm, still bearing the stains of the blood of helpless innocence about him; clothed with rags and covered with chains; yet daring to raise his manacled hands to heaven, with a spirit soaring above the attributes of man; I looked on him and my blood curdled in my veins. (18-19)

Such tropes pathologize the individual black mind. For Jeanne DeWaard, Turner's *Confessions* demonstrate how "gothic devices facilitate the legal production of black agency as individualized,

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[219] Browne, "This Unparalleled and Inhuman Massacre," 318. Browne writes, "Authenticity… provides the epistemological frame within which Nat Turner can be focused and made intelligible."

[220] The Gothic genre of Turner's "Confession" has been widely remarked. Casting about for a comparison for Turner, Thomas Wentworth Higginson rejected Stowe's *Dred*, which "seems dim and melodramatic beside the actual Nat Turner," pointing instead to a gothic tale of murder published in 1838: "De Quincey's 'Avenger' is his only parallel in imaginative literature: similar wrongs, similar retribution" (Tragle, *The Southampton Slave Revolt*, 347). Teresa Goddu notes the gothic conventions of newspaper articles about Turner's rebellion, which, because it "actualized the imagined terror of slave rebellion, …gave whites responding to Turner's rebellion a discourse to symbolize and contain their terror" (Goddu, *Gothic America,* 134). Laura Scales suggests that this gothic framing arose from both financial motivations and "to try to domesticate the terror," a task at which she believes the pamphlet fails, as it provides Turner a medium to express "a testimony of pure action, a kind of direct revelation" (Laura Thiemann Scales, "Narrative Revolutions in Nat Turner and Joseph Smith," *American Literary History* 24, no. 2 [May 5, 2012]: 221.)

apolitical criminality" as the cause is placed in Turner's mind rather than the slavery system of Southampton.[221] Gothic fiends and the extremity of Otherness, DeWaard suggests, enabled the growth of "Psychiatric explorations of the dark, mysterious inner self."[222]

Gray especially emphasizes the gothic trope of disjunction between internal and external states: "whilst every thing upon the surface of society wore a calm and peaceful aspect; whilst not one note of preparation was heard to warn the devoted inhabitants of woe and death, a gloomy fanatic was revolving in the recesses of his own dark, bewildered, and overwrought mind, schemes of indiscriminate massacre to the whites" (4). Here Gray emphasizes the problem of opacity: the "surface" was calm, while the "recesses" of the mind held gothic horrors. DeWaard writes that, "In keeping with the materialist tendencies of Victorian culture…gothic tropes project inner turmoil onto physical forms."[223] Gray presents himself as a capable reader of Turner's inner life, but his narration reveals the tension between interior and exterior: "When I questioned him as to the insurrection in North Carolina happening about the same time, he denied any knowledge of it; and when I looked him in the face as though I would search his inmost thoughts, he replied, 'I see sir, you doubt my word'" (18). The scene reveals the fiction of the ability to read a face: Gray only makes himself *appear* "as though" he could "search his inmost thoughts," revealing that appearances can be operationalized and used for the purposes of deception. Anxieties about the frightening ends of an inability to read interior states through exterior signs are the same as those that motivated the psychiatric jurisprudence of Ray and his colleagues, animating the publication, seven years later, of Ray's seminal *Treatise on the Medical Jurisprudence of Insanity*. Moral insanity, partial insanity, and their

[221] Jeanne Elders DeWaard, "'The Shadow of Law': Sentimental Interiority, Gothic Terror, and the Legal Subject," *Arizona Quarterly: A Journal of American Literature, Culture, and Theory* 62, no. 4 (2006): 14.
[222] DeWaard, 17.
[223] DeWaard, 9.

relatives problematized this trope: they were founded on the premise that interior states *could not* be detected externally without expertise.

Narrating Liminal Disorder in Early Forensic Psychiatry

How Turner's "fanaticism" was represented, whether pathological, reprehensible, or environmentally shaped, might change how individuals understood his mind and consequently his culpability, but ultimately made no legal difference. Turner's judge writes, "Borne down by this load of guilt, your only justification is, that you were led away by fanaticism. If this be true, from my soul I pity you; and while you have my sympathies, I am, nevertheless called upon to pass the sentence of the court."[224] The trial and reactions to Turner's violent acts make clear the lack of consensus on the right way to grapple with the unreadable criminal mind. Filling that void, Ray and his peers suggested that they had the expertise to render such minds readable. Claiming expertise to navigate such complicated lines—early alienists positioned themselves as not just medical, but legal authorities.

The idea of moral disorder that Benjamin Rush introduced to the American medicine of the mind gained greater legitimacy fifty years after he originally proposed it. Among the major contributions of British physician James Cowles Prichard's 1835 *A Treatise on Insanity and Other Disorders Affecting the Mind* (printed in Philadelphia in 1837) was a strong endorsement of the concept of moral insanity. Too many equate insanity with "false conviction," Prichard suggests, which fails to capture those cases in which the disorder is in perversion of the "moral and active principles of the mind," the loss of self-government, or of carrying on "with decency or propriety" in daily life.[225]

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[224] Gray, *The Confessions of Nat Turner,* 21.

[225] James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (Philadelphia: Haswell, Barrington, and Haswell, 1837), 14–15. He says that the "older nosologists, Sauvages, Sagar, and Linnaeus"

Thus, in opposition to the three forms of "intellectual insanity"—monomania, mania, and incoherence—is "*Moral Insanity*, or madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties."[226] This lack of "remarkable disorder" meant that moral insanity required expert scrutiny to identify; the morally insane pose serious problems for medical jurisprudence, because they are capable of appearing sane before the court. "The laws have made inadequate provision" for those with "this ambiguous modification of insanity" which is capable of fooling a jury because "the individual gives pertinent replies to the questions that are put to him, and displays no particular mental illusion."[227] Recasting insanity to encompass moral disorder, Prichard argues for medical intervention in the courts.

Acknowledging the difficulty of a clear definition of insanity, Prichard relies, as had Rush, on narrative forms. He begins his text with "a short nosography, which will answer many of the purposes of a definition… by summing up the characteristics of the different forms."[228] As discussed in the prior chapter, "nosography" implies an understanding of mental disorder more descriptive than static. Drawing on his own experience and the experience of other medical writers, he seeks to provide "a statement generalized from a multitude of particular examples," attempting to provide delineations of disease in an organization the "most simple that is admissible."[229] It is this case-based formation of his diagnostic system that provides the tools to discriminate between hazy

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make some note of this and in addition to vesaniae or hallucinationes (about problems of understanding) they also spoke of morositates and morbi pathetici—"depraved appetites and other morbid changes in the feelings and propensities" (16). Pinel has a category of "madness without delirium" (16). He gives an example from Pinel who has already talked about "moral insanity as a distinct form of derangement" and Esquirol also writes of this possibility (21).

[226] Prichard, 16.

[227] Prichard, 21.

[228] Prichard, 17.

[229] Prichard, 17-18. The "more extensive arrangement" provided by Professor Heinroth in *Treatise on Derangement of the Mental Faculties* is comprehensive, but "singular and absurd in some of its fundamental principles" (18).

forms of disorder. Discussing the ability of the morally insane to pass without notice, he writes, "An attentive observer will often recognize something remarkable in their manners and habits, which may lead him to entertain doubts as to their entire sanity."[230] But how is that observer to differentiate between "moral insanity" and "eccentricity of character"? Prichard suggests that "The discrimination—if indeed the two things are essentially different—could only be made in particular instances by taking into the account a variety of circumstances, such as the hereditary history of the individual and his consanguinity with persons decidedly insane, his former character and habits, and the inquiry whether he has undergone a change in these respects at some particular period in his life."[231] The emphasis on histories and change over time makes clear the narrative basis of these diagnostic assessments.

Although he does eventually include statistics and post-mortem information, the substance of his medical theory is narrative and case-based. Each of Prichard's cases follows the pathological plot of a patient-character for between two and eight pages. In one section of his text, for example, he offers cases meant to clarify the relationship between moral insanity and monomania: the cases Prichard uses to demonstrate the difficulty of discrimination are detailed, with the shortest still spanning several paragraphs. He gives seven cases of his own, and then shares cases reported by others that corroborate his system, including transcribing a letter from another doctor that contains nine more. These narratives enabled the diagnostic process to gain access to the hidden mind of the patient. Moral insanity resides in "deep obscurity," and its phenomena are "so difficult to explain" that "we might be tempted to doubt its existence as a primary affection."[232] Arguing against those who look to root moral insanity in intellectual insanity or misperception, he presents a discriminating anecdote: consider a person rageful to the point of murder. If their justification is because of some

[230] Prichard, 20.
[231] Prichard, 28.
[232] Prichard, 89.

error, for example the belief they are subject to a plot, then they are intellectually insane. If such justification does not exist, then their insanity is moral.[233] Prichard's cases attempt to establish a character and then show how they are acting it—most often a person of good character, breeding, and education who falls into moral decline.[234]

These narrative-diagnostic concerns—of origin of behavior, of character, of change over time—are the same that animated Gray's portrayal of Turner in the *Confessions*, and are, moreover, familiar to literary critics tracing the development of Gothic genres across the early nineteenth century. Indeed, Prichard's cases bear striking resemblance to the work of Poe, with their idiosyncratic figures reduced to madness. The first case presented is that of a man whose early moral insanity transitioned to monomania. Many of his friends "supposed him to be only *very eccentric;* while some, who had opportunities of observing him closely, were convinced that he was deranged."[235] The latter, Prichard suggests, were correct, as the man eventually committed suicide. Like the unreliable preface to a work of fiction, Prichard gives us "the details of this case as I received them from an intimate friend of the individual affected."[236] Another case documents the change of a woman slightly "deformed" who is initially calm, measured, cautions, and intelligent, who becomes increasingly energetic and manic despite her ill health. Beyond content, Prichard communicates her increasing energy formally, jamming together her actions with semi-colons, attempting to capture grammatically her "disquietude" which "exhausts every person who is long with her."[237] In this case, literary style allows him to communicate the predominant feature of her disorder.

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[233] Prichard, 27.
[234] For Prichard, who considered himself an "ethnologist" and is also known in medical history as an early British anthropologist, moral insanity provided evidence of monogenic theories of mankind. Rejecting materialism and phrenology, "Prichard believed that humans had a moral sense and that the best way to support his belief in monogenesis —the view that humanity had a common origin—was to demonstrate the unity in the psychological structure of human beings" (Bower, "Religion," 78).
[235] Prichard, *A Treatise on Insanity*, 36.
[236] Prichard, 36.
[237] Prichard, 41.

This narrative psychiatry was also important to the work of Isaac Ray, whom Susanna Blumenthal calls "perhaps the most outspoken and unrelenting" advocate for moral insanity.[238] Ray rejected the Common Sense approach to mental disorder, decrying the "self-consciousness" of metaphysicians and demanding practical experience.[239] This experience would provide the bank of stories required for expert discrimination. The year after Prichard's treatise was published in America, Isaac Ray published his seminal *Treatise on the Medical Jurisdiction of Insanity* (1838).[240] The text was remarkably influential both in the United States and Great Britain. Ray argued that although works on psychiatry may have a chapter or two on legal questions, in general, the science of the mind in the courts lagged significantly behind its developments in medicine. While great strides had been made in the management and cure of mental disorder, he writes, "yet the English language does not furnish a single work in which the various forms and degrees of mental derangement are treated in reference to their effect on the rights and duties of man."[241] Particularly at fault, he believed, were assessments of mental capacity that acknowledged only total and complete insanity—the "wild beast" test. Arguing for a more robust legal view of psychiatric disorder, he sets out to describe the impact of a broad range of forms of disorder and their impacts on criminal and civil liability in order to help resolve conflicts about "who are really insane, in the meaning of the law."[242] Claiming an arsenal of "well-observed, well-authenticated facts," Ray's "imperative duty" was "to

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[238] Blumenthal, "The Mind of a Moral Agent," 132.
[239] Blumenthal, 136.
[240] Prior manuals, he suggests, are too short, too vague, or speak only partially about law. He notes that other Europeans seem to have a more advanced science, although the work of Johann Hoffbauer is insufficiently focused on physical causes, and he is particularly impressed with the work of Éttiene-Jean Georget. Ray's manual, however, must be an American one: although first considering translating Hoffbauer or Georget into English, he decided that the extensive notes that would be required to update the manual for American laws meant that he ought "to prepare an original work,—original strictly in plan and in many of its general views only, —for the materials have been necessarily drawn, in a great degree, from other sources than the author's own experience." (Ray, *A Treatise on the Medical Jurisprudence of Insanity*, vii.) In the preface to his manual's second edition in 1844, Ray praises Prichard's work.
[241] Ray, iv.
[242] Ray, 3.

present them in the strongest possible aspect."[243] Seizing authority over the lines that guided "who are really insane," Ray offers observation as a counterweight to imagination.

Among the fruits of this observation, Ray believed, was the ability to detect simulated illness, or to detect hidden madness. The presence of liminal cases of insanity justified the role of the psychiatric specialist. The specialized service of distinguishing true from false madness was vitally important: he suggests that fear of fraud is a major reason that people are not more humane toward the mentally disordered.[244] Because the insane were increasingly institutionalized, Ray argues that the average doctor does not have enough contact with the mad to make such distinctions, calling for the specialization of an asylum doctor. Alienists were able to detect simulation so effectively because simulators drew their "mad" behavior not from first-hand experience, but from literature and popular culture. These simulators tended toward "caricature" because they relied on "the representations of mania put forth in the works of novelists and poets" which are "of all their attempts to copy nature, the least like their model."[245] Presented with true madness, the lay public would be fooled: "The real disease would not present insanity enough for them; in other words, its outward manifestations would not sufficiently strike their senses, by which, not by their intellect, they judge of the existence of the disease."[246] For that reason, the truly mad have often been accused of underzealous simulation and punished: "the simulator has occasionally eluded the grasp of the law, many a real maniac has been sacrificed to popular ignorance."[247]

There were a few "admirable exceptions" to the failure of literary models of mania, and Ray's discussion of these exceptions provides important information about the literary logic of Ray's diagnosis. The exceptions named in Ray's 1838 treatise were "the Lear and Hamlet of Shakespeare"

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[243] Ray, ix.
[244] Ray, 350.
[245] Ray, 351.
[246] Isaac Ray, "Shakespeare's Delineations of Insanity," *American Journal of Insanity* 3, no. 3 (April 1847): 307–8.
[247] Ray, 308.

(351). In an 1847 article for the still young *American Journal of Insanity*, Ray further develops this claim, arguing for the accuracy of Shakespeare's representations of madness and diagnosing familiar characters.[248] Benjamin Reiss has argued that asylum superintendents, including Ray, Amariah Brigham, and A.O. Kellogg, used William Shakespeare to gain the cultural authority necessary to establish specialist knowledge of mental science. "It was William Shakespeare," Reiss writes, "more than Phillippe Pinel, Benjamin Rush, or Amariah Brigham, who did the most to justify the authority of the asylum superintendents."[249] In the twenty years beginning in 1844, the *American Journal of Insanity* published thirteen substantial articles on Shakespeare, in which psychiatrists claimed that Shakespeare's views on insanity coincided with their own in viewing insanity as a physical disease.[250] Among other explanations for this concurrence, Reiss suggests that "asylum medicine was actually a self-conscious attempt to put into practice ideas about insanity that had originated in classic literature."[251] Shakespeare held popular appeal in Jacksonian America, and, Reiss argues, his use in psychiatry served not just to establish the cultural bona fides of the members of a profession aspiring to the middle and upper classes, but also to argue that their medical views came from the same knowledge of the "natural" and "real life" in which Shakespeare excelled.[252] Thus, the turn from early rationalist models of medicine toward empirical ones was justified, in part, by literary thought.

Diagnosing Shakespeare's characters was not mere entertainment. Rather, the skills of literary genius were the same as those that Ray and his peers attempted to cultivate. Establishing the value of literary thinking, he writes,

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[248] Ray, "Shakespeare's Delineations of Insanity."
[249] Reiss, *Theaters of Madness*, 80.
[250] Reiss, 81.
[251] Reiss, 88.
[252] Reiss, 92–93.

> It is a curious fact, that metaphysicians whose special province it is to observe and analyze the mental phenomena, have shown much less knowledge of mind as affected by disease, than writers of poetry and romance whose ideas are supposed to be the offspring of imagination, rather than a sober observation of facts. No one would look into Locke, or Kant, or Steward, to find any light on the subject of insanity; but in the pages of Shakespeare and Scott, are delineations of this disorder that may be ranked with the highest triumphs of their masterly genius. The cause of this difference is obvious. The one looks at mind in the abstract; the other, in the concrete. The former seeks for its laws and modes of operation exclusively in the inmost recesses of his own being. The latter is more curious to observe the workings of minds around him, and none of them are deemed to be unworthy of attention, even though controlled by the influence of disease.

Thus, literary expertise like Shakespeare's was superior to the writing of moral philosophers and metaphysicians. This claim echoes the epistemological move made by Ray and other alienists of the time, as they rejected the introspection of moral philosophy for the clinical observation of madness.[253]

In his praise of Shakespeare, Ray aligns the skill of asylum physicians closely with that of literature. Shakespeare had an uncanny ability to move from observation to inference, which Ray casts in terms of medical theory-building. Shakespeare "observed [the insane] as the great comparative anatomist of our age observed the remains of extinct species of animals,—from one of the smallest bones, reconstructing the whole skeleton of the creature, reinvesting it with flesh and blood, and dividing its manners and habits. By a similar kind of sagacity, Shakespeare, from a single

[253] Boyer, "Religion," 74.

trait of mental disease that he did observe, was enabled to infer the existence of many others that he did not observe."[254] This ability to infer from the part to the whole resulted in a clear nosographical vision, and he "clearly perceived at a glance those numberless shades of distinction that entirely escape the notice of ordinary observers."[255]

Ray attributes a remarkable degree of realism to Shakespeare's "delineations of insanity," allowing him to use them as medical source material. In the hands of less skilled poets, mad characters are like "automata that execute a series of motions, by an ingenious combination of springs and levers." Hamlet, though, "is no machine, but a living, human soul" and thus "his character is not so easily read."[256] Ray notes that Shakespeare's characters are not "copies" but "real, mortal men."[257] It is the reality of these characters that allows him to use them as medical cases. He hypothesizes, "assuming Lear to be an historical portrait instead of a poetical creation, we should say there existed in his case a strong predisposition to insanity."[258] Reading Lear as medical case, he asks who could read the play without "feeling that he has read a new chapter in the history of mental disease, of most solemn and startling import?"[259] Lear's raving, Ray explains, can be "physiologically explained" as resulting from "cerebral excitement."[260] Turning his diagnostic eye on Shakespeare's characters, he concludes that Lear is a maniac and Hamlet a monomaniac. In Macbeth, "Shakespeare has exhibited a mental phenomenon of a pathological kind which he seems to have correctly understood, and in that respect, was greatly in advance of the current notions of his own, and perhaps the present times" (325); in Lady Macbeth, "a mental condition of a most curious and interesting kind which though not strictly insanity, is unquestionably of a pathological nature" (328).

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[254] Ray, "Shakespeare's Delineations of Insanity," 291.
[255] Ray, 290.
[256] Ray, 310.
[257] Ray, 290.]
[258] Ray, 292.
[259] Ray, 298.
[260] Ray, 299–300.

Ironically, considering that characters in a play are of necessity "simulators," Ray suggests that Shakespeare provides a kind of training manual in detecting simulated illness. He argues strongly against, for example, the common notion that Hamlet was simply feigning disorder. Shakespeare is not just representing insanity, in Ray's view—he is training others in its detection: "We are left in no doubt as to his views of what is and what is not genuine insanity; and by holding before us an elaborate picture of each, he enables us to compare them together, and to judge of his success for ourselves….Not more true to nature is the representation of Lear writhing under the stroke of real insanity, than is that of Edgar playing upon the popular curiosity with such shams and artifices as would most effectually answer the simulator's purpose" (304). It is Shakespeare's representation of Edgar's feigned madness that Ray suggest "evinces the accuracy and extent of Shakespeare's knowledge of mental pathology. … In no other way could the fidelity of his delineations have been subjected to a severer ordeal" (304). Turning patrons of his plays into "practised observers," Ray imagines, Shakespeare demonstrates that overwrought emotionality is evidence of simulation more than of true insanity.

Relating a more difficult case, Ray turns his expert eye on the madness of Hamlet. He writes that it is "somewhat curious" that Hamlet's madness was "universally regarded as feigned" and finds it difficult to conceive of any foundation for this opinion." [261] Because Hamlet represents "the most faithful delineation of a disordered mind ever made by man," he is shocked that readers might think it "represents a deceptive counterfeit, not a truth, a reality." Despite Hamlet's claim that he would "put an antic disposition on," he writes, "Poetically, dramatically, and pathologically true, is this exhibition of Hamlet is his interview with Ophelia."[262] Repeatedly, Ray justifies inconsistencies in his theory through medical explanation: Hamlet's ability to reason persists because his madness is

[261] Ray, 307.
[262] Ray, 316.

in its early stages, and the moral perversion has not yet progressed to intellectual perversion (318-9). In a footnote, he rebuts the argument that the original source text is about simulated madness, because Shakespeare altered material all the time. One might fairly ask why Ray is so deeply invested in the project of diagnosing Hamlet's true disorder.[263]

In part, this investment stems from the fantasy that belief in Hamlet's simulation could be banished by "the attentive reader" (307). To prove that sufficient training and rationality could provide clear answers about sanity, Hamlet's state of mind cannot be ambiguous, and the truth of Hamlet's mind is intimately related to the truths that justify Ray's authority over moral disorder. Ray writes that those who suggest that Hamlet is not mad, but merely disordered, "embrace the popular error of regarding madness as but another name for confusion and violence, overlooking the daily fact that it is compatible with some of the ripest and richest manifestations of the intellect" (309). Hamlet serves as evidence that partial and moral insanity exist, and that medical experts capable of managing them are required. He writes, "it is enough to state it as a scientific fact, that Hamlet's mental condition, furnishes, in abundance, the pathological and psychological symptoms of insanity, in wonderful harmony and consistency" (309).

Because both revealed such "scientific facts," Ray held that the best preparation for psychiatric jurisprudence was personal observation, but the second best is reading literature by people like Shakespeare or Moliere.[264] Diagnosing Shakespeare's characters and establishing their truth-to-nature, Ray argues that the bard's texts are required reading in the American courtroom. Clarifying the lines between true and false sanity, and thus between culpability and compulsion, Ray sees Shakespeare's delineations—and by extension his own—as crucial medical evidence[265]:

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[263] Mrs. Lunt, a former asylum inmate, argues in her 1871 memoir that Hamlet was not mad at all, and was instead misinterpreted by ignorant others, including, by extension, her own physicians (Reiss, 100).
[264] Reiss, 92.
[265] Shakespeare's qualifications as a jurist had precedent. In 1828, a London physician developed a test of mental functioning, "Hamlet's test," in response to a case in which a mentally disabled man in a period of

> Had the great jurist, in forming his opinions on this subject meditated upon the pictures of Shakespeare as well as the principles of Lyttleton and Coke, it would have been better for his own reputation, and better—ah, how much better—for the cause of humanity. Would that we were able to say that the Courts of our own times have entirely avoided his error, and studied the influence of insanity upon human conduct more by the light of Shakespeare and of nature, than of metaphysical dogmas and legal maxims. (332)

Having established Shakespeare's predominance as a mental scientist, Ray offers a provocative suggestion when he closes the Shakespearean article with a turn to the novel. "[T]he novelist," he writes, "possesses an advantage over the poet in the broader limits within which he may exercise his art, untrammelled by the restrictions imposed upon the other by severer rules of composition and the comparative brevity of his efforts." If Shakespeare's "wonderful fidelity to nature," renders his texts both "valuable as pathological illustrations" and "wonderfully effective in producing dramatic impression" (331), we may well ask how any writer could hold an advantage. In his suggestion that the looser structure of prose fiction provides new opportunities for developing a literary mental science, Ray anticipates the rise of psychological fiction—a fiction that would disseminate the diagnostic logic of forensic psychiatry.

Edgar Allan Poe's Diagnostic Vision

Edgar Allan Poe is often noted both for his horrifically mad characters and for originating the modern detective story. Combining these lines of enquiry, I suggest that Poe's interest in

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lucidity wanted to change his will. Relying on Hamlet's claim that he can reword his case, a task that "madness would gambol from," the physician challenged the man to reword his will (Reiss, 89).

detective work and analysis is a helpful frame through which to view his sensational psychological thrillers, and I focus in particular on the role of the diagnosing and classifying vision in his works as a tool for experimenting with new forms of madness that resembled those imputed to Turner and later codified by Prichard and Ray. Although men of science worked to render interior truths discernable, Poe's work reveals both faith and doubt about this possibility. Many of his texts are built around the theme that hidden madness must and can be detected and those who hide their insanity behind rationality must be quarantined in order to protect social order. "The Fall of the House of Usher" (1839) functions as an important transitional point in Poe's catalog of stories—between earlier stories like "Berenice" (1835), "Morella" (1835), and "Ligeia" (1838), in which sensationally mad first-person narrators populate horror tales, and the later detective stories, such as "Murders in the Rue Morgue" (1841), "The Mystery of Marie Roget" (1842-3), and "The Purloined Letter" (1844), in which an analytical genius decodes a troubling world. Positioned between these works both chronologically and thematically, "Usher" features a narrator closely watching the degeneration of an estate holder. Significantly, Roderick Usher is not a criminal, and thus the work shows Poe's engagement with psychiatric jurisprudence beyond the criminal, to account for the civil matters like estate ownership that preoccupied white psychiatric jurisprudence.

Previous writers, including Maurice Lee and DeLombard have placed Poe's fiction in general, and his detective story "The Murders in the Rue Morgue" in particular, in the context of Turner's rebellion.[266] DeLombard reads Turner's confession alongside Poe's tale, which was inspired by an account of a violent murder by an African American. She writes, "By revealing the culprit in the nation's first detective story to be a homicidal Ourang-Outang— patterned on a deranged free black murderer— Poe anticipates Cartwright in elucidating how the denial of criminal responsibility

[266] Maurice S. Lee, "Absolute Poe: His System of Transcendental Racism," *American Literature* 75, no. 4 (2003): 751–81.

to a violent actor might be tantamount to the denial of personhood, even human status."[267] She concludes that "Gray's Confessions, Williams's Narrative, Poe's story, and Cartwright's 'Report' reach remarkable consensus in setting aside for white citizens the answerability traditionally held to be constitutive of legal personhood."[268] Supplementing these readings of Poe's tale of black crime, I turn to his earlier tales of psychological detection, in which he applies the forensic vision of a moral diagnostician on (uncannily) white characters.

Poe fostered his reputation as an analytic mastermind, starting with early work like the puzzle poem "Enigma," published in the *Baltimore Daily Visiter* in 1833. The editor of the magazine encouraged this understanding, saying that Poe "seemed to forget the world around him, as wild fancy, logical truth, mathematical analysis, and wonderful combinations of fact flowed, in strange commingling, from his lips, in words choice and appropriate as though the result of closest study."[269] Poe advocated for method "in all forms of thought" and in this vein began publishing cryptograms and conundrums in December 1839.[270] A letter from W.B. Tyler to Poe during his stint as a magazine cryptographer reads, "You have exhibited a power of analytical and synthetical reasoning I have never seen equaled; and the astonishing skill you have displayed…will, I think, crown you the king of 'secret readers.'"[271] Poe's vanity about his analytic powers even extends to photographs taken of him, in which he posed to emphasize his large forehead, phrenologically speaking a sign of his intelligence and power of analysis.[272] The strategy seems to have worked, and Poe was seen by most

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[267] DeLombard, *In the Shadow of the Gallows*, 169.
[268] DeLombard, 169.
[269] Kevin Hayes, *Edgar Allan Poe* (London: Reaktion Books, 2009), 32.
[270] Shawn Rosenheim, ""The King of `Secret Readers'": Edgar Poe, Cryptography, and the Origins of the Detective Story,'" *ELH* 56, no. 2 (1989): 376.
[271] Rosenheim, 375. Rosenheim writes that "close reading" reveals that the letter from Tyler was likely written by Poe himself
[272] Satwik Dasgupta, "Photography," in *Edgar Allan Poe in Context*, ed. Kevin Hayes (Cambridge: Cambridge University Press, 2013), 320.

"as a man of extraordinary analytic power."[273] By many accounts, Poe's obsessive interest in analyzing signs and deciphering clues culminates in his string of detective stories, beginning with "The Murders in the Rue Morgue" in 1941, which many critics cite as the origin of the modern detective story.[274] Silverman writes that, while Poe's work had long been involved with analysis and the revelation of mysteries, the detective stories were different because "now Poe treated his inventions not as the stuff of narrative but as puzzles to be solved by a cunning intelligence" (172). Troubling this line between "narrative" and "puzzle," I connect Poe's analytic obsession more closely with his tales of madness, showing how earlier tales about mentally ill characters also work as "puzzles to be solved."

Poe wrote as scientific discourses emphasized new ways to read inner truths could be read on the surface of the body. Kevin Hayes writes that, "By the middle third of the nineteenth century, the whole world was becoming more legible—or so it seemed," and Paul Hurh suggests that "If ever there were a place and time to get your skull read, it would have been Philadelphia in 1839."[275] The development of photography enabled people to analyze the expressions of those they had never even seen in real life.[276] Poe himself once claimed that the daguerreotype was "the most important, and perhaps the most extraordinary triumph of modern science."[277] Poe's work throughout his life reflected his knowledge and use of these scientific developments: in the early part of the 1840s, he

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[273] W. K. Wimsatt, "What Poe Knew about Cryptography," *PMLA* 58, no. 3 (September 1943): 778.
[274] Hayes claims "Rue Morgue" "established the conventions of the genre" (*Edgar Allan Poe,* 103), Kenneth Silverman points out that Poe had "few if any precedents for such 'tales of ratiocination,' as he called what he attempted" (*Edgar A. Poe: Mournful and Never-Ending Remembrance* [New York: Harper Collins Publishers, 1991], 171). He also notes also that "At the time Poe wrote, the word *detective* did not exist in English, and for many readers his story had the delight of profound novelty" (173). Rosenheim specifically links the earlier work on cryptograms with the later detective pieces saying that the former experiment with signification, and "form a matrix out of which not only the language, but the plots and much of the generic form of the detective story emerged" ("The King," 376).
[275] Hayes, *Edgar Allan Poe*, 93; Paul Hurh, "'The Creative and the Resolvent': The Origins of Poe's Analytical Method," *Nineteenth-Century Literature* 66, no. 4 (March 2012): 478.
[276] Hayes, *Edgar Allan Poe*, 95.
[277] Silverman, *Edgar A. Poe*, 195.

wrote an "Autography" series in which he analyzed the character of a variety of famous writers by close attention to copies of their signatures, while in 1846 he wrote "Literati" and discussed "the characterology and physiology of literary reputation-making…In each case he discussed the subject's age, hair and eye color, height and weight, physique and dress, smiles and gestures."[278]

Such a heady scientific context was tied up in a cultural fantasy about the potential for total legibility, and Poe's work, both literary and cryptographic, played to this desire. Rosenheim puts forward Poe's detective stories, "in which Poe imagines a completely textualized world, where his readerly skills would finally come into their fullest play," as the ultimate fantasy of a decipherable world.[279] For Rosenheim, Poe's cryptographic experiments are extended into three dimensions as Dupin puzzles through clues—and once the code is cracked, everything is transparent to the fictional detective, because there is a supposed "indexical relationship between a person's behavior and his or her physical appearance" (382). He goes so far as to frame Poe's attitude as a "hostility to depth" (384-85), and comments that Poe's writing in the detective genre must "convert all experience into a system of signs" (384-85), pointing out the prominence of this approach even in less obvious detective stories like "The Man in the Crowd," where the narrator believes he can gather a great deal of information about the people walking by his window from just a brief glance. He notes, too, that both Dupin and Poe prefer cards to chess, where players play not only a game but also one another through inferences drawn from minute attention to physical detail (386).

Fears about misreading are a necessary counterpart to this fantasy, as in the popular trope of the "confidence man" who is able to deceive through appearances.[280] Poe's relationship to phrenology was obviously not a simple one, though, and he regularly purged references to phrenology in later revisions of his work—though this didn't stop him from using a cultural

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[278] Silverman, 214, 305.
[279] Rosenheim, "The King," 382.
[280] Dasgupta, "Photography," 317–18.

fascination with physiognomy to strategically comment on his literary peers in "Literati."[281] Poe's struggle with sciences meant to decode human interiors reveals itself in much of his writing. Although he wrote in *Alexander's Weekly Messenger* that "human ingenuity cannot concoct a proper cypher which *we* cannot resolve," Poe's writings leave plenty of uncracked codes.[282] Silverman and others have noted that in "The Man of the Crowd" (1840) the narrator ultimately can't decipher the old man who he follows through the streets, while in *The Narrative of Arthur Gordon Pym* (1838), "The narrative proper brings both Pym and the reader into a treacherous world of disguises, forgeries, and impersonations where appearances lie."[283] Poe's approach to such anxieties comes across in other, more playful forms as well, as in his (often unsuccessful) attempts to fool his reading audience with hoaxes like "Hans Pfall" (1835). In a letter to Phillip Cooke, Poe addresses the illusion of analysis in his detective fiction: "Where is the ingenuity of unraveling a web which you yourself have woven for the express purpose of unraveling? These tales of ratiocination owe most of their popularity to being something in a new key. I do not mean to say that they are not ingenious—but people think they are more ingenious than they are—on account of the method and *air* of method."[284] The illusion of an understood world extends beyond forensic investigations and codebreaking, however. Rosenheim suggests that Poe's constant return to corpses in his work "reveals his continuing anxiety over the body's refusal to suffer complete encipherment into language."[285] I suggest that his mad characters represent an even fuller enactment of this anxiety, an anxiety Poe answers by narratively advocating for obsessive and classifying psychiatric and moral vision.

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[281] Hayes, *Edgar Allan Poe*, 152.
[282] Wimsatt, "What Poe Knew about Cryptography," 776.
[283] Silverman, *Edgar A. Poe*, 133.
[284] Shawn Rosenheim, *The Cryptographic Imagination: Secret Writing From Edgar Poe to the Internet* (Baltimore: The Johns Hopkins University Press, 1997), 154.
[285] Rosenheim, 155.

