Symptoms of Femininity:
Novelistic Treatments of Sensibility, 1760-1820

by

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A thesis submitted in conformity with the requirements for
the degree of Doctor of Philosophy
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At the end of the eighteenth century in England, the popular discourse of sensibility took a toll on the bodies of literary heroines, disabling them through faints, blushes, hysteria, and other symptoms. At this same time, the reading public had increasing access to medical knowledge through publications advocating self-awareness and preventative medical practices. In this thesis I therefore locate a medical narrative logic and rhetoric in novels by select women authors in order to suggest that these novelists—Mary Wollstonecraft, Mary Hays, and Jane Austen—were, in fact, working with varying degrees of success, to treat heroines disabled by the symptoms of sensibility. My thesis reads the medical writings of William Cullen, William Buchan, John Leake, and Thomas Beddoes, among others, alongside the novels of Wollstonecraft, Hays, and Austen. By this means I identify the discursive tools provided by popular medical texts and show how they were employed by these authors to treat the symptoms of sensibility. In Chapter One I examine the case studies Wollstonecraft presents in her novels to illustrate the tragic consequences that result when women are not permitted to maintain authority over their own health and habits. Chapter Two considers the writings of Mary Hays as she sought to diagnose her personal health and habits through her autobiographical novel. Her self-diagnosis in Memoirs of Emma Courtney enables her to optimistically offer preventative suggestions to try and ensure the health of future generations of women. Finally, in Chapter Three I look at Austen’s successful treatment
of sensibility in *Sense and Sensibility*, her first published novel. In determining that the symptoms of sensibility did not actually warrant medical treatment, Austen freed her future heroines to engage in a healthier way of feeling, namely for others through feelings of sympathy. All three authors employed the tools afforded them by medical discourse to treat their heroines’ symptoms of sensibility, and to rethink the possibilities for healthier models of female literary heroism. This thesis therefore offers insight into the ways in which romantic-period novels by women were not only informed by, but also engaged with, popular medical discourses during the late eighteenth century.
Acknowledgments

To express my gratitude to all those who have helped with this project is no small thing. The list could easily be as long as the project itself. To start from the very beginning, I was grateful to receive funding from the Social Sciences and Humanities Research Council, as well as the University of Toronto to undertake this work.

My supervisor Deidre Lynch was patient, rigorous, and always challenged me to ask sharper questions and to push for more productive, fruitful answers. I am tremendously grateful to have had her support and insights over the years. Thank you also to Alan Bewell and Thomas Keymer, committee members who provided thoughtful, engaged feedback on my work and who, along with Deidre, were always ready with advice, support, and encouragement. I am also indebted to other University of Toronto faculty members who assisted me throughout the PhD program—Brian Corman, Linda Hutcheon, Jeremy Lopez, Carol Percy, Heather Murray, Will Robins, Paul Stevens, and my various course professors. I also very much appreciate the feedback provided by Professor James Allard from Brock University as my external examiner. Thank you to Margaret Atwood as well, for tips along the way. And I will always be grateful to the University of Guelph’s Susan Brown for teaching me how to research, and to Danny O’Quinn, for showing me the power of reading closely.

The administrative and support staff in the English department at the University of Toronto have always been second to none. Gillian Northgrave, Tanuja Persaud, Sangeeta Panjwani, Clare Orchard, and Marguerite Perry number among the truly
wonderful, kind souls who have provided invaluable, tireless assistance to so many students, myself included, day in and day out.

The women in my cohort at the University of Toronto are among the most amazing, intelligent, witty, lovely, and generous people I know, and have helped me shape the ideas for this project and beyond. In particular, to Suzanne Grégoire, Dr. Ceilidh Hart, Dr. Katherine McLeod, Dr. Emily Simmons, and Jackie B. Wylde, thank you for sharing your laughter, brain power, and conversation with me. A special thank you to Dr. Marybeth Curtin without whose determination, perseverance, and thirst for knowledge, I’d have been lost. And thanks also to those who went before and helped to show me the ropes: Dr. Darryl Domingo and Dr. Rory McKeown.

Thank you to my many friends around the globe who encouraged me to persevere with this project, and to Mark Ussher, who would have been pleased and proud to see it done. Finally, to my family, to my mother who had me reading before I could talk, and who encouraged me, drove me, helped me, taught me, loved me, I can never say thank you enough. To my father who taught me the value of clear writing (among many, many other things), and to my sister whose pictures often say more than my thousands of words, I love you and am so grateful to all of you. And to my husband, Travis, my partner in crime, and my rock, thank you always, for the easy silence that you make for me, and the way you keep the world at bay for me.
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THE
Ladies Dispensatory:
OR
Every Woman her own Physician.
TREATING OF THE
Nature, Causes, and various Symptoms, of all the
Diseases, Insirmities, and Disorders, natural or contracted, that most peculiarly affect the
FAIR SEX, in all their different Situations of Life, as Maid, Married Women, and Widows;
Under the following HEADS:

Of contracted Weakness, before Marriage especially; with proper Advice concerning it.

Of the Courses, their various Irregularities, as Suppression, Obstruction, immoderate Flux, Supputation, Complication with other Diseases, &c.

Of the Hysterical Disease, or Vapours, and all Hypochondriacal Disorders: Also of the Green Sickness, and Furor Uterinus.

Of the Whites, the Piles, Relaxations of the Uterus and Fundament, Swellings, Ulcers, and other Uterine Affections.

Of the Generative Parts in a Woman; with an Account of Generation and Conception, and other curious Particulars relating to the Use of the Marriage-Bed.

Of Barrenness in Women, and Impotency in Men, in all the possible known Circumstances of either.

Of the Management of Women with Child, and the Disorders attending Pregnancy: Likewise of Moles, False Conception, and Miscarriage.

Of the Symptoms preceding, and Disorders attending Delivery, whether natural, difficult, or unnatural; with particular Directions regarding the Office of a Midwife.

Of the Disorders consequent upon Delivery, both in the Breast and elsewhere, both those immediate and those of longer Continuance.

Of the Management of new-born Infants, and the Diseases they are usually subject to, from their Birth till four or five Years of Age.

WITH
Variety of PROPER REMEDIES, in Words at length, adapted to each Particular Case, agreeably to the best modern Practice: By the Help of which any MAID or WOMAN, who can read English, may not only come at a true Knowledge of her Indisposition, but be enabled to cure it without applying, or even discovering her Condition, to any Person living.

ALSO,
A compleat Index, an Explanation of difficult Terms, and a copious Preface, including a pathetic Address to all fashionable Mothers, in behalf of themselves and their tender Offspring.

LONDON:
Printed for JAMES HODGES, at the Looking-Glass on London-Bridge; and JOHN JAMES, at Horace's-Head under the Piazza of the Royal-Exchange.
M.DCC.XXXIX.
Introduction: “Every Woman her own Physician”

_The Ladies Dispensatory, Containing the Natures, Vertues, and Qualities of all Herbs, and Simples useful in Physick. Reduced into a Methodical Order, for their more ready use in any sickness, or other accident of the Body_ first appeared in 1652.\(^1\) The work offered basic remedies to the general reading public and, according to its modern editors, reflected “the major surge during the seventeenth century of public interest in both medicine and preventative health among the literate public, who could be cast in the roles of both lay patients and health-care providers.”\(^2\) While the content was not new—its sources included Dioscorides’ _Materia Medica_, Gerard’s _The Herbal or General History of Plants_ (1597), and the writings of Leonhart Fuchs (1501-1566)—there was nevertheless something novel about the text. What was distinct from earlier medical books was _The Ladies Dispensatory_’s clear address towards female readers. Furthermore, though the volume addressed the afflictions of both men and women, the work’s title suggested that women would be primarily responsible for administering the prescriptions.

When the _Dispensatory_ appeared again during the eighteenth century,\(^3\) both its title and contents had undergone further significant transformations. Instead of the simple, point-form prescriptions offered in the earlier work, the new volume is written in

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\(^1\) This is the date most widely given. The OCLC Worldcat, however, lists an edition as having been published in 1651 as well, [http://www.oclc.org/worldcat.en.html](http://www.oclc.org/worldcat.en.html) (accessed October 12, 2008).

\(^2\) Leonard Sowerby, _The Ladies’ Dispensatory_, ed. Carey Balaban, Jonathan Erlan and Richard Siderits (New York: Routledge, 2003). All subsequent notes refer to this edition. It should be noted that while Sowerby is cited as the author for this particular early edition, many of the subsequent editions (including the edition discussed below, that of 1739) were published anonymously, presumably by more than one author.

\(^3\) According to the OCLC Worldcat, editions were published in 1739, 1740, 1755, 1769, and 1770.
fluid prose, offering case studies of conditions contracted and treated. The full title of the
1739 edition is much longer than that of the first version and is worth including in full:

*The Ladies Dispensatory: or Every Woman her Own Physician. Treating of the Nature,
Causes, and Various Symptoms, of all the Diseases, Infirmities and Disorders, Natural
or Contracted, that most peculiarly affect the Fair Sex, in all their Different Situations of
Life, as Maids, Married Women, and Widows.* The work then promises:

A variety of proper remedies, in *words at length*, adapted to each
*Particular Case*, agreeably to the best modern practice: by the help of
which any maid or woman, who can read *English*, may not only come at a
true knowledge of her Indisposition, but be enabled to cure it without
applying, or even discovering her condition, to any person living.⁴

To begin with, the appositive subtitle is telling: “Every Woman her own Physician.”