Attention to the discriminating gaze occurs even in Poe's earliest published story, "Metzengerstein" (1832). Poe's narrator emphasizes careful physio-psychological examination by including an "insignificant and misshapen little page…whose opinions were of the least possible importance."[286] Silverman notes that "Maelzel's Chess Player" (1836) is unusual in the close attention of its narrative eye. In it, Poe "detailed seventeen minute observations on which he based his conclusions, for instance that as Maelzel invariably arranged the six candles on the chest, those furthest from the spectator were the longest. He had begun sketching, that is, a new type of narrator, an investigator of the hidden activities that can be deduced from homely physical facts."[287] John Irwin suggests too that Poe engages in a sort of observational competition with readers of stories like "Rue Morgue" by challenging them to reach the correct conclusion by catching small hints through the process of a slow reveal.[288] The narrative emphasis on observation becomes most fully apparent in the context of madness.

Poe's tales of madness eschew clear moralization. Both Cleman and Shen read Poe as claiming through works like "The Tell-Tale Heart" and "The Black Cat" that the "morally insane" ought to be held legally accountable for their actions—Shen even goes so far as to suggest that we aren't meant to read the narrator in "The Tell-Tale Heart" as mad at all, and that the reader ought to give credence to the narrator's claim that he has exceptionally sensitive hearing.[289] Such claims miss a central point in the anxiety about newly formed categories of mental illness. Although people may have worried that criminals could claim insanity and thus avoid appropriately severe punishments, it was also the case, as alienists like Ray argued, that those who were legitimately mad were being

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[286] Edgar Allan Poe, *The Complete Works of Edgar Allan Poe: Tales*, ed. James Albert Harrison (G. D. Sproul, 1902), 195.
[287] Silverman, *Edgar A. Poe*, 117.
[288] John Irwin, *The Mystery to a Solution: Poe, Borges, and the Analytic Detective Story* (Baltimore: The Johns Hopkins University Press, 1994), 195.
[289] Cleman, "Irresistible Impulses," 640; Shen, "Edgar Allan Poe's Aesthetic Theory."

mistaken for sane. A story like "The Tell-Tale Heart" does not undercut the insanity defense, but rather, exhibits the importance of observing someone's actions rather than listening to their words—it is a story about refusing to let people account for their own behavior. In this reading of Poe's story, we shouldn't be worried that people will claim insanity to escape punishment, but rather that we will fail to detect their pathological character before it reaches its violent and disruptive zenith. By creating unstable narrators or focusing the gaze of more reliable narrators on unstable objects, as in "The Fall of the House of Usher," Poe encourages his readers to sharpen their ability to diagnose irrationality—the same task that Isaac Ray attempted to narrate in the mid-nineteenth century.

Mental illness has often been read as a challenge to our political and social system, which is based on free agents acting from a place of rationality. Thus, attempts like Prichard and Ray's to clarify who should and should not be given this agency are attempts to strengthen the rational base of a society, or, more cynically, attempts to shape this base by excluding those with features and opinions opposed to the dominant model. Poe highlights the danger of disruptive moralities and emphasizes the particular fear of a mad man "passing" for a sane one. Many of his stories, like "William Wilson," "MS. Found in a Bottle," and "The Black Cat," to name a very few, rely on unstable narrators attempting to pass as stable, and it is this tension from which Poe draws much of the horror of his tales. The most troubling madman, we are told by both Poe and Prichard, is the one that can hide their insanity while secretly perpetrating immoral acts. This fear can be mitigated through detailed scrutiny of behavior. Just as the façade of the House of Usher appears sound, though ancient, it is the attentive gaze of our narrator that detects the crack that will later split the house. Similarly, his attention to his comrade and his knowledge of physiognomy allow him to detect fissures in the sanity of his friend.

Poe's stories of madness reflect his obsession with analysis, even though they predate his tales of Dupin's ratiocination and his cyphers. "The Fall of the House of Usher," one of Poe's prominent stories of horror and madness, was first published in September 1839. Through many of his early stories of madness, and especially through "Usher," Poe exhibits the mind as a viable subject for minute analysis. By presenting ambiguously sane characters, Poe encourages his audience to step into the role of analytic diagnostician: part of the thrill of his stories is discerning when his narrators are or are not reliable sources. Often, as in "The Tell-Tale Heart," they are obviously not, but at other times it can be more difficult to tell. In "William Wilson," for instance, it is never clear whether his double is a figment of his imagination, or a supernatural occurrence. Many of Poe's narrators attempt to convince the reader that, although their tale may be a mad one, they themselves are sane. Asking the reader to exercise their own skeptical discriminating vision, Poe creates readers proficient in the art of mental detective work, and more suspicious of what lies behind eccentricities. His work thus trains what Elizabeth Donaldson has called "the psychiatric gaze." Though Donaldson writes about film, Poe's narrative lens works much like the camera: "diagnosing vision assumed by a camera and the spectator's complicity in that vision, or the self-diagnosing dynamic created by antidepressant ads and web sites that encourage would-be consumers to screen themselves for mental illness."[290] In this way, Poe's works of madness and horror are not so different from his detective works, as both encourage the exercise of reason to solve a mystery, though in his horror stories this takes the form of psychiatric detective work.

The cases related in work by early psychiatrists sound uncannily similar to work by Poe. Consider Prichard's claim that "an attentive observer" may detect hints of madness that could be confirmed "an hereditary tendency to madness….He has become an altered man, and the difference

[290] Elizabeth Donaldson, "The Psychiatric Gaze: Deviance and Disability in Film," *Atenia* 25, no. 1 (2005): 32–33.

has, perhaps, been noted from the period when he sustained some reverse of future… or the loss of some beloved relative."[291] The case may sound familiar to those familiar with Roderick Usher, whose transformation, though grounded in heredity and environment, is also precipitated by the illness and supposed death of his twin sister. Poe's narrator writes of Usher:

> Surely, man had never before so terribly altered, in so brief a period, as had Roderick Usher! It was with difficulty that I could bring myself to admit the identity of the wan being before me with the companion of my early boyhood….The now ghastly pallor of skin, and the now miraculous lustre of the eye, above all things startled and even awed me. The silken hair, too, had been suffered to grow all unheeded, and as, in its wild gossamer texture, it floated rather than fell about the face, I could not, even with effort, connect its Arabesque expression with any idea of simple humanity.[292]

Combining the radical alteration of Usher's appearance, the shock of losing his sister, the congenital characteristics that had been warped through generations, and culminating in the chin elsewhere described as "lacking moral energy," Poe presents us with a case study of Prichard's moral insanity.

The legal component of "Usher" is not one of criminal liability, but rather with the discrimination of cases in which heads of household are unable to "manage affairs," ultimately evidenced by the destruction of his estate—the exact kinds of cases that Prichard believed required new laws.[293] The primary concern is the health of those who hold capital, and how a society can ensure that this power remains in the hands only of the obviously and fully sane. Prichard advocates for a revised legal system that would increase the ease with which a man could be deemed unfit to

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[291] Prichard, *A Treatise on Insanity*, 21.
[292] Edgar Allan Poe, *Selected Tales* (Oxford: Oxford University Press, 1998), 52.
[293] Prichard, *A Treatise on Insanity*, 21.

carry out his own affairs. Hence, Prichard's project is to solidify the grounds for a diagnosis of "moral insanity" in order to facilitate the policing of these "eccentric" individuals. As Prichard sets forth exercises and criteria for judging sanity, he expresses anxiety about the possibility that those with legal power are not infallible, and encourages the constant monitoring of those granted with agency.

By associating Usher so strongly with his inanimate estate, Poe calls for close scrutiny of Usher as an object of study, and thus a prime target for analysis. In the story, the setting and those who inhabit it are collapsed to the point where it is unclear whether the "melancholy House of Usher" is the cause or the result of the nervousness of its inhabitants. By using human terms to describe the building's "eye-like windows" (49) while using architectural language to describe the "stony rigidity" (64) of its master, Poe links the two closely. He points out, too, that this notion is so commonplace that "The House of Usher" is "an appellation which seemed to include, in the minds of the peasantry who used it, both the family and the family mansion" (50-1). Poe uses this connection to dramatic effect up through the story's conclusion, when the house collapses almost immediately upon the death of the final heir. If the reader has been attentive, noting the disrepair of both "Houses" of Usher, this ending will not come as much of a surprise. The degeneration of both is so clear that Poe could trust a reader through visual clues to differentiate between sanity, exemplified by sound progeny and a well-built home, and insanity, with its overemphasis on sensuality and the resulting disrepair of the home.

The reader is also led to see Usher as an object of study because of the role of the narrator. Unlike many of his earlier tales of madness, "The Fall of the House of Usher" is narrated not by the deranged perpetrator of horrific events, but rather by an ostensibly reasonable man who seems largely reliable. Though his earlier stories about madmen, such as "Berenice," in which our narrator removes the teeth of his cousin's corpse, also encourage the reader to identify madness, the gothic

details are played so strongly that it is not so much an exercise in detection as a rapid revelation of shocking events. By including an intermediary in the monitoring process in "House of Usher," Poe begins to portray a more subtle model of unreason—the reader, along with the narrator, is able to see signs of agitation manifest themselves early, before any catastrophic event occurs. The narrator, we are told, has been drawn to the house by a letter from Usher in which we begin to piece together the clues of Usher's "mental disorder":

> The MS. gave evidence of nervous agitation. The writer spoke of acute bodily illness—of a mental disorder which oppressed him—and of an earnest desire to see me, as his best, and indeed his only personal friend…It was the manner in which all this, and much more, was said—it was the apparent *heart* that went with his request—which allowed me no room for hesitation; and I accordingly obeyed forthwith, what I still considered a very singular summons. (50)

Usher's madness is established not simply by his claim to have a "bodily illness," but also by our narrator's sense that something in "the manner" of the letter that "gave evidence of nervous agitation." Thus, the narrator's perception guides the action of the story, and alerts the reader to heed not only Usher's words, but also the manner in which they are communicated—to monitor his language closely, not for what it says, but for how it can be interpreted. The narrator's close attention to and relation of Usher's physiognomy also allows the reader to take on a quasi-medical gaze to aid in the service of diagnosing the doomed man.

Edgar Allan Poe's "William Wilson," published the year after Ray's textbook, also trains the reader in psychiatric detection. In the short story, the narrator, pseudonomynously introducing himself as "William Wilson," begins at the end: he is miserable and evil. This "prognosis" is quickly linked to pathological causes: to his hereditary predisposition (passed from "weak-minded" parents and having characterized his "race" for generations) to a temperament "imaginative and easily

excitable."[294] The story he relates, he tells us, is his attempt to revisit the time and place where he now knows sees the "first ambiguous monitions" (67) of his destiny. Thus, beginning from his place at the end of the narrative (which is the beginning of the narrative for the reader), he reaches back to pull out the salient details of his past, highlighting those things he now sees as significantly demonstrative of his eventual demise (what we might think of as "symptoms"). As he relates his relationship to his rival—also named William Wilson—he drops symptomatic clues (a shared birthday, similarities of clothing, disregard of friends) that ultimately lead the reader to a "diagnosis": William Wilson has a doppelganger, or double consciousness, or externalized conscience of some sort, which takes a physical form and which he murders, resulting in his eventual misery.

Read straight as a case study, the story shares the medical purpose of tracing an eventual state back through its origins and symptoms. But the fictional format allows Poe to play with this genre in interesting ways. We approach an interesting dilemma that could only play out in fiction: it's not clear whether William Wilson literally has a doppelganger or whether he is mad. If the former, Poe introduces an element of mysticism that reaches beyond possible understanding (medical or otherwise). If the latter, though, the text becomes the speech of a madman (we know of his hereditary predisposition to imagination, and there are various curious mentions of the precision of his memory) and he becomes a patient, rendered textual, and the reader is able to compose a mental "case study" of their own, participating in the process of medical discrimination. So, the text both rejects and reaffirms the medical "gaze"—but it isn't an either/or proposition—it is both. This kind of ambiguous resolution challenges the fantasy of psychiatric jurisprudence, emphasizing the persistence of failures to know the other.

The anxiety about detecting madness is not solely about determining agency, but also expresses a fear about the mutability of identity. Teresa Goddu argues that the kind of anxiety about

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[294] Poe, *Selected Tales*, 67.

the fluidity of identity expressed in a novel like Poe's *Narrative of Arthur Gordon Pym* is rooted in theories of evolution proposed by Jean Baptiste de Lamarck, whose *Zoological Philosophy* was published in 1809.[295] In this work, Lamarck proposed that creatures were not formed perfectly to their environment by God, but rather, that they evolved over time to suit their environment. Natural selection was not yet the principle at work; rather, a single individual was believed to mutate to fit their environment, and then to pass along those mutations. The constant stressing of the connection between the members of the Usher family and the House of Usher encourages a Lamarckian reading in which the house's atmosphere is capable of corrupting the family line. The narrator's comparison of the family line to a plant that has "put out no enduring branch" strengthens this sense that the problem is that the soil in which the family sows its seeds is barren—their seclusion in the House of Usher results in their demise. So, in addition to the hereditary features with which Roderick was born, the physiognomical traits that Poe may have believed structured much of his character, Usher's appearance is also able to transform under the effect of his environment.

We can see this effect at work on a shorter timeline as well, as we observe the transformation of the narrator under the sway of the house, which heightens the anxiety about the possibility of madmen "infecting" those with whom they come in contact. He notes initially that even looking at the house he experienced "an utter depression of soul…an iciness, a sinking, a sickening of the heart" (49). Upon residing in the home for a time, the narrator begins to express symptoms similar to the heightened senses of Usher: "His long improvised dirges will ring forever in my ears. Among other things, I hold painfully in mind a certain perversion and amplification of the wild air of the last waltz of Von Weber" (55). The emphasis of his own sensitivity to sound at this point, and more startlingly toward the end of the story, when he is unable to sleep on the night that Usher dies, show how the house and his companionship with Usher can begin to effect changes in a

[295] Goddu, *Gothic America*, 84.

relatively short period of time. Were the narrator to give us physical descriptions of himself, we have reason to believe that we would see him growing increasingly cadaverous as well, justifying his vigilance regarding his own rationality and reflecting the fear that unmonitored madness can impact the larger social body through contagion.

Poe's narrator in "Usher" is aware of this danger and can be seen testing his own sanity—a self-directed psychiatric gaze. When feeling beset by superstition, he reverts to reason, as though to reassure himself of sanity. When the first wave of melancholy hits him as he sees the House of Usher, he explains it away using a rational system, invoking Burkean notions of the sublime to account for the landscape's impact on his psyche. Upon further reflection, he self-consciously remarks, "The increase of my superstition—for why should I not so term it?—served mainly to accelerate the increase itself" (51), but concludes his fanciful musings on the house by "shaking off…what *must* have been a dream," and scanning "more narrowly the real aspect of the building" (51). The "real" aspect of the building, then, must be differentiated from his initial, superstitious look. He clearly worries that his state is being influenced by that of his friend, writing, "It was no wonder that his condition terrified—that it infected me. I felt creeping upon me, by slow yet certain degrees, the wild influences of his own fantastic yet impressive superstitions" (60). This fear of contagion undergirds the narrator's many reality checks. When, on the night of the story's conclusion, he is unable to sleep for terror, he still attempts to position himself as the rational agent posed against Usher's hysteria. In the face of an eerie storm, he cautions Usher, "These appearances, which bewilder you, are merely electric phenomena not uncommon—or it may be that they have their ghastly origin in the rank miasma of the tarn" (62). Diagnosing the irrationality of others serves as a kind of inoculation through monitoring—the kind of monitoring that Poe encourages through his works, and that Ray and Prichard mark diagnostically though their treatises.

By including a narrator so intent on his own rationality, and having this character mediate the object of study and the reader, we begin to transition toward the "tales of ratiocination" Poe published later in his career, and what emerges is a medical detective story concerned with the detection of "moral insanity." The first paragraph of "The Murders in the Rue Morgue," the first of Poe's proper detective stories, includes a meditation on the joys of exercising reason:

> As a strong man exults in his physical ability, delighting in such exercises as call his muscles into action, so glories the analyst in that moral activity which *disentangles*. He derives pleasure from even the most trivial occupations bringing his talent into play. He is fond of enigmas, of conundrums, of hieroglyphics; exhibiting in his solutions of each a degree of *acumen* which appears to the ordinary apprehension praeturnatural. His results, brought about by the very soul and essence of method, have, in truth, the whole air of intuition.[296]

By prioritizing the fruits of rationality and exalting its practice, Poe emphasizes the importance of solving "enigmas" and "conundrums," the same practice demanded by Gray, encouraged in "House of Usher," and described in work like Prichard and Ray's.

Conclusion

That Poe's characters often seem to fit the model presented by early psychiatrists does not simply mean that literature reflects the dominant scientific discourse at the time—it is equally the case that science and literature are mutually constitutive, as established in my previous section.[297]

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[296] Poe, *Selected Tales*, 92.

[297] This phenomenon has been well documented in the case of hysteria in France, which escalated as it bounced between symptom and popular culture and back to symptom. According to Asti Hustvedt, in *Medical Muses: Hysteria in Nineteenth-Century Paris* (New York: Norton, 2011), "The relationship between nineteenth-century French medicine and literature was one of mutual fascination" (100), and "during this period,

The constant interchange between medical science and literary culture means that, in the construction of psychiatric nosology, we must look not only to medical authorities, but also to the authors and poets that formed the context for pathology. Certainly, as Americans read the news and fictional accounts of madness, they formed their opinions on how to think about and judge those demonstrating mental disease, and the centrality of these types of figures in Poe's works and his emphasis on detecting and observing them places his work as a key player in this discussion.

Poe's "madmen" were not peculiar fancies of Poe's disturbed psyche, but figures that were of central concern across medicine, law, and literature in nineteenth-century America. That psychiatric monitoring was an important part of Poe's culture, and that it continues to be so, is evidenced in ongoing fascination with Poe's own pathological representation. As early as the mid-1830s, Poe was seen as an erratic figure, and when White dismissed him from the *Southern Literary Messenger,* he noted that Poe was a "victim of melancholy" who he anticipated might commit suicide.[298] By 1842, he was widely enough recognized as a drunk to be fictionalized in a temperance magazine.[299] Later in his life, his hyperrationality began to be seen not as a sign of incredible mental powers so much as an attempt to cover up his erratic behavior. Silverman writes that in 1845, "Poe struck some observers at the time at overcontrolled, 'rather formal,' as Lowell thought him, or 'under restraint,' as he seemed to Briggs, 'as though guarding against a half-subdued passion.' … As if to deny any drift toward unreason, he presented himself as a champion of order, analysis, mind" (263-64). Readings of Poe as pathological were cemented after his death when Rufus Griswold,

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literature and medicine were so intertwined that in one case a gynecologist wrote the preface to a novel, and in another a gynaecologist appealed to a novelist, Alexandre Dumas fils, to write the preface for his medical thesis" (101). Charles Richet, an intern at the Saltpetriere, once wrote a medical article about hysteria that included citations not only from other physicians, but also from contemporary novels whose characters provided models for the hysteric "type," including a full-page quotation from Madame Bovary (102). As the public read literary accounts of hysteria, they learned the symptoms of the disorder, increasing the likelihood that those with psychological stress would land in wards filled with hysterics.

[298] Silverman, *Edgar A. Poe*, 106–7.

[299] Silverman, 184.

using a false name, wrote Poe's obituary, in which the urge to monitor and draw conclusions about the inner state from the outer is clear: "Thin, and pale even to ghastliness, his whole appearance indicated sickness and the utmost destitution" and "he walked the streets, in madness or melancholy, with lips moving in indistinct curses, or with eyes upturned in passionate prayers… or, with his glances introverted to a heart gnawed with anguish, and with a face shrouded in gloom, he would brave the wildest storms."[300]

The pathologizing gaze didn't end with Poe's death, and in the absence of a physical body to regard, future commenters on Poe turned to his textual body. An extreme approach can be seen in the 1920 article "Edgar Allan Poe, Pathologically," in which Merton Yewdale tries to break down Poe's habits by lining them up with his ancestry—his love of drink from the Irish, his analysis from the French, and so on—admitting in shock that "even this does not explain why the man was as he was."[301] Yewdale's eventual diagnosis is that Poe was born without "human feeling," and attempted to gain it through drink and drugs. In his biography, Silverman writes, ""The Philosophy of Composition' seems but a larger and more fortified hedge against his increasing irrationality," and he compares Poe's authorial voice to that of the "crazed narrators in some of Poe's tales, whose tone of eerie calm is intended to demonstrate their lucidity and self-control, but arouses only the reader's fear and pity."[302] In his entry on Sarah Margaret Fuller's in "Literati," Poe wrote, "The soul is a cypher, in the sense of a cryptograph; and the shorter a cryptograph is, the more difficulty there is in comprehension."[303] The difficulty of decoding a short or complex cryptograph seems to draw people into the attempt to solve it—an urge lying behind Poe's gestures toward the problems of

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[300] Benjamin Fisher, ed., *Poe in His Own Time* (Iowa City: University of Iowa Press, 2010), 74, 77, 77.
[301] Merton S. Yewdale, "Edgar Allan Poe, Pathologically," *The North American Review* 212, no. 780 (November 1, 1920): 688.
[302] Silverman, *Edgar A. Poe*, 296, 297.
[303] Rosenheim, "The King," 375.

insanity, and behind generations of readers looking to find a sign of Poe's mental pathology through his writing.

Returning to a depiction of the rebellion of Nat Turner twenty-five years after the original event clarifies how convincingly beliefs in the ability to read the mind of the other had been narrated in the intervening years. In 1856, Harriet Beecher Stowe's *Dred* reimagined the Nat Turner rebellion, with Dred, the fictional child of Denmark Vesey, standing in as a Turner-style fanatic and would-be insurrectionist. Many of the questions circulating in the wake of the Turner rebellion are central to the novel. The novel ostensibly questions the branding of insurrectionists as mad, and questions "The hot and positive light of our modern materialism," decrying that "There are but two words in the whole department of modern anthropology—the sane and the insane; the latter dismissed from human reckoning almost with contempt. We should find it difficult to give a suitable name to the strange and abnormal condition in which this singular being, of whom we are speaking, passed the most of his time."[304] Although theoretically making space from the "strange and abnormal condition" between sanity and insanity, Stowe's description of Dred cements him as a pathological figure.[305]

With a biography remarkably similar to Turner's, including his apparent ability to read without being taught (273), Dred is physically transformed into a perfect phrenological specimen of the personality. We are introduced to "a tall black man, of magnificent stature and proportions" with skin "intensely black." His head

> was large and massive and developed with equal force both in the reflective and perceptive department. The perceptive organs jutted like dark ridges over the eyes,

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[304] Harriet Beecher Stowe, *Dred: A Tale of the Great Dismal Swamp* (Edinburgh: Edinburgh University Press, 1999), 353.

[305] Murison demonstrates Stowe's belief that African Americans are more susceptible to religious nervousness. She also argues that the novel suggests that the nervousness of religious revivalism is not always pathological (*Politics of Anxiety,* 109).

> while that part of the head which phrenologists attribute to the moral and intellectual sentiments, rose like an ample dome above them. The large eyes had that peculiar and solemn effect of unfathomable blackness and darkness which is often a striking characteristic of the African eye. But there burned in them, like tongues of flame in a black pool of naphtha, a subtle and restless fire, that betokened habitual excitement to the verge of insanity. If any organs were predominant in the head, they were those of ideality, wonder, veneration, and firmness; and the whole combination was such as might have formed one of the wild old warrior prophets of heroic ages. (261)

Offering an exaggerated portrait enacting the fantasy of those who made a specimen of Turner's skull, Stowe's novel clarifies the dehumanization of abolitionist rhetoric about black insurrection.

This dehumanization is explicitly gothic: the novel's hero, Clayton, "became interested in Dred, as a psychological study. … He compared him, in his own mind, to one of those old rude Gothic doorways, so frequent in European cathedrals, where scriptural images, carved in rough granite, mingle themselves with a thousand wayward, fantastic freaks of architecture; and sometimes he thought, with a sigh, how much might have been accomplished by a soul so ardent and a frame so energetic, had they been enlightened and guided" (632). Fictionalizing Nat Turner's insurrection, Stowe provides Dred with an exterior perfectly aligned with his interior, without even requiring the forensic activity encouraged by Poe.

In the years since Gray's pamphlet, the sciences of character had supposedly developed. In a major move toward the use of moral insanity in law in 1846, a lawyer used moral insanity defense buttressed with "expert medical testimony obtained at his own expense" with some success on behalf of a client, who '"had so often been whipped brutally across the spinal cord that he had become insane and irresponsible' Seward's defense was persuasive enough to produce a hung jury,

with a retrial scheduled for June."[306] Although this case was on behalf of a white client, the racial science of responsibility was also changing as the ethnologist Samuel George Morton published the 1844 Crania Aegyptiaca which offered physical measurements to prove that "race was fixed and racial inferiority a matter of fact."[307] The popularity of increasingly determinist and physicalist representations of the mind in the mid-nineteenth century, I suggest, rose out of the preoccupations I have sketched out above with narratives of unclassifiable minds that presented problems for social order. In the decades to follow, such representations would be challenged by physicians like Oliver Wendell Holmes, who would question whether these materialist notions could be accurately diagnosed and successfully deployed in community life.

[306] DeLombard, *In the Shadow of the Gallows*, 216.
[307] DeLombard, 216.

Chapter Three

Romantic Physiology and the "Physiological Romance": Narrating Diagnoses in Oliver Wendell Holmes's *Elsie Venner*

"I do not wonder that you find no answer from your country friends to the curious questions you put. They belong to that middle region between science and poetry which sensible men, as they are called, are very shy of meddling with"

-Oliver Wendell Holmes, "The Professor's Story"[308]

At the center of Oliver Wendell Holmes, Sr.'s 1861 novel *Elsie Venner* is a mysteriously disordered girl. Holmes was an American physician and author active throughout the second half of the nineteenth century. His contemporary William Osler once called him "the most successful combination which the world has ever seen, of the physician and the man of letters"[309] Within medical history, his primary legacies are a campaign for the contagion theory of puerperal, or childbed, fever, and against the field of homeopathic medicine. Holmes never had a robust medical practice—he was a writer and a teacher of anatomy more than a clinician—but nonetheless contributed to the development of medical knowledge, just in the "academic" rather than "practical" realm.[310] Within literature, his popularity was sealed by his early work in *The Atlantic*, for which he proposed the name and to which he was an early and consistent contributor.[311] *Elsie Venner,* first

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[308] Oliver Wendell Holmes, "The Professor's Story," *The Atlantic*, August 1860, 222.
[309] Quoted in Charles S. Bryan, ""The Greatest Brahmin': Overview of a Life," in *Oliver Wendell Holmes: Physician and Man of Letters*, ed. Scott H. Podolsky and Charles S. Bryan (Sagamore Beach, Mass.: Science History Publications for Boston Medical Library, 2009), 3.
[310] John T. Morse Jr., *Life and Letters of Oliver Wendell Holmes*, vol. 1 (New York: Chelsea House, 1980), 161.
[311] Morse, 1:204–5. His most popular literary works were the "Breakfast-Table" series (all originally published in the magazine), written as conversations between an array of boarding house guests on topics like art, morality, and mortality.

serialized in *The Atlantic* in 1860 as *The Professor's Story*, was published in book form in 1861.[312] Followed by *The Guardian Angel* in 1867 and *A Mortal Antipathy* in 1885, *Elsie* was the first of what would eventually be called his "medicated novels," each of which follows narrative of a mysteriously psychologically troubled figure.[313] Though the novel is not a particularly well-established member of the literary canon writ large, the symbiosis between medical and literary thought in *Elsie Venner* have made it a major text for work on literature and medicine in the nineteenth century.

Following the story of the strange title character, this novel dramatizes the literary logic of diagnosis and the diagnostic logic of literature, inviting readers into a book-length investigation of the mechanism, power, and ethics of diagnosis and classification. Elsie's schoolmistress exclaims, "I don't know what she is….if there were women now…possessed of devils, I should think there was something not human looking out of Elsie Venner's eyes!"[314] (127). Jane Thrailkill suggests that a central question of the novel is, "What's the matter with Elsie Venner?" and that the narrative "presents Elsie Venner as an epistemological riddle."[315] Among other symptoms, we read of her wild, uncontrollable behavior, her capacity to mesmerize others, and her love of strangely patterned clothes. The novel elicits diagnostic appraisals of her malady, dropping descriptive clues throughout, and narrating the intense curiosity of all the characters surrounding her. Bryce Traister writes that

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[312] The novel was serialized from January 1860-April 1861. It shared issues with a series of reviews on Darwin's *Origin of Species*, a serialization of Rebecca Harding Davis's *Life in the Iron-Mills*, and a review of Hawthorne's *Marble Faun* (which Holmes rejects as an influence for *Elsie* in an 1883 preface). As Altschuler also notes, the "Professor" of the original title would have been familiar to readers, as the "The Professor at the Breakfast-Table" was serialized throughout 1859, concluding the month prior to the appearance of "The Professor's Story" (*The Medical Imagination,* 176).

[313] The book is one of Holmes' three "medicated novels," which all focus on "anomalous life stories…that pose severe problems of diagnosis for the central doctor/psychologist figures in each plot," and conclude with a revelation of the illness's source—a snakebite, a head wound, a birth in a foreign country—arrived at through a doctor-patient conversation or confessional (Gibian, "Doctor Holmes: The Life in Conversation," in Podolsky and Bryan, *Oliver Wendell Holmes*, 78). For an extended discussion of Holmes' relationship to the "medicated novel" label, see Altschuler 181-3.

[314] Oliver Wendell Holmes, *Elsie Venner: A Romance of Destiny*, Standard Library Edition, vol. 5, The Works of Oliver Wendell Holmes (Boston: Houghton Mifflin Company, 1892), 127. Hereafter, all page numbers refer to this edition unless otherwise noted.

[315] Thrailkill, *Affecting Fiction*, 86, 59.

through "diagnostic curiosity…the narrative teases the reader…into wanting more information about its eponymous heroine. The text solicits a readerly interest in a literary figure remarkable because biologically enigmatic in much the same way that a sick person presents a puzzle for an attending physician to piece together."[316] This interest pays off, as the end of the novel reveals a rather strange etiology for her malady: her mother was bitten by a rattlesnake in the final weeks of her pregnancy, and as a result there is something constitutionally snaky about Elsie. For many critics the narrative solidifies the triumphant authority of the male, professional gaze that appropriately diagnoses the aberrant woman, whose own gaze is pathological.[317]

The novel, though, is not a straightforward medical mystery. Indeed, the nature of Elsie's complaint is likely clear to readers some two hundred pages (or more) prior to its formal revelation by a physician. The reader's interest, then, is not just directed toward puzzling through her symptoms, but instead, the drama of the novel arises as we watch other characters watching Elsie—attempting to "solve the mystery of Elsie Venner" (204). What these scenes of professional and amateur diagnosis reveal is that everyone, from small town gossips to Harvard-trained medical professionals, dons distorting lenses when they view and assess others. These distortions play out in often unexpected ways, belying any certainty that Holmes is privileging the medical perspective. Our hero, medical student Bernard Langdon, is among the least capable of seeing Elsie for what she is, being bested by a clothing-obsessed young girl and Elsie's black governess.

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316 Bryce Traister, "Sentimental Medicine: Oliver Wendell Holmes and the Construction of Masculinity," *Studies in American Fiction* 27, no. 2 (1999): 205. The most obvious example is Oberndorf's 1946 *The Psychiatric Novels of Oliver Wendell Holmes*, which diagnoses each of the medicated novels, with chapters called: "Elsie Venner: A Story of Schizophrenia"; "The Guardian Angel: Hysteria in an Adolescent Girl" and "A Mortal Antipathy: A Young Man's Morbid Fear of Women [Gynophobia]." (Clarence Paul Oberndorf, *The Psychiatric Novels of Oliver Wendell Holmes* [Westport, Conn.: Greenwood Press, 1971]).

317 For a variety of takes on this argument, see Traister, "Sentimental Medicine"; Cynthia Davis, "The Doctor Is In: Medical Insight, Oliver Wendell , and Elsie Venner," *Nineteenth-Century Contexts* 24, no. 2 (2002): 177–93; Jane Thrailkill, *Affecting Fictions*; and Cheryl Spinner, "The Spell and the Scalpel: Scientific Sight in Early 3D Photography," *J19: The Journal of Nineteenth-Century Americanists* 3, no. 2 (2015): 436–45.

The novel thus functions as a book-length investigation of the logic and circulation of diagnosis, highlighting the ways in which a would-be diagnostician's profession, background, gender, race, and class shape the interpretation of others. Holmes knew that diagnosis was a local, contingent fiction, as often distorting as clarifying, and the form of the novel, by withholding and revealing diagnostic information in unexpected ways, drives home the uncertainty of the "science" of medical observation—a surprising contrast to the rhetorics of medical advancement and expertise visible in some of Holmes' work and defining the field of medicine in its struggle for professionalization in the antebellum years. By dramatizing the quest to diagnose and categorize, complete with its many failures, and by implicating the reader in that diagnosis, Holmes' novel moves toward the ethics of diagnostic logic: How does personal perspective color our capacity to view others? What good is a diagnosis in the first place? And ultimately, how ought we manage our relationships with others based on our assessment of their pathology or normality?

The frame of the Romance allows Holmes to use a fictional illness—the pollution of prenatal rattlesnake venom—to illustrate the contingencies of diagnosis. This genre allows Holmes to root Elsie's behavior in a single, discrete, and identifiable cause (an antenatal snakebite) in order to access philosophical questions about heredity and the will. As argued by Sari Altschuler, then, literature works as a kind of ethical laboratory for Holmes.[318] In his medical practice and pedagogy, Holmes grapples with the difficulty of diagnosis and the subjectivity inherent in the professional gaze—the very difficulties he dramatizes in *Elsie*. Crafting a narrative around a fictional illness though, is a tool for extending beyond these limits to construct a medical fantasy that is stable enough to get to the moral questions that are too difficult to erect on the movable sand of madness in the real world. By novelizing diagnosis, the reader and the implied author can wink at the biases of our narrator and other characters to share a moment of otherwise impossible clarity that both

[318] Altschuler, *The Medical Imagination*, 182.

facilitates criticism of the seemingly universal diagnostic failures and to ask ethical questions about our responsibility toward the ill.

While their objectivity may be compromised, the novels' physicians still play the most significant moral role in articulating answers to these questions, with the country doctor Dr. Kittredge delivering disquisitions on medical ethics that push back against locals' fears and superstitions. While physicians' observational power may be limited within the novel, Holmes still envisioned medicine as having an important role to play: that role is not entirely diagnostic or clinical, but rather narrative, social, and ethical. Through these physician sermons, the novel's ethical vision suggests that in a world of uncertain knowledge of the other, the path toward generosity and destigmatization is an understanding of all persons as products of their heredity and environment—as constitutionally and pathologically bound to their moral capacities. Through this novel, Holmes, a lifelong critic of dogmatic religious teachings of the fall of man,[319] explores a medical re-narration of theological doctrines of original sin (immoral woman-snake relations and all). Rather than rejecting the notion of inherited sin, though, he claims that it is a physiological heredity rather than a spiritual one. He clearly sees the power of an imaginative work to influence ideology: in his belief that teachings of the fall warp the minds of young New Englanders, he is particularly offended by Pilgrim's Progress, since it is a "wonderful work of genius, which captivates all persons of active imagination" but has "unreasonable" and "repulsive" ends.[320] Perhaps *Elsie,* with its supposedly more humane gospel, could serve a function in better supporting the moral growth of American youth. As Holmes later wrote, "the imagination is a very powerful physiological agent."[321]

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[319] Morse, *Life and Letters of Oliver Wendell Holmes*, 1:39.
[320] Morse, 1:42–43.
[321] Quoted in Scott H. Podolsky and Charles S. Bryan, eds., *Oliver Wendell Holmes: Physician and Man of Letters* (Sagamore Beach, Mass.: Science History Publications for Boston Medical Library, 2009), 161.

The seriousness of Holmes' enquiry, though delivered through a fantastical premise in a largely comical tone, is clear in a series of prefaces for the novel spanning thirty years, in which Holmes discusses how this "physiological romance" served a "very serious purpose," which was to test out a hypothesis for moral liability.[322] In the 1861 preface to the work, Holmes writes, "The real aim of the story was to test the doctrine of 'original sin' and human responsibility for disordered volition coming under that technical denomination. Was Elsie Venner, poisoned by the venom of a crotalus before she was born, morally responsible for the 'volitional' aberrations, which translated into acts become what is known as sin, and, it may be, what is punished as crime?"[323] The move from theology to medicine thus shifts the location of moral responsibility. Holmes suggests that Elsie is not responsible for her actions, since she had no control over her disease. Holmes' effort to inspire charitable feelings toward Elsie—recasting an immoral girl as victim rather than perpetrator—works by analogy for those with less definable "maladies." It is obvious we should pity Elsie. Should we not, then, also pity other characters in the novel predisposed to immorality, including Elsie's dangerously criminal cousin Dick, afflicted by wild Spanish blood? Or the greedy master of a local school, deprived of moral generosity by generations of New Englander ancestors buffeted by "east winds" and sustained on "salt fish"?[324]

In what follows, I begin by laying out key pieces of Holmes' medical philosophy, demonstrating his suspicion of the notion of medical objectivity and his corresponding belief that physicians could provide narrative, if not therapeutic, relief through administering diagnoses and prognoses, and by reframing human failures charitably, because medically rather than theologically or morally. I turn next to Holmes' deployment of diagnostic narratives within *Elsie Venner*. I argue that by employing the romance's capacity to fix a fantastical truth in order to ask ethical questions,

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[322] For a more extended reading of Holmes' prefaces, see Altschuler, *Medical Imagination,* 175-7.
[323] Holmes, *Elsie Venner: A Romance of Destiny*, ix–x.
[324] Holmes, "The Professor's Story," May 1860, 606.

Holmes gives the reader almost immediate access to the "correct" diagnosis so that the bulk of the text is spent negotiating the dramatic irony of everyone else's failure to properly diagnose her—including, or especially, her physicians. By demonstrating the failures of diagnosis in the supposedly objective physicians, the novel emphasizes what the physicians do ultimately offer, which is an ethical reorientation toward the ambiguously unwell that calls for social support rather than individual stigma. The lack of objectivity does not forestall the ethical imperative of medicalization, for Holmes, the appropriate medical response is not entirely clinical—it is environmental, educational, and moral. I will conclude by exploring both the possibilities enabled by a view of illness that demands social redress and the corresponding dangers, including the enabling factors for institutionalization and eugenics.

Holmesian Medical Thought

Much previous work on *Elsie Venner* refers to Homes' position in a medical profession fighting for authority in a nation lacking clear and universal requirements for medical education and licensure—requirements that would be solidified in wartime bureaucracy to the professional benefit of "regular" (university-trained allopathic) physicians.[325] The final number of "The Professor's Story" was published in the same month as the Battle of Fort Sumter, and so reflects the pre-bellum state of the field, in which "regular" and "irregular" (homoeopathic and folk) doctors warred for authority.[326] The American Medical Association (AMA) was founded in 1847 as part of this ultimately successful campaign for legitimacy, and the organization's first ethical code illustrates the

[325] Justine S. Murison, "Quacks, Nostrums, and Miraculous Cures: Narratives of Medical Modernity in the Nineteenth-Century United States," *Literature and Medicine* 32, no. 2 (2014): 419.

[326] On the many factors involved in the rise of the medical profession, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

tension between factions: it foregrounds the duty of physicians to campaign against homeopathic medicine and to present a united front based on rational principles, with any disagreements to be handled *within* the profession, not advertised to patients and professional foes.[327] Paul Starr notes that in the mid-nineteenth century the medical profession, whose insecure status clearly ranked them below the clergy and the law, required two factors in an attempt to grasp professional status: internally, consensus, and externally, legitimacy.[328] Oliver Wendell Holmes fit uncomfortably within this schema. In one sense, he was among the most outspoken advocates for the profession, lecturing on "Homœopathy and its Kindred Delusions" in 1842, and reprinting the essay in 1861 in *Currents and Counter-Currents* alongside "Some More Recent Views on Homœopathy," originally written for *The Atlantic* in 1857. Notably, however, although Holmes was a well-respected member of the medical field, he rejects many of the tenets of the "regular" profession in this essay collection. The title essay, "Currents and Counter-Currents," was first given as an address to the Massachusetts Medical Society at their annual meeting on May 30, 1860 (contemporaneous, then, with the fifth number of "The Professor's Story") and suggests his distance from his peers. In the preface to the published volume a year later, he indicates that the talk—the general thrust of which was that the practice of medicine is largely faddish—inspired outcry in the medical community, which he takes as proof that it had touched a "weak spot in a profession."[329] While he had rallied against homeopathy (by his own admission, not particularly effectively, as the practice continued to grow in popularity [vii]), in this address he accuses allopathic medicine of partaking in the same superstitions.

The metaphor structuring his essay, which suggests a river of medical progress backed up by various superstitious and cultural eddies, illuminates much of his medical philosophy. On the one

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[327] American Medical Association, *Code of Medical Ethics* (Chicago: American Medical Association Press, 1847).
[328] Starr, *The Social Transformation*, 81, 80.
[329] Holmes, *Currents and Counter-Currents*, vi.

hand, Holmes, who did a portion of his medical training in France, was a central figure in the adoption of clinical methods in the United States. Among the teachings of the new, clinical medicine were, as Gibian writes, "close empirical observation of individual patients, broad statistical study of patient communities, anatomical investigation, and laboratory research."[330] Pointing to Holmes' advocacy of new medical approaches, Cynthia Davis reads the novel as an exemplar of clinical medicine's paternalistic medical gaze, aided by new technologies of medical vision, like the microscope (of which Holmes was an early adopter). She suggests that by emphasizing the power of the physician's capacity to expertly view the world, Holmes attempted to raise science "above the miasmas of uncertainty and ineptitude threatening to bog down the emergent discipline," and points to Holmes' own language about the desire "to render visible everything which the eye could take cognizance of, and so turn abstractions and catalogs of names into substantial and objective realities."[331] Jane Thrailkill's chapter on the novel in *Affecting Fictions*, though, makes clear Holmes' suspicion of clinical objectivity, placing the novel in the context of Holmes' work on childbed fever, which saw him embroiled in controversy with an earlier generation of "regular" physicians who rejected statistical findings about the cause of maternal death. In contrast to "traditional therapeutics" driven by individual relationships between doctor and patient, Thrailkill argues, Holmes was "reconfiguring what counted as evidence" (69) by suggesting that "the numerical system could short-circuit the distorting effects of one's expectations and track a phenomenon in the face of uncertainty about its ontology."[332]

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[330] Gibian, *Oliver Wendell Holmes and the Culture of Conversation,* 3. For more on Holmes' relationship with changing medical epistemology, see chapter 6 of Gibian and Charles E. Rosenberg, "Medical Therapeutics and Its Kindred Delusions: Oliver Wendell Holmes on Drugs, Disease, and Rational Care," in Podolsky and Bryan, *Oliver Wendell Holmes: Physician and Man of Letters*, 59–70.
[331] Davis, "The Doctor Is In," 177, 178.
[332] Thrailkill*,* 66.

Despite his advocacy for new clinical methods, then, Holmes was well aware that the "regular" profession always contained the shadow of homeopathy's disqualifying problems. In "Currents and Counter-Currents," he writes, "The truth is, that medicine, professedly founded on observation, is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to the changes of atmospheric density" (7-8). Holmes' critique of medical theory in *Currents and Counter-Currents* centers on the misperception that "experience" can turn observation into objective truth. He writes, "A medical man, as he goes about his daily business after twenty years of practice, is apt to suppose that he treats his patients according to the teachings of his experience" (5). Though he grants that this is partially true, he asserts men with "experience" erroneously believe it is founded on "permanent facts of nature" (5)—but, given that physicians across the generations have been equally experienced but used different treatments, the practice of medicine has more to do with the "going out of fashion of special remedies, by the decadence of a popular theory from which their fitness was deduced, or other cause not more significant. There is no reason to suppose that the present time is essentially different in this respect from any other" (6). In this salvo, Holmes launches a major critique of the notion that medical progress marches steadily on toward objective clarity.

So, somewhat paradoxically, the new clinical medicine was not marked just by a turn to faith in objectivity and medical progress but by an understanding of the power of subjective experience. Holmes was one of the noisiest proponents of this skepticism and credited his time in Paris not just for teaching new methods but for teaching him "the uncertainty of medical observation."[333] Indeed, as Gibian argues, the major thrust was "negative" rather than "positive," intent largely on exploding the old even without offering replacements. Focusing on the errors of earlier systems of diagnosis and treatment, a new generation of physicians expressed "diagnostic optimism" alongside

[333] Morse, *Life and Letters of Oliver Wendell Holmes*, 1:93.

"pessimism about all current therapies."[334] Although this is a time when medicine in general and Holmes in particular were trying to professionalize, according to Gibian, "the thrust of his writings nonetheless tended to tear down that temple, undercutting the distinctions between 'regulars' and 'irregulars,' and highlighting the crisis of all medicine in this liminal moment before the birth of 'modern' practice."[335] Despite his investments in the advancement of scientific medicine through statistical thinking and technologies of viewing, Holmes was a prominent "therapeutic skeptic." He once infamously claimed of the modern pharmacopeia, "I firmly believe that if the whole materia medica, *as now used*, could be sunk to the bottom of the sea, it would be all the better for mankind,--and all the worse for the fishes."[336] (Though he hedges, hoping to hold on to opium, anesthesia, and a few others.) Traister writes that Holmes waged "nearly life-long war against this interventionist model of medical therapeutics" and that his belief in "Nature" as the optimal cure "threatened the status of American doctors."[337] Holmes' medical philosophy rejected both the infinitesimal doses of the homeopaths and the excessive ones of the heroics.

Holmes' fight against both homeopathy and interventionist heroic medicine revealed a consistent trend: medical narratives are often fictional ones. In attempting to point to the "current" of his own medical environment—which he understands will eventually seem outdated—Holmes stresses the "observing and computing mind of the nineteenth century" (12). He suggests that doctors and patients alike are easily swayed by "self-delusion" (17) and notes several "common modes of misunderstanding or misapplying the evidence of nature," including in some a "natural incapacity for sound observation," in others "a singular inability to weigh the value of testimony," and in more still, a bias towards positive outcomes and a false understanding of cause and effect:

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[334] Gibian, *Oliver Wendell Holmes and the Culture of Conversation*, 167–68.
[335] Gibian, 173.
[336] Holmes, *Currents and Counter-Currents*, 39.
[337] Traister, "Sentimental Medicine," 211.

"false induction from genuine facts of observation" (17-18). As a result, physicians overestimate their efficacy, believing that their treatment cured an illness that would never have been fatal in the first place. In some sense, Holmes here offers a critique of the literary logic of diagnosis: as soon as doctors insert themselves into the story arc of the illness, they assign themselves a misplaced role as protagonist. Moreover, the taxonomic structures of diagnosis can both empower and delude: in an early lecture, "Position and Prospects of the Medical Student" (1844) Holmes writes that, "A just classification, like the lens in an optical instrument, converges and brings into a clear image the scattered and refracted rays of individual observation."[338] But "O," he cautions, "beware how you commit yourself in a too confident prognosis!...Remember that the errors of stethoscopists spring much oftener from the faults of their brains than of their ears" (299). The trouble, he suggests, is the move from "observation" to "inference." A prognosis, then, is at best an observationally based narrative, and at worst a total fiction. Superstitions abound in medicine, and doctors and patients alike are too likely to have faith in the curative power of pills—he talks about what we would now call the placebo effect, in which people's beliefs about whether a cure will work decide whether or not it will work. In a lecture to Harvard graduates in 1858, he advocates in some circumstances to "medicate" the truth "with the deadly poison of honest fraud."[339] The oxymoron of "honest fraud" highlights the conundrums facing allopathy's attempts to distance itself from homeopathy. Narratives—of cure, of prognosis—have the power to shape the trajectory of both individual illness and best practices for treatment.

Holmes' ambivalent view of medical vision is especially marked in the case of what he calls "visceral diseases," which are not readily apparent to the eye: "Surgical diseases, speaking broadly, reveal themselves, as it were, in articulate confessions. The language of visceral disease is a kind of

[338] Holmes, *Currents and Counter-Currents*, 295.
[339] Holmes, 392.

ventriloquy….Our method with the first, if we talked metaphysics, would be objective-subjective, and with the second, subjective-objective."[340] In contrast to surgical diseases, which speak largely for themselves, requiring only physician interpretation, "visceral disease" requires that the physician begin in the hazy world of the "subjective"—the physician must elicit patient testimony, do a physical exam, and then attempt to render that into "objective" information. Although he notes that a physical exam can "*almost* turn *some* medical diseases into surgical ones" (emphases mine), his confidence even a generation after *Elsie* is not strong on this front. The ventriloquy metaphor suggests the artificiality of the process. Ultimately, he notes that, "[T]he physician has frequent difficulties to meet which require the keenest exercise of the most carefully trained faculties and with all his knowledge will too often find the riddles of nature beyond his power to unravel."[341]A large swath of disease, then, falls through the cracks of "objective" medicine, and for these diseases, narrative becomes the primary tool for ventriloquizing the illness, and it is this process that is dramatized in *Elsie Venner*.

For Holmes, this power of imagination over physiology provides one powerful social role for medicine, whatever its observational and therapeutic failures. The physician's intervention is a narrative one: he can help patients' navigate illness narratives humanely. At the individual level, communicating diagnosis and prognosis is a form of emotional—and even medical—care, while at the social level, the physician can replace theological doctrines of sin with medical doctrines of heredity and environment. Holmes suggests that even without medicines and other technologies, physicians could still offer their most useful service: "to give those predictions of the course of disease which only experience can warrant, and which in so many cases relieve the exaggerated fears

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[340] Oliver Wendell Holmes, "Introductory--Sept. 26th, 1879," in Podolsky and Bryan, *Oliver Wendell Holmes: Physician and Man of Letters*, 246.
[341] Holmes, 246.

of sufferers and their friends, or warn them in season of impending danger."[342] In this formulation, diagnosis and prognosis are the central aspects of clinical medicine: a physician can look at an illness and largely conclude what narrative it will follow over time, and the mere communication of this information can shape a patient's experience.[343] This appears to have been a commonly held view: the AMA's 1847 code demonstrates the complications arising from the need for verbal communications throughout the diagnostic process. Physicians are to avoid giving patients "gloomy prognostications" which can hasten death: "not only by the acts, but also by the words or the manner of a physician" (94). However tenuous the basis for physician knowledge may be, diagnostic narratives that place suffering into a comprehensible framework both physiologically and emotionally play an important role in securing comfort.

Physicians also played a role in reframing social narratives: as discussed in the introduction, Holmes believes that medical explanations can provide a kind of generous explanatory power in the face of theologically damning ones. In *Elsie Venner,* our narrator praises phrenology, despite acknowledging that it is a pseudoscience, because despite its shortfalls it has "proved that there are fixed relations between organization and mind and character. It has brought out that great doctrine of moral insanity, which has done more to make men charitable and soften legal and theological barbarism than any one doctrine that I can think of since the message of peace and good-will to men" (227). The biological determinism of phrenology, however fictional, opened up the possibility for more generous readings of the aberrant behavior of others: this person is sick, not a sinner. As one physician in *Elsie Venner*, frustrated with the lack of sympathy for those with moral or psychological trouble, asks, "How long will it be before we shall learn that for every wound which

[342] Holmes, *Currents and Counter-Currents*, 16.
[343] See chapter 3 of Jane Thrailkill's *Affecting Fiction*, which discusses Holmes' later medicated novel, *A Mortal Antipathy,* elaborating the relationship between narrative and verbal and physical testimony at great length.

betrays itself to the sight by a scar, there are a thousand unseen mutilations that cripple, each of them, some one or more of our highest faculties?" (246).

Narratives of hereditary and environmental determinism were one way to illuminate the "unseen mutilations" to the moral senses. Charles Rosenberg notes a tradition in the nineteenth century of defense lawyers utilitizing hereditary and physiognomic explanations to say criminals aren't culpable.[344] Rejecting that such explanations were inherently bound to scientific changes, though, he writes that determinism has more to do with the spirit of the defense: it's not that the deterministic science was right, it's that it allowed forgiveness: "It seems more important that they quote German sources as transcendent authorities—even if these authorities are wrong—than that they quote the Bible or the rules of criminal jurisprudence. The heart of the matter lies in one's attitude toward the criminal offender" (xv). So, while scientific views change, they serve a stable "social function" (xv). This function extends beyond jurisprudence as in Rosenberg's project, but to labor and public health reform. Where individual physician's potency is imperfect, reforms that targeted environment and education could prevent illness from happening in the first place, while medical determinism could theoretically reduce stigma.

Elsie lives a seemingly determined life, incapable of following gendered norms of moral behavior, to the point, it is suggested, of attempted murder. Fictionalizing a cause for this behavior allows Holmes to investigate the social possibilities and theoretical limits of medical determinism. The ante-natal bite lets Holmes skirt the nature-nurture debate that was as active then as now[345]: the mythical etiology stands in both for heredity, since passed along through the blood of her mother, and environment, given the attention the narrator pays to the exact location and ecology of the

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344 Charles E. Rosenberg, *The Trial of the Assassin Guiteau: Psychiatry and Law in the Gilded Age* (Chicago: University of Chicago Press, 1968), xiv.

345 Diane Paul and James Moore, "The Darwinian Context: Evolution and Inheritance," in *The Oxford Handbook of the History of Eugenics*, ed. Alison Bashford and Philippa Levine (Oxford University Press, 2015), 29.

rattlesnakes' distinctive lair. Furthermore, creating a clear identifiable cause for Elsie's malady allows him to avoid the murky terrain of the cause of madness or legitimacy of moral disorder (understood by some as a fictional complaint employed as a courtroom dodge). By fully enacting an organic etiology in the venom of a snake, the novel explores the logic of materialist determinism. The serialization of "The Professor's Story" was well-positioned to imagine the consequences of environment and heredity in determining character. Appearing in the pages of the same issues were the industrial critique of Rebecca Harding Davis's *Life in the Iron Mills*, anxious reviews pointing to the implications of Darwin's *Origin of Species,* and an article on the mystery of Kaspar Hauser, advertised by Barnum as half-man, half-monkey.[346] In this venue, the novel acts out the powerful urge to diagnose in the face of mystery, dramatizes its failures and oversights, and in so doing highlights powerful possibilities for ethical positions that move beyond the clinical encounter to allow structural or public health frameworks of understanding and intervention.

Literary Diagnosis

The period when Holmes was composing *Elsie* saw him actively publishing in both literature and medicine. His first novel, *Autocrat at the Breakfast-Table,* had been published in 1858, and in 1861 he collected several of his previously written medical essays as *Currents and Counter-Currents in Medical Science with Other Addresses and Essays.* As both Justine Murison and Sari Altschuler have previously argued, for Holmes, medical and literary pursuits were inseparable. Murison writes that for Holmes, "fiction tested, imagined, and extended…medical developments."[347] Altschuler has proposed at least five ways in which fiction gave Holmes the power to move beyond traditional medical study, including that poetic license gave full imaginative play and fiction allowed for the "perfect test case,"

[346] On Hauser, see Ralph James Savarese, "Neurocosmopolitan Melville," *Leviathan* 15, no. 2 (2013): 7–19.
[347] Murison, *Politics of Anxiety,* 5.

could overcome the shortfalls of objective study, permitted the complexity rather than the binary options of medical truth claims, and points to questions not just of physiology but of ethics.[348] Literature was thus an imaginative laboratory in which he could work through the moral implications of medical knowledge. The results of this literary experimentation worked their way into his medical writing, and many of the ethical questions about biological determinism that he develops in *Elsie Venner* remained at the center of his medical writings for years to come, as later in his career he began to work on what he called "physiological psychology," including treatises like "Mechanism in Thought and Morals" (1870) and "Crime and Automatism" (1875). Indeed, in a recently published "quotable Oliver Wendell Holmes," practically the entire section on "Holmesian Psychiatry" consists of quotes not from his psychological essays but from this early novel.[349]

Holmes, then, uses literature as a way to get beyond the failings of objective medical science and to pose ethical questions as argued by Altschuler, and *Elsie Venner* is a prime example. In Elsie, he evokes diagnostic logic but also critiques the hunger for it, documenting its success and failures in an entire community of people who are shaped by their profession, their geography, their heredity (each of whom is in turn "diagnosed" in the text). Even given the power of the romance to secure a fictional etiology for her disorder, people are bad at finding it, emphasizing the subjectivity of the pursuit. Notably, doctors are as bad or worse than everyone else at this task, with one exception: the ethical outlook that accompanies their view of immorality as a problem of heredity and environment rather than personal failing. For Holmes, then, the medical model (in contrast with the theological or moral model) *is* the social, humane model, which allows for something like social justice and public health, though haunted with the negative implications of materialism and fatalism.

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[348] Altschuler, *The Medical Imagination*, 182.
[349] Podolsky and Bryan, *Oliver Wendell Holmes: Physician and Man of Letters*, 122–23.

In the 1861 preface to the novel, Holmes suggests that there is something like *literary* truth that operates differently from *scientific* truth: "Through all the disguise of fiction a grave scientific doctrine may be detected lying beneath some of the delineations of character….It was adopted as a convenient medium of truth rather than as an accepted scientific conclusion. The reader must judge for himself what is the value of various stories cited from old authors. He must decide how much of what has been told he can accept either as having actually happened, or as possible and more or less probable."[350] Holmes here recognizes that adopting the benefits of fiction, which allows him to write a nonexistent diagnosis into being, can provide a space to ignore the uncertainties dogging medical thought in order to consider the ideological stakes of diagnosis. In this fictional space, Holmes can render the cause of human behavior unambiguous. As articulated by Gregg Crane, for its practitioners, the Romance enabled in its "more overtly imaginative and inventive features, in its mingling of the marvelous and the plausible, a superior route to certain important truths—a route that is not available to the mere fact-gatherer and reporter."[351] Crane writes, "Believing in the existence of truths or realities that exceed or elude empirical approaches, the romancer sets aside the requirements of plausibility in the interest of making a stronger claim on a deeper, more imaginative form of veracity" (28). For Holmes, then, the romance is perfect for investigating medicine's empirical failures. Elsie's bite, by exceeding plausible medical explanation, becomes a tool for accessing another kind of truth about our ethical orientation to the will.

Elsie Venner explores the problems posed by this observational uncertainty and the resulting imposition of faulty illness narratives. The novel is narrated by a medical professor writing a second-hand account of the experience of one of his star students. Bernard Langdon is compelled to take a

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[350] Holmes, *Elsie Venner,* vii.
[351] Gregg Crane, *The Cambridge Introduction to the Nineteenth-Century American Novel* (Cambridge: Cambridge UP, 2007), 28.

leave of absence from medical school for financial reasons, and our narrator follows his journey into teaching in rural New England. Upon taking a position at a girls' school in the small town of Rockland, Langdon becomes "fascinated" by Elsie Venner, a strange girl whose wild behavior and unsettling gaze provoke intense anxiety in her community (even to the point of hysterical fit, in the case of her schoolmistress). The remainder of the novel follows Bernard's attempt to figure out what is wrong with Elsie—a quest complicated by her (unreciprocated) romantic interest in him and the murderous plot of her cousin, Dick, who hopes to marry her for her inheritance and is thus deathly jealous of Bernard. In the end, upon being rejected by Bernard, Elsie becomes mortally ill and eventually dies, while Bernard marries a wealthy girl and becomes a well-established doctor upon his return to the city in the final pages of the novel.

The importance of the novel genre, specifically, for Holmes' theorizing is made clear by his reaction to seeing it as a play put on by the Boston Theater in 1865. Holmes lamented that "It was bad, very bad." In an 1894 interview he complained, "It was a great shock to me, that performance,--a great shock. You may imagine Elsie, with her strange eyes and the snake look in them, but you cannot see her on the stage: the illusion will not hold there."[352] The written word thus allowed for a play of imagination that could render Elsie a sympathetic character, but as soon as an actual woman is seen, the sympathy Holmes relied upon evaporates. Above all, literary narrative allowed Holmes to imaginatively coerce his readers into sympathizing with the character of his conjuring. In a letter to Harriet Beecher Stowe written mid-serialization, he emphasizes that his goal was to "write a story with enough of interest in its characters and incidents to attract a certain amount of popular attention. Under cover of this to *stir* that mighty question of automatic agency in its relation to self-determination."[353] Holmes here articulates that he is using the popular appeal of literature to sneak in

[352] Morse, *Life and Letters of Oliver Wendell Holmes*, 1:258.
[353] Morse, 1:263–64.

a bioethical question in through the back door—the "interest" is meant to "*stir*" questions about the capacity for human will in in the face of determinist medical views.

The first installment of "The Professor's Story" puts the novel's fictionality front and center. It begins with a section of "preliminary correspondence," a series of satirical letters about the details and pay for a requested serialized novel for the *Oceanic Miscellany* magazine (this frame was removed in the publication of *Elsie Venner*). The professor haughtily refuses to condescend to a "*fictitious* narrative" (emphasis original), but "could, however, relate some very interesting events which have come to my knowledge, and which if told in a connected form, might undoubtedly be taken by the public for a work of fiction."[354] In another letter, he repeats that he will not tell "an 'imaginary' story, or …write a romance, or anything of the kind," and will instead share "some curious matters that have come to my knowledge, arranging them in a collective form, so that they would probably pass with most readers for fictitious, and perhaps excite very much the same kind of interest they would if genuine fictions" (89). The last letter is addressed to the reader, which opens, "Finding myself in possession of certain facts which possess interest sufficient to warrant their publication, I am led to ask myself whether I shall put them in the form of a narrative." He then debates whether he ought, and says, "If I had to *make up* a story, now, it would be a very different matter. I could ever conceive how some of those romances go to work, in cold blood, to draw, out of what they all their *imagination*, a parcel of impossible events and absurd characters" (89). He worries, too, that people will think it is fiction, which he regards as a series of lies. He begins, then, not a romance, but instead a "connected statement of facts" by giving "an essay on a social phenomenon not hitherto distinctly recognized" (91). We end the prefatory material prepared to be instructed rather than amused. But we've been informed of that in such an amusing way that we are amused by the notion of instruction itself.

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[354] Holmes, "The Professor's Story," January 1860, 88.

Holmes' play with the slipperiness of truth in literature echoes the sentiment of his friend Nathaniel Hawthorne in the famous preface to *The House of the Seven Gables,* which opens by asserting, "When a writer calls his work a Romance, it need hardly be observed that he wishes to claim a certain latitude, both as to its fashion and material, which he would not have felt himself entitled to assume, had be professed to be writing a Novel."[355] Gibian notes that Holmes and Hawthorne were in regular conversation and their interests were consistently interwoven—Hawthorne was particularly interested in Holmes' work on pseudoscience and homeopathy and Holmes echoed and responded in fictional form to Hawthorne's earlier medical stories like "Rappacini's Daughter" and "The Birth-Mark." *Elsie Venner* and *The Marble Faun* were regularly read as companion pieces.[356] The men were united in their fascination with the intersections of medicine, psychology, sin, and guilt, and the overwhelming power of language in the treatment of the ill. "Exploring such questions," Gibian writes, "both writers often turned to medical fictions to study with much ambivalence the role of the doctor as a moral physician" (295). The play of Romance and fact was central to their studies, and each man was "Exploring the possibility of translating grave moral-theological questions into the terms of medical-physiological science, working in a hybrid fictional mode that combines vestigial traces of Romance magic and myth with Naturalistic realism" (294). By drawing the fantastical into their narratives, Hawthorne and Holmes constructed moral cautionary tales. Moreover, fiction allowed Holmes to skirt the problem of the unknown within the medical profession. Making use of a fictional diagnosis, he can ask the audience to consider *what if* it were true. He can craft a narrative with a true snake-woman at its heart and be taken at his word by those reading along.

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[355] Nathaniel Hawthorne, *The House of the Seven Gables*, ed. Milton R. Stern (New York: Penguin, 1981), 1.
[356] Gibian, *Oliver Wendell Holmes*, 292-4.

Through this frame, the novel routinely invokes the ethical potential of medicalizing immorality, narrating the diagnostic logic that pervades the novel. The ability to name Elsie's illness is a central concern of the novel, as when her school mistress opines that is "just one of those cases that are ten thousand thousand times worse than insanity….the worst of all diseases of the moral sense and the will are those which all the Bedlams turn away from their doors as not being cases of insanity!"[357] Diagnoses imply possibilities for treatment or management—they insert deviance into comprehensible frameworks. As Barbara Sicherman writes in "The Uses of a Diagnosis," "In what is frequently a highly charged atmosphere, the physician's primary task is to identify 'it.' To transform the diffuse symptoms of this patient into a condition that can be rationally understood and treated."[358] This desire for diagnosis is shown most strongly in the case of Elsie's father, Dudley Venner, a loving but ineffectual figure. He wishes that she were diagnosed as hysteric,[359] which would explain her behavior and give him a sense of treatment options and prognosis: "He had heard that hysteric girls showed the strangest forms of moral obliquity for a time, but came right at last. She would change all at once, when her health got more firmly settled in the course of her growth" (194). This wished-for diagnosis masks, in this scene, Dudley's fear of something more unexplainable. Somewhere within him, Dudley has what the narrator calls not just an "unworded" but even an "unthoughted" sense that there is something more complicated going on. He cuts himself off from knowledge, thinking, "There was nothing ever heard of like it; it could not be; she was ill" (194). Illness—nameable illness—is the best case scenario, which structures what he sees as possible for his daughter.

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[357] Holmes, *Elsie Venner,* 400.
[358] Barbara Sicherman, "The Uses of a Diagnosis: Doctors, Patients, and Neurasthenia," *Journal of the History of Medicine* June (1977): 37.
[359] This is an interesting counter to our contemporary sense that hysteria was the ultimate medical confounder. Hysterical fits in the novel aren't muddying boundaries but are quite clear and resolved by reading Coleridge.

His desire for a healing narrative is so strong that he invents wholesale a kind of folk prognosis—if she can live to be twenty-one, "her whole frame would have been thrice made over, counting from her birth, [and] she would revert to the natural standard of health of mind and feelings from which she had been so long perverted" (270). Dudley Venner's mistaken beliefs about his daughter are presented as the natural outgrowth of anyone who has an emotional investment in the subject of his or her medical interest. He is constantly reading medical text books to search for an explanation, but, "As in all cases where men meddle with medical science for a special purpose, having no previous acquaintance with it, his imagination found what it wanted in the books he read and adjusted it to the facts before him" (278). Building on his views in his medical writings, Holmes gives sympathetic motivation to the emotional lenses through which actual "facts" become distorted, while also demonstrating how misguided these views are.

Despite the failures of language and vision for characters within the novel, the narrative provides the reader a kind of clarity, giving us a shortcut around this diagnostic desire. Although the novel ostensibly follows the quest to diagnose Elsie's malady, culminating in Doctor Kittredge's explanation in the final number of the serialized story, Holmes gives the reader a pretty clear sense of her malady almost immediately. After a digressive farce in another small town, the second number gives an extended environmental description of Bernard's new home, Rockland, where he will be working as a school teacher. We read that a rhumba of rattlesnakes has a well-established den in the mountains outside of town, and they once bit a nameless young pregnant woman. Several pages later, on the closing page of the section, we read about "that strange, wild-looking girl" who is "winding a gold chain about her wrist, and then uncoiling it," and the number closes ominously with the words, "That is Elsie Venner."[360]

[360] Holmes, "The Professor's Story," February 1860, 235.

Although the mystery briefly heightens through the third number with a discussion of Elsie's eerie handwriting and off-putting affect, the end of the third number contains a description so clearly serpentine that most readers would put together the clues dropped so far. She has "a peculiar undulation of movement… with a flash of white teeth which was always like a surprise when her lips parted. She wore a checkered dress, of a curious pattern, and a camel's-hair scarf twisted a little fantastically about her," and is once again playing with the bracelet on her wrist. She has "black hair, twisted in heavy braids.—a face that one could not help looking at for its beauty, yet one that one wanted to look away from for something in its expression, and could not for those diamond eyes….The girl spoke in a low tone, a kind of half-whisper. She did not lisp, yet her articulation of one or two consonants was not absolutely perfect" and she is carrying a flower that was "found only in one spot among the rocks of The Mountain"–the spot where rattlesnakes gather.[361] At this point it is pretty clear what is going on, and in case we miss it, the "symptoms" are repeated over the next few installments, given more specificity, and surrounding her with accessories like a serpentine bracelet. We hear unceasingly about her "diamond" eyes, her ability to entrance people with her gaze, her penchant for slithery jewelry, her slight hint of a lisp, her love for dancing with rattling castanets, and her general wild, voluptuous, sinuous movement. The snake-case is built against her through a repetition of observed symptoms: visual, aural, and interpersonal.