While there is no verb, the phrase’s possible meanings are nevertheless clear. The terms
“as,” “is,” “becomes,” “might be”, “can be,” even “must be” are all appropriate. The
implication is that it is possible for a woman to discreetly assume responsibility for her
own health, and health in this context implies the absence of the items listed below the
title: “symptoms,” “diseases,” “infirmities,” and “disorders,” both “natural and
contracted.” The division of afflictions into “natural” and “contracted” will be discussed
at length below, but briefly, it implies that women are biologically predisposed to some
disorders, and particularly susceptible to others. The dispensatory promises treatment
options for any affliction that might “disorder” the female body. Furthermore, the work
offers to empower all women, regardless of their age and social or marital status. This

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⁴ *The Ladies Dispensatory* (London, 1739), prelims. I am grateful to the University of Toronto’s Robarts
Library for assistance in reproducing the frontispiece on page 1, above, accessed through *Eighteenth-
text is lifetime reading for those “who can read English;” in other words, the same literate crowd interested in, and purchasing novels would stand to benefit from the narrative methods, or “words at length” on offer here. Such “words,” given according to the “best modern practice,” reveal a connection between reading, narratives, and medical practices, both prophylactic and restorative, that warrants further examination.

The title then enumerates some of the specific afflictions from which the “fair sex” might suffer, and the subsequent text promises: “Words at length, adapted to each Particular Case, ...By the Help of which any MAID or WOMAN, who can read English, may not only come at a true Knowledge of her Indisposition, but be enabled to cure it without applying, ... to any Person living.” Compared to other medical texts emergent around this time, publications such as George Cheyne’s The English Malady or, A Treatise of Nervous Diseases of all Kinds (1733) which offered “the Author’s own Case at Large,” or Dr. Colbatch’s The Generous Physician (1733), containing, “Descriptions of the Causes, Symptoms, and Method Proper for Cure of Several Distempers,” the framing of this edition of the Dispensatory marks it as uniquely intended to provide terms and methods for use by female readers. The particular process described—women using “words ... adapted to” their individual cases to become informed, enlightened, and enabled—constitutes the core of my project. As I will show, one particularly dominant discourse within late eighteenth-century British culture dictated that women were often cast as patients, burdened with the disabling effects of sensibility. A guide such as the Dispensatory “enabled” women to access “true Knowledge” of their bodies to “cure”

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what was believed to ail them. Author Hester Lynch Piozzi reveals the empowering nature of such rhetoric when writing to her friends in 1800 about physician Thomas Beddoes’ newest publication: “Have you read Beddoes’ Book, Dear Ladies? All about Oxygen Air and Gas, and how we have Power over our own Lives, and I know not what strange things. It is a curious Performance.” The discernible shift between the first two printings of the Dispensatory signifies the appearance of a discursive toolkit for women, one equipped with rhetoric, logic, and a lexicon, one enabling a method of understanding and narrating through medical discourse.

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In the seventh chapter of Jane Austen’s Pride and Prejudice (1813), Jane Bennet becomes unwell, and is the subject of some debate and diagnostic discussion, though most characters are in agreement that she has a “cold.” In illustrating how this single term, “cold,” is wielded to different effects by different people, Austen works to show the polysemousness of the language of diagnosis and reveals the rather urgent necessity for women’s self-diagnosis and self-knowledge. Elizabeth Bennett receives a note from

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6 Hester Lynch Piozzi to the Ladies of Llangollen (Lady Eleanor Butler and Sarah Ponsonby), May 2, 1800, in The Piozzi Letters: Correspondence of Hester Lynch Piozzi, 1784-1821 (formerly Mrs. Thrale), ed. Edward A. Bloom and Lillian D. Bloom (Delaware: Associated University Presses, 1993), 3: 188. The editors cite Piozzi as referring to Beddoes’ work Notice of some Observations Made at the Medical Pneumatic Institute (1800), but provide no evidence as to how they know which title Piozzi is discussing. It seems equally likely that Piozzi could have been referring to Contributions to Physical and Medical Knowledge, Principally from the West of England (also published in 1800). This work also had several chapters that would fit the description of being written about “oxygen, air and gas,” and furthermore, seems a work more likely to have inspired Piozzi to say that “we have Power over our own lives.” Despite the wrongheadedness of many of Beddoes’ claims therein, for example, that nitrous acid was responsible for curing a gentleman “seized with sickness and bilious vomiting” after “eating of cheese much decayed” (418), he offered many inspiring assertions using empowering rhetoric. He declared his volume to be “among the smaller means of rendering education an apprenticeship to happiness and qualifying people to take themselves into their own keeping” (5).
her sister, who has been visiting Mr. Bingley and his sisters at Netherfield. In the note, Jane talks of how, after walking through the rain to get there:

I find myself very unwell this morning, which, I suppose, is to be imputed to my getting wet through yesterday. My kind friends ... insist on my seeing Mr. Jones—therefore do not be alarmed if you should hear of his having been to me—and excepting a sore throat and head-ache, there is not much the matter with me.7

Surprisingly, Jane’s self-diagnosis of “not much” being the matter is seconded by her mother, who is usually prone to nervous hysteria and tends to view her own symptoms in the most serious light. Mrs. Bennet, pleased at the prospect of having Jane stranded in Bingley’s home, tells her husband, “I am not at all afraid of her dying. People do not die of little trifling colds” (27). Elizabeth, however, once she has walked to Netherfield to talk with Jane face to face, remains unconvinced by her assurances and sends for the apothecary. Mr. Jones, “having examined his patient, said, as might be supposed, that she had caught a violent cold, and that they must endeavour to get the better of it” (29). He advises her to return to bed “and promised her some draughts. The advice was followed readily, for the feverish symptoms increased, and her head ached acutely” (29). Elizabeth goes on to take extra precautions: “she requested to have a note sent to Longbourn, desiring her mother to visit Jane, and form her own judgment of her situation” (35).

Between the characters’ varying diagnoses of Jane’s rather common symptoms, it is difficult to determine precisely the nature and severity of her condition, though the combination of a cold, fever, and sore throat do indicate that she was suffering from something fairly acute.

Austen explained to her sister Cassandra, “I have not much compassion for colds in the head without fever or sore throat.”8 Since Jane Bennet has both fever and sore throat, the situation could be serious indeed; and according to William Buchan’s wildly popular Domestic Medicine (1769), an “inflammation of the throat” could be a “most acute and dangerous distemper which sometimes takes the patient off very suddenly.”9 When Mrs. Bennet visits, however, she is quickly satisfied “on seeing that [Jane’s] illness was not alarming” (35). Since Mrs. Bennet is prone to raising the alarm needlessly, the reader may find some comfort in her dismissive diagnosis. Certainly Mr. Jones’ calm determination that “they must endeavour to get the better of it” is intended to assure readers that there is no need to panic, for time only will determine the outcome of her disorder. What I would emphasize, however, more than the specific nature of Jane’s affliction, is the reason for her illness: Jane does not become ill because of her feelings for Bingley; she becomes ill because her mother, who would perhaps not object to her dying for love (provided she got the wedding ring and money first), wants her to stay at Netherfield, and denies her the carriage, forcing her to ride there in the rain. Jane becomes ill because her mother wished her to enact the role of a heroine of sensibility, telling her: “No my dear, you had better go on horseback, because it seems likely to rain; and then you must stay all night” (26). A lone girl in the rain mirrors Sense and Sensibility’s Marianne Dashwood (as we will see in Chapter 3), who, unlike Jane, chooses, nay, prefers to walk in the rain and risk illness; Jane, on the other hand,

9 William Buchan, Domestic Medicine: Or, a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines (London, 1790), 286. Domestic Medicine was first published in 1769, and was one of the most popular guides to medicine, found in many households throughout England and America. All subsequent references are to this edition.
becomes ill thanks to her mother’s efforts to cast her as a stranded maiden, in need of rescue. The medical context for the incident itself is rather indeterminate, but the scene is one version of a scenario of illness that is important to the Austen novels as a group, and which is relayed in different ways in different novels.

As I show in my final chapter, following the composition of the 1811 novel, *Sense and Sensibility*, Austen wants no more to do with needless narratives of female illness. The episode in *Pride and Prejudice* is therefore brief. Jane is clearly ill; she knows it, and so do those around her. She understands the circumstances of her case, recognizing what has led to the development of her illness ("getting wet through" [27]), and readily follows the advice offered by her family and the physician. Austen’s own voice seems to come through in the character of Mr. Jones, a credible figure of medical authority, who agrees with Jane in his diagnosis of her case.\(^{10}\) Kathryn Montgomery Hunter notes that whether one is patient or physician, the “fixed conventions of medical narrative” control one’s subjectivity.\(^ {11}\) Jane’s agency is therefore diminished in her role as patient; following the composition of her note home, for example, Jane becomes passive and silent: the medical “advice was followed readily” by “the sick lady” (29, 35). When she “feels herself to be right” again, her agency returns, and she resumes her quiet strength of purpose. She joins with Elizabeth’s “positive resolv[e]” to leave Netherfield and persuades Bingley to lend them his carriage in order to do so. Austen writes of Bingley: “The master of the house heard with real sorrow that they were to go so soon,

\(^{10}\) It should be noted that the character of the physician in literature was often a comic figure—see N. Cousins “Quacks and Clowns” in *The Physician in Literature*, ed. N. Cousins (Philadelphia: Saunders Press, 1982). This is most definitely not the case for Austen, and for the other authors discussed.

and repeatedly tried to persuade Miss Bennet that it would not be safe for her—that she was not enough recovered; but Jane was firm where she felt herself to be right” (52). The wording here is important—Jane “felt herself to be right.” Not only does she “feel” in a moral sense that it would be more appropriate for her to leave, and to not overstay her welcome, but she also corporeally feels “right.” She is aware that her body is again sound and that it is safe for her to return home. This incident, one of many narratives of illness in Austen’s work, reveals the author’s subtle determination to tell the stories of healthy heroines, for when not in good health, a woman cannot be in control of her own narrative or, as in the case of *Persuasion*’s Mary Elliot, the narrative is not likely to be very interesting.