Beyond our physical exam, we also get to "take a history"—we learn, through a series of scenes of local talk, of increasingly clear hints about mysterious ailments of past governesses, and the way a bite she landed on her cousin in childhood was nearly fatal and still burns. We hear that as a baby, she was a "little diamond-eyed child" with a "coral necklace" and a "rattle in her hand."[362] Even the least perspicacious reader will have no doubts about Elsie's snake-like tendencies in the

[361] Holmes, March 1860, 357.
[362] Holmes, *Elsie Venner,* 275.

seventh number when the repeated descriptive clues—her "diamond eyes" and undulating movements--are echoed in the description of the local den of snakes: their "diamond eyes, small, sharp, cold, shining out of the darkness," their "gliding…smooth, steady motion," and their tendency to paralyze their prey with their eyes.[363] If we have not yet picked up on the clues, the snake link is here rendered totally unambiguous, a full seven monthly installments before Bernard begins to admit this possibility to himself.[364] This sense of diagnostic clarity allows Holmes first to encourage sympathy since, as suggested above, diagnosis and medicalization are understood to be morally exculpatory, and thus the novel encourages readers with compassion. But second, it allows us to witness the failures of Elsie's textual diagnosticians.

The impact of this early reveal for the reader is to shift the focus away from puzzling through Elsie's symptoms and toward observing various other characters doing so, as her father attempts to do above. In a later novel, one character voices skepticism of the rabidity with which people cling to medical diagnoses: "Everybody …want[s] to know what is the matter with somebody or other who is said to be suffering from 'a complication of diseases,' and above all, to get a hard name, Greek or Latin, for some complaint which sounds altogether too commonplace in plain English. If you will only call a headache a Cephalgia, it acquires dignity at once, and a patient becomes rather proud of it."[365] This desire—to put a technical name on a "complication of diseases"—provides the impetus for narrative progression in *Elsie*.[366] In Rockland's world of seemingly perfect legibility, Elsie is enigma. She muddles the clean categories of the town, and her

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[363] Holmes, "The Professor's Story," July 1860, 100.
[364] Holmes, "The Professor's Story," February 1861, 220.
[365] Quoted in Podolsky and Bryan, *Oliver Wendell Holmes: Physician and Man of Letters*, 142, from *The Poet at the Breakfast Table*.
[366] Interestingly, the desire to diagnose Elsie circulates not just within the novel, but outside of it, as hypotheses about the real heart of the novel proliferate. It lends itself easily to allegorical readings: it is "about" race, gender, madness, maternal transmission, puerperal fever, or new principles of evolution and the proto-eugenic attitudes they entailed.

existence sparks community-wide interest in sorting how what kind of person (or being) she is. In a typical query, her cousin thinks, "But then there was something about Cousin Elsie…there was something about Cousin Elsie he couldn't make out. What was the matter with her eyes, that they sucked your life out of you in that strange way? What did she always wear a necklace for?" (199). We learn that "there were stories floating round, some of them even getting into the papers,--without her name, of course,--which were of a kind to excite intense curiosity, if not more anxious feelings" (146). This anxiety is manifest in other characters' psycho-somatic responses. Talking about Elsie, the schoolmistress's "breast rose and fell tumultuously as she spoke, and her voice labored, as if some obstruction were rising in her throat" (127). Having largely settled the issue for ourselves, readers turn to the diagnostic journeys and errors of those within the novel.

It is not just Elsie's family and peers whose vision is skewed by their subject position: the novel's three physicians are equally implicated, suggesting that the novel does not work purely as an affirmation of medical authority. The comedically heavy hand of our narrator, a medical professor, for example, reinforces the sense that all we read is colored by opinion and personal perspective. In the penultimate chapter of the book, he writes, "This was the way in which I, the Professor, became acquainted with some of the leading events of this story. They interested me sufficiently to lead me to avail myself of all those other extraordinary methods of obtaining information well known to writers of narrative" (480-81). The fallibility of the narrator is driven home by the confession that "What conversation had taken place since Helen's rhetorical failure is not recorded in the minutes from which this narrative is constructed" (469). Earlier, we receive extensive information about his personal worry for the threatened bachelordom and financial prospects of Bernard, and at one point he announces that he is condensing Kittredge's conversation into a cohesive disposition on morality. But the playfully biased nature of our narrator does not overturn the seriousness of the novel. Judith Yaross Lee argues that scientific humor offers "an index to the spread of scientific ideas and a

window on popular thinking about them," showing both the author's scientific knowledge and assumptions about the knowledge of others.[367] In this, the role of the narrator, a Harvard medical professor like Holmes himself, is key. The classificatory spirit in which he describes the world is presented, professorially, as a sort of lesson to the reader, and one of which we ought to be skeptical.

The medical professor who narrates the novel views the world through a parodic extreme of classificatory thinking, simultaneously inviting us into his way of viewing the world and critiquing it. He is the very model of Holmes' "observing and computing mind." Perhaps the most consistent trope of the novel is the perpetual classing of people and things into kinds, and the narrator is our guide, delighting in explaining the various hierarchies in the world of the novel. The novel opens with an extended reflection on the various kinds of people who live in Boston and the ease with which an observer can make class and character assessments from the face. He distinguishes between country folk and the Brahmin "*caste"* with its "distinct organization and physiognomy" (3). We learn about types of girls, and the types of papers they invariably submit for marking, the types of homes they live in —the "intermediate class of houses" or the "farm-houses" which "were something of the following pattern…" (58-9)—and by extension the types of attitudes those home-owners have. The medical stakes of these classifications are pointed out, tongue in cheek: people are referred to as "specimens" and our introduction to Bernard, the protagonist, includes the information that his was "a handsome face, —a little too pale, perhaps, and would have borne something more of fulness without becoming heavy. I put the organization to which it belongs in Section B of Class 1 of my Anglo-American Anthropology (unpublished)" (8) while country doctors would be "classified in the Linnæan scale" as "Genus *Homo*; Species *Rotifer*

[367] Judith Yaross Lee, "(Pseudo-) Scientific Humor," in *American Literature and Science*, ed. Robert Scholnick (Lexington, KY: University Press of Kentucky, 1992), 128.

infusorius,—the wheel-animal of infusions" (139). He even subjects his own language into this classificatory scheme: including chapters with names like "An Old Fashioned Descriptive Chapter." The satirical bent of this narrative style indicates what Thrailkill has called the novel's "suspicion of taxonomy" (78-9), but at the same time it provides our only window onto the world of the novel, and as readers we cannot get outside of these taxonomical structures.

The cracks in this outlook begin to show early, though, as he notes the constructedness of these categories, writing, "Of course I shall choose extreme cases to illustrate the contrast between them" (4-5). He is crafting the world, choosing details and creating "specimens" for us to observe—he is writing diagnosis into being. Notably, despite its ostensible focus on our fantastical quasi-heroine, the narrator pays almost total disregard paid to her through the bulk of the text. Morse writes that in general, Holmes could "draw characters but could not work out plots" (266), and the novel's larger than life plot at times feels merely like scaffolding to allow Holmes the privilege of a wide range of "local color" character sketches. Chapters at a time will dispense with the larger narrative to turn out a caricature of a local clergyman or conniving widow. In one example, the fourth number (April 1860), is among the longest in the run and is one extended chapter drawing together various figures for "The Event of the Season." Though Elsie appears briefly at this event, many more pages are dedicated to poking fun at provincialisms, with multi-page descriptions of characters that never reappear.

The profusion of character sketches in the novel draw attention to the diagnostic features of fiction, creating something like a diagnostic manual of local color, down to the hereditary and environmental causes. While a diagnostician sorts through a great deal of information, deciding what is relevant and what can be left out, an author can create the illusion of discrimination in the reader: by directing our attention, narrators indicate what is and is not relevant in assessing character. Despite his similarities with Holmes, though, the novel's criticism of the professor is clear, creating a

disjuncture between the narrator and the "implied author" of the text. The implied author criticizes the kind of diagnostic schemas that structure the narrator's thinking. To take the narrator at his word is to view the entire novel as produced by the imagination of someone only tangentially involved in the narrative. Interestingly, our professorial narrator does not seem to be in on the joke, for he is presented rather as a caricature of the "type" of the medical professor, and so we are winking not just at the professor, but at Holmes himself. In Gibian's words, Holmes is "flattering most readers with his winking recognition that they, at least, are not among those who have shown themselves to be priggish, prudish, censorious, literal-minded, or dull."[368] Readers can have a kind of knowledge that "characters" cannot.

Bernard's eventual insight into Elsie's diagnosis also emerges from the clarifying potential of literature. Speaking to Holmes' proposition in "Currents and Counter-Currents" that medicine reflects culture, Bernard gets his first major hint about Elsie's true nature from a literary source. He discovers one of Elsie's mountain flowers marking a page in the Aeneid, which leads him to the story of Laocoön, killed by serpents. He is "Fascinated" (176)—the same term used for Elsie's pull on him. Literature, then, provides him an impulse that reminds him of interactions with her and begins to give him the descriptive tools that structure his capacity to classify her. He follows up on this instinct, and among the many questions he poses in a letter to his professor, our narrator, are: "Have you read, critically, Coleridge's poem of 'Christabel,' and Keats' 'Lamia'? If so, can you understand them, or find any physiological foundation for the story of either?" (220). (Both poems involve snake-persons). Thus, literature is part of what informs his medical vision—as it is informing ours.

His attempts to follow up on these clues dramatize the process by which he attempts to move the unexplained into medical knowledge, although he ultimately fails. The narrator describes

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[368] Gibian, *Oliver Wendell Holmes*, 145.

Bernard as a well-trained observer: "A person accustomed to watch the faces of those who were ailing in body or mind, and to search in every line and tint for some underlying source of disorder, could hardly help analyzing the impression such a face produced upon him" (183). He tunes into increasingly minute observations, noticing a mark on Elsie's neck when her necklace is "slightly displaced" and hearing "the least possible imperfection in articulating some of the lingual sounds" (184). The process through which he attempts to concretize a diagnosis is dramatized through a chapter titled "Physiological." He engages in several kinds of experiment: he gathers rattlesnakes to observe in cages, reads up on the physiology of mesmerism, and, upon finding that the country doctor has no up-to-date medical texts, writes to his old professor (our narrator) asking him for a sort of case history of snakeliness--a report on "the curiosities of medical literature" (219). The professor responds with a long list of similar cases, pulled largely from literary, historical, and even biblical work: "there is no end," he writes, "to cases of this kind, and I could give some of recent date, if necessary, lending a certain plausibility to at least the doctrine of transmitted impressions" (222-23). Thus, we see an attempted medical classification through the concatenation of multiple similar cases—and often overtly mythical ones.

For all these attempts, Bernard remains strangely clueless. Even after witnessing Elsie communing with rattlesnakes on the mountain about halfway through the novel, he remains in a kind of denial. As he is about to compare her hair to "a wreathing coil of--" he interrupts himself: "Shame on such fancies!" (203). He needs about two hundred more pages before he's ready to face the explanation we as readers already understand, creating a sense of irony about the utility of medical training and the physiological experimentation we've watched. The book establishes this irony explicitly, and near the end of the book, our narrator writes, "It would be needless to repeat the particular suggestions which had come into his mind, as they must probably have come into that of the reader who has noted the singularities of Elsie's tastes and personal traits" (397). This delay

occurs not just in spite of Bernard's medical training, but because of it. Despite cultivating keen powers of observation and understanding of the experimental process, it has made him "slow to accept marvelous stories and many forms of superstition" (396). Paradoxically, in the world of the novel, not believing that which seems superstitious is itself a kind of medical superstition. Bernard is not sufficiently open to the possibility of fancy being real—which, here, it is—but we are, so the reader gets to feel superior to Bernard in his shortsightedness. Bias isn't removed by medical training, only changed.

Bernard's quest in particular is generically structured by the novel's subtitle: "A Romance of Destiny." By diagnosing his novel a "romance," Holmes invokes literary prognosis. (In the second preface to his work, he calls it, further, a "physiological romance.") If we conceive of the romance genre in Frederic Jameson and Northrop Frye's terms, the "tacit agreement"[369] the author makes with the audience is an arc following a hero through a world of unreliable perception as he successfully navigates a conflict between good and evil. In this "physiologic" romance, though, the magical elements of the hero's quest are replaced with medical ones, and biology becomes the agent through which the novel negotiates questions of morality. Our doctor-hero is represented as on a quest in a world of unreliable perception, and the "evil" being fought seems to be the medical unknown.

That the novel doesn't take seriously this hero's quest highlights the failure of medical authority in the text. Bernard's fulfillment of the role of hero is taken to the point of parodic extremes, including an excessive and amusing body-building scene. Further, despite taking on a quest, he has no real evil to overcome. In a compelling inversion, Elsie herself seems to be the primary candidate for monstrous Otherness, but the novel redeems her as a sympathetic figure. The

[369] Frederic Jameson, "Magical Narratives: Romance as Genre," *New Literary History* 7, no. 1 (1975): 135.

more clear candidate for "evil" is Elsie's murderous and scheming Cousin Dick, but the end of the novel sees him excused from accountability through analogy to Elsie: just as she can't control the snake-quotient of her own blood, he cannot control his Spanish lineage. Still, the "magic" that resides at the core of the romance genre is not fully sublimated into a secular medicine—Holmes employs physiologic explanations but roots them in romantic tropes of monstrosity and danger. Murison writes of Holmes' medicated novels that, "where medicine leaves off, romance begins; however, Holmes insists that he grounds his version of 'romance' in science even as it stretches beyond known scientific limits."[370] His later compounding of "physiological" with "romance" indicates a playful deviation from this form— Jameson notes that hybrid genres like Scott's "historical romance" make an "implicit commentary on the system itself" (153). By appending the "physiological" to the "romance," he both evokes the tropes of the latter genre and articulates dissatisfaction with it—what he is doing is different enough to require a new name. If we conceive of a genre as a kind of literary diagnosis, then even his refusal to allow the romance to play out is a further affront to diagnostic logic. Holmes' deployment of and play with the "romance" genre hints at another kind of categorical instability, and the satirical approach of the novel raises questions about whether the novel is a romance at all. If the archetypal romance provides a magical world in which the workings of good and evil are rendered visible and conquered by a hero, then *Elsie Venner* subverts this trope, taking at its center the notion that knowledge of the other is always imperfect.

Dr. Kittredge's relationship to diagnosis provides an interesting middle point between the professor's top-down thinking-in-kinds and locals' superstition and gossip. If anything, he eschews diagnostic thinking for intuition. He laughs off Bernard's request to see his medical literature. He responds: "I don't want to undervalue your science…but I know these people about here, fathers and mothers, and children and grandchildren, so as all the science in the world can't know them,

[370] Murison, *The Politics of Anxiety*, 6.

without it takes time about it and sees them grow up and grow old, and how the wear and tear of life comes to them" (211). His knowledge is individualized, instinctual, and accrued through experience: "The Doctor knew a good many things besides how to drop tinctures and shake out powders. … He knew what a woman is, and how to manage her. He could tell at a glance when she is in that condition of unstable equilibrium in which a rough word is like a blow to her and the touch of unmagnetized fingers reverses all her nervous currents" (98). Despite his own bias, which is a provincial and even pseudoscientific medicine, he has a common-sense approach that takes the needs of his patients into account and reflects Holmes' ideal of interpersonal care. For instance, he regularly gives placebos to one of his nervous patients because they so clearly make him feel better. In important ways, Kittredge provides the "just-right" balance between over-educated medical practice and local superstition. He's not perfect in his knowledge—in the end he is unable to save Elsie–but this judicious combination of experience and local knowledge give him a kind of credibility that the novel leverages into an ethical response to diagnosis.

In one of the ironies of the work, the superstitious village people occasionally come closer to the truth than the physicians. The hysterical school mistress is right when she sees something inhuman looking out of Elsie's eyes, if not for the right reasons, and the gossips of the town conjecture about Elsie's trouble and we hear about the circulation of "strange stories." Many of their assessments are portrayed as ungenerous and inaccurate: "Some, of course, said she was a crazy girl, and ought to be sent to an Asylum. But old Dr. Kittredge had shaken his head, and told them to bear with her, and let her have her way as much as they could, but watch her, as far as possible, without making her suspicious of them" (147). Others, though, seem to have a reasonable handle on her malady, often recounting Elsie's mother's demise. The foregrounding of gossip within the novel shows a kind of folk diagnosis—gossip as an alternative classificatory system with its own insights and problems.

The vision that the townspeople bring to bear on Elsie is shaped by race, gender, and profession. A local girl whispers the gossiped diagnosis into her father's ear. The narrator suggests this conclusion comes from a specifically female kind of observation, as she is able to give minute attention to "the oddest patterns" (180) of fabrics Elsie wears: "there is not an end of ribbon or a turn of a ringlet which is not a hieroglyphic with a hidden meaning to these little cruisers over the ocean of sentiment."[371] Professional training, too, is implicated in the ability to assess. This girl's father, a judge, thinks he can tell how dangerous Dick is just by looking at him because he knows the criminal "type" through his professional training: "there is an expression in all the sort of people who live by their wits when they can, and by worse weapons when their wits fail them, that we old law-doctors know just as well as the medical counselors know the marks of disease in a man's face. Dr. Kittredge looks at a man and says he is going to die; I look at another man and say he is going to be hanged, if nothing happens" (178). It is not just physicians who have developed technologies of viewing and sorting their objects.

However, the person most in tune with Elsie's plight is her lifelong servant Sophy. Although a stereotyped, essentialist, even animalized representation of a black woman, Sophy is eventually the one to reveal the diagnosis. She tells the whole narrative to the minister midway through the novel (though the narrator withholds this disquisition from us, saying that it is too sensational and he would avoid sharing the painful facts unless "in the course of relating the incidents I have undertaken to report, *it tells itself*"[372]), she warns those in danger of the impact of Elsie's bites, and is the person best able to pick up on and manage Elsie's moods, but her understanding is portrayed as

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[371] *Elsie Venner,* 421. In a medical lecture, Holmes says that he wishes wives could come on medical visits because their "natural clairvoyance" would mean many fewer suicides: a woman could see despair where a man sees dyspepsia. And in an 1879 address he talks about the exceptional vision of the "ovarian sex" for medical matters and how it makes them excellent nurses (Podolsky and Bryan, 149, 249).

[372] Holmes, "The Professor's Story," September 1860, 366.

superstitious folk wisdom—even biological instinct attributable to her race. She has "quick, animal-looking eyes…and inherited the keen senses belonging to all creatures which are hunted as game."[373] In a conversation with Kittredge in which she displays her superior knowledge, she asks, "Who tol' you Elsie was a woman, Doctor?" (349) Kittredge dismisses this as superstition—but he is at least partially wrong. "Don' never speak in this house 'bout what Elsie's mother died of!" she said. "Nobody never says nothin' bout it. Oh, God has made Ugly Things wi' death in their mouths….my poor Elsie!—to have her blood changed in her before—It was in July Mistress got her death, but she li' till three week after my poor Elsie was born" (434). Eleven pages later, Kittredge provides his own, more technical description: "She has lived a double being…" (445) Despite the strong threads of medical superiority in the work, demonstrated by Kittredge getting to give the "official" explanation, the diagnostic logic is a particularized, local affair.

The dramatic irony created by the gap between our knowledge and Bernard's is expanded to virtually the entire range of characters in the novel, displaying how each individual's view is skewed. Bernard's attempts to work Elsie into the scientific process fail in part because of his medical training, but Holmes exposes us to a wider range of responses, and the novel spends a great deal of time describing local figures' reactions to and beliefs about Elsie. Holmes would later write, "Nothing sheds such light on the superstitions of an age as the prevailing interpretation and treatment of disease,"[374] and by foregrounding the biased approaches of many characters, he gives us a global view of the reigning "superstitions" of the age. While some are overtly superstitious in the traditional sense of the word, the physicians' approaches are just as implicated in the occasionally distorting, occasionally clarifying local diagnosis. This works as a version of the conversational model that Gibian has argued lies at the center of Holmes' work: he reads Holmes' "medicated

[373] Davis, "The Doctor Is In," 151.
[374] Quoted in Podolsky and Bryan, *Oliver Wendell Holmes: Physician and Man of Letters*, 153.

novels" as combinations of the conversational form of Holmes' more popular "Breakfast-Table" conversation novels with the case study genre. For Gibian, one function of this focus on dialogue is to unseat singular moral authority.[375] In a fascinating metaphor, Holmes elsewhere suggests that the truth is best seen as "the *parallax* of thought and feelings as they appear to the observers from two very different points of view. If you wish to get the distance of a heavenly body, you know that you must take two observations from remote points of the earth's orbit…To get the parallax of heavenly truths, you must take an observation from the position of the laity as well as of the clergy."[376] On the subject of Elsie, the reader gets the parallax of many more than two views, highlighting the impossibility of pinpointing her exact location from one standpoint—except for the standpoint of the reader of romance.

From this standpoint, we can see that there is no singular medical authority in the novel: the three physicians at the center of the novel represent a range of approaches, and it's ultimately unclear who comes out on top. For Davis, the physicians across the board represent the medical gaze; for Thrailkill, the novel pits them against one another and ultimately favors the statistical thinking of the Professor; while for Gibian, the country physician Kittredge shows Holmes' "conversational ideal: he is not chauvinistic, not always certain of his positions or diagnoses, and not detached in his judgments of others," as opposed to the professor's "city smugness..., racial and class biases, academic pomposity, and absolutist opinions." [377] Bryce Traister points to the "professional self-fashioning" of Bernard, and notes that through all three physicians, "Elsie Venner thus becomes intelligible in narrative in the same way she communicates with the other characters in the novel: not with language but with a series of snakelike performances and metaphors that indicate an 'ophidian'

[375] Peter Gibian, "Doctor Holmes," 81.
[376] Gibian, *Oliver Wendell Holmes and the Culture of Conversation*, 142.
[377] Gibian, 156.

morphology decipherable only through medical, even clinical, examination," although that examination does not disclude, and is perhaps even predicated upon, a sentimental and sympathetic reaction.[378] Although my reading of the physicians is closest to Gibian's, this range of interpretations demonstrates unequivocally that the moral seat of the novel is unstable.

Holmes' primary message is thus one of skepticism. Scientists were as much the target of Holmes' anti-dogmatism as the clergy.[379] He writes, "Scientific knowledge, even in the most modest persons, has mingled with it a something which partakes of insolence. Absolute, peremptory facts are bullies, and those who keep company with them are apt to get a bullying habit of mind," and "Scientific certainty has no spring in it, no courtesy, no possibility of yielding."[380] "Facts," he notes, are "intended to stop all debate."[381] In his letter to Harriet Beecher Stowe in the midst of the serialization of the novel, he foregrounds the value of epistemic humility: "A man may fulfil the object of his existence by asking a question he cannot answer, and attempting a task he cannot achieve," and hopes through this mechanism to render the reader more "human."[382] While valorizing the medical gaze, the novel critiques it; while advocating for statistical medicine, it lambasts the classificatory urge; while diagnosing Elsie, it dramatizes the pitfalls of diagnostic logic.[383] Physicians do not need a perfect, unbiased vision, which Holmes is aware is a fiction, and they should be suspicious of any sense that they've grasped the root of a problem. Thrailkill observes that any singular reading of *Elsie* is a failure: "In generating such a proliferation of competing and overlapping narratives to explain Elsie Venner's oddness—hysteria, genetic influence, insanity, moral depravity, prenatal poisoning, verbal incapacity, morbid sexuality, poor

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[378] Traister, "Sentimental Medicine," 218.
[379] Gibian, *Oliver Wendell Holmes*, 134.
[380] Quoted in Gibian, 135.
[381] Quoted in Gibian, 136.
[382] Morse, *Life and Letters of Oliver Wendell Holmes*, 1:264–65.
[383] On the gaze, see Davis; on statistical thinking, see Thrailkill; on diagnoses, see Gibian (and most everyone else).

parenting—the novel seems to replicate the novel of disease within traditional therapeutics and to affirm that health and human flourishing are never reducible to a single source" (80). And indicated by the title of the degree Bernard receives in the final pages of the novel, there is plenty of room for mystery within institutionalized medicine. Davis notes that Bernard's thesis, presumably about Elsie, cements his medical authority at the end of the novel.[384] But this authority is a strange one, seeming to institutionalize uncertainty and doubt: the paper that eventually gets Bernard his degree is called "Unresolved Nebulæ in Vital Science" and "It was a general remark of the Faculty…that there had never been a diploma filled up, since the institution which conferred upon him the degree of *Doctor Medicinæ* was founded, which carried with it more of promise to the profession" (481). If *Elsie Venner: A Romance of Destiny* were in the market for a sub-sub-title, it could do worse than "Unresolved Nebulae in Medical Science." Bernard's success emphasizes the value of imagination, humility, and even literary thinking within medical science.

Rather than representing medical science as perfectible and moving toward masterful knowledge of taxonomies of illness, Holmes lays out a model of ethical medical progress that is coherent with medical mystery and even inconsistency.[385] We ought to observe and medicalize those around us (up to, potentially, institutionalizing them), but we should reflect deeply on our incapacity to truly understand or to master the root causes. In other words, we should assume medical causes though we shouldn't assume our ability to identify or treat them. We should attempt to handle them medically, but for Holmes, appropriate medical response is not clinical—it is environmental, educational, and moral.

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[384] Davis, "The Doctor Is In."

[385] Holmes' explicit interest in medical ethics is established by, among other things, the inclusion of a dead-end narrative about a doctor whose inappropriate interest in a patient is quelled by reading the Hippocratic Oath in his second "medicated novel" *The Guardian Angel* (Boston: Houghton, Mifflin and Company, 1867).

Ethics

Despite their diagnostic failures, the novel's doctors are distinct from the laypeople who live in town by virtue of their united ethical response, which is to forestall personal judgment by medicalizing morality and character. Tellingly, despite their many differences, the idea of biological determinism is one place where Dr. Kittredge, the Professor, and Bernard's ideologies align, indicating, perhaps, that despite internal friction in the discipline, physicians have a united social goal. Dr. Kittredge argues strenuously for a biologically and environmentally deterministic view of character by equating moral and mental activity with organic physical disease. Holmes' stated moral in the preface to the work is explicitly spelled out in a sort of physician's sermon midway through the book. Whereas it is Kittredge who gives the longest disquisitions on the topic, the Professor, in a letter to Bernard, writes of the incredible medical advances that have brought morality into the medical, rather than theological, realm. Even one of the town's clergymen, Reverend Doctor Honeywood, begins to see things through the medical lens, to the point of stepping "his foot into several heresies":

> He did not believe in the responsibility of idiots. He did not believe a newborn infant was morally answerable to other people's acts. He thought a man with a crooked spine would never be called to account for not walking erect. He thought if the crook was in his brain, instead of his back, he could not fairly be blamed for any consequence of this natural defect, whatever lawyers or divines might call it….[s]upposing that the Creator allows a person to be born with an hereditary or ingrafted organic tendency, and then puts this person into the hands of teachers incompetent or positively bad, is not what is called sin or transgression of the law necessarily involved in the premises? (247)

At the core of this claim is a hypothesis of physiologic determinism that sees personality and impulse as beyond personal control—the moral are not "good," they are "lucky," and Holmes asks why we view psychological or moral disorder more judgmentally than we do physical disease—why and how do we distinguish between "organic" and "moral" problems? In the end, a moral "wound" deserves respect that a moral failure does not.

Holmes positions this medical model of inherited immorality as a humane corrective to the theological doctrine of original sin. An early biographer writes that, more than anything else, Holmes was "attracted by theology" and all of his work obsessively circled the topic.[386] Indeed, his annoyance with the label "medicated novel" was due in part to his understanding of the book as taking up theological rather than medical topics.[387] The medicalization of his theological enquiry, though, must not be undersold. Holmes' skepticism and distaste for orthodoxy defined his relationship with religion throughout his life. Reflecting on his childhood, he writes that his "instincts were shocked and disgusted beyond endurance" by religious attempts to instill fear about damnation.[388] He goes on at length about the extent to which the idea of the "fallen race" and "inherited guilt" structures the youth of New England children, destroying their capacity for thought and normal growth and claimed that anyone who believed much of religious thought "ought to go mad."[389] Morse suggests that one of Holmes' missions is to take away from the clergy the power to call a man a "sinner," substituting his own model of the sympathy for "crippled souls" (276-7). The serpent-infected Elsie is a model of the "crippled soul" rather than the sinner. But, one doesn't need to have been bitten by a snake in order to be justifiably ill. One might have been born to a "mixed-race" household, like her treacherous cousin Jack, or might be the very type of greedy schoolmaster

[386] Morse, *Life and Letters*, 1:268.
[387] Morse, 1:263.
[388] Morse, 1:39.
[389] Morse, 1:44, 270.

that small New England towns invariably spawn or might naturally be the kind of woman to overwork herself toward death. And while the novel suggests that these causes are all physiological in nature, they do not require a diagnostic manual. In one of the grimmer formulations of the book, all people are "self-conscious blood-clocks with very limited power of self-determination" (323), and, by embracing a medical attitude, we can at least respond more generously to moral failures.

Beyond generosity, there is some sense of hope for environmental and moral cure for those not so dramatically afflicted. Elsie's schoolmistress Helen, for example, is "one of those women who naturally overwork," suggesting an inborn tendency, but her actual breakdown is spurred by the abusive labor of a cruel, greedy boss. Bernard sees her as "a picture of the martyr by the slow social combustive process" (126). Her boss, however—he of the salt fish and harsh east winds—is himself a product of his upbringing and environment, and so on in an infinite regress. Holmes' experiment in testing social generosity by appealing to biological determinism reveals cracks in the assessment of culpability. Where is our sympathy meant to end? With the cruel capitalist overlord of the girls' school? With the murderous Dick Venner? Dr. Kittredge releases Dick Venner, despite the man's serious attempt to murder Bernard, by pointing to Dick's innate qualities. Such a conclusion, I suspect, gave many readers pause, asking at what point the principle is taken too far, and its ultimately unclear what conclusions we're meant to draw.

In broad terms, informed by the context of the scientific study of heredity and degeneration, the novel asks whether and how we can hold people accountable for their moral failings if they were born to a particular disposition and educated in a particular environment. For Holmes, this reframing, though still centered around innate pathological immorality, offers a charitable, humane gospel. At its heart, the assumption is that we treat the ill more charitably than we treat the sinful, even if they are different names for the same behaviors. In the words of our narrator, "*treat all bad*

men as if they were insane. They are in-sane, out of health, morally"[390]—a kind of medical model of charitable relations with the deviant other that assumes sympathy with and care for the insane. What is curious in his rebuttal to religious teachings of the fall is that he is not rejecting the notion of inherited guilt, but rather sees medically inherited guilt as exculpatory while religious inherited guilt is oppressive. This kind of medical fatalism does not indicate, though, that physicians are useless. Indeed, they are the ones framed as being able to spread this secular gospel to the rest of society. The redemptive possibilities of a biological view are made manifest in the schoolmistresses' reaction to Elsie. Though she has feared and avoided her throughout the novel, Helen becomes kinder and more understanding after figuring the physical cause of Elsie's personality. She even becomes her primary caregiver at a great cut to her pay (438).

Thus, pathologization allows for increased charity to those previously seen as simply immoral—those "supposed to be sane"—and so broadens the jurisdiction of medicine: "We see all kinds of monomania and insanity. We learn from them to recognize all sorts of queer tendencies in minds supposed to be sane, so that we have nothing but compassion for a large class of persons condemned as sinners by theologians, but considered by us as invalids" (322**)**. The universal distribution of "queer tendencies" puts all of society on a medicalized spectrum of moral capability. These capabilities emerge both from birth and environment, including the environment of an unregulated version of American capitalism: morality is naturally compromised whenever "nervous energy is depressed by any bodily cause, or exhausted by overworking…. The conscience itself becomes neuralgic, sometimes actually inflamed" (169). Unlike priests, who rail against the immorality of hysteric girls, Dr. Kittredge argues, "We give her iron and valerian, and get her on horseback, if we can, and so expect to make her will come all right again" (322). The logic of the novel also clarifies, though, that such interventions are insufficient, as heredity and environment are

[390] Holmes, *Elsie Venner,* 228. Emphasis in original.

implicated in healthy morality—Elsie could never be medicated to normalcy (though she is redeemed through love prior to her death).

In his medical writing, Holmes responds facetiously to those who say there will one day be medicines for every disease: "when a man can enter the second time into his mother's womb and give her back the infirmities which twenty generations have stirred into her blood, and infused into his own through hers, we may be prepared to enlarge the National Pharmacopoeia."[391] We ought not rely, then, on medical technology or medications to counteract this medicalization of morality. Rather, we must consider social forces, preventing such behavior in the first place. Holmes, a fierce advocate for preventative medicine and public health, was not alone in this view. [392] The AMA code of 1847 warns of the inextricable link between public hygiene and morals and includes hygiene and medical jurisprudence as among the physicians' duties.[393] This approach looks to replace religious dogmatism with a focus on social determinants of health, thus calling for medical approaches to morality rather than theological ones. By combining critique of clear diagnostic vision within the clinical encounter with a focus on hereditary and environmental frameworks for disorder, Holmes implicitly suggests that medical frameworks can usefully focus on the social rather that the individual: something more like public health than clinical medicine.

Given Holmes' assurance that language and narrative have the power to impact physiology, the publication of *Elsie Venner* itself can be seen as a kind of public health measure. Ultimately, the novel puts forth a vision of a socially constructed and imperfect medical practice: it is not the physician protagonist who first diagnoses Elsie, but rather the reader, the gossiping local girls, and the black servant—though each of these diagnosers fails in unique ways. The power of diagnosis is represented as distributed, local, and ethically fraught. The novel acts out Holmes' argument in

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[391] Holmes, *Currents and Counter-Currents*, 48.
[392] Gibian, *Oliver Wendell Holmes*, 177.
[393] American Medical Association, *Code of Medical Ethics*, 86.

"Currents and Counter-Currents" that all seemingly objective observation is obscured by dominant cultural narratives and self-delusion. Moving that claim into a fictional space allows him to demonstrate the principle in action, coupled with the emotional investment in characters and outcomes a romance entails, and so ultimately leads to a series of questions about the ethics of diagnosis and culpability.

Among the questions *Elsie* poses are: How do we assess new categories in the face of medical uncertainty? How does that assessment shape our capacity for sympathy? What is as stake when we assess people? How do our biases and standpoints prejudice our vision? How should we respond to the pathological? And, by narrating a fictional diagnosis that substitutes an organic disorder for a moral one, Holmes ultimately asks why we view psychological or moral disorder more judgmentally than we do physical disease—and why and how we distinguish between "organic" and "moral" problems. The novel uses a fictional medical case study as a way to think through a genuine ethical case study. But though Elsie is unique, the novel experiments with making the implications more universal. Clearly, Elsie is not morally culpable within the logic of the novel. As one of the prefaces suggests, however, "What difference does it make in the child's responsibility whether his inherited tendencies come from a snake-bite or some other source which he knew nothing about and could not have prevented from acting" (xii).

Holmes's medical philosophy complicates the line between the medical and the social models and between individual and community health. Read most generously, *Elsie Venner*, serves as a precursor to those calls made within the field of disability studies to dismantle the binary of the medical and social models—calls sometimes made through reference to the precarity of the health of marginalized populations and the dangers of environmental stressors caused by social ills, as in the disability produced by lead in the pipes of poor and often black communities, or by grueling

working conditions, or by warfare.[394] Holmes's approach is unquestionably medical, but for him medicine is a social question, and by medicalizing previously sinful behaviors, he points toward social, rather than individual, interventions that are rooted in distinct geographies. Thrailkill suggests that the novel pushes back on "those accounts that affirm the necessary alignment of statistics with determinism and dehumanization" (58-9), and in its view of physicians in tune with the social environment points to potential avenues for rethinking the vision of the medical model as a dehumanized one.

This biosocial assessment of the action of will and faults still leaves the question of what ought to be done with those who stray from accepted behavior and puts much of the responsibility on the failures of society rather than individuals. As to how society ought to manage the immoral, Dr. Kittredge advises containment and management without judgment:

> Avoid collision with them, so far as you honorably can; keep your temper, if you can,--for one angry man is as good as another; restrain them from violence, promptly, completely, and with the least possible injury, just as in the case of maniacs,--and when you have got rid of them, or got them tied hand and foot so that they can do no mischief, sit down and contemplate them charitably, remembering that nine tenths of their perversity comes from outside influences, drunken ancestors, abuse in childhood, bad company, from which you have happily been preserved, and for some of which you, as a member of society, may be fractionally responsible. (228)

This "fractional responsibility" calls for a new kind of response to "sin"—a personal accountability for the immoral actions of those less fortunate than you. His belief in the need for

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[394] See, for example, Nirmala Erevelles, *Disability and Difference in Global Contexts: Enabling a Transformative Body Politic* (New York: Palgrave Macmillan, 2011) and Jasbir K. Puar, *The Right to Maim: Debility, Capacity, Disability* (Durham: Duke University Press Books, 2017).

social rather than medical responses to various degrees of madness is tied to his acknowledgment that medical progress and knowledge will always be imperfect. Moreover, as suggested by his reference to education and institutionalization, the medical approach also allows for possible correctives.

Despite the redemptive intention of Holmes's view, however, the above quotes reveal a troubling consequence of the novel's philosophy. Among the ways that society could charitably take responsibility for the moral shortcomings of others was to institutionalize them—in some cases to cure them, and in others to indefinitely isolate them. As Bernard explains, "No doubt, there are people born with impulses at every possible angle to the parallels of Nature, as you call them….Slight obliquities are we have most to do with in education. Penitentiaries and insane asylums take care of most of the right-angle cases" (74). Because everyone is the product of their environment and education, we cannot fault them for their angle to the moral right—but while this might lead people to "sit down and contemplate them charitably," as Kittredge suggests, that charity is enabled by containment.

A disturbing correlate to this philosophy is found in an annual report published a year after *Elsie Venner* by the State Lunatic Hospital at Worcester, where many patients came from Holmes's Boston and surrounding areas. Psychiatric institutions were becoming more common throughout the mid-nineteenth century for a variety of reasons, including a new diagnostic optimism (which the Worcester reports share) and the increasing difficultly of home care for the ill as more people worked outside the home.[395] In the Worcester report, optimism about cure is directly linked the future financial productivity of the inmates, and thus the community's responsibility for maintaining the facilities is a matter of public good, both in protecting the sane from the insane, but also for returning the insane to productivity. In the report, the trustees ask for more money from the

[395] Starr, *The Social Transformation of American Medicine*, 72–73.

government, noting that in other states, "a large proportion of the expense of supporting the hospitals is received directly from the public treasury."[396] The request for funds for public measures that can rehabilitate the disordered evokes Dr. Kittredge's "fractional responsibility" for the morally unwell. In the context of the insane asylum, however, this fractional responsibility becomes tied to financial resources. Within *Elsie Venner*, the asylum only exists as a specter—a place where some prejudiced townspeople believe that Elsie should be sent. And Elsie herself does not appear tractable to environmental or educational cures in the institutional sense, but the novel's logic of societal management of disorder enables the institution along with other reforms.

In giving a brief history of their institution and profession, the directors of the Worcester hospital note that while they began to protect society from the mad, they began to discover that cure was often possible, leading to a more humane institution. To affect this, however, they note the humane impact of broadening diagnostic criteria. By law, of the three classes of admitted patients, the hospital only had to accept the "furiously mad and the dangerous." They write, "Fortunately for the insane, the courts, by a very liberal interpretation of the law, early began to include all the insane in the first class" (8). Holmes' philosophy of the generosity of a "furiously mad" label is here revealed to bear penalizing fruit in the real world at the same time that it articulates optimism. The hospital understood its mission as newly charitable and able to restore back to society many "useful" members.

Thus, the humanitarian ideal that Holmes seems to advocate through the novel is rooted in the same assumptions that enabled a myriad of abuses. Most obviously, the novel's view of character determined by heredity evokes the kind of determinist and ethnological beliefs that would support eugenic ideals and policies later in the century. Phillipa Levine argues that it was the "biologization"

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[396] *Thirtieth Annual Report of the Trustees of the State Lunatic Hospital at Worcester* (Boston: Wright & Potter, State Printers, 1863), 21.

of aboriginal populations that made their destruction seem natural—and that the preexisting narrative of the fall of man provided the study of degeneration with its logic.[397] In his article on the early American figure of the rattlesnake, Hutchins notes that the "powers of fascination" of the rattlesnake made it an ambivalent symbol but what that, among other things, would have invoked the specter of miscegenation.[398] Asa Gray's review of the *Origin of Species* that appeared alongside *The Professor's Story* points out that Darwin's theory "makes the whole world kin," but then continues, "as we said at the beginning, this upshot discomposes us."[399] Earlier in the essay, he had written disparagingly, "The very first step backwards makes the Negro and the Hottentot our blood-relations;--not that reason or Scripture objects to that, though pride may" (111). Holmes' novel itself emphasizes how character is shaped to environment and passed along through heredity. Diana Paul and James Moore argue that, while Darwin avoided the topic of human breeding in *The Origin of Species,* the work established the principles employed by people like his cousin, Francis Galton, and Darwin was ambivalent on the issue. They argue that Darwin himself maintained Lamarckian views about passing along learned characteristics, and so partook of the view of the time that "Even if pauperism, criminality, and other undesirable behaviors were attributable to bad heredity, they could in principle be ameliorated through environmental improvements." (35).

Elsie Venner's connection to these sciences of heredity and breeding is clear in one of Holmes' later prefaces: he writes that Elsie is not a person but rather a composite, "like Mr. Galton's compound photographic likenesses" (xiii). By invoking Galton's photographs, he links the novel to larger practices of social sorting, and to beliefs about the social good of human breeding. Anthropology, too, has been linked to the rise of eugenics, and through this frame, our narrator's

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[397] Philippa Levine, "Anthropology, Colonialism, and Eugenics," in Bashford and Levine, *The Oxford Handbook of the History of Eugenics*, 50.
[398] Zachary McLeod Hutchins, "Rattlesnakes in the Garden: The Fascinating Serpents of the Early, Edenic Republic," *Early American Studies* 9, no. 3 (2011): 681.
[399] [Asa Gray], "Darwin on the Origin of Species," *The Atlantic*, July 1860, 116.

"anthropological manual" of human kinds takes on a more sinister tone. The twined threads of Holmes' attempt for social reckoning and apparent endorsement of the kind of racist and classist profiling that would enable campaigns to manage human stock scientifically speak to the ambivalence of medicalization: an identifiable biological defect is at once exculpatory and condemning. The novel does not ultimately embrace a hard hereditary determinism, however, instead demonstrating a soft heredity in which environment can exacerbate or mitigate many hereditary impulses. Ultimately, while the idea of social responsibility for the "morally unwell" does have liberatory potential, it was linked even before the rise of eugenics to a sense of regional biological inferiority and the problem of reproduction. Holmes' reference in *Currents and Counter-Currents* to "the infirmities which twenty generations have stirred into her blood" thus uncomfortably prefigure the notorious sentiment of Holmes' son, Supreme Court Justice Oliver Wendell Holmes, Jr., that "Three generations of imbeciles are enough."[400]

[400] Oliver Wendell Holmes, *Currents and Counter-Currents,* 48; Buck v. Bell, 274 U.S. 200 (1927).

Chapter Four

"A Wasted Sympathy": Winifred Howells, the Illness Narrative, and Illness Poetics

Winifred Howells, the first-born child of realist author William Dean Howells, was born in Venice, Italy on December 17, 1863. Growing up in the company of family friends like Henry James and Henry Wadsworth Longfellow, she dreamed of becoming a famous poet. Her father recorded her rhymes before she could write herself, [401] and her juvenile verse circulated among Will Howells' friends, with Mark Twain declaring in 1875, "Winnie's literature sings through me yet! Surely that child has one of those 'future's' before her."[402] Hoping to secure such a future, she worked assiduously on her verses, and had her first publication, of a poem called "The Deserted House," in the youth section of *St. Nicholas* in 1877 when she was thirteen. Though she used only her initials to disguise her lineage, the poem was, to her father's great distress, noticed by publications like the *New York Tribune* and *American Socialist*, the latter of which claimed that the poem was proof of "heredity of genius."[403] She was an avid reader (her mother proudly despaired, "She is reading Tasso's Jerusalem Delivered with great delight. She has read Froude's Caesar and Bacon's Essays. What is she coming to!"[404]) and traveled with her father, visiting Twain and other luminaries, accumulating

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401 William Dean Howells, *Winifred Howells* (Boston: Privately printed, 1891). Hereafter *WH*.
402 Henry Nash Smith and William M. Gibson, eds., *Mark Twain-Howells Letters: The Correspondence of Samuel L. Clemens and William D. Howells, 1872-1910* (Cambridge, MA: Harvard University Press, 1960), 1:75. Hereafter cited in text and notes as *T-H*.
403 John William Crowley, ed., *The Mask of Fiction: Essays on W.D. Howells* (Amherst: University of Massachusetts Press, 1989), 86.
404 Elinor Howells to Achille Frechette, 8 Nov [ ], The Elinor Gertrude (Mead) Howells Collection, 1784.5(33), Howells Family Papers, Houghton Library, Harvard University. The year is not noted, but the return address is "Red Top," their home in Belmont, MA between 1878 and 1881.

signatures and poems in her autograph album from him and others including Sarah Orne Jewett, George W. Cable, Louisa May Alcott, and James Russell Lowell.[405]

Winifred's health, though, became of serious concern in her teenage years, as she was debilitated by nervous disorder in cycles of health and serious illness. After experimenting with a variety of treatment options, which I describe at more length later in this chapter, the persistence of her case led her father to entrust her treatment to the notorious S. Weir Mitchell. In letters to his father, William combines frustration over what he sees as her willful malingering with fears for the health of his daughter. After ultimate failures with the often expensive health movements of the day, what little hope he does have about her treatment under Mitchell centers on the physician's reputation for stern treatment. He can see no "sentimentality in the business; she would instantly take advantage of that" and hopes that she will be "forced along the path to health with a very firm hand, which fortunately he has."[406] Specifically, Howells writes that Mitchell "did not conceal from me that he thought it a very difficult case; her hypochondriacal illusions and obstinancy in her physiological theories complicate it badly; but everything that can be done will be done. As if she were my own daughter,' he said."[407] The patriarchal implications of Mitchell's surrogate fatherhood were well developed in Winifred's case: she insisted that she was suffering from a physical ailment, while Mitchell's treatment relied on treating her illness as hysterical. The treatment became a battle of the wills, with Winifred insisting that her health had not improved, and her father and Mitchell insisting that it had. Mitchell told Howells that while she is "in a very good way physically…she still continues rebellious, and wont admit that she's at all better, though she has gained fifteen pounds,

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[405] Howells took Winifred along to stay with the Clemens' in December 1877 while Howells lectured (T-H, 1:209) and on a trip to the Berkshires in August 1880 (T-H, 1:317); "Autograph Album," The Winifred Howells Collection, 1784.7(5), Howells Family Papers, Houghton Library, Harvard University.
[406] Crowley, *The Mask of Fiction*, 96.
[407] Crowley, 97.

and is able to do anything she likes."[408] Despite the frustration, Howells reported to John Hay that "Misery has been our meat with regard to Winny's invalidism for a year past, but now she's better,"[409] and when he visited his daughter in February 1889, concurs that she appears healthier, but remains "hypochondriacal as ever."[410] Having gained weight, Winifred was sent by Mitchell to his country clinic to breathe healthier air, and perhaps, as John Crowley suggests, to isolate her and break her will. One week later, on March 2, 1889, Winifred Howells died.[411]

Although the letter in which Mitchell reports her death is missing,[412] W.D. Howells' response is often read as suggesting that Mitchell discovered an organic cause for Winifred's illness: "We are almost happy to be assured that it was not through any error or want of skill; though this was what we believed from the first. The torment that remains is that *perhaps* the poor child's pain was all along as great as she *fancied*, *if* she was so diseased, as *apparently* she was" (emphases mine).[413] Edwin H. Cady, in his 1956 biography of William Dean Howells, writes of the anguish her death caused her father, heightened by a realization that he had erred in his assessment of the nature of her illness. Based mostly on this highly equivocal letter, he suggests, "Mitchell apparently ran an autopsy and discovered that nothing could really have saved Winifred. That her disease was organic, not merely

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[408] Crowley, 98.
[409] Mildred Howells, *Life in Letters of William Dean Howells* (Garden City, NY: Doubleday, Doran & Company, Inc., 1928), 1:420. Hereafter LiL.
[410] Crowley, *The Mask of Fiction*, 98.
[411] Crowley, 98.
[412] On Nov 18, 1919, W.D Howells wrote to Mitchell's widow asking that correspondence related to his daughter be suppressed. He says he will send her some letters for use in Mitchell's biography with one stipulation: "I should like to add now only the caution as to such as refer to my eldest daughter who became, by his utter kindness, his patient after he had warned me that she had 'delusion.' She died under his care—thirty years ago. Of course you would be careful to guard the use of any letters of mine which refer to her" (November 18, 1919, S. Weir Mitchell Correspondence and Writings, box 1, folder 9, S. Weir Mitchell Collection, 1861-1935, Kislak Center for Special Collections, Rare Books, and Manuscripts, University of Pennsylvania). Mitchell's feelings about his daughter's legacy shape the limited record that remains today—he refers to notebooks full of sketches and poems, but these do not appear to have been archived.
[413] Howells to Mitchell, March 7, 1889, box 1, folder 7, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania Kislak Center.

psychic, and that her pain had been all too physiologically real."[414] This hypothesis—what I refer to throughout as the "organic thesis"—has been transmitted through several generations of scholarship. The autopsy and the organic lesion are powerful images that pin a medical resolution onto a troubling story, the sensational vindication of which makes for a compelling narrative that travels through virtually every account of Winifred Howells.

Winifred appears rarely in scholarship, but when she does it is typically in one of two veins. The first is in scholarship on William Dean Howells. There have been several extensive biographies of this "Dean of American Letters," and each addresses Winifred's decline and death and its role in Howells' future writing.[415] The most detailed work in this vein is John Crowley's 1989 "Winifred Howells and the Economy of Pain." More recently, she appears in Michael Anesko's article "Guilt by Dissociation; or, the Merciless Quality of 'The Quality of Mercy,'" in which he finds echoes of Winifred's illness in Howells' novel *The Quality of Mercy* to show the influence of her death on his work.[416] A second collection of references to Winifred Howells come from scholars of late-nineteenth-century medicine. In pieces from Susan Poirier, Anne Stiles, and Nancy Cervetti, Winifred's case is placed alongside that of other literary "nervous women," like Jane Addams, Charlotte Perkins Gilman, and Virginia Woolf, as evidence of the logical ends of the misogynist treatments ill women of the time were forced to endure. Dying in the care of the same doctor who inspired Gilman's "The Yellow Wallpaper," Winifred's case goes beyond even the end of that tale. For both groups, the organic thesis is at the heart of her role in the critical narrative. For

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[414] Edwin H. Cady, *The Realist at War: The Mature Years 1885-1920* (Syracuse, NY: Syracuse University Press, 1958), 98. Cady notes that Howells' memorial pamphlet of his daughter is the best source. His sources in this section include letters between Howells and Mitchell, Mrs. Fields, and his father, held at University of Pennsylvania, the Huntington, and Harvard libraries respectively (and now consolidated in the Selected Letters). But he writes that "perhaps the key letter is to Mitchell," March 7, 1889.

[415] See Cady and Susan Goodman and Carl Dawson, *William Dean Howells: A Writer's Life* (Berkeley: University of California Press, 2005).

[416] Michael Anesko, "Guilt by Dissociation; or, the Merciless Quality of 'The Quality of Mercy,'" *American Literary Realism* 39, no. 2 (January 1, 2007): 126–37.

Howellsians, it cements guilt as a primary affect alongside grief, influencing his later works, while for feminist health scholars it serves as a case study of misogynist medical practice ignoring her own somatic complaints, with the diagnosis of organic disorder serving as posthumous vindication and a rejection of the hysterical label.[417]

For feminist health scholars, because Winifred claimed to be suffering from organic illnesses while being treated for hysteria, and because she seemingly died of those physical, rather than psychical, complaints, her story works as a sort of punch line to critiques of gendered diagnosis—not only was the treatment of hysterics misogynist and cruel, it was deadly. In the accounts of Howells scholars, Winifred herself is obviously secondary to her father—interesting at least in part through her ability to shed light on his psyche. This is stated most overtly in Cady's early biography: "It is essential to an understanding of Howells' life and work from this point forward to see that

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[417] Among Howellsians, citations root back to Cady's earlier work. Years later, Crowley's essay cites Cady's earlier work as the origin of the widely accepted conclusion that Winifred died of an organic disorder, noting that although direct evidence of the autopsy and its findings do not exist, it is, based on the posthumous letter, "reasonable to infer that Mitchell had performed [an autopsy] and that he had discovered evidence of some fatal organic condition." (Crowley, *The Mask of Fiction*, 99.) Goodman and Dawson's detail Mitchell's abuses, claiming that Winnie died of heart failure and that "To the last, Winny had insisted—contrary to Mitchell's opinion—that she was not improving. If her condition resulted from a congenital defect or a childhood disease such as measles, whooping cough, or scarlet fever (or the doses of arsenic used to treat them) rather than what might be called a twentieth-century disease like anorexia, she had, nevertheless, been misdiagnosed and mistreated." (Goodman and Dawson, *William Dean Howells*, 295.) Scholars writing about the history of women's health and hysteria rely on the same evidence. Poirier, citing Kenneth Lynn's biography, uses the organic thesis to drive home an argument about the cruelty of Mitchell's rest cure, noting that she died soon after he began force-feeding her, and that "An autopsy revealed an organic cause for her illness." (Suzanne Poirier, "The Weir Mitchell Rest Cure: Doctor and Patients," *Women's Studies* 10 [1983]: 30.) In her excellent biography of S. Weir Mitchell, Nancy Cervetti claims, based on both Cady and Lynn, that "Mitchell's autopsy revealed that Winifred's illness had been organic, not psychological" (144) and concludes that "it is clear that Mitchell failed this patient. Because his initial examination failed to reveal any organic disease, he assumed there was none. Failing to listen and thinking the pain psychological, he isolated Winifred and treated the case as a battle of wills." (Nancy Cervetti, *S. Weir Mitchell, 1829-1914: Philadelphia's Literary Physician*, Penn State Series in the History of the Book [University Park, Pa: Pennsylvania State University Press, 2012], 143–44.) Anne Stiles cites Cervetti, noting that Winifred was sent to Mitchell "for the treatment of a disease supposed to be psychological in nature… When Mitchell conducted an autopsy, he discovered that her complaint was organic in nature….This episode suggests that on occasion, Mitchell's refusal to listen to 'nervous' female patients could have tragic results. Even if Winifred's disease was incurable, as Mitchell alleged, the doctor's failure to take her complaints seriously surely augmented her suffering in the weeks leading up to her death." (Anne Stiles, "The Rest Cure, 1873-1925," *BRANCH: Britain, Representation and Nineteenth-Century History*, ed. Dino Franco Felluga, extension of *Romanticism and Victorianism on the Net*, 2012.)

Winifred's death was altogether a turning point. Otherwise," he continues, "there would be no warrant for discussing the event so closely."[418] Crowley's essay, which engages her life most fully, uses her illness to investigate the Howells family's complex psychodynamic in which members cycled through breakdowns, writing that her death "darkened nearly everything he would write after her death."[419] Though later writers deal with her more humanely (Goodman and Dawson even strongly censuring Howells for his treatment of her), in general she serves as emotional motivation, not actor, with suppositions about her cause of death as supportive evidence of claims about Howells and his work.

The problem with the ubiquitous "organic" thesis is that there is no indication that such an autopsy ever took place. Cady's assumption that Howell's acknowledgment of the reality of Winifred's suffering does not on its own justify the reading—especially given all its qualifying "seems" and "appears"—nor does his claim in some letters that she died of a "a sudden failure of the heart" and "a heart clot, instantly."[420] For Howells and his contemporaries, hysteria bred contradictions—simultaneously viewed as personal failure, fraud, and potentially fatal disorder—and Mitchell wrote elsewhere that hysteria often attacked the heart, causing symptoms "almost as lasting as if they owed their parentage to obvious and course structural lesions."[421] Indeed, Howells' letters give several possible precipitating factors in her death, including a fall a year earlier.[422] In one letter written before her death, Howells demonstrates the tension between suspicion of illness and certainty that even "false" symptoms could be fatal, belying the notion that "true" pain would have to be organically verified to be fatal:

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[418] Cady, *The Realist at War*, 98. This supposed excess of attention consists of four pages out of a three-volume biography.
[419] Crowley, *The Mask of Fiction*, 83.
[420] Crowley, 99.
[421] S. Weir Mitchell, *Lectures on Diseases of the Nervous System, Especially in Women* (Philadelphia: Henry C. Lea's Son & Co., 1881), 174.
[422] Crowley, *The Mask of Fiction*, 99.

> She has fairly baffled us, and has almost worn her mother out. There are some proofs that she suffers little or no pain, but she manages to work upon our sympathy so that we are powerless to carry out our plans for her good.—It will be a fearfully costly experiment, —perhaps $2000 in all—but we *must* make it, or else let her slide into dementia and death."[423]

Whatever guilt he may have carried, he apparently believed that his only error in sending his daughter to Mitchell was in doing it too late to be of use. Several years after Winifred's death, his sister Annie's daughter Vevie was unwell, and he wrote: "I hope now she will be patient to give up everything, for a while, and will make herself an oyster, and lie in bed till she becomes the fattest kind of oyster. …You know that the Weir Mitchell cure (which we tried too late) is perfect rest and continual nourishment of the richest sort- meat, milk, soup, whiskey—in great quantity."[424] Together, this evidence suggests a high degree of doubt that Mitchell performed an autopsy and located an organic condition that belied their earlier diagnosis of her nervous invalidism.[425]

The most definitive piece of evidence suggesting that the organic thesis is overstated is that Winifred's death certificate, not referenced by previous scholarship, does not list "heart disease" or any other organic malady as her cause of death. Rather, she is labeled with the amorphous and likely euphemistic "brain disease," with a noted duration of "about six years."[426] Thus, we have no real

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[423] Stiles, 94–5.

[424] William Dean Howells to Annie Frechette, November 17, 1893, Letters from William Dean Howells, 1784.1(57), Howells Family Papers, Houghton Library, Harvard University. In another letter about Vevie he indicates another potential pathogen: "Only, now, Annie, do keep her from study hence-forward, or at least till she is stronger than she ever was before. Such a brilliant child does not need the hard discipline the teachers give. Let her read all she likes, and let it go at that" (December 13, 1893, Letters from William Dean Howells, 1784.1(57), 58).

[425] In his medical writings, Mitchell ascribed several deaths to hysteria, and he was at least sometimes disallowed from performing an autopsy (*Lectures on Diseases of the Nervous System*, 20).

[426] Winifred Howells Death Certificate, 2 March 1889, reference no. 1888-89.15-H31, New Jersey State Archives, Camden County. The certificate is not signed by Mitchell, but rather by S. Preston Jones, attending physician at the small Stockton Sanitarium in Merchantville, New Jersey where she had apparently spent her final days. In a cruelly ironic report at the Philadelphia Neurological Society's March 26, 1888 meeting, about a year before her death, Preston responded to a paper cautioning against force-feeding that "he had never

reason to think that her death was ascribed to an organic illness by either Mitchell or Howells. The persistence of the theory can be explained in several ways: first, by an anachronistic application of a Freudian model, in which hysteria is primarily a question of psychology rather than physiology, to a pre-Freudian diagnosis. For Mitchell and Howells, hysteria was not a psychological disorder but a truly psychosomatic one, which could be both produced by and productive of organic disorder. And second, from the narrative allure of a vindicating lesion, and, relatedly, an enduring bias against the legitimacy of illnesses without recognized organic basis. The subtext of the narrative that uses Winifred's death from physical causes as a vindicating feature is that Winifred's treatment was particularly horrible because she was "really" ill rather than simply "hysterical." The organic thesis allows critics to make something out of her illness and death that they otherwise could not. The case of Winifred Howells is, among other things, a case of the pleasure and ease of the diagnostic narrative, both during and after her life. Surely, Winifred Howells' treatment was rife with misogyny and cruelty, but it was equally so regardless of whether of her disease was psychic or somatic—and indeed, the division of hysteria into a psychic rather than somatic disease is not tenable. By reading Winifred's story through a predetermined narrative arc, moreover, other possible readings of her work are foreclosed.

I do not intend to get to the bottom of Winifred's illness, nor will I make any suggestions about what hysteria "really is" or if she "really" had it.[427] In short, I intend to hold off on questions

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seen any serious results from forcible feeding" ("Forcible Feeding of the Insane," *Medical and Surgical Reporter* 58 [April 21, 1888], 503).

[427] Indeed, my use of hysteria to describe what Will Howells most often called her "invalidism" is problematic—the term was not used in Mitchell and Howells' correspondence, and their focus on her belief in organic disorder was a characteristic trait not just of hysteria, but also of neurasthenia and hypochondria (the terms more often used). The focus on her despair and emotionality, however, align her with descriptions of hysteria. The boundaries between these disorders, though, were incredibly porous. Moreover, whether or not they would have understood her illness as hysterical, it is unlikely that they would have deployed the term. Regardless, the epistemic conundrums Winifred's illness posed to her doctors, her family, and herself are the same as those Mitchell articulates for hysteria, and her treatment with the rest cure suggests that she was treated as hysterical. Many critics attempt retrospective diagnoses: Unlike Cady who perceives the organic

of the ontology of illness and attend instead to its phenomenology and rhetorical negotiation, arguing that it is less interesting whether Winifred was right about the physical origin of her illness—regardless of its origin her experience of illness was a physical one—and more interesting that she articulated it that way and was able to maintain confidence in her testimony in the face of authority figures who denied its legitimacy. In order to flesh out how hysterical narratives circulated in the life of Winifred Howells, I will talk about attempts at control over the illness narrative for different stakeholders: S. Weir Mitchell, William Dean Howells, and Winifred Howells.

Mitchell's hysteria, marked by symptoms of physical disorder without evidence of an underlying organic cause and by what he thought to be poorly regulated affect and self-control, had hazy boundaries that he acknowledged were often wholly illusory. Nonetheless, he spent much of his career attempting to define those boundaries and draw the hysterical into the realm of the scientific through the narrative genre of the case study. As other critics have argued, neurological science had a narrative problem—the lack of physical markers of disease required patient testimony, but patient testimony without physical evidence was inherently unreliable[428]—and this was especially

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nature of her death to be clear-cut, Crowley notes that her true cause of death was never fully clear, but his own posthumous diagnosis, relying on a Freudian model of "somatic compliance," is that Winifred died as a result of the physical harms of "hysterical anorexia." Reading psychoanalytically, Crowley writes that "Winifred's death itself may be regarded as a final hysterical conversion, a mnemic symbol of her psychological failure of heart, the ultimate denier of her womanhood…an unconscious suicidal wish, a desire to end her misery" (109). Anesko suggests that "Biographers and critics may never fully unravel the mystery that surrounds Winifred's illness and death, although most modern researchers would probably agree that (like many other middle-class Victorian women who suffered from neurasthenia) she betrayed all the classic symptoms of *anorexia nervosa*" (130). Anorexia was often viewed as a symptom of hysteria more than as a disorder on its own terms. William Gull talks about "hysteric apepsia" in 1868 which in 1873 he relabels "Anorexia Nervosa (Apepsia Hysterica, Anorexia Hysterica)" (Andrew Scull, *Hysteria: The Biography*, Biographies of Disease [Oxford: Oxford University Press, 2009], 102.) Mitchell routinely uses the term anorexia to denote a common symptom of hysteria.

[428] Lisa Long has compellingly argued that this reliance on narrative evidence was troubling for Mitchell and other early neurologists, arguing that doctors and patients became "adversarial" as patient narratives were required to align with medical authority. (Lisa Long, *Rehabilitating Bodies: Health, History, and the American Civil War* [Philadelphia: University of Pennsylvania Press, 2004], 44.) Taking the case of Mitchell's work with "phantom limb," a diagnosis defined by the impossibility of visibility, Aura Satz demonstrates how Mitchell's attempts to classify phantom limb and the "science" of spiritualism similarly relied on narrative and belief, as both try to "map invisible forces, employing at times a similar rhetoric of substantiation" (Aura Satz, "'The

so for hysterical women, believed to be pathologically immoral. I suggest that his attempt to grapple with whether hysteria was legitimate or illegitimate, psychic or somatic, was largely a narrative pursuit—in order to impart what he thought was expert knowledge, he relied on the case study genre to transmit and naturalize his categorizations. He believed that hysteria required a narrative intervention: you could model for patients the health that should be mimicked, and thus narrative and belief could be as important as biology. As part of his assault on hysterical narratives, Mitchell disseminates fictions meant to penetrate the body, shape symptoms, and instill cure narratives and belief in doctors' authority. I move beyond his medical work, turning to his novel, *Roland Blake*, which does the cultural work of cementing the stereotype of the foolish, weak hysterical woman, drawing on previous models and infusing them with medical authority.

This stereotype was at least somewhat convincing to William Dean Howells, whose letters to family prior to Winifred's death contain sentiments aligned with Mitchell's philosophy. Following her death, however, Howells attempts to narrate a different kind of legacy for his daughter through a self-published memorial pamphlet titled simply *Winifred Howells*. This pamphlet has been a major source text for Howellsians writing about Winifred, who read it as pure biography. Through a comparison of this pamphlet with Howells' original manuscript, housed at the Houghton Library and previously unmentioned in the critical literature, I unsettle the role of this document as factual account of her life, demonstrating Howells' efforts to shape it into a particular kind of blameless image of suffering. Herndl's *Invalid Women* suggests that there were two models for the invalid woman in the nineteenth century, which she relates to Mrs. St. Clare and to Eva: "On the one hand, the invalid is a selfish, hateful, and spoiled woman whose illnesses are feigned to enable her to avoid any kind of work; she lives in luxury and thinks only of herself and her imagined ills….On the other

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Conviction of Its Existence': Silas Weir Mitchell, Phantom Limbs and Phantom Bodies in Neurology and Spiritualism," in Salisbury and Shail, *Neurology and Modernity*, 114.)

hand, the virtuous female endures her illness without complaint, more concerned with those who will be left suffering after her death than with herself."[429] Whereas Mitchell's invalid woman falls in the former camp, and that stereotype also influenced at least part of Howells' reaction to his daughter, the biography shows us a Winifred in the model of Eva.[430] His pamphlet takes seriously her impulses and skills as a poet, and it is in this pamphlet that her remaining poetry can be found, but he reads her poems through the lens of his loss as providing a mimetic window into the truth of her suffering, rather than as stylized artifacts. Unfortunately, her own archival record is minimal, and we lack an unmediated voice, with the exception of a handful of letters and a small number of poems—an archival gap especially notably in its contrast to the enormous archives of both S. Weir Mitchell and William Dean Howells, each of which self-consciously crafted their letters and works for posterity.

These master narratives have challenged our ability to see her as a poet in her own right. The question of who holds the narrative power of diagnosis is central to Winifred Howells's story, since she was disbelieved in her own lifetime and accused of loudly malingering, while after her death she was praised for her angelically silent suffering, and so my chapter ends with her own limited catalog of poetry. Winifred Howells has doubtless been a minor figure—rarely mentioned at all, and, as pointed out above, not taken on her own terms when she is. I would like to reframe her poetry so that it is not viewed as a window into her illness, but as a series of texts that engage with the rhetoric of health and illness and reject sympathy, and which by their very from could be read as illness counternarratives.

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[429] Diane Price Herndl, *Invalid Women: Figuring Feminine Illness in American Fiction and Culture, 1840-1940* (Chapel Hill: University of North Carolina Press, 1993), 51. Herndl suggests that Mrs. St. Clare and Eva "represent the two extremes of mid-century representations of the female invalid."

[430] A point also made by Crowley.