My project contends that certain novels by women during the second half of the eighteenth century employ a medical discourse and a narrative logic of the sort made available in works such as the *Dispensatory*. Novelists used this discursive toolkit to diagnose and treat the conditions of their female characters on one level, and on another, to examine the conditions affecting the social body more generally. *Pride and Prejudice* was published in 1813, more than seventy years after the new edition of the *Dispensatory* had appeared. By this time, such discursive employment is subtle, quietly following the logic of the case in a brief episode to illustrate that walking in the rain in pursuit of a husband is likely to make a woman needlessly and senselessly ill. In the works of two of Austen’s literary precursors, Mary Wollstonecraft and Mary Hays, the engagement with medical logic and narrative structure is much more apparent. My project reads a text such as *The Dispensatory* as an artefact indicative of a transition in social knowledge, and of the ways in which this social knowledge provided women novelists the language of case
studies and medical narratives with which to represent and treat their female literary characters.

The Eighteenth-Century Medical Narrative

To effectively discern and read medical narratives within literary ones, it is necessary to examine and determine the nature of the “medical narrative.” Medical historians generally agree that while the eighteenth century saw relatively few specific medical and scientific breakthroughs, there was nevertheless a more optimistic outlook concerning the role and benefits of medicine, as well as increasing standardisation of medical methods and practices. Guenter B. Risse suggests that a healthy and expanding population was one of the most important elements among the newly perceived requirements of national power: “a comprehensive system of health preservation sought to portray sickness as an avoidable evil that endangered both individuals and the community.” Risse and Roy Porter both cite an increasing number of medical publications during the eighteenth and nineteenth centuries as evidence of the dissemination and popularization of medical knowledge. Indeed, the multiplication of popular medical texts was significant. Porter argues that while publications in “general scientific journals” diminished during the eighteenth century, monographs appeared with increasing frequency, and doctors “exploited new publishing openings; ... the newspaper,

... [and] the superior monthly periodicals catering for polite and enlightened
readerships."¹³ Among the reading public, medical knowledge was increasing.

Three of the most significant trends that can be credited with enhancing medical
knowledge at this time were related: the development and refinement of nosology, the
branch of medicine concerned with the classification of diseases; the refinement and
increasing publication and availability of the medical case study; and public education
encouraging the practices and habits of preventative medicine. In Britain, medical
authors such as Thomas Sydenham (1624-89), William Cullen (1710-1790), Thomas
Trotter (1760-1832), and John Brown (1732-1788), and abroad, Herman Boerhaave
(1668-1738), Giorgio Baglivi (1648-1701), and later Carl Linnaeus (1707-1778) sought
to collect and classify information. Sydenham, for example, recognized that “medical
progress results from the accumulation of repeated careful observations of patients
suffering from disease, and of the consequences of various treatments for their diseases”
and he therefore worked to carefully document the results, or effects produced by
medical trials and errors. W. F. Bynum summarizes some of the key questions that arose
as Sydenham and his peers undertook these endeavours: “What is the difference between
a disease and a syndrome; between a disease and a symptom; between a disease and its
causes; between a disease and the person experiencing it; between disease and sickness
or illness?”¹⁴ Such questions demanded a clear articulation of the order of events leading
up to, during, and following a disorder.

¹³ Roy Porter, “The Rise of Medical Journalism in Britain to 1800,” Medical Journals and Medical
The explanation of events preceding, during, and after illness took—and still takes—the form of narrative. Bynum proposes that during the mid- to late eighteenth century increasing numbers of physicians adopted Francis Bacon’s suggestion to begin collecting “histories of disease.” This move reflects a general cultural tendency in seventeenth and eighteenth-century Britain; the Royal Society, for example, also began mandating protocols for both scientific experiments and voyage narratives. Such collections rapidly appeared in print—some for personal profit, some for posterity, and as Roy Porter claims, “the Georgian century did see the origins of the medical press.”

Michel Foucault’s *Birth of the Clinic*, trans. A. M. Sheridan (New York: Vintage Books, 1994) is obviously an important background text here for its articulation of the particular significance of this late eighteenth-century moment in medical history. Foucault writes: “The examination of cases, the writing up of detailed accounts of them, and their relationship with a possible explanation belong to an essential tradition that has never been in question in medical experience; the organization of the clinic is not correlative with the discovery of the individual fact in medicine; the innumerable collections of cases published since the Renaissance is proof enough of this. Furthermore, there was also a very wide recognition of the need for teaching through practice itself: hospital visits by apprentice doctors was now widespread; and some of these apprentice doctors would complete their training in a hospital in which they lived and practiced under the supervision of a doctor. What, therefore, was so new and so important about those clinical establishments that the eighteenth century, especially towards its close, valued so highly? In what respect could this proto-clinic be distinguished from the spontaneous practice that had once been synonymous with medicine, on the one hand, and the clinic as it was later to become organized into a complex, coherent corpus combining a form of experience, a method of analysis, and a type of teaching, on the other?” (23-24). His answer suggests a combination of factors including the collective study of cases alongside the organized “corpus of nosology” operating within the space of the “clinic.”

According to Ilse Vickers, Fellows of the Royal Society of London for the Improvement of Natural Knowledge explicitly stated that they recorded nothing but “severe, full and punctual Truth” (65). In addition, travelers were provided with the Society’s *Catalogue of Directions* “the better to capacitate them for making such observations abroad, as may be pertinent and suitable for [the Society’s] purpose” (*Defoe and the New Sciences* [Cambridge: Cambridge University Press, 1996], 133).

See also Roy Porter “Medical Journalism in Britain to 1800,” *Medical Journals and Medical Knowledge*, which suggests that while publication rates increased overall, debates raged within medical circles concerning the extent to which information *should* be made publicly available. See note 13 above. William Buchan, author of *Domestic Medicine*, was perhaps one of the most radical, seeking to empower people with knowledge about their own health. Beddoes was only slightly more conservative in his seeking “restricted circulation” of information, concerned as he was that too much self-treatment could lead to irreparable damage.

very act of composing such narratives demanded that distinctions be made between causes and effects, and disorders and symptoms. As the case study increased in popularity and availability, so too did physicians’ collective awareness of its merits continue to grow. Thomas Beddoes (1760-1808), physician, author, and scientist, remarked:

> It will hardly be denied that books of medicine abound in falsified or erroneous or mixed narrations much more than in genuine facts. ... But such during its infancy is the chaotic state of the records of every science. Something is perceived, much imagined, and little understood. Authors blend what they imagine with what they perceive; nor have they the prudence to refrain from attempting to explain what they do not understand. But in time, they acquire patience to look more steadily and learn to distinguish better.¹⁶

Indeed, prefatory material for medical publications generally promised enhanced knowledge, clearer narrations, and “genuine facts.” Case histories could increasingly be read in several venues—in popular medical guides, professional instructional manuals, periodicals, and medical monographs.¹⁷

Regardless of the format of the work in which they appear, case studies themselves always exhibit certain features; according to Kathryn Montgomery Hunter, “case presentations are, in fact, highly conventional narratives. They are strictly ordered and their language is meant to be narrowly descriptive and toneless.” Despite attempts at objectivity, however, they are always “narratives,” complete with metaphor and interpretive possibilities.¹⁸ The continued development and refinement of this genre was

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¹⁶ Thomas Beddoes, *Contributions to Physical and Medical Knowledge* (Bristol, 1799), 14.
¹⁷ In using terms such as “medical publications” or “medical writings” I am referring to works concerned with the preservation of human health that almost always include case studies, but that are not necessarily limited to one form.
instrumental for both nosological and preventative medical practices, as eighteenth-century practitioners increasingly recognized the value of clear, complete case histories in developing an understanding of disease progression. David Wooton reminds us that there was very little medical or laboratory testing done; rather, doctors “relied upon what we would now call anecdotal evidence ... individual case histories of successful treatment.” Indeed, the case history remains today a critical part of medical practice: “medicine’s focus on the individual patient, fitting general principles to the particular case, means that knowledge possessed by clinicians is narratively constructed and transmitted.” Beddoes encouraged the accurate and precise keeping of medical records and histories in several of his works. In *Contributions to Physical and Medical Knowledge from the West of England*, for example, which sought to amass a geographically disparate body of knowledge in one text, he celebrated the periodical press for preserving “short and otherwise fugitive pieces.” To these “repositories,” he continued, “we owe much of the superiority of the modern over ancient medicine. To establish them on the one hand, and to supply them on the other, is perhaps the utmost

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that can be accomplished by the co-operation of the members of the profession.”21

Doctors evidently responded to such appeals and were increasingly diligent in recording, preserving, and making public their medical case histories.22 Beddoes certainly followed his own advice, including case study narratives either formally—as with the numbered cases he provides in Observations on the Nature and Cure of Calculus, Sea Scurvy, Consumption (1793)—or more informally and anecdotally as he does throughout Hygēia (1802), describing, for example, “a lady of observation [who] has favoured me with the following account of an occurrence.”23

The careful ordering of events in a medical narrative was particularly stressed by those advocating more structure and consistency within the genre of the published case study. William Cullen begins his influential First Lines on the Practice of Physick for the Use of Students in the University of Edinburgh (1777) with the assertion that: “In teaching the practice of physic we teach to discern, distinguish, prevent and cure diseases as they occur in particular persons.” The most effective way of doing so, he explained, is “attained by an accurate and complete observation” of disease phenomena “as they occur in concourse and succession; and by a methodical nosology ... established upon

21 Thomas Beddoes, Contributions to Physical and Medical Knowledge from the West of England (Bristol, 1799), 7.
22 Christopher C. Booth cites the growth of both medical societies and medical publications as contributing to the increasing availability and preservation of case studies. He notes that clinical observations and pathological dissections also increased in frequency during the eighteenth century, resulting in more information to record and fill in narrative gaps. See “Clinical Research” in the Companion Encyclopedia of the History of Medicine, 1: 207. It should be noted that not all publications were good or legitimate: many “quacks” saw financial opportunity here as well. See also Roy Porter’s “Medical Journalism” in Medical Journals and Medical Knowledge.
23 Thomas Beddoes, Hygēia; or Essays Moral and Medical on the Causes Affecting the Personal State of our Middling and Affluent Classes (Bristol, 1802). (This text is divided into three volumes, with separate essays printed with non-sequential pagination. References will be marked as follows: Volume: Essay, page.) 1:1, 38.
observation, abstracted from all reasoning.”