Mitchell's Hysterical Narratives

Hysteria looms large in the history of women's health. When thinking about late-nineteenth-century hysteria, though, people often think first of the neurologist Charcot, whose patients' roles in theatrical illness performances have led to analyses of hysteria as iatrogenic performance,[431] or of his student Freud interpreted hysteria as a disease "mostly of reminiscences." American hysteria, however, as articulated most fully by S. Weir Mitchell, was a unique disease. Toward the end of *Lectures on Diseases of the Nervous System, Especially in Women* (1881), Mitchell concurs with a colleague at the Philadelphia Hospital, Dr. Mills, who wrote to him that, "cases of grave hysteria, such as the hystero-epilepsies of Charcot, are rare in this city and country." Mills continues, "Neuralgia, spinal irritation, ovarian hyperæsthesia, and special forms of mental and moral perversion are, in my experience, the more usual forms of American hysteria," and Mitchell notes that his experience and correspondence suggests that this view is widely held.[432] The emphasis on "mental and moral perversion," however, did not mean that the organic causes and manifestations of the disease were viewed as secondary, as they would later in the "somatic compliance" of psychoanalysis.

Mitchell understood hysteria neither through the neurological lens nor the psychological one—or, more properly, he viewed it through both of them.[433] He understood it to be a

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[431] Didi-Huberman's *Invention of Hysteria,* for example, is a philosophical and lyrical examination of the relationship between the new technology of photography and the creation of hysteria in Charcot's Saltpetriere, documenting the "extraordinary complicity between patients and doctors," the production of "theatricalized bodies" as a "spectacle," and arguing that hysteria is "fabricated" in this environment. (Georges Didi-Huberman, *Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière*, trans. Alisa Hartz [Cambridge, Mass.: MIT Press, 2003], xi, 4.) Both Andrew Scull's *Hysteria: The Biography* and Shorter's *History of Psychiatry* (113ff) make similar claims. The anti-psychiatrists understood the diagnosis as medical trick and invention, with both patients and doctors manipulating disease categories for individual gain (Porter, "The Body and the Mind," 234).

[432] Mitchell, *Lectures on Diseases of the Nervous System,* 202.

[433] Charcot's eventual admission of some psychological influence in hysteria was shaped in part by observing the success of the Weir Mitchell rest cure, which called for a change in environment. (Shorter, *Psychosomatic,* 193-4). Scull suggests that Mitchell reacts against the view that hysteria is fake, and along with Beard, sees nervousness as a physical problem with the nerves, rather than from emotional problems, and that this

psychosomatic disease in the truest sense—the psychological aspects of hysteria were both produced by and productive of somatic disease. It was a disease of morality: but morality could be a casualty both of long organic illness and of improper education or social environment. It was above all a disease of mimicry, both intentional and unintentional, in which symptoms took the shape of previously defined disease categories. He understood hysteric women as embodying beliefs about illness—as taking on the character of an ill woman, as following the narrative trajectory of physical and mental decline. These narratives were not superficial and could become so thoroughly embodied that they could lead to death. The doctor, then, worked through narrative intervention, coaching the patient toward a healthful resolution through a steady upward narrative arc of cure. Essential to this project was the de-sentimentalizing of the illness narrative—sympathy, he believed, encouraged invalidism and fed into the illness narrative.

Mitchell was a dominant figure in the popular imagination of the late nineteenth century, well known both for his medical philosophy and his literary output.[434] Called by some the "Father of American Neurology,"[435] Mitchell was an early adopter of laboratory medical science in America and his incredibly detailed and well-documented work with wounded soldiers in the Civil War revolutionized neurological science. He provided detailed descriptions of medical concepts still used today, including causalgia, phantom limb syndrome, and erythromelalgia (once "Mitchell's disease"). Moreover, his moral philosophy toward the nervous illness that dominated his late medical career has been read as directly prefiguring the psychoanalytic revolution (although he was unimpressed by Freud).[436]

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resistance cements the neurological explanation in America (*Hysteria,* 93). Mitchell's philosophy of hysteria, with its complicated understanding of simulation and mimicry, however, complicate this thesis.

[434] For a detailed and nuanced approach to Mitchell's life, see Cervetti, *S. Weir Mitchell.*

[435] Cervetti, 1.

[436] Nancy Cervetti divides his medical career into three linked phases: first, his early physiological work with vivisection and rattlesnake venom; second, his turn to neurology with gunshot Civil War soldiers; and third, his development and propagation of the "rest cure" for hysteric women. Cynthia Davis reads him as an early

This last point, though, has earned him a different legacy. Biographer Nancy Cervetti notes that he has become "a legendary villain for many scholars" (155). Mitchell, who developed and popularized the "rest cure" for nervous and hysteric women, earned the misogynist label that follows him still. For many literary critics, Mitchell's name is most recognizable in the ominous threat leveled at the narrator of Charlotte Perkins Gilman's 1892 story "The Yellow Wallpaper," in which a woman is prescribed a treatment resembling Mitchell's rest cure and driven mad by it. At one point, she worries, "John says if I don't pick up faster he shall send me to Weir Mitchell in the fall."[437] Indeed, in the brief article "Why I Wrote The Yellow Wallpaper" that Gilman composed some twenty years after the story's publication, she says that she wrote it for the express purpose of overthrowing the tyranny of the rest cure—and claims that she sent the work to Mitchell, who, though never acknowledging it, changed his treatment after reading the story, though there is no evidence that this is actually the case.[438]

The lack of clarity around the etiology of Winny's invalidism was built into the structures of Mitchell's hysteria: paradoxically, while diagnosing hysteria by excluding organic disorder, Mitchell

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psychologist and in some of his views a precursor to Freud and Breuer. (Cynthia Davis, *Bodily and Narrative Forms: The Influence of Medicine on American Literature, 1845-1918* [Stanford, CA: Stanford University Press, 2000], 123.)

[437] Gilman, *"The Yellow Wallpaper" and Other Stories* (Mineola, N.Y.: Dover Thrift Editions, 1997), 6.

[438] Gilman, "Why I Wrote The Yellow Wallpaper." Scholars like Julia Bates Dock have pointed to inconsistencies in Gilman's claims about her relationship with Mitchell and to factual inaccuracies propagated about Gilman and her story. (Julia Bates Dock et al., "'But One Expects That': Charlotte Perkins Gilman's 'The Yellow Wallpaper' and the Shifting Light of Scholarship," *PMLA,* 111, no. 1 [1996]: 52–65.) Such inconsistencies hardly negate the oppression that Gilman felt under his care, but point to Gilman behaving not simply as a victim of cruel misogyny (though nobody denies that Mitchell was sexist and autocratic in his treatment) but as a canny social activist who effectively used the form of the short story to combat his autocratic methods for dealing with unwell women. Interestingly, for the purposes of this paper, William Dean Howells was the original recipient of "The Yellow Wallpaper," which he claims he attempted to have published in *The Atlantic* before he was editor, referring it to Horace Scudder in October 1890 as "pretty blood curdling, but strong, and is certainly worth reading" and, when that failed, to have advocated for it tirelessly until it was eventually published in *The New England Magazine*. Gilman's story is different, but Howells' reaction to the story is not disputed. He read it a mere two years after Winifred's death, and could not have missed the critique of Mitchell's treatment, despite his ongoing friendship with Mitchell and his belief that earlier intervention could have prevented her death.

took for granted that hysteria was in many ways an organic condition. Many of the hundreds of hysterical and nervous cases Mitchell relates in his lectures and casebooks begin with a physical illness or wound. In his view, organic maladies sowed the seeds for the kind of disordered morality and will that manifest in hysteria. Nor did Mitchell believe that hysterical symptoms—symptoms created or amplified non-organically—were physically innocuous, and hysteria and nervousness could wreak serious havoc—even to the point of death—on the physical system. In recounting the case of young woman with hysterical vomiting, the organic results of her condition are graphic:

> She was lying on her back, staring upwards, with glassy eyes set deep in dark rings, which faded into a sallow leathery skin, drawn tense over projecting bones. Her mouth was wide open, the jaw dropped, and the whole cavity literally lines with thrush (muguet).... As I stood and looked at this singular spectacle, apparently that of a dying child, she groaned at brief intervals, and also coughed a good deal, at such times expressing pain in her face, but usually lying quite still, with a look of merely the most profound melancholy. A careful study enabled me to find no organic disease.[439]

This narrative reveals that even without an observable "organic disease," hysteria was nevertheless a disorder of the body.

His entire catalog of medical work circulates around the genre of the case study, and he routinely notes that the general medical theory and categories he is putting forth will become more comprehensible once put into narrative form, as in the following*:* "The following histories may serve better to illustrate the clinical features of acute neuritis than any more methodical details"[440] or "Perhaps a full sketch of one of these cases will be better than any list of symptoms."[441] Narrative

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[439] Mitchell, *Lectures on Diseases of the Nervous System*, 77.
[440] S. Weir Mitchell, *Injuries of Nerves and Their Consequences* (Philadelphia: J.B. Lippincott & Co., 1872), 63.
[441] S. Weir Mitchell, *Fat And Blood: And How to Make Them* (Philadelphia: J.B. Lippincott & Co., 1877), 27.

has a unique power to aid comprehension, to seal taxonomies of illness in the mind of the reader. As Lisa Long notes, it is "through the meticulous layering of case history upon case history that individual bodies would become recognizable and, ultimately, treatable as they were amalgamated into a theoretical composite."[442] The rendering of patient experience into "text" is most apparent in a line from *Lectures* in which he writes, "The man before us is a feeble anæmic creature, who complains that he has become nervous, an ill sleeper, and has lost weight….He has no organic malady, and I only speak of him at all because one symptom of his case is of sufficient interest to serve as a text" (153). The case study was, for Mitchell, the most enduring form of medical meaning making, and in *Doctor and Patient* (1888), he advocates for reading outdated medical texts, suggesting that patients can ignore the theories, and read for "cases."[443]

This narrative was necessary because hysteria posed obvious problems for this fantasy of empiricism. In his unpublished autobiography, Mitchell writes of the medical profession's "desire to know the truth as to disease," which must be tempered with humility: "There is always a little fog around all our medical conclusions. We can rarely be absolutely certain. The power to act with decision within the limits of the medically attainable, with the attendant knowledge that uncertainty is with us ever, is valuable in medicine."[444] Hysteria, specifically, he once called "the nosological limbo of all unnamed female maladies. It were as well called mysteria for all its name teaches us of the host of morbid states which are crowded within its hazy boundaries."[445] Navigating these hazy boundaries, Mitchell relied on narrative structure and grouping cases by genre.

His incapacity to read organic disease onto the body meant that he had to rely on patient testimony. Because it seen as an illness of moral perversion and simulation, patient testimony was

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[442] Long, *Rehabilitating Bodies*, 32.
[443] S. Weir Mitchell, *Doctor and Patient* (Philadelphia: J.B. Lippincott & Co., 1888), 20.
[444] S. Weir Mitchell, "Autobiography," typescript draft, series 7.1, folder 2, S. Weir Mitchell Papers, College of Physicians and Surgeons of Philadelphia, 98.
[445] Quoted in Cervetti, *S. Weir Mitchell*, 114.

intrinsically unreliable, as reflected in Weir and Will's doubt of Winny's illness. According to Long, physicians like Mitchell became obsessed with battling this subjectivity problem by determining new methods for "objectively" proving the reality of invisible symptoms to the general population.[446] Mitchell, with his collaborators Morehouse and Keen, developed techniques for detecting malingering in the nervous wards of the Civil War that relied on various tricks and threats to determine the reality of patient-reported suffering[447] His one-time student Beverley Tucker eulogized him long after his death as a diagnostic genius, relating stories of him accurately pinpointing either organic or hysterical conditions when everyone else failed—he even paints him as a true Dupin-esque medical detective, using scientific deduction to solve a local robbery.[448]

Mitchell's beliefs about simulation indicate how strongly he felt narrative and imagination could shape not just the subjective experience of a symptom, but its physical manifestation. While he believes that everyone is subject to the impact of belief on health, he writes that simulators are especially "prone to dwell on physicians' opinions, to deduce exaggerated possibilities of trouble, and in obedience to the least prediction of ill to consent or hasten to take extreme precautions" (*Lectures* 54). Thus, a physician's opinion can fundamentally alter these patients' illness. The doctor's power could also be negative, and he gives the case of a girl with minor symptoms who descends into hysteria after a surgeon assigns a serious diagnosis which becomes a kind of self-fulfilling prophesy. This diagnosis, in conjunction with pampering and sympathy she received, leads to serious physical problems (*Lectures* 80). The power of belief in a diagnostic narrative, then, is more than simply a theoretical struggle—beliefs about illness and disorder could structure not only the patient's experience but the function of their body. Thus, physicians must craft a potential cure narrative that

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446 Long, *Rehabilitating Bodies,* 44–45.
447 See Wm. Keen, S. Weir Mitchell, and Geo. Morehouse, "On Malingering, Especially in Regard to Simulation of Diseases of the Nervous System," *The American Journal of the Medical Sciences* 96 (October 1864): 367. Long's essay discusses this issue at greater length.
448 Beverley Tucker, "Speaking of Weir Mitchell," *The American Journal of Psychiatry*, no. 93 (1936): 344.

they can transmit to a patient. For instance, if a woman believes that her eyes cannot bear the light of open curtains, you can tell her that, once she's had a few days of the rest cure, she will find herself able to stand the light. A few days later, she will be able to do so (*Lectures* 68).

Because mimicry provides a physiological mechanism for embodying narrative, narrative can be positioned as life-or-death medical factor Mitchell can use to claim control over the illness narrative. The doctor's own "realist" narrative must overpower the sentimental narrative of the family, and it is a physician's duty to impose his own narrative and moral vision so that the patient begins to mimic models of health and not illness. The many forms of narrative he lays out in different genres, then—from medical work for other professionals, to popular health books for a mostly female audience, to fictional representations of illness—are meant to shape the acceptable presentation of illness and so to impact people's health in very concrete ways. For Mitchell and his patients, the stakes of narrative control are not just verbal or political, but embodied.

Mitchell's attempt to secure this surrender did not only take place in the sick room, and he actively propagated his views in a variety of media. That he understood his writing to have a physiologic effect is clear in the introduction to his popular medicine text *Doctor and Patient*; Mitchell cautions nervous women from reading the text, targeting instead the recovered or those hoping to avoid its onset (7). The power of mimicry meant that reading about a symptom could produce disorder in the nervous. (That Howells, too, ascribed to some version of this is clear in a letter to his sister on the occasion of an extended stay from thirteen-year-old Winifred: "We would rather Winny would not read such excruciating novels as Jane Eyre. If you could get her Jane Austin's stories, or Miss Mulock's, out of the library, we should be very glad. And for my own part, I wish she would read biography, history, and poetry, rather than any sort of novels."[449]) In addition to shaping views

[449]Howells to Annie Frechette, 18 February 1877, Letters from William Dean Howells, 1784.1(57), Howells Family Papers, Houghton Library, Harvard University, 33

of popular health through openly medical tracts, though, Mitchell also wrote fiction that often centered around illness.

Mitchell used literary narrative to solidify the physician's narrative authority and expand the imagination of potential patients, shaping their sense that illness can be overcome (or not) by following the models offered by the sick women of his novels—a shift in imagination he would have understood as a therapeutic intervention. He pulls on pre-existing stereotypes about vaguely ill women, but also strengthens them by lending them the authority of medicine. In *Wear and Tear* (1871), he writes, "My phrase may seem outrageously strong, but only the doctor knows what one of these self-made invalids can do to make a household wretched. Mrs. Gradgrind is, in fiction, the only successful portrait of this type of misery, of the woman who wears out and destroys generations of nursing relatives, and who, as Wendell Holmes has said, is like a vampire, sucking slowly the blood of every healthy, helpful creature within reach of her demands" (30). In his view, the moralizing medical philosophy he shares with Holmes has yet to be adequately disseminated, and he understands fiction as a possible realm in which to diagnostically capture the "type" of the invalid woman, to suffuse certain kinds of illness with shame, and to model what he felt was the appropriate response to illness.[450]

Mitchell moved back and forth through literary and medical realms. His letters suggest that he routinely sent copies of his novels and poems to fellow physicians, and his patients included literary figures like Edith Wharton, Walt Whitman, and James Russell Lowell.[451] He leveraged medical relationships into literary connections, seeking literary advice and critique from former and current patients. Mitchell was interested in the relationship between the two modes of thought. He wrote, repeatedly, to George Milbry Gould, editor of a medical journal, fishing for an article on his

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[450] Long's chapter also demonstrates how Mitchell uses fiction—specifically "The Case of George Dedlow"—to disseminate medical epistemologies.
[451] Cervetti, *S. Weir Mitchell*, 171, 198.

work as literary physician: once, "I wish some one would review my books with pure reference to the clinical studies in all of them – I hate to have my profession feel that even in fiction I am drifting away from it – The medicine of novels is usually stupid stuff."[452] Literature and medicine were not distinct pursuits for Mitchell, who understood the techniques and knowledge of one to translate to the other.

Much as his medical writing relied on literary from, Mitchell's literature drew on medicine. In the 1880s, well established in nervous medicine with several influential medical tracts and a handful of short popular health books, Mitchell turned to fiction, with which he'd had some early success with the anonymous stories "Autobiography of a Quack" and "The Case of George Dedlow."[453] His first novel, *In War Time*, was published a year after his masterwork of hysterical classification *Lectures on Diseases of the Nervous System*. A few years later, hysteria played a major role in his second novel, *Roland Blake* (1886). Frustrated with the dissatisfying and inaccurate representation of physicians in literature, he rails against medical error.[454] Writing of his use of pathology in literature, he argues that "The great art in this work is to conceal the knowledge which a doctor has of these cases and to use

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[452] Mitchell to George Milbry Gould, 4 April [1898?], series 4.2, box 8, folder 6, S. Weir Mitchell Papers, College of Physicians and Surgeons of Philadelphia.

[453] Several interesting articles have been written about the "Case of George Dedlow." Mitchell frames the story, published in *The Atlantic* in 1866 as a true medical case rejected by medical journals. Supposedly, despite featuring a quadruple amputee reunited with his limbs through a spiritualist séance, at least some readers took this story seriously and sent donations for Dedlow's care. Long notes that the popularity of the story is connected to "the amorphousness of medical authority at the time but also to the public's fears and desires about the authenticity of nerve injuries" (*Rehabilitating Bodies*, 41) In addition to Long, Robert Goler reads the story as changing attitudes toward the disabled in the post-bellum era, while D.J. Canale looks at the story in relation to Mitchell's later work on phantom limb. (Robert I. Goler, "Loss and the Persistence of Memory: 'The Case of George Dedlow' and Disabled Civil War Veterans," *Literature and Medicine* 23, no. 1 [2004]: 160–83; D. J. Canale, "Civil War Medicine From the Perspective of S. Weir Mitchell's 'The Case of George Dedlow'," *Journal of the History of the Neurosciences* 11, no. 1 [2002]: 11.)

[454] His concern with accuracy, though, was not a concern with a graphic realism. He wrote, "Since, however, the growth of realism in literary art, the temptation to delineate exactly the absolute facts of disease has led authors to dwell too freely on the details of sickness. So long as they dealt in generalities their way was clear enough. Of old a man was poisoned and done for. Today we deal in symptoms, and follow science closely in our use of poisons" which can be "as disgusting and inartistic a method as fiction presents" (*Doctor and Patient,* 72), and he decries the "realistic atrocities of Zola" (73).

only enough to interest without disgusting; for instance, in War Time there is a description of a case of Locomotor Ataxia; in Roland Blake hysteria is used; in Far in the Forest there is a case of delirium of persecution and in Hugh Wynne we find the degenerative changes in the brain of an old man; also in Francois there is the first use in fiction known to me of a case of what we call circular insanity. I had hardly thought of this fact myself; it was almost by instinct that I used this kind of knowledge."[455]

Roland Blake opens on the battlefields of the Civil War before jumping to another battle scene in the North: the sickroom. The combatants in this latter war are Octopia Darnell, an hysterical invalid, and Olivia Wynne, her once vigorous young cousin who has become progressively nervous through waiting on Octopia and providing her with constant sympathy. Mitchell's stereotyped characters and preaching narration leave little doubt about where our allegiances are meant to lie, and the novel works as a kind of dramatization of the popular advice he will publish the next year in *Doctor and Patient*, a health tract for popular audiences that stresses the horrors possible when hysteric women are tended to by members of their household, the dangers of inactivity on vigorous women, and the capacity for nervousness to sap willpower. Arguably, the narrative does more to solidify the place of his medical theories in the popular imagination than the more openly didactic medical text—at the very least, it extended his reach, engaging readers' judgment and emotion.

Olivia, an intelligent and lively twenty-year-old, is being stifled by living with her elderly grandmother and invalid cousin. We quickly learn that she finds Octopia overbearing and that she rarely leaves the house, and we begin to see obvious symptoms of a dangerously encroaching nervousness. As much as the Confederate scoundrel Richard Darnell, plotting to marry Olivia for

[455] S. Weir Mitchell to George M. Gould, 9 December 1899, series 4.2, box 8, folder 6, S. Weir Mitchell Papers, College of Physicians and Surgeons of Philadelphia.

her money, the villain of the novel is Octopia, whose sickbed demands are sapping Olivia's vital force and hope for a healthy future. Alongside the romantic drama, we witness a nervous one: will the invalid corrupt a healthy young woman into a lifetime of nervousness? The question is not subtle: "The exactions of her nervous, sickly cousin were surely sapping the wholesome life of the younger woman, and as surely lessening her power of self-restraint."[456] (50). Some lines from the novel could even be directly drawn from his works of popular medicine: "The moral and mental machinery may, like the muscular mechanism, become disordered from lack of chance to develop. When fate denies the sunshine to gracious seed of nature's sowing, some evil comes of it,—decay, distorted growths, too late a fruitage. There were these risks for Olivia." (209)

At the same time that our sympathies are invested in Olivia's health, we are shown in Octopia a stereotypically tyrannical invalid. In *Doctor and Patient,* Mitchell writes, "for the most entire capacity to make a household wretched there is no more complete human receipt than a silly woman who is to a high degree nervous and feeble, and who craves pity and likes power" (117). Octopia fits the trope: she is self-involved, annoyed at the smallest rustle of Olive's dress or creak of her shoes and demanding that Olivia read to her until her own eyes are tired and damaged. Beyond the demands of her illness, she is also scheming to marry Olivia to her brother Richard, blackmails her grandmother, and moreover, is pro-Confederacy. Mitchell here unites a wide range of moral failures, crafting a singularly unpleasant character. At one point, angry with her servant for a perceived failure of sympathy, she threatens, "You shall be punished for this…I will make you a field-hand" (54), before being reminded that the woman is a free northerner. Following the type of Harriet Beecher Stowe's invalid Mrs. St. Clare, Octopia unites the immorality of the slavery-lover and the obstinately sick woman, clarifying beyond doubt how readers are supposed to evaluate this woman.

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[456] Silas Weir Mitchell, *Roland Blake* (Boston: Houghton, Mifflin and Company, 1886), 50.

By portraying Olivia, a woman whose return to health we are emotionally invested in, Mitchell builds cure into the narrative structure of the novel. Despite the battlefield setting and the marriage plot, Mitchell's own description of the novel suggests that the representation of women's health is at the heart of his story. In a letter to Amelia Gere Mason, he writes, "At present I have drawn a woman whose love of power lures her on to suggestions of crime and recoils when her example brings another into range of like temptings. Also a woman who is nearly wrecked by the claims on her feelings and body by a sick woman's exaggerated crave for sympathy and help and 'glutinous affection. It is a long and rather original story involving pits of war, etc."[457] Then tension in the cure arc arises from Olivia's instincts about her own needs to secure health and an environment where she is trapped. Olivia knows that her care for her cousin is defeating her character, she wants to leave the house and take exercise, and attempts self-control (41). The first of these she cannot escape because of the demands her family puts upon her, while the last is often ineffective as time and again she becomes irritable and takes Octopia's bait—again, for Mitchell, an unmistakable symptom of early nervousness. In the end, Olivia's rejection of illness takes the form of a removal to a rural town where she recreates outdoors and becomes acquainted with the locals, Mitchell's approved plan, as suggested by the final chapter of *Doctor and Patient*, "Out-Door and Camp-Life for Women." Moreover, her complete rejection of illness is contemporaneous with her engagement: Roland proposes to her on a boat, which she has resolved to board in order to face her fear after a near-death boat ride because, she says, "I have no patience with nervousness" (341). The marriage plot and the cure plot are one and the same.[458]

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[457] Mitchell to Amelia Gere Mason, 24 September 1885, Series 4.3, folder 4, S. Weir Mitchell Papers, College of Physicians and Surgeons of Philadelphia.

[458] This is not unique to his fiction. In *Fat and Blood*, Mitchell gives a case study of a woman who he says studied too much too quickly at college. He gives a history of her breakdown and then what she ate at what times every single day until she has gained forty pounds. At the end, she regains her period after five years and becomes pregnant eighteen months later—so the long case history ends in a medical marriage plot where she is ushered in to reproductive life (86). In *Roland Blake,* the medical and the romantic are inartfully mashed

The novel, much like *Doctor and Patient*, offers explicit advice about how to "choose" health over illness. But there is a striking omission in the novel: a doctor. For all of his insistence on the power of an autocratic physician in the cure of nervous women, and for all of his interest in the depiction of physicians in novels, Olivia's cure and Octopia's improvement are both effected without such an expert. Poirier notes that the doctors in Mitchell's stories demonstrate the importance of authority in the medical relationship, but his novel demonstrates that he could communicate the imperative of disregarding personal understandings of illness without the use of a doctor, suggesting a more diffused medical vision.[459] By narrating medical truths explicitly to his readers, he welcomes us into the kind of medical discrimination he attempts to outline in his explicitly medical works—he encourages the dispersal of his medical philosophy through literary means, as the role of the medical doctor is displaced by the observational power and drive for cure that the narrator grants the reader (we know exactly what Olivia should do—leave the house, get out of the sickroom, meet some [northern] men). In the novel, the road to health seems common sense, and missing the turn onto that road becomes an issue of moral failure.

That the moral judgment of the novel was taken seriously, and at least somewhat effectively transmitted to readers can be seen in letters written to Mitchell. Although Mitchell relies on conventional plots and stereotyped figures, Sarah Orne Jewett wrote that Octopia is "wonderfully true—altogether a perfectly drawn character. I read her with hungry delight!"[460] Amelia Gere Mason

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up: when one chapter ends on high emotion, with the anticipated engagement between Roland and Olivia, the next opens: "The surgeon's idea of 'shock' as a result of sudden physical injury should be imported into the domain of criminal psychology. The ball which crushes a joint stops or weakens the distant heart, or palsies a remote limb, or enfeebles the whole frame. In the sphere of mind and morale the abrupt shock of fear or shame may in like manner affect distant nerve-cells and thus deaden memory, palsy the organs of reason, annihilate for a while the power to love or hate, and even reduce a man for a time to the verge of inert idiocy" (345). Even at the height of romance, Mitchell can't help but moralize about medicine.

[459] Suzanne Poirier, "The Physician and Authority: Portraits by Four Physician-Writers," *Literature and Medicine* 2, no. 1 (1983): 21–40.

[460] Quoted on Cervetti, 160.

wrote, "Poor Octopia, her name doomed her. She is too real not to have been drawn from life. You deal with very subtle shades of motive and feeling and give a singularly delicate analysis of many forms of unconscious self-deception. It is quite possible that the multitude, intent upon striking events, may overlook many of your finest points." She is convinced by his portrayal of Octopia, and only criticizes Olivia's servitude: "Perhaps your autocratic position with regard to invalids, who have no choice but to be patient under professional commands, has led you to over-estimate her humility under masculine despotism. A woman loves strength, but not a despotic assertion of it. She may love to yield, because she prefers some other will to her own, but never to be made to yield, unless she belongs to a certain spaniel type which you would not choose for a model. It is a popular fallacy which I think the coming woman will dissipate."[461] For Mason, then, it is the pathologization of the healthy woman, not the disdain for the unhealthy, that is a problem in his representation of women.

A letter from his longtime correspondent, Elizabeth Stuart Phelps, though, indicates that this disdain was not universally unremarked:

> This is to tell you that I have read "Roland Blake" with many sorts of interest. It is a good story. Pretty hard on the typical invalid! … This winter I have been a cripple for four months with a sprained ankle; and now, *après cela*, a sprained back, which prevents me from even getting into a carriage. In this (to me) perfectly unprecedented experience of helplessness, and galling infliction of being waited upon—Octopia gave me the heart-ache. I never had to use a hot-water bag, before, in all my sick life, and *hers* is 'ever before me,' so that I hide mine from view like a guilty secret!

[461] Amelia Gere Mason to Mitchell, 27 December 1887, series 4.3, box 9, folder 1, S. Weir Mitchell Papers, College of Physicians and Surgeons of Philadelphia.

> But that does not interfere with the excellence of the story. Give me the other kind of invalid sometime? You must know her." [462]

Phelps' reaction to Mitchell's story fuses accusation with shame, suggesting that the novel shaped the illness experience of at least one reader. Her accusation suggests that his stereotypical characterization was not simply typical for the times—she could reasonably have expected a more thoughtful representation, and she understands the power that his characterization of invalidism could have. The shame drives home this latter point. Even a woman able to critique this portrayal and understand its cruelty internalizes its message—she becomes self-conscious in her own invalidism, hiding the medical apparatus that she feels signal her selfishness and weakness. In the closing jab, "You must know her," Phelps confronts Mitchell with the inaccuracy of his character—his friendships with ill women, like her, provide him plenty of material for more complex, empowered representations of female illness, but he relies on (and medicalizes) stereotype.

Ultimately, Mitchell's literary and medical work were complementary pursuits. His emphasis on narrative and case study helped to naturalize the nervous diagnosis, as suggested by Schuster: "Written with a novelist's flair, Mitchell's books, articles, and lectures on neurasthenia exerted a powerful influence on popular and professional understanding of the illness."[463] Octopia is a moral medication, demonstrating the foolishness of taking one's own suffering seriously, while Olivia's decline serves as narrative evidence of his argument against caring for the ill at home. Reflecting on his writing career in his autobiography, he wrote, "as an eminent neurologist has said, there is a clinic in every one of these books. Of this I was hardly conscious until of late years, but I am quite sure that as pictures of doctors and patients, they are not surpassed in English by any except Lydgate in

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[462]Elizabeth Stuart Phelps to Mitchell, 11 February 1887, series 4.3, box 9, folder 27, S. Weir Mitchell Papers, College of Physicians and Surgeons of Philadelphia.

[463] David G. Schuster, "Personalizing Illness and Modernity: S. Weir Mitchell, Literary Women, and Neurasthenia, 1870-1914," *Bulletin of the History of Medicine* 79, no. 4 (2005): 701.

Middlemarch."[464] This framing—of the novel as clinic—emphasizes the didactic role of his creative output. Frank writes, "disease can compel bodies, but how ill people are motivated to act depends on the imaginative conceptions of illness provided by storytellers."[465] The clinic, that institution for training the vision and speech of the physician, is imagined capaciously, as the reading public are welcomed into the surgical theater to observe the dissection of the pathological female mind and body.

William Dean Howells' "Sketch of Winnie's Life"

Among those whose view of illness was shaped by Mitchell was William Dean Howells. Their relationship predates Winifred's treatment, and lasted long after her death. Indeed, the sweeping *Standard Letters of William Dean Howells* features Mitchell in all six of its volumes, despite using only a small percentage of men's correspondence, now held in the University of Pennsylvania archives. Their early relationship was one of literary patronage: in July of 1886, in his capacity as editor of *The Atlantic*, Howells defended Mitchell's "Case of George Dedlow" to James Comply as "ingenious and well-written."[466] Several years later, he wrote to accept a new story by Mitchell, "though I don't think it's so good as some of your psycho-physiological things, at which, by the way, I wish you would try your hand again for us. I am always so glad to have your writing in the magazine that I wish I might have your name also."[467] Also clear in the letter is that Mitchell had been courting Howells' acquaintance, sending invitations to meet that Howells declined. Over a

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[464]S. Weir Mitchell, "Autobiography," typescript draft, series 7.1, folder 3, S. Weir Mitchell Papers, College of Physicians and Surgeons of Philadelphia, 129c.
[465] Frank, *The Wounded Storyteller*, 187.
[466] Howells to Comply, 8 July 1866, William Dean Howells, *Selected Letters*, ed. George Arms (Boston: Twayne Publishers, 1979), 1:263. Hereafter SL.
[467] 3 November 1872, SL 1:405.

decade later, in 1883, Howells replied to a letter from Dr. Mitchell, "I don't know why you should think yourself a subject for any such oblivion, mine least of all, for wasn't I your first and most devoted editor?" The letters between the two men are full of literary praise—Mitchell thanks Howells for his "wholesomeness," while Howells speaks highly of Mitchell's *In War Time*.[468] Mitchell, then, is at least in some sense writing *for* Howells, whose literary taste he respected, while on the other hand, Howells' interest in Mitchell's "psycho-physiological" works suggests that his approach to the mind-body relationship may have been influenced by the doctor.

An explicitly medical dimension was added to the relationship in the mid-eighties. Howells wrote to Mitchell on October 20th, 1885 that they would not yet be seeking his care for Winifred because Dr. Putnam assured them that "there is not a crisis in Winifred's case….We are just going to take her into the country with us, where the conditions as to freedom and quiet will be infinitely better than here, and where she will continue under his treatment until he sees that she is getting no good from it. Then he will frankly tell me, and I shall turn to you."[469] In response to this letter, Mitchell put a bit of pressure on the situation, writing, "If you want at any time to send Miss Howells to me I can so arrange things as to make the expenses comparatively small, & without real loss to anyone. Again- if it is to be done at all – if your country experiment fail, do not postpone the other too long. Lastly let me assure you of the real pleasure it would give me to serve you in any way & at all times. I am on tap always."[470] The tone of the letters show Mitchell interested in Howells' patronage—he clearly respects the man and likely had an eye to his power as arbiter of literary taste.

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[468]Howells to Mitchell, 19 Dec 1883; Mitchell to Howells, 4 June 1885; Howells to Mitchell, 20 October 1886, box 1, folder 7, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania.
[469] Howells to Mitchell, box 1, folder 7, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania.
[470] Mitchell to Howells, n.d., box 1, folder 7, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania.