Observations of patients needed to be “accurate and complete,” and physicians were encouraged to place particular emphasis on the “concourse and succession,” the order of events leading to illness. Such understandings might then enable both cures in the present, and prevention in the future. Cullen’s work was accessible to his students at the University of Edinburgh as well as the general reading public, and its several printings testify to its popularity and importance. Cullen was by no means alone: writings by countless other physicians sought to share information gleaned from observing cases of illness, and to clarify when “the effect has been mistaken for the cause, and the cause for the effect.”

Establishing and recording the correct order of events, and determining which cause resulted in which effect, were the means through which consistent medical treatment was believed to be achieved.

Though “case history” is a twentieth-century term, one understanding of “case” that developed during the eighteenth century was “a record of the progress of disease in an individual.” This “record of progress,” the documenting of a narrative of the progression (and perhaps regression) of illness, is one characteristic of the genre of the case study. Citing the work of André Jolles, James Chandler summarizes a second key feature:

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25 John Leake, *Medical Instructions Towards the Prevention and Cure of Chronic or Slow Diseases Peculiar to Women*, 2nd ed. (London, 1777), 76. This comment from Leake is taken from his discussion of women’s menstruation. He writes: “Observation and repeated experience clearly present us with the following facts: ill health, to which women are subject from causes in common with men, will frequently bring on an obstruction of the menses; such as an hereditary bad stamina or consumptive habit; but if health can be restored, this evacuation, like others natural to the body, will again return without much assistance from medicines. Hence it is evident, that the *effect has been mistaken for the cause, and the cause for the effect*, to the great injury of the female constitution.”
The case names not only the anomaly for a scheme or system, but also the scheme or system itself, as well as those processes by which anomalies and norms are adjudicated. The case ... is the very form of ‘deliberation.’ It is always calling for judgment, and it is by virtue of judgment that it offers formal mediation between the particular and the general, between instance and rule, between circumstance and principle.\(^{27}\)

A medical case study necessarily recalls the circumstances leading up to illness in order to deliberate on the cause and offer judgment on treatment; in other words, diagnosis and prescription. There is a careful ordering of events, “circumstance,” in order to illustrate the factors that are believed to have led to the condition, “principle.” Events from the start of the narrative are generally affirmed retroactively by the narrative’s conclusion to have been causal—either through the patient’s improvement when conditions are changed and the patient recovers, or, as in the example provided below, when the patient is unable to improve because the effects from the initial events or conditions are too powerful.

The following case study from John Leake’s *Practical Essay on Diseases of the Viscera* (1792), illustrates the form and style of the medical narrative. The following excerpts reveal how a narrative structure of cause and effect, combined with a call for deliberation and judgment, are integral to the genre of the case study:

The life of the patient was sedentary from his earliest youth: At school, during the hours of play, his time was spent in his father’s study in close application to the languages; so much that his attention was lost to almost every other matter. This way of life was probably the cause that, at the age of fourteen, he was reduced to a very emaciated state, attended with night-sweats, bleeding at the nose, upon the least exertion, and frequently, while in a learning posture over his books which continued to a very alarming degree. Relaxation from study, gentle exercise, better air than that of a large town where he then lived, milk diet, and proper medicines relieved

him at that time from his declining state, and he enjoyed tolerable health and good spirits till near twenty, when he resided in London; but immoderate application to his favourite studies, business and its confinement again brought on his old complaints, with the addition of a violent cough as well as night-sweats, and in the day-time, immoderate perspiration upon the least motion, though in the winter season. These symptoms and an almost continual hectic fever reduced him to a shadow and the weakness of an infant.

Some time in the month of April, 1785, ... he was seised [sic] with a pain on the left side, a little below the short ribs, which affected his breath, and prevented his standing upright; but which he thought so little as not to apply for medical assistance, but sought his remedy in abstinence, small drink, rest in bed which in some measure relieved but did not entirely remove his pain.

The narrative continues describing further symptoms as they occurred: spasms in June are followed by prescriptions of mercury, tonic medicines, and gentle purges. The medical methods are detailed: “embrocations, volatiles, and opiates were applied without the least benefit,” while a “tumour by this time had extended itself lower than the umbilicus and across the right side.” Symptoms both short-term and incidental are described, as are more lasting conditions: “The right leg, from great pressure of the tumour above, began to be much distended, as well as the parietes of the abdomen, which was enormously enlarged.”28 Leake then notes that after additional discomfort, no abatement in symptoms, and no response to further treatments, the patient died in September of that same year. The hypothesis initially presented—that the patient’s sedentary lifestyle was responsible for this condition—“this way of life was probably the cause”—is supported with evidence gained through autopsy. The state of the patient’s

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28 “Parietaes of the abdomen” refers to the walls of the abdomen.
inner organs is described and the following highly dubious, though utterly confident conclusion is offered:

This singular case tends to illustrate and confirm several observations in the preceding part of this Essay; particularly the inconvenience of a sedentary, studious life; the danger of drinking cold liquors when the blood is heated by exercise; and the great injury to health, by sitting constantly in a half-double position of the body by which the abdominal viscera sustain almost its whole weight and being violently compressed, the circulation of blood through their vessels is obstructed, and the several secretions, and excretions necessary to life impeded or suppressed.29

The sequencing of events is crucial, as is the judgment or interpretation offered. The retrospective third person narration of the medical case study means that it generally begins at the point the diagnostician believes the condition was caused, and finishes with either improvement or death. In the case of this gentleman, it seems clear to a contemporary reader that some form of abdominal cancer was likely to blame for his death and not, in fact, his sedentary habits. The way in which his case study is structured, however, nevertheless illustrates the workings of a diagnostic narrative towards the end of the eighteenth century.

Case studies naturally require a beginning (cause), middle (conflict / symptoms) and an ending (death / improvement): in the case above, the doctor believed the condition to be caused by the patient’s sedentary lifestyle— he therefore chooses to begin his narrative by detailing those circumstances and habits, and then develops the case history from that point. It is this very logic (occasionally flawed and unscientific as it may be)

that can be read in novels by many women authors of the late eighteenth century. The medical case study models an accessible, valuable, and credible form of authority for authors such as Mary Wollstonecraft, Mary Hays, and Jane Austen, in that its very structure enabled the combining of observations into a meaningful narrative, and provided a way to give lived experiences structure and meaning.

**Nervous Disorders and Habits of Sensibility**

The medical case study was used for all nature of diseases. Beddoes felt that for many disorders, “the parts concerned ... have been so often examined by dissection, ... the physician can read the state of the interior as plainly as if the body were a book, the alterations in organs accessible to sense, and the patient’s account of his feelings, serving him for letters.”

Such a statement recalls the promises of the *Dispensatory*; if the “patient’s account of his feelings” are “letters” comprising a text, then the possibility exists for the patient to author her own narrative, and furthermore, to take a more active role in determining how the narrative ends, or how the case is to be treated.

Narratives of disease were becoming easier to compose and easier to read, for doctors, patients, and authors alike. In general, however, the class of disorders known as “nervous” presented particular challenges to diagnosis, treatment, and explanation through narrative. The category of nervous disorders was broad and included (according to *Domestic Medicine*) melancholy, epilepsy, swooning, low spirits, hysterick affections,

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and hypochondriac affections, among other conditions. Physicians generally agreed that the causes of disorders affecting the nerves and their functions were frequently indistinguishable from the effects or symptoms of these afflictions. William Rowley explains: “it is easy to conceive the mind and body becoming reciprocally and alternately the cause and the effect; the effect and the cause of miserable sensations, bursting forth into violent passions.” Beddoes also remarked upon the confusion: “By extending the term nervous upon the strength of one or two circumstances of resemblance, we are in danger of losing all meaning, and reducing the most heterogeneous afflictions to one head.” Despite his wish to avoid this “embarrassment in language,” however, the term “nervous” was played fast and loose, and was applied in the late eighteenth century to a variety of conditions.

Nervous disorders were generally thought to be emergent from the functionality, the “sensibility”—be it an excess or a deficiency of responsiveness—of the nerves. The difficulty lay in the fact that any disorder was termed “nervous” if it was thought to be caused by the nerves or if its symptoms (effects) were in accordance with those expected from a malfunction of the nerves. While these disorders were believed to affect both men and women, the symptoms produced often seemed to differ dramatically depending on the gender of the patient. According to Leake, “hysterical and hypochondriacal affections are of the same nature, for both proceed from weakness, and too much sensibility of the nervous system: The symptoms are only diversified by the difference of sex; in women,

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32 Beddoes, *Hygeia*, 3:9, 8.
therefore, the malady is called *hysteric passion*; in men, *hypochondriac melancholy.*”

For women, the symptoms were as follows: “general debility; an unaccountable lowness of spirits; listlessness, ... a total aversion to any thing requiring attention; grief, fear, sorrows, suspicions, anxiety, agitate the mind violently; dullness, or increased sensibility, in all the external and internal senses; faintings, watchfulness, drowsiness, or stupor.”

For men, “when the mind adheres to one subject almost exclusively, when passion is connected with this set of ideas, and when there is at the same time great loss of sleep,” melancholy was believed to be the cause. Both conditions, believed to be brought about by “habits” of sensibility, were held to require medical treatment.

Sensibility is a tricky concept. G. S. Rousseau notes that the “label” of sensibility was “generated in the seventeenth century, by diverse types of thinkers, ... who referred to themselves as creatures of sensibility living in an epoch of nerves.” Citing the writings of Locke, Shaftesbury, Hume, Smith, and others, Rousseau traces the collective development of a “scientific approach to every aspect of the study of man *by means* of a theory of sensory perception and a theory of knowledge that directly followed from their understanding of the physiology of perception.” Such an approach suggested that those with finer, more sensitive, and perceptive nerves would be capable of heightened levels of both virtue and sympathy. This understanding gradually came to be reflected in the

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34 Rowley, *Treatise on Female*, 55.
36 G. S. Rousseau, *Nervous Acts: Essays on Literature, Culture and Sensibility* (Houndsmills, Basingstoke, Hampshire; New York: Palgrave Macmillan: 2004), 158. Rousseau largely attributes the emergence of discourses of sensibility to the increase in scientific research on nerves and the brain, with the latter being increasingly cited as the seat of the soul.
37 Ibid., 169.
novels of the early eighteenth century. Ann Jessie Van Sant suggests, “when sensibility becomes central to an understanding of psychology, it becomes the basis for an experimental approach to character.”38 Thus the eighteenth century saw the appearance of nerves, fibres, passions, spirits, impressions and feelings, in literary characters such as Samuel Richardson’s eponymous Clarissa (1748), Henry Mackenzie’s Harley in The Man of Feeling (1771), and Yorick in Laurence Sterne’s Sentimental Journey (1768). Sensibility was generally held to be a good quality to have, at least initially—indicative of benevolence, sympathy, perception, refinement, and virtue.

Samuel Johnson’s Dictionary definition lists sensibility as signifying both “sensation” and “perception;” perception through either the mind or the senses; “moral perception;” or, paradoxically, having “intellectual feeling.” The juxtaposition of sensation/sense and perception/mind betrays the uncertainty regarding whether sensibility was biologically inherent or culturally developed. As Vivien Jones puts it, the term became gradually “pathologized” through its association with “medical language.” George Grinnell agrees, noting that while “nervous sensibility” had originally been understood as the “experience of life” through the senses, literally, “the functioning of the nerves,” by the end of the eighteenth century, it had also come to mean “a pathological condition of the altogether too-sensitive body.” He continues: “to be nervous remained potentially salutary, especially for poets and writers, yet sensibility was not

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always easy to turn off and it could produce paralyzing states of introspection and attention to the body that prompted calls for treatment and correction." And while both men and women were believed to suffer from nervous disorders, it was the female body in particular that was thought to require more urgent medical treatment and supervision. John Mullan explains:

The female body is not merely ‘connected’ with disorder, it is the very visibility, at once the form and formlessness, of that disorder. Because of the shifting nature of sensibility, both privilege and ailment, refinement and excess, this trembling body is appropriated by eighteenth-century novelists, as the sign of a sentimental extravagance which may be either stubbornly virtuous or manifestly debilitating.

The trembling bodies of literary leading ladies such as Clarissa and Rousseau’s Julie (1761), and the psychological deterioration of more minor characters—Sterne’s Maria (1768), or Mackenzie’s nameless “daughter” in Bedlam in The Man of Feeling (1771), for example, led them to be celebrated as examples of sensitive, virtuous women. Thus by the end of the eighteenth century, the question of whether such susceptibility and debility were natural to women’s bodies or constitutions, or were acquired habits, necessarily became one of signal importance particularly for women authors, and for the literary characters they created.

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Women were generally believed to suffer more from sensibility, both in terms of the sheer number of cases, and in terms of the nature and severity of their symptoms. In *Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases* (1788), William Rowley remarks that while ill health is common to both men and women, “the delicate structure of the female body; the peculiar sensibility of the nervous system, ... and the singularities of each individual constitution, all require the most serious attention of the physician.”\(^{41}\) And, as noted, while women were often believed to be disabled by nervous sensibility, men could apparently subsist, and even prosper creatively under the symptoms. In his history of melancholy, for example, Stanley Jackson cites William Cullen’s observation that melancholics are mostly of a “serious, thoughtful disposition, ... less moveable than others by any impression, and ... therefore capable of a closer or more continued attention to one particular object, or train of thinking.”\(^{42}\) Claudia Johnson’s work on the masculinisation of sentiment has delineated the “recoding” of “formerly feminine gender traits” to make it “acceptable,” even “prestigious[,]” for men to engage in and display behaviours classically associated with women; fainting, weeping, ... being overpowered by feeling,” helping to explain why, for men, there was little urgency to find ‘cures’ for such behaviour.\(^{43}\) Furthermore, as physicians, surgeons, and apothecaries were all men at this time, they could generally treat themselves if so desired.\(^{44}\) Cheyne, for example, was a self-diagnosed melancholic who famously detailed

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\(^{41}\) Rowley, *Treatise on Female*, 1 (emphasis is mine).
\(^{44}\) The seventeenth century saw, as Johanna Geyer-Kodesch explains, “a severe curtailment of [women’s] freedom to practice” as “the regulation of medical practice through the need to obtain licenses was discriminatory in regard to sex” (891). From 1614, women were forbidden from practise surgery, and
his self-treatment in *The English Malady*. He offered the work to his “fellow-sufferers” in order to “try what a little more just and solid Philosophy, joined to a method of cure, and proper medicines could do, to put a stop to so universal a lunacy and madness.”

These distinctions concerning the treatment of men’s and women’s nervous disorders are important as they help account for the more noticeable presence of medical discourse and logic in novels by women authors; women had been given a diagnosis, and were consequently working to establish a method of treatment for themselves and for their literary heroines.

There was a convenient triangulation to the connection stressed by popular medical authors between women, sensibility, and the need for medical attention. Several of the medical authors on whose writings I focus—Thomas Beddoes, William Rowley (1742-1806), William Cullen, William Buchan (1729-1805), and John Leake (1729-1792)—indulge in circular reasoning based on the idea of women being biologically predisposed to sensibility and therefore necessarily requiring more medical attention.

From 1617 prevented from becoming apothecaries. Examinations and fee payments were enforced for midwives after 1662. In Britain, women did not qualify to legally practice medicine until the Russell Gurney Enabling Act of 1876.

The only realm in which women were occasionally believed to have some medical “authority” was in midwifery. Yet this too during the eighteenth century became a predominantly male practice. Irvine Loudon remarks: “It was the public ... who in substantial numbers deliberately chose to engage a medical practitioner when there were plenty of skilled and capable midwives of high reputation to choose from. Their choice must have had something to do with the rise in status of the medical practitioner. ... At all events, the employment of medical men for normal childbirth occurred quite suddenly” (1051). Geyer-Kordesch suggests more plausibly that women were not “displaced by male predominance as such, but by gradual monopoly powers (regulations of licences, access to medical corporations, and medical education) of hospital doctors and surgeons” (893). Loudon, “Childbirth” in Bynum and Porter’s *Companion Encyclopedia of the History of Medicine*, 2: 1051-1060; Geyer-Kordesch, “Women and Medicine” 2: 888-914.

46 Though I draw upon the writings of several popular medical authors throughout my discussion, they are all generally representative of the common beliefs and practices of eighteenth-century medicine. Some had a particular interest in obstetrics (Rowley and Leake), while Cullen’s instructional manuals provide insight into another side of medical discourse more geared towards professionalization, and are valuable
Rowley directly connects women’s bodies and minds: “the slender in body more commonly agitate their minds on slight occasions than the corpulent; because they possess, in general, more sensibility”; and “where an exquisite sensibility pervades the human frame, without a masculine habit of body and mind; long-continued vexation has been productive of insane grief, melancholy, and suicide.” Most women, lacking Rowley’s aforementioned “masculine habit,” were therefore advised on prophylactic and remedial measures to improve or strengthen their sensibilities. In 1777, for example, Leake instructs his female readers that to “effectually cure nervous or hysterical disorders, [one] must do it by general means, which uniformly and permanently act on the general habit of body; and not by directing a new medicine for every new symptom, which ... can only produce a momentary relief, but will never effect such a change in constitution, as to end in a lasting cure.” Of the literary authors whose works I examine, Wollstonecraft and Hays are especially concerned with the ways in which the habits of women are developed.

Habit, like sensibility, is an unstable concept with both biological and social connotations. According to the OED, as early as the fifteenth century, habit indicated clothing, as well as a repeated tendency to behave in a certain manner. By the mid-sixteenth century, however, habit had also come to refer to a bodily condition. Citing Chambers’ Encyclopedia (1727-51), the OED suggests, “Habit, in medicine, is what we otherwise call the temperament or constitution of the body; whether obtained by birth, or

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in that respect. Most of the other texts I have chosen were intended for the purchasing, literate, “middle class” patient.

47 Rowley, Treatise on Female, 1, 85, 291.
48 Leake, Medical Instructions, 254. Second emphasis is mine.
occasioned by the manner of living.” The entry continues, “A thing is said to enter the habit, when it becomes intimately diffused throughout the body, and is conveyed to the remotest stages of circulation.”

The term is also listed in some eighteenth-century medical dictionaries. In John Quincy’s Lexicon Physico-Medicum (1726), for example, “habit” is described as “any particular disposition or temperament of Body, obtained by Birth, or Manner of living.”

By the late eighteenth century, “habit” therefore connotes either an innate or an acquired characteristic; a voluntary or an involuntary act; something external and applied, or something as internal and integral as the beating of the human heart. As the ill-fated Miss Milner declares in Elizabeth Inchbald’s Simple Story (1791): “Habit, ... is everything” (20).

Unsurprisingly, “habit” is used very ambiguously within the medical writings of the day. A browse through Domestic Medicine reveals that habits can be bad, spare, delicate, tainted, dropsical, hectic, peculiar, relaxed, scrofulous, consumptive, weak, lax, plethoric, gross, sanguine, gouty, ill, full, and phlegmatic, to name but a few of the adjectives used alongside the term.