The record suggests that Howells withstood the death of his daughter in Mitchell's care without bitterness toward the doctor. In his response to Mitchell's notification of her death, he wrote, "All now is over, and my wife and I are united in recognizing the devoted efforts you made, in your great science, to give her back strong and well. Her death does not change our sense of this." Moreover, he laments not just that he was away from her daughter when she died, but that she was deprived of Mitchell's company, lamenting that "homesickness was added when she had to leave you [to go to the country clinic]."[471] Her death did not end the men's relationship, and within a year or two they were corresponding again with literary praise, though now punctuated with mentions of Winifred: "I have, my dear Howells, a paper, or letter receiver, sent me by that dear child whose great eloquent eyes every now & then stare at me of a sudden out of my past of countless memories of those who suffered & are gone. I have a fancy that in some of her intervals of rest she did the broidery on it which is simple."[472] Their discussion of literature, too, took on a more emotional course: "I have read the poems, nearly all, and of course all those you call A Psalm of Deaths. These that seemed to have the most message* for me are Of One Dead, which I know is about your brother, and Pained unto Death which might have been about my daughter, but was meant no doubt for some other." [473] Although relatively infrequent, Howells's letters to Mitchell grew longer throughout the years, and he would respond to Mitchell's letters within days at great length, often about changes in life as he aged and lost friends. On December 19, 1905, he concluded a letter, "If you would let me know when you come to New York, I would so gladly go to see you, and I go to see very few people gladly now."[474]

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[471] 7 March 1889, box 1, folder 7, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania.
[472] 29 February 1891, box 1, folder 7, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania.
[473] 2 April 1891, box 1, folder 7, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania. The poem that reminded Howells of his daughter began, "One life I knew was a psalm, a terrible psalm of pain, / Dark with disaster of torment, heart and brain / Racked as if God were not, and hope a dream / Some demon memory brought to bid blaspheme / All life's dismembered sweetness. …"
[474] 19 December 1905, box 1, folder 8, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania.

In 1908, Mitchell dedicated his novel The Red City to "Wm. D. Howells in payment of a debt long owed to a master of fiction and to a friend of many years." On October 30, 1908, Howells wrote that the dedication "deeply, deeply touched me. I had always hoped, but I had not quite known that you cared for me in that way. No form of thanks could bear you my gratitude, which is shared and doubled by the feeling of my wife. You have been part of our life and our death. If she could forget that, she would not be the unforgetting mother she is, and we are in nothing more united than our sense of your wish to do everything for us when it was to late to do anything."[475] In 1913, at the age of 76, he praised Mitchell's work as among the best, and says, "I too lament that we do not meet; you are the only contemporary left whom I could talk with" before telling him about drug interactions.[476]

Prior to Winifred's death, Will occasionally represented his daughter as the kind of stereotypical invalid from *Roland Blake* (1887)—as exaggerating her illness as trying to "work upon them for their sympathy."[477] The anxiety about the reality of her symptoms and the manipulation of sympathy bear Mitchell's mark. After her death in 1889, however, he reframes her as an angelic woman suffering in silence, too good for the world. In 1891, he self-published a memorial pamphlet about Winifred, printing a small run for family and literary friends, like Henry James.[478] The printed pamphlet, titled simply *Winifred Howells*, is twenty-six pages long, and includes three pictures—taken

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[475] 30 October 1908, box 1, folder 9, S. Weir Mitchell Collection, Kislak Center, University of Pennsylvania. Mitchell responded, "If I did not think it, honest & a true characterization of some who lived & of some who never did live, it would not carry your honored name in the dedication – accept this slight expression of a friendship which allows of only one regret, that I trust that you too share. I shall be in New York very soon. I shall try to find you and lessen my share of this regret that we meet so rarely" (1908, folder 8).

[476] 22 November 1913. In both literary and medical terms, Howells appears to have maintained great faith in Mitchell and wrote on November 21, 1907 that "there was something equally attractive in his mystic, his realistic, and his scientific things, perhaps because they were all alike scientific" (*SL* 5:233-4).

[477] Crowley, 94-5.

[478] James to Howells, 10 Jan 1891, in Anesko, *Letters, Fictions, Lives: Henry James and William Dean Howells* [New York: Oxford University Press, 1997]. Hereafter LFL). James wrote to thank him for "the lovely little memorial to Winnie—which, touching & charming, produced for me feelings that made me enter into those—delicate & sacred as they were—that had led you to put it forth" (*LFL*, 283-4).

at ages seven, twenty, and twenty-five —as well as fourteen poems and fragments written by Winifred from her adolescence through her early adulthood, when she died from what he calls "the slow martyrdom of her malady."[479]

Clearly written from a place of deep mourning, the short work indulges in a sentimental and even gothic mode, and ultimately reads more as apotheosis than biography. In a letter to Alice James, he articulates his incapacity to relay something meaningful about his daughter: "I wish I could say something fit about her. I cannot. Only this I say, that she now seems not only the best and gentlest, but one of the wisest souls that ever lived. It is hard to explain; but she was *wise*, and of such a truth that I wonder she could have been my child."[480] His attempt to do just this—to "say something fit" although it is "hard to explain," results in the biography, where he tries to do her memory justice: "every impulse in her was wise and good… She had the will to yield, not to withstand; she could not comprehend unkindness, it puzzled and dismayed her. She had an angelic dignity that never failed her in any squalor of sickness; she was on the earth, but she went through the world aloof in spirit, with a kind of surprise."[481] The pamphlet is a moving testament to grief, guilt, and fatherly pride, and has served as a major source for biographers and those writing about how Winifred's death impacted her father's career: John Crowley cites the pamphlet throughout his essay on Winifred, and Goodman and Dawson's biography echoes it not only in content but in syntax in their biographical sketch of her life and death.

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[479] Howells, *WH*, 4.
[480] *LiL*, 425-6.
[481] Howells, *WH*, 25. That Howells found comfort in narrative is apparent in his response to a letter from Henry James after her death, which emphasized her release from suffering. Howells wrote "My wife and I both felt that you had given words to the mute despair and wonder we were in, and had lightened our burden by speaking out its very form and essence for us" (*LFL,* 273-4). He included pieces of James' letter in the pamphlet. James wrote "I hope there is a sort of joy for both of you in the complete extinction of so much suffering. To be young & gentle & do no harm, & only to pay for it as if it were a crime—I *do* thank heaven, my dear Howells, both for your wife & yourself, that *that* is over. What an endlessly touching memory!" (*LFL*, 273)

A handwritten draft, though, is also extant in the Howells family papers at the Houghton library, and attention to revisions highlights certain rhetorical and narrative decisions that guided this memorial, emphasizing its style and unsettling its use for pure biographical insight. This section will deal with two levels of revision: first, the changes Howells made to the handwritten document—some of which appear to be written in the same ink, while others are penciled in later—and second, the changes between the manuscript copy and the final printing. Howells labored over the document for over a year—his initial opening line that it had been "almost half a year" since Winnie's death is scratched through in manuscript to read "almost a year," suggesting a roughly six month period for this first round of revisions, and by print in 1891 reads "more than a year," suggesting anywhere from a few more months to another year between edits.[482]

The revisions demonstrate Howells' competing impulses in the wake of his daughter's death. The biography shows Howells working through the epistemic conundrums posed by his daughter's death from nervous disorder, narrating a coherent life story in which her illness was intrinsic to her character and her death inevitable, redeeming her from the charges of depravity and fraud so often leveled at hysteric women. In the revisions, Howells is clearly still working through the tension between her narrative and his own. On the one hand, Howells works to strengthen Winifred's voice posthumously, combating the urge to infantilize and deify, while granting her the authority to testify to her own suffering by presenting her poems as accurate portraits of her inner life. On the other, he attempts to narrate Winifred's life in a way that preserves her legacy as a being of almost supernatural goodness, vindicates him from responsibility for her death, and forges a

[482]William Dean Howells, ["Sketch of Winnie's Life,"], 1784.16(19), William Dean Howells Additional Papers, Houghton Library, Harvard University, 1 (hereafter cited as "Sketch"); *WH, 3*.
On June 23, 1880, Howells wrote to his sister Annie, "I wish, if you have any of dear Winny's poems in print or MS. you would send them to me. I am going to make a little book for friends about her" (Letters from William Dean Howells, 1784.1[57], Howells Family Papers, Houghton Library, Harvard University). On November 17, 1889, he wrote again to say that the book was finished (ibid).

comprehensible story from the seemingly meaningless course of the illness—one that emphasizes aesthetic rather than physical etiology. His editorial struggle reveals the complicated emotional, epistemic, and aesthetic stakes of the hunger for narration in the face of medical incomprehensibility, stakes which shape the view of her that has been preserved in biography.

In the first paragraph of the pamphlet, he writes that her nature was "transfigured for us in the light of death," which has shown her "as we could never otherwise have seen her."[483] This framing acknowledges his misperceptions while she lived but suggests that since her death he has learned to see her truly. Howells understood the stakes of his posthumous narration. Reflecting on her improved health during a visit to Venice, where she was born, he wrote that "Since then, and since her death, in that hopeless but helpless striving with which we go back and reconstruct the history of those we have lost from this point and from that, so as to keep them with us, our love has questioned whether if we could only have staid on and on with her there, she might not have been living and happy now."[484] Howells casts the desire to renarrate the trajectory of illness as a kind of reclamation—if only they can land on the right story, they can hold on to the one they've lost. His awareness of this folly is apparent, as he corrected "so as to keep them with us" to the more hopeless "as if we might so keep them with us."

Revisions in a particularly heavily edited passage suggest Howells' preoccupation with finding the right language to capture his daughter's ill-health. Early in the manuscript, he begins to write, "years afterwards, when the mal…" cutting himself off from finishing the word malady, striking it through, and writing instead "sickness," which he strikes through again, adding "the slow martyrdom of her sickness," signaling a purposefulness to her death for some greater cause. Her symptoms are no longer symptoms but sacrifices at the altar of beauty. Still not satisfied, he cuts

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[483] Howells, *WH*, 3.
[484] Howells, "Sketch," 9-10.

"sickness," reverting again to "malady," which, beyond its elevated sound, evokes a sense of a more constitutional problem—sicknesses can be cured, maladies remain—and a more ethereal one. "Sickness" calls forth the embodied experience of illness, with all its unpleasant symptoms, in a way that "malady" does not.[485] Later on the same page, he wrestles with granting agency to her illness and the external forces impacting it, striking out that the winter in Florence had been "cruel to her," opting for a less anthropomorphic "a failure," and then writes that upon returning to her native Venice, "the tortured nerves began to find peace," which he edits to the reflexive "began to calm themselves."[486] In these small shifts, the balance of health is secured as internal—self-calming as opposed to seeking peace, failure as opposed to the victimhood of cruelty.

His revisions routinely emphasize spirit and aesthetics, crafting a less embodied illness narrative. He writes, "The motion that was rest, and the rest which was motion, in the gliding, dreaming gondola, was the medicine which her eager and fragile body craved," which is amended to read "her eager *spirit* and fragile body *needed*."[487] Her malady is revised to include both spirit and body, skipping too the potential impropriety of a body that is eager and craving.[488] Several pages later he again edits out bodily detail. His first manuscript indicates that her poems "bring her again to our knees; we feel the soft push of her little tender bo-" and then scratches out the word "body" before it is even finished, substituting the less corporeal "form" before adding in a parenthetical "afterwards to be wrung to death with such years of anguish!"[489] The entire revealing passage was cut from the pamphlet prior to publication.[490]

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[485] "Sketch," 6-7.
[486] "Sketch," 6-8.
[487] "Sketch," 8, my emphasis.
[488] The craving is instead moved to a later phrase as he replaces the "deepest need of a life born to the intensest love of beauty" with the "craving" of one.
[489] "Sketch," 14.
[490] *WH*, 5.

Howells frames her illness as a poetical one by emphasizing the medicinal effects of Venice's loveliness, so powerful because of "how much and how truly she had her being in what was beautiful."[491] He imagines a different end to her story, suggesting that perhaps, had they stayed in Venice, she would have lived. This suggestion solidifies a narrative of Winifred's illness—divorced from the question of organic heart trouble or hysterical melancholy, Winifred's malady was an aesthetic one. Moreover, it was constitutional, related to her birth in Venice, "as if something of that unearthly loveliness might have entered into her life and estranged it at the beginning from the world in which we lived with her, apart from her."[492] Equally constitutional, though, he writes, was a level of meekness that was incompatible with securing the aesthetic environment she needed to thrive. He writes that she was "so gentle and so yielding, so ready to give up her will to ours, so tacit of her feelings and desires, so heavenly meek, that her love of beauty was always submissive to what was better, or what she was told was better," acknowledging both his previous power over the course of her life, and his fallibility.[493] That her meekness and silence were so pronounced, though, works as a hedge against the possibility that they could possibly have understood or prevented her suffering, despite their earlier frustration with her overly noisy assertions of illness. Her frustratingly strong will has been subsumed by a posthumous weak one. Here, and elsewhere, Howells alternately defends his relationship with her and expresses remorse about his inability to fully comprehend her suffering and danger.

Framing her as actively blocking them from her consciousness excuses him in part for missing the seriousness of her illness. He speaks of "the suffering she kept from us," writing that "Her life was deeply interior; and it sank more and more beyond our sight; and it is only the records of it which teach us how intensely poetical it was. I might almost say we grew less and less

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[491] *WH,* 4.
[492] *WH*, 3.
[493] *WH*, 4

acquainted with its inner meaning, as time went on, and only knew the surface where it was like other lives."[494] He asserts, again, that what he did not know then, he has come to know now, and he imagines her poetry as the vehicle. He mentions several times how little they understood of her internal life—recalling that it was often her siblings who shared when she had written a poem and that she hid her pain after having poems rejected.[495] These phrases echo syntactically ("she did not let us know" and "she never let us see"), emphasizing his sense of having been actively blocked out of her consciousness. He imagines her poems as revealing her inner self, as when he writes, "Some hint, some glimpse, of the silent melancholy which lurked in all her apparent participation in the matter-of-fact events of the world around her, was given in the verse she wrote."[496]

Howells' emphasis on Winifred's poetry also reflects his desire to share her work rather than simply meditate on his grief. He came to this gradually, as revealed in the opening paragraphs of the pamphlet, which are among the most heavily revised. In his first version, Howells writes an emotional tribute to a lost loved one, reflecting on mourning in general. His first round of edits reveal a toning down, an impulse to speak more clearly about his daughter and not let his own grief obscure his recollections. The tone of Howells' pamphlet is especially striking given his reputation as an anti-sentimental realist. In her recent book, Dawson articulates Howells' engagement with sympathy and sentimentality. For Howells, she writes, emotion is "ideologically necessary and narratively suspect."[497] He declares that sentimental fiction can "clog the soul with unwholesome favors" and is "innutritious."[498] Dawson writes, sympathy is "both impossibly diffused and a potentially inauthentic form of emotion" (56), and his own aesthetic privileged tying emotion to

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494 *WH*, 8.
495 *WH*, 37-9
496 *WH*, 8.
497 Melanie Dawson, *Emotional Reinventions: Realist-Era Representations Beyond Sympathy* (Ann Arbor, Mich.: University of Michigan Press, 2015), 41.
498 Quoted on Dawson, 44.

"limited scenarios and personal detail" (39). This orientation helps us understand the editorial decisions that he relied upon as he shaped the aesthetic of his daughter's legacy. He strikes through several religiously tinged and hyperbolic words, editing out the "angelic" in "angelic beauty and gentleness" and the "heavenly" from "heavenly patience and courage," and cutting out a reference to "eternity." Cut, too, are qualifications about his emotional excess, as in a line reading "I know that I cannot say it too largely, too proudly for those, who have suffered," and a hedge about whether he seems to "say too much."[499]

From manuscript to printed copy, though, much of text he grappled with is gone, and the final round of revisions reveal a decision to deemphasize his own experience with grief and to foreground her own. He added as justification his daughter's desire for a literary legacy, and after establishing as he does in manuscript that he will only manage a "faltering image of the beauty and gentleness, the patience and courage, the wisdom and the goodness," he continues, "perhaps I should not, finally, have come to speak of our dear child at all, if I had not realized from the records left us, how much she had her happiness in the hope of making herself remembered for what she wrote." Writing that he wanted "to offer to her friends some of the poems in which she put the sad sweetness of her baffled and bewildered being,"[500] he thus presents the poems as able to function diagnostically, communicating the truth of her experience with illness and suffering.

This desire to share her work animates much of the pamphlet, which contains sixteen poems in its draft form, and fourteen poems by printing. His presentation of her work combines respect for her literary powers with condescension and a desire to curate her poetic legacy. The respect leads him to share the poetry in the first place, and he works against her infantilization, as in one recurring edit geared toward presenting Winifred's work with dignity and respect. In his first pass, Howells

[499] William Dean Howells, *WH*, 1-2.
[500] *WH,* 3

routinely qualifies her work with the pejorative "little," as in the infantilizing "little stories" and "little book of poems," but he crossed out many of these hedges. He writes of her "fine courage" in sending out poems to editors and stresses her compositional self-sufficiency.[501] She wouldn't show him poems until she had perfected them as far as possible without his feedback, and then works several times through a sentence of evaluation, beginning "They always surprised me by their mastery of technique, and by their clear divinations of truth" before granting her more agency by noting "her mastery" and "her clear divinations" instead of "theirs," and by editing out his surprise. He simply states, "Her mastery of technique, and her clear divinations of truth, oftenest needed no criticism from me."[502] Notably, there is no mention whatsoever of a poem which Winifred had accepted into the *Atlantic Monthly* by Thomas Bailey Aldrich but apparently never printed, though this seems likely to have been one of the greatest successes of her brief poetic career.

Howells takes on the role of posthumous editor, leaving certain poems out of the pamphlet, omitting stanzas of others, and altering the punctuation in still more, showing both a respect for her work and unwillingness to cede complete control over her language. The manuscript contains Winifred's poem "A Monologue (Being the Answer of a young Lady to one who hopes she wont quite forget him, now the Summer is over" with the note that it "seems to have been sent some where and rejected."[503] The cynical poem is written in the voice of a young woman who will forget her summer love as soon as they part ways while she attends parties and sewing circles, and coheres with his characterization of her despair about "the cruelty and hardness of certain girls who were beautiful, and who wounded her expectations by their vulgarity of heart."[504] That the poem is cut

[501] "Sketch," 20, 26, 27.
[502] "Sketch," 37.
[503] "Sketch," 43.
[504] "Sketch," 35.

suggests that Howells may have wanted to trim the appearance of unkindness or cynicism from her legacy.

He shares another poem, called "A Mood," which he says was "expressive of the despair of her last years."[505] Of it, Will writes:

> It was her spirit indeed that fell, but not until after such a struggle with pain, with bodily weakness, as seems not less than heroic in the retrospect. Almost everything she wrote has now its heart-breaking history for us; and these pathetic breaths of rhyme, with the surprise, the bewilderment in them of the doom she could not escape, whisper to me out of a misery of thwarted and foregone endeavor running far back of the time when we began to fear even temporary arrest in her beautiful achievement.[506]

The narrative elements of his reading—the "retrospect," the history," the endeavor "far back of the time"—culminate in the diagnosis through the somatic metaphor of the "pathetic breaths." In the draft, he writes (with several edits and rephrasings before crossing it out entirely) that "It expressed indeed the main truth of her life, and its words speak to me now like some of these belated utterances of the wishes that grew to be fainter and fainter impulses."[507] What is notable, then, considering the revelatory weight he put on this poem, is that he substantially edited its text. The first two stanzas, imagining the spirit rising on the wind before falling back to earth despite the wind's continuing motion, are presented unchanged. The third stanza, though, has a brief but significant line edit, and is ultimately left out altogether. The stanza originally reads:

> O! Fancy so sweet and strange,
>
> On whom shall I lay the blame

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[505] *WH*, 9. Cady suggests this is her best poem. (*The Realist at War,* 97.)
[506] *WH*, 10
[507] "Sketch," 30.

That a moment you made me change,

Then left me as when you came,

With my spirit's narrow range

And life before me the same?

The line edit is significant. "Whom" is crossed out and "what" is substituted in what appears to be Will Howells' hand, to read less accusingly "On what shall I lay the blame." This edit is not a grammatical one, since the original "Whom" is more *coherent* with the "you" that follows. He could have left out this stanza for many reasons. Perhaps he simply found the final stanza too melodramatic, preferring the more understated option of ending with the image of the spirit dropping while the wind is rising. Also possible, though, is that the accusatory tone of the final stanza, which points to some external person for causing the suffering he portrays as constitutional, was incoherent with the memory of his daughter as he was attempting to narrate it.

Howells' description of the poems is bound so fully to the narrative of an aesthetic, spiritual malady that he sees them as characteristic of her inner self, and hence both emotionally valuable and diagnostically useful. Taken together, the pamphlet edits reveal Howells' preoccupation with how to comprehend his daughter's suffering, and show him crafting a posthumous narrative of her illness that increasingly ties her submissive temperament and her powerful aesthetic sense to her disorder.[508] Nevertheless, his portrayal of his daughter as too poetical for this world reflects earlier mid-century sentimental of what Diane Price Herndl has called "invalid women."

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[508] Howells' framing of the aesthetic origins of Winifred's illness develops a trope that Herndl roots in Washington Irving's *Biography and Poetical Remains of the Late Margaret Miller Davidson* (1841), in which a doomed female poet must choose either physical health or artistic labor: when she writes she happily wastes away and when she rests, she is miserably robust. Herndl notes that Irving "dwells on her precocious storytelling, her quickness to learn, the diversity of her reading. Throughout, however, he evinces the worry that such efforts were making her more interesting and attractive at the same time that they were killing her" (*Invalid Women,* 78). A similar narrative was disseminated more widely by Lilian Whiting's short memorial of Winifred, "A Beautiful Life" (*The Chautauquan* 13, no. 6 [September 1891], 766-7), which sanctifies her, emphasizing her romantic and literary upbringing.

That Howells, a stylistic innovator campaigning against sentimentalism, fell back on these stereotypes as he revised his daughter's legacy is a testament to the comforting power of such representations, and their explanatory potential in the face of emotional devastation. The incomprehensibility of illness always calls forth narrative—and how much more so for a novelist? But narrative forms clearly fail him in expressing certain kinds of pain, which he sees poetry as uniquely equipped for, as in a letter to Twain about a visit to Winny's grave. He can't describe his emotions, but writes, **"**Do you know those awful lines of Emily Dickenson [sic]? The sweeping up the heart, / And putting love away / We shall not want to use again / Until eternity. They express the awful despair of it."[509] After his daughter's death, Will Howells attempted to honor her memory and process the incomprehensibility of her death through tempered sentimental tropes that granted meaning to her suffering. His narration of her life and work, a labor of love and respect, reveals a great deal about the values he saw fit to memorialize, but the frame of sentimentalized illness also obscures the reader's view of her work and life, which are mediated for us today by his memorial practices.

Winifred Howells' Illness Poetics

[509] *T-H*, 2:681. In the same period that Howells was writing his daughter's biography, he was crafting a review of a posthumous book of Emily Dickinson's poems (William Dean Howells, "Editor's Study," *Harper's Monthly Magazine*, January 1891, 316-321). The review included the high praise that, "If nothing else had come out of our life but this strange poetry we should feel that in the work of Emily Dickinson America, or New England rather, had made a distinctive addition to the literature of the world, and could not be left out of any record of it" (320). He may have been influenced by thoughts of his daughter. Among the poems he reviews is the one beginning "I like a look of agony," of which he says, "All that Puritan longing for sincerity, for veracious conduct, which in some good New England women's natures is almost a hysterical shriek, make its exultant grim assertion in these lines" (319-20). Highlighting the peculiarity of her life, he notes that, "She could not have made such poetry without knowing its rarity, its singular worth; and no doubt it was a radiant happiness in the twilight of her hidden, silent life."

Winifred Howells's poetry, often earnest and confessional, appears to welcome biographical readings, and the modern reader may well feel her father's impulse to read them as symptomatic. With a shift in orientation, perhaps, we can read the poems as engaging with the tropes of the stylized illness narrative rather than enacting them. Her familiarity with discourses of health was established through intimate relationship with a range of wellness practices: in addition to Mitchell, she was treated by homeopathic physicians, upscale water-cure spas, and a range of other institutions. Her poetry speaks to the hope for cure through reflection on nature, to the nostalgia and despair of boredom, to the frustration of undesired pity.

Winifred wrote poetry off-and-on during cycles of health and illness. In the summer of 1880, a sixteen-year-old Winifred, exhausted from the school year, was sent to a seaside retreat to recuperate and take drawing lessons.[510] For the next two years, Howells family correspondence consistently pairs disappointment with her health with hopes for new cures, constantly renarrating the trajectory of her illness, which cycled through periods of improvement and decline. Early in this period, for example, Will turned down an invitation on her behalf to the White House due to illness, but had hopes of "great good from the gymnasium for her.[511] Shortly after, though, he writes to Twain that "Winny is quite broken down. She has not been in school for five months, and for a while she could not cross the room alone" though she had improved and was beginning to take "amusement" at the theater.[512] Despite improvements in early 1881, William Dean Howells wrote to his father that "she suffers more now from weakness than from anything else—she trembles, after a little exertion, and is morbid and hypochondriacal."[513] By mid-August the same year, Howells

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[510] Howells to Aurelia Howells, 19 January 1880, 1784.1 (67)18, Howells Family Papers, Houghton Library, Harvard University.
[511] Crowley, 88; William Dean Howells to William Cooper Howells, 5 December 1880, *LiL*, 1:289.
[512] *T-H*, 1:348.
[513] Crowley, *The Mask of Fiction*, 88. Howells scholars will connect "hypochondria" with Will's own teenaged illness.

reports with a sense of despair that his daughter was in bed trying the "rest cure" with Dr. James Jackson Putnam, which consisted of varying levels of rest, feeding, massage, and other techniques. With Putnam, "She is bathed, rubbed, and lunched continually. It is too soon yet to hope for any effect, but there seems sense in the theory. At any rate we have tried everything else in vain."[514] A month later, though, they had given up Putnam's rest cure, with Howells writing, "If she could have been allowed to read, I think the experiment might have succeeded; but I think the privation has thrown her thoughts back upon her, and made her morbid and hypochondriacal."[515] By October he writes that she is "at last beginning to get up,"[516] and early in 1882 that "Winny, who was down for nearly two years with nervous prostration, is now quite herself again."[517] Again, the next year saw another cycle of decline and improvement, this time effected by a trip to Venice where she "has recovered in her native air as if by magic,"[518] noting that "The sea-air does her good, and the novel beauty fills her romantic soul. I begin to understand what an intensely poetic nature she has, and that she suffers, or enjoys as her poetic sense is starved or gratified."[519] For the next two years following Venice, her health remained relatively strong, and she published several more poems in the *Century,* and had another accepted to the *Atlantic*.[520]

Sadly, the improvements to her health did not last, and the family became increasingly hopeless about potential cures and frustrated with Winny's long inhabitance of the illness role. Around her twenty-second birthday, Will wrote to his sister that "Winny seems really improved,"

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[514]William Dean Howells to Annie Frechette, 14 August 1881, Letters from William Dean Howells, 1784.1(57), Howells Family Papers, Houghton Library, Harvard University.
[515] *LiL*, 301.
[516] *T-H*, 1:375.
[517] William Dean Howells to John Hay, 18 March 1882, *LiL,* 311.
[518] *LiL*, 340.
[519]William Dean Howells to William Cooper Howells, 22 April 1883, box 1, William Dean Howells Miscellaneous Papers, Houghton Library, Harvard University.
[520] Thomas Bailey Aldrich to Winifred Howells, 25 May 1885, Winifred Howells Materials, 1784.7 (1), Howells Family Papers, Houghton Library, Harvard University.

but that "Her sickness has been a great trial and a perpetual expense."[521] This improvement was unstable--Howells' correspondence for the next several years is still marked by statements of hope (a year after the above, for example, we hear that she "seems at last to have got her feet on the rising ground again"[522]), but the trial and expense were relentless, however, and she returned to Putnam's care once again in 1885, followed by a stint in a sanitarium, and a move to a progressive water cure treatment in Dansville in 1887, first for the whole family, and then only for Winifred.[523] She remained in the institution until 1888, when she was brought back to New York City "for such doctoring as we can get there."[524] In 1888, the money for this wildly expensive treatment ran out, and Winifred was brought home. W.D. Howells's frustration with his daughter's health is clear in letters, where he writes about their attempts to increase her activity level because in Dansville she was allowed to, in his own words, "form every bad habit of invalidism, and now we must break them up by force."[525] Driving home the impact of illness on the life of the bookish young woman with literary ambitions, Will wrote to Henry James in October of 1888 that "poor Winny hasn't read a book in years" (LFL 272).

Will Howell's pamphlet reads Winifred's poems retrospectively through the narrative of her decline and death, ascribing psychological realism to the highly structured verse forms through which she explores themes of dejection and ennui—in essence, reading diagnostically in order to make aesthetic sense of her suffering. Crowley reads them biographically and psychoanalytically,

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[521]William Dean Howells to Aurelia, 20 December 1885, Letters from William Dean Howells, series 1-B, 1784.1(67), Howells Family Papers, Houghton Library, Harvard University.
[522] *LiL*, 389.
[523] Around this same time, Will's frustration with the dynamics of family care and the burden of illness are manifest in another way, as he writes to his sister about care for their brother Henry, who had mental disabilities, arguing that he needs to be institutionalized: "I don't believe in the family system with Henry, and never did; I think it's made him the horrible burden that he now is." William Dean Howells to Aurelia, 9 January 1887, Letters from William Dean Howells, series 1-B, 1784.1(67), Howells Family Papers, Houghton Library, Harvard University.
[524] Howells to Henry James, 10 October 1888, *LFL*, 272.
[525] Crowley, *The Mask of Fiction*, 94.

highlighting themes of childhood that align with a psychoanalytic interpretation of her desire to die before entering adulthood. These readings make some sense: the speaker of Winifred's poems often speaks of alienation from health and happiness. However, rather than reading the poems as indexes of her mental state, we can engage with the complex representation of health and morality that emerged from Winifred's experience with the discourses of cure and wellness that would have pervaded her extensive treatments. Recent work on figures like Alice James emphasizes returning agency to marginalized "invalid" women.[526] Reframing Winifred's agency in the composition of these poems enables a different kind of analysis: reading them not as providing emotional insight, as Howells does, or as confessional grist for a psychoanalytic mill, as Crowley does. Such readings deemphasize her ambition and her will to be a successful published poet. However much she may have been expressing herself as she composed her poetry, she also drew on poetic tropes and used the language of illness and despair in order to place publications. Howells' recollection of her, studiously working the lines of her poems to metrical satisfaction, show not just emotion but analysis.

The very genre in which Winifred chose to write may be read as a rebuttal to medical narratives. Stepping outside the bounds of narrative forms, poetry may reveal a different engagement with the questions of point-of-view, time, vocabulary, arrangement, and purpose. Susannah Mintz has argued that in poetry, figures like Dickinson assert "the right to name their pain in defiance of cultural strictures ….Dickinson [has] a sensibility in which pain prompts (or is the adjunct of) audacious expressions of self in the face of powerful others—whether God, lovers, or physicians."[527] Mintz argues that by writing about pain, Dickinson makes herself an authority over

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[526] Kristin Boudreau, "'A Barnum Monstrosity': Alice James and the Spectacle of Sympathy," *American Literature* 65, no. 1 (1993): 53–67; Elizabeth Duquette, "'A New Claim for the Family Renown': Alice James and the Picturesque," *ELH* 72, no. 3 (2005): 717–45.
[527] Susannah B Mintz, *Hurt and Pain: Literature and the Suffering Body* (London: Bloomsbury, 2013), 10–11.

male doctors (36). While Winifred's poems may not match the authoritative expression of Dickinson's work, her verse experiments with the language of health and happiness.

The few poems that Will Howells includes in his daughter's pamphlet seem to represent the totality of her extant work. Howells refers in the pamphlet to "the book where she once began to copy her poems, printed and unprinted" saying there "are several others, each holding some striking thought or vivid fancy, and all full of the incommunicable sense of her to our hearts. But I must not give them…"[528] Unfortunately, there is no indication of this copy-book in the Winifred Howells collection at the Houghton. The pamphlet manuscript gives what he calls her first and last poems (though the first is cut by printing), ranging from around the age of six to twenty-four (c. 1870-1888). The poems we still have access to are those that Howells printed in the pamphlet. There are sixteen in his manuscript, two of which ("Joys of the Youngness," her "first" poem, and "A Monologue") are cut from the printed pamphlet. It appears that seven of them were published in magazines and papers in her lifetime, not including "A Mood," which as "The Wind Exultant" was rendered into music by Francis Boott and printed alongside adaptations of poems by Longfellow and Tennyson in 1887, and reprinted in several magazines and papers afterward.[529] When she was younger, her poems were printed in venues like the "Young Contributors' Department" of *St. Nicholas*, *Bedford's Canadian Monthly*, *The Transcript*, and *The Youth's Companion*, but beginning in 1883 with "Love's Chase: After Reading Herrick" she published three poems in *The Century Magazine,* previously *Scribner's Monthly* (the second and third were "The Missing Glove" in 1887 and "Past" in 1886).

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[528]"Sketch," 58[2], edits silent.

[529]Francis Boott, *Boott's Album of Songs No. 2* (Boston: Oliver Ditson Company, 1897), 38-40. Howells writes in the pamphlet that playing the song to herself was one of Winifred's pleasures late in life (*WH,* 9). The truncated version of the poem Howells presents is the one both in Boott's song and Stedman's anthology, which has the further edit of removing the stanza break, as the two numbered stanzas in the pamphlet are condensed into one, with the period that originally end stopped the first stanza transformed to a comma.

Perhaps most significantly, though also most mysteriously, on May 25, 1885, Thomas Bailey Aldrich, Will's successor as editor of the *Atlantic*, wrote to Winifred: "Your lyric seems to me very fresh and sweet and I have taken it for The Atlantic. You shall have a proof of the verse when the time comes, and perhaps I shall have a suggestion to make touching the phrasing of one of the lines."[530] Less than a year later, Howells On Feb 1, 1886, WDH wrote to Aldrich: "You told me some time ago of having the proof of Winny's little poem. Will you kindly send it to me with your suggestions?"[531] Despite this clear indication of the poem's acceptance in the most influential literary organ of its day, this unnamed poem does not seem to have appeared in print, nor do there appear to be any anonymous poems unaccounted for published in this period. Nor is this acceptance mentioned in Will's memorial pamphlet, although it would clearly have been a point of pride for the aspiring poet. Others of Winifred's productions did reach print, some notably. Edmund Clarence Stedman, a friend of Will Howells', published five of Winifred's poems ("A Mood," "A Wasted Sympathy," "Forthfaring," "Past," and "The Poet and the Child") posthumously in *An American Anthology, 1787-1900*, as well as three of her sister Mildred's and nine of Will's.[532]

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[530] Thomas Bailey Aldrich to Winifred Howells, 25 May 1885, Winifred Howells Materials, 1784.7 (1), Howells Family Papers, Houghton Library, Harvard University.