A series of examples from varying medical texts further illustrates the several ways in which “habit” was used and understood. Beddoes in


51 Note that Miss Milner’s guardian Dorriforth overhears this comment as well as laudatory comments she makes about him. When he unexpectedly enters the room her own sensibility is made clear: “his accidental entrance at the very moment this praise had been conferred upon him ... heightened the blush to a deep glow on every feature: confusion and earnestness caused even her lips to tremble and her whole frame to shake” (A Simple Story, ed. J. M. S. Tompkins [Oxford: Oxford University Press, 1991], 20).

Samuel Johnson also attributed some of his physical afflictions to the same cause: when asked what caused his “tics,” he replied that they were caused by “bad habit.” See John Wiltshire, Samuel Johnson in the Medical World: The Doctor and the Patient (Cambridge: Cambridge University Press, 1991), 31.

52 Buchan, Domestic Medicine.
Hygēia, for instance, explains that consumption frequently affects “those, who by descent, by defective original conformation, and by peculiar habits of life, have a more than common tenderness of the parts.” Meanwhile, in an earlier discussion of epilepsy he notes that “females have probably, from the peculiarities of their habit, a stronger predisposition.”53 In the first instance, Beddoes uses “habits” to suggest routine practices or activities; in the second, the term refers to women’s bodily constitutions. In both instances women’s habits are “peculiar” and leave them susceptible and vulnerable to disease. Leake argues that there is a “particular habit of body, whether original or acquired, which renders women more immediately subject to consumption;”54 and as cited above, Rowley asserts that a “masculine habit” alone can ward off nervous disorders in women. Thus the very “habits” of women render them more susceptible to disease, particularly diseases relating to the nerves. Whether these habits are, to borrow Leake’s terms, “original” or “acquired,” is not made readily apparent.

What is clear, however, is that the habit(s) of females frequently require(s) very particular medical treatment. With the growing popularity of preventative medicine, medical “treatment” in the late eighteenth century often began before the onset of illness. “Treatment” appears as a medical term only around 1744, referring to “management in the application of remedies; medical or surgical application or service.”55 And while treatment is traditionally understood as a remedial course of action (i.e. taking place once illness is already present), Buchan’s urging of preventative medical treatment for women suggests a need for intervention beforehand to forestall ill health. The implication here is

53 Beddoes, Hygēia. 3: 9 41, 29 (emphasis is mine).
54 Leake, Medical Instructions, 306.
that women are already and always patients, requiring medical supervision both in health and in sickness. Rowley reassuringly insists, for example, that a mother should not “take alarm at medical advice, when I tell her that my object is to enable her to do without medicine.” The increasing availability of published preventative medical advice, coupled with the belief that women generally had more need of medical supervision than men, resulted in increased diagnosis and treatment for women in general. Ginnie Smith examines the increase in publications advocating preventative medicine, regimen, and advice for healthy living during the eighteenth century and lists three pertinent questions arising from her survey of medical advice books: “who read them, what was in them, and what did they do? All three questions revolve around the works as medical belief systems and as simple artefacts.” Smith concludes that these works had a wide readership, both lay and professional; and furthermore, that the advice handed out “was in a real sense part of the common language of daily life, dealing as they did with the management of the body and its immediate (and extended) environment.” In particular, she suggests that repeated use of phrases such as “proper conduct,” “gradual culture,” “constant habit,” and “steady and equal progress” invoked the techniques of “low-level management” of a patient from life to death. As previously noted, it was women who found themselves as patients more often than not.

56 Rowley, Treatise on Female, prelims.

58 Thomas Beddoes articulated a desire to formalize prophylactic medical practices: “Preventative medicine, [is] the destined guardian of infancy, youth, manhood, and old age. ... We want not to be taught how to prescribe, but how to avoid the necessity of prescriptions.” A Lecture Introductory to a Course of Popular Instruction on the Constitution and Management of the Human Body (Bristol, 1799), 58, 62.
Thus there are two significant points in the following assertion from William Buchan: “Females are liable to many diseases which do not afflict the other sex: besides, the nervous system being more irritable in them than in men, their diseases require to be treated with greater caution.” His claim first legitimizes the female body as a site for medical observation and, second, makes clear that this level of medical scrutiny must be continually maintained. The diseases of women, he notes, must always be “treated” with caution (my emphasis). Smith argues that after Buchan’s publication of *Domestic Medicine* in 1769, “the moral belief in popular medical education took hold in certain professional circles, with doctors turning authors.” I argue that the reverse also happened, with authors—particularly women novelists—turning doctors. Thus female literary characters often receive dual treatments around this time—that is to say, treatments both artistic and medical. My project monitors and charts both the health and habits of certain eighteenth-century female characters in order to demonstrate that the authors who wrote them were experimenting with precisely such “lasting cures.” Indeed,

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While regimen was by no means new (regimen itself dates back to ancient Greece; and to borrow Ginnie Smith’s phrase: the two “classic divisions of European medical science” have always been “prevention and cure”), Smith notes a significant increase in the availability of popular printed material on this subject (281). In “Prescribing the Rules of Health,” she calculates, for example, that there were at least 310 separate medical titles for self-help and prevention published during the eighteenth century in English in Britain, a substantial increase from the 153 between 1486 and 1604 (281).

There are several relevant factors which help to account for the increase in publishing activity on the subject of preventative medicine, too many for discussion in this space; most fall within the broader question of increasing rates of “medical professionalization.” See works by N. Parry and J. Parry, Nicholas Jewson, Irvine Loudon, and Michel Foucault. Suffice to say that by 1804, Sir John Sinclair explained in his *Code of Health and Longevity*: the “preservation of health and the prevention of disease, is a kind of neutral ground, between the several branches of medicine, and the common sense and daily observation of well informed men, and of course is open to everyone” ([Edinburgh, 1807], 170).

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59 Buchan, *Domestic Medicine*, 156.
60 Smith, “Prescribing the Rules,” 276.
there were several women authors undertaking the examination, diagnosis, and treatment of the health and habits of their female literary characters.

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In this project I examine three female novelists of the late eighteenth century—Mary Wollstonecraft, Mary Hays, and Jane Austen—whose works I read as employing the rhetoric and logic of medical case studies to provide diagnoses of the female condition, both social and biological. Considering these texts with a novel, interdisciplinary approach reveals their careful employment of a medical narrative structure, as well as their diagnostic conclusions. I am concerned with the verdicts they reached as well as the narrative structure of case history, in other words, their process of arriving at a diagnosis through the narration of events. Ian Watt claims that the realist novel could be “distinguished from most previous fiction by its use of past experience as the cause of present action: a causal connection operating through time replaces the reliance of earlier narratives on disguises and coincidences.” Watt’s point supports my argument that at this time fiction and medical treatment were coming to share a narrative logic, that is, the logic of the case. 61 For example, borrowing from the case study by Leake cited above: the studious and sedentary habits of the young man (A) are believed to have led to the development of disease within his abdominal area (B). And while this particular diagnosis strikes contemporary readers as erroneous, it nevertheless reflects an ongoing effort to narrate and then accumulate medical case studies in order to try and better determine patterns of disorder.

The causal relationship that is established between events or circumstances and their effects on the body can often be recounted in more than one way: for instance, if B is the result then A must have happened, or when A occurs, B will follow. Tropes of causality were a commonplace in eighteenth-century writing. To begin with, explanations once founded on religious belief were gradually being replaced with philosophic and scientific rationales. According to Ildiko Csengei, “‘passions’, ‘affections’ and ‘moral sentiments’ featured repeatedly in the writings of seventeenth and eighteenth-century Christian clergymen, preachers, philosophers, and literary figures. According to the Classical Christian model, ... passions and affections were movements of the soul.” Such notions, however, gradually came to “incorporate more secular arguments and mechanistic ideas.”

In their interest in hidden and invisible causes, Hays and Wollstonecraft, in particular, reflect multiple influences, from Pope’s poetic “self-love, the spring of motion” (“Essay on Man”) to the philosophical inquiries on causality of John Locke (Essay Concerning Human Understanding, 1690), David Hume (Enquiry Concerning Human Understanding, 1748), and later, William Godwin. Alan Bewell reminds us that for many writers at this time, “the philosopher is a social physician who uses knowledge and inquiry to cure social and bodily ills. Disease is less a product of nature than a social problem. Political reform is thus metaphorized as a movement from sickness to health, an undertaking that perfects both the social and the physical body.”

As I will show, the philosophical investigations of Hays and Wollstonecraft indeed work

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63 Alan Bewell, Romanticism and Colonial Disease (Baltimore and London: Johns Hopkins University Press, 1999), 207.
within a medical context, concerned as they are with the effects of education and social practices on the habits of women’s bodies and minds. Wollstonecraft writes:

In the education of women the cultivation of the understanding is always subordinate to the acquirement of some corporeal accomplishment; even while enervated by confinement and false notions of modesty, the body is prevented from attaining that grace and beauty which relaxed half-formed limbs never exhibit. Besides, in their youth their faculties are not brought forward by emulation; and having no serious scientific study, if they have natural sagacity, it is turned too soon on life and manners. They dwell on effects, and modifications, without tracing them back to causes.64

These statements show Wollstonecraft’s concern with educating women, in particular, to understand causes, not simply “effects, and modifications.” Her deliberate connection of a cause (poor education) with particular effects (half-formed limbs, underdeveloped intelligence) exemplifies the diagnostic narrative logic of the case, the hypothesis that one condition or set of events leads to particular physical, mental, or emotional symptoms. In this instance Wollstonecraft is applying the logic of the case to a more general problem. As I discuss in Chapter One, she also provides specific, individual case studies more particularly in her didactic writings for children in order to help them distinguish between a “real” and a “false,” a “laudable” and a “blameable, an innocent and a dangerous sensibility.”65

Literary representations of sensibility have long been a topic of interest for scholars of literature and historians of medicine alike. In his discussion of the “nervous patient,” Bynum remarks on the distinction between “structural” diseases of the “nervous

system” and the “functional” nervous diseases with which my project is concerned. G. J. Barker-Benfield explains that the belief that “women’s nerves were normatively distinct from men’s, normatively making them creatures of greater sensibility, became a central convention of eighteenth-century literature,” and it is this very convention that Wollstonecraft, Hays, and Austen undertake to treat. Such treatments are enabled by their inclusion of physician characters within their works, and the fact that, as John Mullan argues, the physician and the patient were often held to share a particular susceptibility. The “ambiguous status of sensibility,” Mullan suggests, “is part of the language of the physician as much as that of the novelist.” In other words, these authors created characters able to translate their own potentially debilitative “feelings” into constructive diagnoses and prescriptions. Dino Felluga furthers this connection between the “sensible” physician and the role of literary genius modeled in particular by some of Wollstonecraft’s characters, and to a lesser extent, also those of Mary Hays. He cites an increasing medical specialization as inspiring “the literary specialist to adopt a similar model of professionalization, including the adoption of a medical rhetoric of nerves, in order to define certain literary endeavours and a certain kind of genius as healthful while diagnosing others as inherently pathological.” Finally, Kathryn Montgomery Hunter’s

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68 Mullan, Sentiment and Sociability, 206, 219.
69 Dino Felluga, The Perversity of Poetry: Romantic Ideology and the Popular Male Poet of Genius (Albany: State University of New York Press, 2005), 8. See also Andrew Elfenbein’s consideration of genius in
interdisciplinary work on narrative and medicine—her assertions that “medicine is fundamentally narrative” and that “in medicine, the case is the basic unit of thought and discourse, for clinical knowledge, however scientific it may be, is narratively organized and communicated”—provide a foundation for my interdisciplinary literary readings.\(^70\)

In Chapter One, “Mary Wollstonecraft: Rewriting Women’s Habits,” I begin by examining a number of Wollstonecraft’s fictions, reflecting on her involvement in contemporary medical conversations, and considering how her eponymous heroine, Mary, has a degree of “prescriptive authority,” that is to say, a way in which to participate in the direction, development, and narration, of her own narrative. The work’s title, *Mary, A Fiction* (1788), implies that this authority is both enabled by, and contingent on the work’s fictionality. Claudia Johnson agrees: “by eighteenth-century standards, *Mary, A Fiction* is striking for its subtitle. ‘Novel’, ‘Romance’, or ‘History’ would be likelier terms than fiction to designate prose narrative of this length. But Wollstonecraft must disaffiliate herself from this literary tradition if she is to delineate a ‘Heroine ... different from those generally portrayed.’”\(^71\) Indeed, in enabling her first-person narrator to assume the authoritative voices of the physicians throughout the text, Wollstonecraft creates a new kind of heroine, one at least temporarily imbued with a degree of health and authority. Furthermore, as Felluga and Elfenbein have argued, Mary inhabits the role of the melancholic figure of genius, thereby lending additional

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\(^70\) Hunter, *Doctors’ Stories*, 5, 51.

\(^71\) Johnson, *Equivocal Beings*, 49.
credibility to her diagnoses. In turning to Wollstonecraft’s later, semi-autobiographical work, *Maria, or the Wrongs of Woman* (1798), we see Wollstonecraft working towards the diagnosis and treatment of a broader social condition, as she perceives the position occupied by women to be symptomatic of her disordered, diseased society. Peter Melville Logan’s reading of Maria as a nervous narrator, one whose high responsiveness to cultural conditions makes her an ideal voice for social criticisms, lends support to this claim. Logan, however, stops short of fully exploring the medical context of that work—its hospital setting, for example, and its extensive use of case narratives to show the devastating effects of political and social norms on women’s bodies and minds.

In Chapter 2, as I transition from the works of Mary Wollstonecraft to those of her colleague and friend, Mary Hays, it becomes apparent that the two women shared the conclusion that while women’s biological and social condition stood in need of remedy or treatment, such debility was largely a result of social contamination, and its remedy therefore lay not only in treating women, but in treating society more generally.

In turning to Hays then, I focus primarily on the composition of her semi-autobiographical novel, *Memoirs of Emma Courtney* (1796), particularly examining the therapeutic relationship she sought to establish with William Godwin as her “mind’s physician.” Building upon Laura Mandell’s and Mary Jacobus’ assertion that the relationship between Hays and Godwin resembled that of patient and psychoanalyst, I suggest that it can be, and should also be perceived as a relationship between doctor and patient, in part because of the connection believed to exist between the mind and body at

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72 See note 69, above.
the end of the eighteenth century. In her eventual separation of the novel’s eponymous heroine from Mr. Francis, Godwin’s literary representative, Hays locates a degree of diagnostic authority for herself, thereby enabling and authorizing the prescriptions for social cures with which the novel ends. I balance this reading of Memoirs of Emma Courtney with close analysis of Hays’ personal correspondence, as well as a brief reading of her final novel The Victim of Prejudice (1799). Both texts indicate that Hays’ optimistic belief in women’s ability to treat themselves gradually waned, ending finally with the dark conviction that women’s efforts could not be sufficient against the inveterate habits of her diseased society.

I closely examine the writings of Mary Hays and Mary Wollstonecraft because they display a direct, literal engagement with the diagnostic narrative logic of the case. In turning to examine Jane Austen’s Sense and Sensibility in the project’s final chapter, I argue that we witness the fullest (yet unsurprisingly, the most subtle) employment of medical narrative logic explored in this project. This novel puts into relief the more literal engagements of Austen’s predecessors: Austen does employ the diagnostic narrative logic of the case, but its more seamless integration into the novel’s plot makes it both less obvious, and much more effective. Here, Austen undertakes a diagnosis and treatment of sensibility: closely adhering to medical facts and information enables her to follow the narratives of the Dashwood sisters to their respective, logical conclusions—not in death from the wounds of love, but in healthy, mostly happy marriages. The

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74 The mind and body were thought to be inextricably linked at this time. Beddoes argues, for example, “without reference to the body, it is ... impossible to unfold the nature of the mind.” The reverse was also held to be true. Contributions to Physical and Medical Knowledge, 4. See Laura Mandell, “The First Women (Psycho)Analysts: or, the Friends of Feminist History,” Modern Language Quarterly 65.1 (March 2004): 69-92 and Mary Jacobus, Psychoanalysis and the Scene of Reading (Oxford: Oxford University Press, 1999).
narratives of both Elinor and Marianne can be read as case studies revealing that sensibility is not, in fact, a cause for medical concern; moreover, its very innocuousness means that its symptoms should no longer demand substantial medical or literary treatments. One might consider Austen’s “treatment” of sensibility as somehow vindicating the earlier, less successful diagnostic efforts of Wollstonecraft and Hays to relieve women from the symptoms of their unhealthy habits: the same logic is employed but a more productive conclusion is reached. As with most medical case studies, however, Austen’s work undoubtedly profited from the efforts of those that came before.

Elinor and Marianne are Austen’s final word on the “treatment” of sensibility. In shifting away from the overtly didactic strategies of Wollstonecraft and Hays, Austen is instead able to use medical discourse to effect more substantial changes. As I demonstrate, her subtle examination and treatment effectively depathologizes sensibility. In deeming it to be safe, at best, or vapid, at worst, Austen effectively inoculates her future heroines against sensibility’s purportedly debilitating symptoms, thereby treating the “social disease” lamented by both Hays and Wollstonecraft. In so “curing” heroines of sensibility, her fiction could then also potentially affect her readership; hence, Sense and Sensibility can be considered as a fictional version of the Dispensatory, equipping women with tools to recognize and avoid the falsely debilitating condition of sensibility.

Further to my analysis of this novel, I briefly consider the heroines of Mansfield Park (1814) and Persuasion (1818), emphasizing the way in which Austen has enabled her heroines to move on (or perhaps return to some of sensibility’s healthier roots) and embody healthier ways of feeling, namely through feelings of sympathy.
Wollstonecraft, Hays, and Austen are not the only examples of this kind of engagement with medical narratives, but their works certainly provide rich examples illustrative of my claim that by the end of the eighteenth century, the higher public profile of the medical profession—a function of increasingly accessible medical writings—led to the development of a symbiotic relationship between women’s literary narratives (particularly the novel) and medical forms. Women authors began assessing the health of their female characters (a novel shift away from assessing their virtue) in order to determine the appropriate outcomes for various conditions, including most especially, nervous disorders. My project is therefore contributing to, and building upon, an already substantial body of work on women and the novel of sensibility, particularly in my argument that one significant consequence produced by “curing” female characters’ nervous sensibilities was an overall increase in agency for female literary characters. No longer “slaves to their bodies,” women were at liberty to engage in experiments with other, healthier sources of narrative energy, enabling the creation of characters such as Charlotte Brontë’s Jane Eyre or Elizabeth Gaskell’s Margaret Hale. Nicola Watson has identified the difficulty late eighteenth-century women writers faced in claiming “authority” for a female narrative premised upon sensibility, suggesting that it was neither possible to speak female subjectivity in the language of sensibility, and be heard, nor to speak as a female subject outside sentimental rhetoric altogether. I argue,

75 Other works—texts by Mary Brunton (1778-1818), Maria Edgeworth (1768-1849) (especially Helen), Amelia Opie’s Adeline Mowbray (1804), Elizabeth Inchbald’s A Simple Story (1791), to name a few—would certainly benefit from a similar diagnostic reading within a project of larger scope.
76 Wollstonecraft, A Vindication of the Rights of Woman, (47). Jane Eyre was published by Charlotte Brontë in 1847. Margaret Hale is a character in Gaskell’s 1855 novel North and South.
however, that as Wollstonecraft, Hays, and Austen engage with medical narratives and
the logic of the case, they are indeed able to stake a claim to authority while still
operating within the cultural boundaries of sensibility.
Chapter 1: Mary Wollstonecraft: Rewriting Women’s Habits