[531]William Dean Howells to Thomas Bailey Aldrich, 1 February 1886, Letters to Thomas Bailey Aldrich, MS Am 1429, Thomas Bailey Aldrich Papers, Houghton Library, Harvard University.

[532] Edmund Clarence Stedman, *An American Anthology, 1787-1900* (Boston: Houghton Mifflin Company, 1900). Interestingly, Winifred's poems are sorted under the "Close of the Century" rather than the earlier "Lyrical" periods where her father's are, even though she died prior to the period's beginning in 1890. The poems are sorted, then, by the date of her father's publication of the pamphlet, not by their original pamphlets. In this period she appears alongside poets like Langdon Elwyn Mitchell (son of S. Weir), Stephen Crane, Paul Laurence Dunbar, Grace Ellery Channing-Stetson, and her sister Mildred. The biographical note for Winifred shows the influence of Howells' pamphlet: "HOWELLS, Winifred. b. Venice, Italy, 1863; d. Mass, 1889. Eldest child of William Dean Howells. She was a girl of enduring beauty and promise, gifted with insight, and exhibiting the poet's sensitiveness and reserve. A few of her lyrics have been embodied in her father's touching an exquisitely written memorial of her life and character. (Cp. the sonnet by Mrs. Moulton, p. 811.)" (802). Howells had sent a copy of the pamphlet to Stedman on September 12, 1899 (*SL* 4.213). The sonnet by Mrs. Moulton, called "The Closed Gate," has an epigraph from Winifred Howells: "But life is short, so gently close the gate." This poem marks her eerie presentiment of death, again making it seem poetically inevitable.

Winifred's poems often engage with questions of health. She wrote "Magnolia" while at the seaside art school of the same name where she spent time convalescing following an exhausting year at school in the first year where her ill health began to be of concern. It was published in October 1880 in *The Youth's Companion*[533] and of it Will writes that "the intellectual grasp is firm, and distinct and mature in it" and relays Longfellow's note to "Give Winifred a kiss from me if she will let you, for her beautiful poem in the Youth's Companion, which I have just read with uncommon pleasure."[534] The publication of the poem earned her five dollars, which she donated to "the destitute negroes who were then flocking into Kansas."[535] He notes the poem's strength, "though it was written after her health had begun to break."[536] Reading the poem, however, one wonders whether "because" would have marked a more accurate relationship than "though," as the poem's title, "Magnolia," is a reference to the seaside art school where she convalesced.

My heart of late had been full sore oppressed,
Vext with some trifling trouble hard to bear;
But now at length there was end of care [an end to care],
And all things seemed to join with me in rest.

Like the enchanted forest in the tale,
Where every path leads to the castle door,
Here all the paths lead downward to the shore,
The portal of the ocean and its pale.

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533 Winifred Howells, "Magnolia," *Youth's Companion* 53, no. 42 (October 1880), 346.
534"Sketch," 56.
535 "Sketch," 57[2]-58[1].
536 "Sketch," 56, silent edits.

As slow I wandered down a sandy way
Which ran at[h]wart a row of willows high,
Whose tops stood soft against the evening sky,
The ocean all at once before me lay.

Musing, I stood and watched the waves roll home;
Watched the first swell, which[,] moving, grew apace,
Huger and darker in its onward race,
Till up it leaped and broke and sank in foam.

Then to my glad heart, lightened of its pain,
There came this happy thought which here I write,
And though to others it seem old and trite,
To me it spoke return of hope again.[:]

The breaking wave[s] seem like our troubles sore[,]
Which darken ever with their gathered weight,
Till as we cease to strive against our fate,
Behold they break in foam and are no more![537]

In the poem's themes, Winifred pays homage both to the Romantic and Victorian poets she read and discourses of mental health. The resolution to "cease to strive against our fate" speaks to

[537] "Sketch," insert between 55 and 56, brackets indicate changes from "Sketch" to *WH*.

discourses of mental health that encouraged feminine passivity in the face of worry—to release rather than dwell on trouble. The poem describes the kind of "wear and tear" mentality of physicians like Mitchell, noting the healing power of rest and nature and diminishing the significance of her trouble, as the oppression of the heart was not justified—it was caused by "some trifling trouble" not intrinsically troublesome but "hard to bear" for the speaker. The speaker's "pain" is capable of dismissal with the kind of "happy thought" that the ocean inspires. The poem presents a hopeful narrative of cure through communion with nature—at once Romantic and Mitchellian—suggesting that the kind of pain that the speaker had been experiencing could be easily remedied through turning the attention outward—and that it was largely baseless in the first place. We can read the sentiment both as a testament to the power of sublimity to reframe our mental state—a trope she recognizes is "old and trite"—and as a fantasy of wellness and self-control that Winifred attempted to sustain.

In stark contrast to the optimism of "Magnolia" is "Past," written was twenty-two, and according to Will, her last published work.

There, as she sewed, came floating through her head
Odd bits of poems, learned in other days
And long forgotten in the noisier ways
Through which the fortunes of her life now led;
And looking up, she saw upon the shelf
In dusty rank her favorite poems stand,
All uncrossed by her fond eye or hand;
And her heart smote her, thinking how herself
Had loved them once and found in them all good

As well as beauty, filling every need;
But now they could not fill the emptiness
Of heart she felt ev'n in her gayest mood.
She wanted once no work her heart to feed,
And to be idle once was no distress.

In contrast to the optimism of "Magnolia," the conclusion of this poem is jarring. Although a traditional Petrarchan sonnet, ending with an EFGEFG rhyme, the poem grammatically concludes on a couplet: the poem's first sentence is twelve lines long—its last, only two. The disjoint between rhyme scheme and syntax leaves the poem feeling incomplete, or hanging, which is coherent with the poem's grim nostalgia. Will wrote that in this poem "perhaps [the silent melancholy] reached its clearest expression, as certainly it clothed itself in artistic perfection, in this sonnet, which was printed in the "Century" magazine, and was the last poem of hers printed anywhere."[538] In reflecting Winifred's despair over her inability to read in her illness, the poem's melancholy collapses the space between poet and speaker. Yet by indicting "idleness" with the distinct closing quasi-couplet, she speaks as much against the forced idleness she had recently undergone through the rest cure with Putnam, which Howells believed failed because she wasn't allowed to read. The existence of this poem, too, on which she clearly exerted great effort, also rebuts this idleness.

In a poem speaking directly to the questions of sympathy and pity that suffused her father's biography, Winifred's poem "A Wasted Sympathy," written, in her father's estimation, around her twentieth year, rejects pity as worthless. The poem resonates with Will's recurring focus on her silence in the biography. Indeed, "A Wasted Sympathy" is followed almost immediately by the claim

[538] William Dean Howells, *WH*, 8.

that "she was very silent about all that was painful in her experience."[539] The poem, however, troubles this silence—it was written around five years before her death, and implies that already, she has noisily expressed her grief.

Do not waste your pity, friend
When you see me weep, as now;
Keep it to some better end.
When dry-eyed I went about
    With a leaden heart locked in
    By a silent tongue, ah! then
    Had you brought it, it had been
Sweet indeed to me; but now
    When the depths of my despair
Are upheaved and through the portals
    Of my heart come free as air,
It is useless. If you please,
    Give your thanks that to a woman
Tears are given, and be at ease.

In this short verse, Winifred expresses the need for sympathy before crisis—her emotions needed tending when she was "silent" and "dry-eyed," but with a "leaden heart." The value, then, in sympathy comes only when people attend to unspoken clues that they need support. By the time that release is granted through "upheaved" grief, it is too late. The contrast between the metaphorical "leaden heart" and the more biological "portals / of my heart" underscores the physicality of emotional suffering. Retrospectively, it seems to speak beyond the grave to her father,

[539] *WH,* 13

railing against the outpouring of pity in the sentimental biography pamphlet, with its stark contrast to his frustration and disbelief preceding her death; the sympathy has come too late to be of any use, though in this case the release is death rather than sobs.

Winifred's rejection of sympathy is a rejoinder to accusations that invalid women exaggerated symptoms to elicit sympathetic reactions. The poem rejects the role of the passive sufferer, and the strength of her will is emphasized by the imperative claim, "Do not waste your pity," which is followed later by the confrontational, "When dry-eyed I went about…then had you brought it, it has been / Sweet indeed to me; but now / … / it is useless." She does not dismiss pity outright but insists that it operates most effectively when unsolicited—when the need for emotional support is unspoken. Silence is an important factor, then, for both Winifred and her father, who glorifies her submissiveness and quiet.[540] This passage of the pamphlet reflects uncomfortably on the circumstances of Winifred's final years. There is a wide chasm between William's earlier characterizations of Winifred as stubborn and willful with the impossibly will-less figure presented here. The "silent melancholy" (8) he refers to in the pamphlet is, it seems, far too noisy while she still lived. Although still relying on biography, reading Winifred's poetry not as symptomatic but as a rhetorical response to misogynistic discourses of health allows for a different orientation toward her poetic standpoint as continual patient.

In her rejection of sympathy, Winifred had good company in her fellow "invalid," Alice James, whose more substantial archive demonstrates a complex rhetorical negotiation of diagnostic and illness narratives. Kristin Boudreau has argued that Alice James' deployment of sympathy positions her as an agent, rather than passive recipient, in her family, and in broader cultural discourses.[541] James, another writer from a literary family whose role has long been circumscribed by

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[540] *WH*, 4-5

[541] Natalie Dykstra also works to reclaim Alice as agent, arguing that she frames illness as labor in order to construct "a self both legible and faithful to her own desires" (""Trying to Idle': Work and Disability in *The*

illness narratives, had a unique experience with sympathy that provided special insight. Unknowingly echoing Winifred, Boudreau writes that Alice "gently but firmly warns William not to waste his sympathy on her."[542] In a letter to her brother William, for whom sympathy works philosophically as a corrective to selfishness, and to the benefit of the sufferers rather than the sympathizers, she counters, "the tendency of the age is rather to overdo the sympathetic" and, speaking against pity, says that it's lucky that people don't seem as "flimsy and dismal" to themselves as they do to their friends.[543] She positions her experience as valuable regardless of pain or discomfort, and hence undeserving of pity: "My ill-health has been inconvenient & not aesthetically beautifull, but early in youth I discovered that there were certain ends to be attainted in life, which were as independent of illness or of health, as they were of poverty or riches, so that by turning my attention exclusively to them, even my torpid career has not been without its triumphs to my own consciousness & therefore not to be pitied for."[544] Apparently William's own narrative of his sister's misery and desire for sympathy overpowered her requests, as suggested by a letter in which she writes that his "sympathy makes me feel like a horrible humbug. Amidst the horrors of wh. I hear and read my woes seem of a very pale tint. Kath. & I roared over the 'stifling in a quagmire of disgust, pain & impotence,' for I consider myself one of the most potent creations of my time, & though I may not have a group of Harvard students sitting at my feet drinking in psychic truth, I shall not tremble, I assure you, at the last trump" (54). Mocking her brother's misunderstanding of the value of her life as an ill woman, Alice stakes a claim for the epistemic resources of illness.

Alice's philosophy of sympathy, in Boudreau's formulation, "does not allow one to hear the cries of another's pain, but rather produces a false, because alien, account of that pain. To

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Diary of Alice James" in *New Disability* History, ed. Paul Longmore and Lauri Umansky [New York: New York University Press, 2001], 108).

[542] Boudreau, "'A Barnum Monstrosity'," 54.

[543] Boudreau, 55.

[544] Boudreau, 54.

'sympathize,' this invalid suspected, was to bridge the gap of experience separating two individuals with an invented account of suffering" (55). Such a philosophy highlights the narrative nature of sympathy—the "invented account of suffering" that enables one to feel for another is predicated, in hysteria, with assumptions and suspicious about legitimacy. The organic narrative of Winifred's death, for example, is powerful both because of the perceived vindicating legitimacy of physical disorder, and because it engages our sympathy or pity on her behalf.

Alice and Winifred's rejection of sympathy is a powerful rejoinder to accusations that invalid women were exaggerating their symptoms due to the allure of the sympathetic reaction, reminiscent of the "piss on pity" of later disability rights activists. Certainly, Winifred Howells doesn't take as strong or ironic a stance as Alice James develops through her diary and letters, and she seems more willing to incorporate sentiment and even elicit sympathy given at the appropriate times. However, Boudreau demonstrates that attending to the details of Alice's illness philosophy acknowledges her involvement with broader debates about the role and importance of sympathy in the late nineteenth century—debates she was barred from because of her subject position as an invalid woman, despite the fact that that very position may well have given her firmer philosophical ground to stand on than her more famous brother. Reading Winifred's poetry not as symptomatic of her illness, but as a rhetorical response to discourses of health and illness, including the stigma of perceived sympathy-mongering, allows for a more capacious understanding of what it means to write as a continual patient.

The chronicity of Winifred's illness and treatment may be related to what William suggests is her last poem. He again frames the content biographically, writing that "she wrote these broken lines" "in the last summer of her life, faltering down to the Valley of the Shadow, in such pain and despair as we never realized" But where he sees "broken lines," we might see experimentation with temporality, rhyme, and meter:

She had been used to write rhymes like this;

First from description, Nature in her eyes;

Then part she felt when she had writ of Nature,

Commenting on her own . . .

Then pondering rhymed she of her introspection

Till like a spider lost in her own web,

She suddenly stopped, and ceased to rhyme at all." (WH 24-5).[545]

The unrhymed lines are unprecedented in her work. In some sense writing her own literary autobiography—from observational to introspective poetry to her inability to write when seriously ill—Winifred's repeated "then"s lend a monotony to this trajectory, mimicking a narrative progression through time. She warps the timeline, though, with overwrought verb tenses—" she *had been used to write"*— coupled with the present-oriented "like this" before returning to the past. The closing line—that she "ceased to rhyme at all" could refer to her inability to write when ill, or, more interestingly, as an assertion that rhymed poetic form was a constraint—a web of her own making, in which she attempted to transmit her thoughts—which we might also read as a sophisticated rejection of previous style and form. Sarah Nance recently wrote that disability poetics can "reject…tight, measured language" for an "excessiveness" that can "challenge linear time, narrative structure, and standard modes of production—what we might think of as the heteronormative chronology of time and form."[546] Winifred's early death means we cannot know whether she would have grown into a more experimental poetic style rejecting these "heteronormative" constraints as she earlier attempted to reject gendered expectations of pity, or whether her verse would have

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[545] "Sketch," inserted between 59 and 60. There are a few edits from the typed version in "Sketch": the original line has no "first" but starts "from description" and the fourth line in "Sketch" starts tabbed half way in and begins "then commenting on her own."

[546] Sarah Nance, "An Economy of Illness: The Poetics of Women in Pain," *Literature & Medicine* 36, no. 1 (2018): 173.

remained relatively conventional, or ceased altogether. Writers' and readers' interest in biography—especially the sentimental biography of an ill woman—mean this fragment will more likely be read as symptom rather than as style.

Even when poems by ill women aren't literally being anthologized in a biography edited by a father, they are being read through a quasi-patriarchal narrative linking biography, content, and form. In her article "Chronic Poetics," Hillary Gravendyk argues for "the necessity not of articulating a theory of poetics that relies on knowing the physical conditions of poets but of articulating a theory of the body that acknowledges disability, and particularity, as generalizable features of embodied experience."[547] I agree, and think it would be productive to read Winifred's poems, as Gravendyk suggests, as texts drawing attention to the embodied perception of readers rather than to her own illness. To be sure, Will demonstrates how sentimentalized narratives of Winifred's illness can obscure the ability to see innovations in poetic content and form—those moments that jar and jostle the reader as he himself is obviously jostled and jarred. At the same time, the poem "A Wasted Sympathy," is largely interesting to me because of its rhetorical, rather than lyrical, engagement with discourses of women's health—and it is biography that demonstrates her expertise navigating medical care. Her final fragment is more formally interesting but was recorded by Will and read by me exclusively because of her illness and death. Indeed, my reading of Winifred's "Wasted Sympathy" as proto-disability rights anti-pity verse emerges from an anachronistic narrative I have imposed. Any attempt to sever the illness narrative from the illness poetics, here, seems partial. I am left with questions: Is it possible to read biographically but not symptomatically? Do the ethics of biographical readings change if we clarify the fictional basis of all biography? More broadly, how fully we can disambiguate illness narrative from illness poetics?

[547] Hilary Gravendyk, "Chronic Poetics," *Journal of Modern Literature* 38, no. 1 (2014): 9.

Conclusion

The desire to craft meaningful narratives out of illness is powerful. Mitchell believed that his narratives could secure a measure of objectivity (however incomplete), while Will read Winny's poems as though they were a window into her experience, even noting that a poem he evaluated as hyperbolic and maudlin while she lived had retrospectively shown him her true feelings, showing a naturalization of poetic excess and a recasting of the worth of her work through her death. The narrative features of Winifred's poetry also emphasize timelines of illness and cure, although the breakdown of these timelines through poetic form can challenge the diagnostic eye. The critic, perhaps, cannot avoid reading with this narrative investment. My own—both critical (feminist disability studies, health humanities) and affective (as emotionally invested in Winifred's story)—obviously shape what I am able to do with her work. The process of "recovery" itself is diagnostic and anatomizing, as in Foucault's claim that in recovery we try to "classify the text, define it, compare it with some texts, and contrast it to others. It allows us to 'reveal' or 'characterize' the text's 'mode of being'."[548]

Interpretive frames are multiple in work on hysteria. Regardless of the approach, hysteria asks the fundamental question, what is really going on here? For some, that might mean, what kind of undetectable lesion or pathology is causing this symptom? For others, what kind of psychic distress is being converted to physical symptom? Within cultural criticism and this history of medicine, that question might be framed, how might we diagnose those aspects of culture that enable this particular symptom pool? In his book on psychosomatic disorder, Edward Shorter explains such illnesses as the unconscious's expression of distress in a way that it feels will be taken

[548] Quoted on Herndl, 145.

seriously, and many generations of scholars have argued over whether hysteria is feminist protest or a socially constructed disease created by oppression. Each of these questions is fundamentally diagnostic, asking what lies behind or beneath the hysterical symptom, whether this suspicion takes the Mitchellian form of accusations of malingering or the critical "hermeneutics of suspicion" of Ricouer, always reading behind the text. Among other conclusions in Winifred's case, Crowley argued that her torment between wanting success and being constrained to a female role resulted in her "flight into illness."[549] Is it possible to engage with the phenomenology of hysteria without reading it as hidden sign?

One possible way to attempt the feat is suggested by recent scholarship highlighting the failures of "symptomatic reading" and advocating for other critical approaches, like those put forward in Rita Felski's *The Limits of Critique.* Felski asks "Why is it that critics are so quick off the mark to interrogate, unmask, expose, subvert, unravel, demystify, destabilize, take issue, and take umbrage? What sustains their assurance that a text is withholding something of vital importance, that their task is to ferret out what lies concealed in its recesses and margins?" and "Why are we hyperarticulate about our adversaries and so excruciatingly tongue-tied about our loves?" [550] She advocates for re-engaging with enchantment, knowledge, shock, and other modes of engagement with a text.

The "symptomatic" is at the heart of many attempts to apply literary theory to medical settings. In *Narrative Medicine,* Rita Charon relies on a vision of symptom and the language in which it is communicable becoming decodable text for a newly attuned medical professional: "the headache of the healthy but anxious woman or the nausea of the child who does not want to go to school need not be seen as lies or fabrications. Instead, these reports may fruitfully be received as

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[549] Crowley, 104.
[550] Rita Felski, *The Limits of Critique* (Chicago: University of Chicago Press, 2015), 5, 13.

messages—about fear, about rebellion, about unacknowledged desires—that require more than the usual expertise to decode but that are nonethless replete with news, and even replete with truth."[551] Charon here talks about the positive potential of applying the reading of literary symptom to the reading of the human body, often sounding more like psychoanalyst than primary care doctor. Felski's critique of the symptomatic reading is tied to Freud and psychoanalysis. She writes:

> Freud's patients, as they mixed up their words and fumbled nervously with their reticules, generated a cornucopia of signs for him to interpret. So too, a generation of critics scrutinized literary and cultural texts for their accidental or involuntary betrayal of repressed meanings….The literary work is akin to the patient who unwittingly displays signs of neurosis or psychosis for the analyst to decipher. The goal of such a symptomatic reading is to yoke a text to a larger determining whole. (61-2).

Turning to Mitchell's hysteria rather than Freud's may allow a re-engagement with the physical experience, rather than root cause of, the psychosomatic. Mitchell's hysteria was never "all in the head"—it was an embodied illness that was evidence of the mind-body connection, not a purely psychological one that dismissed physical symptoms. But it was also one deserving of more scorn and social control than Freud's, and gives us ample material for engaging with Justine Murison's claim in *The Politics of Anxiety* that Freud is the reason we don't think of anxiety as so somatic anymore in modern theory, allowing a disembodied "anxiety" that "gestures to authorial motivation, imbues literature with political functionality, and produces a certain shape to historical narrative: a dialectic of repression and exposure fulfilled in the historical analysis."[552]

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[551] Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford, UK: Oxford Univ. Press, 2008), 99.
[552] Murison, *The Politics of Anxiety*, 172.

At the end of a lifetime of general "invalidism," Alice James wrote of the breast cancer that was to kill her:

> 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. Ever since I have been ill, I have longed and longed for some palpable disease, no matter how conventionally dreadful a label it might have, but I was always driven back to stagger alone under the monstrous mass of subjective sensations, which that sympathetic being 'the medical man' had no higher inspiration than to assure me I was personally responsible for, washing his hands of me with a graceful complacency under my very nose.[553]

This desire for "palpable disease" over "subjective sensations" and this frustration with physicians' moral judgment compensating for their lack of competence, illustrate the affective charge of diagnosis. That Alice was relieved by a fatal tumor that validated the amorphous suffering that had come before illustrates the power of Mollow's "epistemological disablement."[554] To this day, conditions that cannot be medically verified are stigmatized even more than illness in general, a fact illustrated both by the troubled place of hysteria in contemporary medicine and society, and by the typical narrative satisfaction of a retrospective somatic diagnosis for Winifred Howells—a kind of critical longing for Winifred's "palpable disease."

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[553] Boudreau, "'A Barnum Monstrosity'," 64.
[554] Anna Mollow, "Criphystemologies: What Disability Theory Needs to Know about Hysteria," *Journal of Literary & Cultural Disability Studies* 8, no. 2 (2014): 186.

Coda

The narrative nature of diagnosis is the focus of much contemporary first-person writing about illness and disability, as people with diagnoses explore their ramifications. These writers—especially those whose conditions elude anatomical, physiologic, or laboratory verification—engage with their diagnoses as stories, unpacking how the tropes of diagnostic narratives shape the experience of those cast as characters. In her book *Authoring Autism,* Melanie Yergeau writes that "autism is a narrative condition….Through diagnosis, autistics are storied into autism, our bodyminds made determinable and knowable through the criteria of neurodevelopmental disability."[555] Very often, she suggests, referring to the prevalence of both stereotypes and bodily functions in these stories, these are "shitty narratives" (3). Diagnostic narratives are not uniformly negative, though, as "the idea of storying brings both comfort and distress" (21). The question that remains for Yergeau is who gets to tell "the story of my people" (21). Positioning diagnosis as an identity that puts her in affinity with a wider community, Yergeau demands control of the diagnostic narrative in part through her constant reference to the diagnostic logic of those who read her texts. She confronts, for example, the diagnostic gaze of her readers, who she imagines will "diagnose the very form of this book, as though this book were an invitation for symptomatological scrutiny" (14).

It is not lost on me that this dissertation is bookended by the purported "fathers" of American psychiatry and neurology. Reflection on and reclamation of diagnostic narratives has become a powerful trope within memoirs of illness and disability in the twenty-first century, as their often female writers confront histories of sexist pathologization and a medical gaze that holds diagnostic authority. Annotated text from the *Diagnostic and Statistical Manual of Mental Disorders*

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[555] Melanie Yergeau, *Authoring Autism: On Rhetoric and Neurological Queerness* (Durham: Duke University Press, 2018), 1.

features in works like Susanna Kaysen's *Girl, Interrupted* or Esme Weijung Wang's *The Collected Schizophrenias*, as the authors present their official diagnoses, critiquing the power generated by the rhetoric of objectivity within these texts. The chapter of Kaysen's memoir titled "My Diagnosis" includes an "annotated diagnosis" that she creates after obtaining her hospital records at which point she "had to read line 32a of form A1 of the Case Record, and entry G on the Discharge on Visit Summary, and entry B of Part IV of the Case Report; then I had to locate a copy of the *Diagnostic and Statistical Manual of Mental Disorders.*"[556] Lampooning the trappings of medical bureaucracy, Kaysen supplements each item on the diagnostic checklist with an anecdote from her own life.

Wang's collection of essays explores many facets of her experience living with a psychotic disorder currently diagnosed as "schizoaffective disorder." Claiming diagnostic affinity, she calls this one of the "collected schizophrenias," which "encompass a range of psychotic disorders, and it is a genus that I choose to identify with as a woman whose diagnosis is unfamiliar to most—the shaggy, sharp-toothed thing, and not the wolf."[557] Listing the diagnostic code of her disorder in the DSM, 295.70 [F25.0], she writes "Humans are the arbiters of which diagnoses are given to other humans….Giving someone a diagnosis of schizophrenia with impact how they see themselves. It will change how they interact with friends and family. It will change how they interact with friends and family. The diagnosis will affect how they are seen by the medical community, the legal system, the Transportation Security Administration, and so on" (13-14). Indeed, structuring how her readers will engage with her book, Wang's opening essay is titled "Diagnosis." In it, Wang both orients her reader to her medical condition and wrestles with the meaning provided by such labels. Like Yergeau, she sees the potential in diagnostic narratives: "A diagnosis is comforting because it provides a framework—a community, a lineage—and, if luck is afoot, a treatment or cure. A

[556] Susanna Kaysen, *Girl, Interrupted* (New York: Penguin Randomhouse, 1993), 150.
[557] Esme Weijun Wang, *The Collected Schizophrenias: Essays* (Minneapolis, MN: Graywolf Press, 2019), 12.

diagnosis says that I am crazy, but in a particular way" (5). She emphasizes diagnosis as provisional: "There is no blood test, no genetic marker to determine beyond a shadow of a doubt that someone is schizophrenic, and schizophrenia itself is nothing more or less than a constellation of symptoms that have frequently been observed as occurring in tandem" (10). Describing her re-diagnosis from bipolar disorder to schizoaffective disorder, she writes of diagnosis as a negotiable, flexible framework that she has the power to accept or reject: "It is a label that I am okay with, for now" (5).

Interwoven with her DSM diagnosis, Wang includes other narrative frameworks for her illness. She discusses being sent for a "complementary and alternative medicine" consultation in which the doctor "used the Chinese three-finger method of examining the pulse in both of my wrists. He told me that my problem was obvious: it was a classic case of a Fire typology that had burned out of control, therefore explaining my ambitious personality, pain, inflammation, anxiety, depression, and symptoms of schizophrenia" (21-2). She lists genetic markers for mental illness alongside the claim by a mystic that Wang appears to be "sensitive to the thin skin between the otherworld and that which we call reality" (24). Experimenting with different narratives of her illness, Wang is "hoping to uncover an origin story" (25).

Such uncovering stories abound in illness narratives, as patients seek medical verification for suffering. Mimicking the structure of a scientific paper in her essay "Devil's Bait," Leslie Jamison includes headings for Introduction, Methods, Results, Discussion, and Acknowledgements. The essay is a meditation on Morgellons Disease, an illness in which fibers emerge from the skin. The disease is not recognized by medical science, and the people that Jamison meets at a conference for the condition are self-diagnosed, gathered together to share their frustration with disbelief of their symptoms and to use a strong microscope that they hope will visually confirm their beliefs about the fibers. Speaking of one patient, Jamison writes, "She wants magnification. She wants evidence. She wants certainty" (38). Physical symptoms could "offer tangible signs that lend themselves to

diagnosis; and diagnosis can lead to closure" (35). This closure is only partial in Morgellons, as patients who diagnose themselves are not validated by medical authorities. One patient explicitly links this disjuncture to the histories lain out above: "I was so angry at the misdiagnosis for so many years…being told that it was anxiety, in my head, female stuff." Jamison writes, "I realize her disease is part of a complicated history that goes all the way back to nineteenth-century hysteria" (32). Like hysteria before it, Morgellons poses narrative problems. Jamison expresses a frustration that I share, which is how the language used to describe a disorder of necessity marks an ideological position: "Do people have parasites or claim to have them? Do they *understand* or *believe* themselves to have them? I wish I could invent a verb tense full of open spaces—a tense that didn't pretend to understand the precise mechanisms of which it spoke; a tense that could admit its own limits. As it is, I can't move an inch, finish a sentence, without running into some crisis of imputation or connotation. Every twist of syntax is an assertion of doubt or reality."[558] At the beginning of her "Results" section, Jamison articulates an aim at odds with the empiricist model she mimics: "This isn't an essay about whether or not Morgellons disease is real. … It's an essay about what kinds of reality are considered prerequisites for compassion" (39).

In a later essay, Wang revisits the diagnostic process and foregrounds the validation provided by a diagnosis of organic disease. Wang describes her attempt to find an explanation for symptoms of exhaustion and weakness. Her neurologist proposes and then rejects of "anti-NMDA receptor encephalitis" (171). She introduces another diagnosis, tying it to a specific location: "This constellation of symptoms was, in Santa Fe, diagnosed as the result of dysautonomia" which in turn is often linked to "chronic, or late-stage, Lyme disease, the controversial primary diagnosis" (172). On the Lyme diagnosis, she explains that it was given by a "Lyme-literature medical doctor" who links her mental disorder to Lyme infection, clarifying

[558] Leslie Jamison, *The Empathy Exams: Essays* (Minneapolis, MN: Graywolf Press, 2014), 40.

> This would not be a diagnosis handed down by a doctor outside of the Lyme community, but I was willing to believe it. Until then, I had thought of my psychiatric illness not only as one of my primary identities, but as a beast all its own with an accompanying origin story. The narrative of bacteria infecting my brain suddenly turned my schizoaffective disorder into something organic—a problem amid a constellation of other problems, to be considered alongside my growing litany of symptoms. (173-4)

Emphasizing how the narrative of Lyme disease cohered with her own desires for a clear biological illness, she notes that "A chronic Lyme diagnosis is a kind of belief system" (174) and one not endorsed by the CDC. In specifying the location of her diagnosis—that these symptoms were diagnosed as dysautonomia and Lyme "in Santa Fe"—highlights again the flexibility of diagnoses. Moreover, the diagnosis is accessible only to those with the "financial, communal, cognitive, emotional, et cetera" resources to access "Lyme literate" care (175). Noting her own skepticism and background in science, she writes, "to be so ill that I couldn't hold down a full-time job, and to simultaneously be without a diagnosis, treatment, or hope, made me receptive to the decree of chronic Lyme when my IGeneX test came back positive. Sick people, as it turns out, generally stray into alternative medicine not because they relish the idea of indulging in what others call quackery, but because traditional Western medicine has failed them" (176). Whether searching for mental or physical origin stories (and, indeed, complicating that dualism), Wang emphasizes the specificity of the diagnostic encounter, as alternative medicine practitioners, neurologists, psychiatrists, and mystics offer explanations built out of their own belief systems, training, and even geographic location.

Wang confronts, as does Jamison's interviewee, gendered histories of diagnosis. She writes that "For years, Dr. M implied that my disabling illness was the consequence of a complex post-

traumatic stress disorder, which I interpreted as a formal way of saying that it was all in my head, a form of hysteria" (181). In contemporary discourse, "hysteria" is the ultimate disqualifier. Anna Mollow writes that "people with undocumented disabilities are routinely hystericized—that is, we are treated as if our impairments were 'hysterical' symptoms rather than legitimate diseases."[559] Those fighting for their conditions to be taken seriously often cite hysteria or its modern descendent "conversion disorder" as evidence that their illness is not being taken seriously—that it is being branded as a fake disorder, rather than a real one. There are many reasons for this view—disorders perceived to be mental in origin are stigmatized more than physical ones, and to be disbelieved about the testimony of your body creates what Mollow calls "epistemological disablement," noting that "Health-care practitioners attribute physical symptoms to 'psychosomatic' disorders, and they dismiss both physical and emotional suffering as 'stress' or 'attention-seeking behavior" (186). Mollow takes up Freud's *Dora,* asking "how do we know that Dora's symptoms do not have physical causes?" (192). Of course, we don't, but an equally interesting is why that should matter.

Stigma and gendered disbelief are clearly present in Mitchell's hysteria, but the suffering was undoubtedly real, and its mental and physical origins and symptoms were inextricably bound together—it was as much a physical as a mental disorder, even without the underlying pathology detected. Mitchell's understanding of the disorder gives us the framework for thinking about hysteria as a "real" disorder—a legitimate experience of illness— at the same time that it allows us to investigate the suspicion leveled at ill women, the stigmatizing rhetoric of the diagnosis, the inequities that rhetoric highlights, and the autocratic and abusive behaviors it enabled from both physician and society. Among my hopes is that this framework will be a useful supplement to the Freudian one used by Mollow or the critics writing about Winifred Howells' hysterical illness, or any of the contemporary diagnostic schemes that have followed to discussing the complex experience of

[559] Mollow, "Criphystemologies," 186.

psychogenic and psychosomatic disorders—among the most marginalized and most poorly treated disorders in American medicine today. By attending to the dynamics of power and narrative control but also to the underlying belief that psychosomatic illness is legitimate, I am to reframe hysteria and its companion moral disorders can be reframed as conditions asking us to focus on the lived experience and the narratives of illness rather than their biochemistry.

In exploring both the politics and poetics of diagnosis—its social stakes and its generic structures—I have tried in this dissertation to ask the questions that still face these women. How do diagnostic narratives accrue legitimacy? How deeply is empathy linked to those authoritative narratives that brand some illnesses legitimate and others illegitimate? Where does empiricism lean on narratives, and how does it cloak those narratives as authoritative? As the work of this dissertation and of the women in this conclusion make clear, diagnosis—and especially the diagnosis of invisible, controversial, or mental disabilities and illnesses—is a negotiation of stories. The memoirs, though, powerfully reveal the possibilities of patients claiming the role of diagnostic narrator.

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