In reviewing Charlotte Smith’s *Ethelinde, or the Recluse of the Lake* for the *Analytical Review* in December of 1789, Mary Wollstonecraft complains that the eponymous heroine was “too often sick, and rather inspires love than respect.” She explains:

Though we are told, in express words, that [Ethelinde] is all perfection—nature’s masterpiece—she appears a frail woman. ... We cannot help wishing that Mrs. S. had considered how many females might probably read her pleasing production, whose minds are in a ductile state; she would not then have cherished their delicacy, or, more properly speaking, weakness. 78

The frail and sickly Ethelinde is not the only subject of Wollstonecraft’s criticisms. The year before, Wollstonecraft had cited Smith’s eponymous Emmeline, who, Wollstonecraft complained, contracts a “seasonable fever” when her lover becomes intent on a dangerous course to which she is particularly opposed.79 He desists from his plans when instructed by the apothecary that to oppose Emmeline’s wishes “might be fatal.” Wollstonecraft reasoned that Emmeline’s opportune illness might “catch the attention of many romantic girls, and carry their imaginations still further from nature and reason.”80

80 Ibid.
By the time Wollstonecraft reviews Elizabeth Inchbald’s *A Simple Story* in 1791, her patience with ailing heroines has apparently reached its limit. In her discussion of Inchbald’s text, Wollstonecraft likens female-authored novels to poison. She writes of the text’s heroine, Miss Milner:

Educated in adversity she should have learned ... how to bear, nay, rise above her misfortunes, instead of suffering her health to be undermined by the trials of her patience, which ought to have strengthened her understanding. Why do all female writers, even when they display their abilities, always give a sanction to the libertine reveries of men? Why do they poison the minds of their own sex, by strengthening a male prejudice that makes women systematically weak?  

In referring to the “libertine reveries of men,” Wollstonecraft makes an early reference to what she would further explore in *A Vindication of the Rights of Woman*: men’s domestication and subordination of women via arguments and practices intended to “weaken [women’s] bodies and cramp their minds.”  

Inchbald’s Miss Milner falls ill part way through the novel following her act of marital infidelity; the text’s narrator notes, she “fell sick and lingered—possessed of youth and a good constitution, she lingered till ten years decline” until “the once lovely Lady, ... pale, half suffocated with the loss of breath” expires. Though the reviewer never makes clear whether she is more upset by Miss Milner’s ten year indulgence in ill health, or Inchbald’s unwillingness to

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allow the existence of a morally flawed heroine, what is made apparent in
Wollstonecraft’s review is a symbiotic relationship between education, health, and
gender. Women such as Miss Milner, she urges, must “learn” to be healthy. Women
writers—novelists in particular—must by extension offer readers instructive literary
models of female health and sensibility.

Wollstonecraft’s interrogation of women’s sensibility has been discussed in a
number of important works. Syndy McMillen Conger devotes her monograph to
understanding the author’s “lifelong struggle to cut through the complex tangle of ideas”
connected to sensibility.84 G. J. Barker-Benfield argues that Wollstonecraft perceived
two versions of sensibility, one bad and one good: the former, “a woman reared to
cripplingly exaggerated sensibility, utterly dependent, and subject to emotional binges,
and herself the latter, the writer, capable of reasoned analysis, physically strong,
independently minded, yet inspired by the positive warmth of sensibility.”85 He notes,
however, that despite this apparent opposition between good and bad sensibility, and
despite her desire to understand and represent herself as embodying the healthy model,
Wollstonecraft was nevertheless “torn between [the two]. Her demand that women
subject sensibility to reason expressed her deepest personal struggle, evident throughout
her published works and letters.”86 In their efforts to understand Wollstonecraft’s
relationship to sensibility, Conger, Barker-Benfield and others largely confine
themselves to examining her relation to the aesthetic, moral, and psychological history of

84 Syndy McMillen Conger, Mary Wollstonecraft and the Language of Sensibility (Rutherford: Associated
University Presses, 1994), 35.
85 G. J. Barker-Benfield, The Culture of Sensibility: Sex and Society in Eighteenth-Century Britain (Chicago:
86 Ibid., 362.
sensibility, that is to say, the ways in which the sensibility of Wollstonecraft’s literary characters impacts their emotionality, rationality, and behaviour. These areas of focus are crucial, but as Ann Jessie Van Sant reminds us, “the problem of defining sensibility arises in part from the ease with which writers modulated between physiological systems and between literal and metaphorical terms.” I propose to add another dimension to the already rich body of writing on Wollstonecraft and sensibility by focusing specifically on the health, both physical and mental, of her literary characters and the way in which their health is treated, both by physicians and by themselves. It is, after all, difficult to discuss literary representations of sensibility without considering the ways in which people generally understood sensibility to be a very physical, almost palpable, part of human, and especially female, existence.

Reading Wollstonecraft’s didactic non-fiction prose and her fictional writings alongside late eighteenth-century medical texts demonstrates that her engagement with sensibility is very much grounded in all that is corporeal, visceral, and physical, and as such, emergent from a historical context in which every effort was made to map, dissect, diagnose, and treat human bodies with increasing diligence and control. Wollstonecraft was particularly invested in exploring whether or not her characters could, in fact, treat themselves. For her, as for many late eighteenth-century writers, the “sensibility” of

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literary characters—their level of aesthetic and moral refinement—is both literally and figuratively connected to their nerves and overall bodily health. Wollstonecraft’s writings—personal, critical, and literary—imply that there are, or should be, “healthy” ways of suffering, of tolerating pain and ill health. Her implicit concern with the health of her female characters is connected to her explicit interest in the politics of gender, and in the health of the social body more generally. Often, the degree to which one of her characters has agency—the ability to speak, write, narrate, or participate in the development of a narrative, and the extent to which she has the authority or agency to prescribe for herself—depends on how well she is able to simultaneously feel and control her feelings.

While critics have thoroughly studied Wollstonecraft’s interest in sensibility, there is room for further exploration of the specific connections in her works between women’s health and the medical treatment of sensibility. A few articles by historians of sport and athletics document her commitment to physical education for women, as expressed in A Vindication of the Rights of Woman.89 Peter Melville Logan offers an insightful understanding of her relation to ill health. He cites “the nervous body” as a defining characteristic of Georgian literature, and argues that the distinguishing feature of this body is its responsiveness to cultural conditions, a quality that makes it highly useful for social commentary. Through close reading of primary eighteenth-century medical texts by Thomas Trotter (1760-1832), William Cullen, George Cheyne, and others,

89 See Roberta J. Park’s “‘Embodied Selves’: The Rise and Development of Concern for Physical Education, Active Games, and Recreation for American Women, 1776-1865.” International Journal of the History of Sport, 24.12 (2007): 1508-1542. From the Vindication of the Rights of Woman: “I am fully persuaded that we should hear none of these infantine airs, if girls were allowed to take sufficient exercise, and not confined in close rooms till their muscles are relaxed, and their powers of digestion destroyed” (67).
Logan seeks to forge a connection between “nervous” literary bodies and narratives: “the narrative of the nervous body is also a history of its own production, a somatic bildungsroman that tells the story of how it came into being, how this body came to have a story to tell.”90 The disorders that plague Wollstonecraft’s heroines in particular, he suggests, are undoubtedly indictments of the “punishing social experiences that cause them.”91 While Logan recognizes Wollstonecraft’s writing as indicting social practices, he stops short of exploring her redeployment of contemporary medical discourses and methods as part of her efforts towards improving the medical, social, and political treatment of women.

Wollstonecraft’s writings suggest a desire for a shift for women from the role of patient reader to that of an author(ity) figure whose condition can be self-diagnosed, and whose treatment, literary and otherwise, can be self-prescribed. “Patient reader” as I use it implies patience, as well as the passivity of a medical patient, one who is examined and treated by another, one who generally yields to the diagnosis of the physician, and one whose condition might be worsened by the consumption of novels, as they were commonly held to sicken or poison the female reader. Furthermore, by “figure of authority” I seek to convey authorship, narrative power, or even simply a shift from passivity to activity. As Wollstonecraft suggests in the second Vindication, “Woman might certainly study the art of healing, and be physicians as well as nurses.”92 This shift for women may entail a move from reader to writer, but not exclusively so; it might also

91 Ibid., 2.
92 Wollstonecraft, A Vindication of the Rights of Woman, 156.
indicate a shift from one who has a reading imposed upon her to one able to create or author her own reading and interpretation. Wollstonecraft explores the connection between medical and political authorities in their shared power over women’s bodies; thus my inquiry is as concerned with the nervous constitutions of Wollstonecraft’s narrators, as it is with the relational dynamics between physicians and their female patients. My reading of her fictions is supplemented by close reading of her letters in which she calls for women to have “power over” themselves, both personally and collectively.  

The Health and Habits of Mary Wollstonecraft

The unequivocally healthy characters in Wollstonecraft’s fiction are few and far between. Given her avowed dislike for sickliness, false delicacy, and debility, it is worth considering what is at stake in her multiple representations of ill health, fraying nerves, and medical diagnoses. Wollstonecraft’s concern with health manifests itself fairly early on, personally in her letters and more generally in her early publications: Thoughts on the Education of Daughters, 1787, Original Stories from Real Life, 1788, and Mary, a Fiction, also 1788. In correspondence, she cites her father’s difficult temperament and the additional familial responsibilities left to her following her mother’s death as initial causes of her own ill health. By the age of twenty-five, she recalls: “I have been very ill—and gone through the usual physical operations—have been bled and b[l]istered—

93 See note 97 below.
yet still I am not well.”94 This method of treatment is consistent with the late eighteenth-century belief in the nervous system as central to a body’s overall health; indeed, the nervous system was understood to be so essential to bodily function that, according to William Bynum, “all diseases could be deemed ‘nervous’” in one way or another.95 Bleeding and blistering were methods intended to increase the nervous system’s response to stimulus, or to restore a body’s “excitability” (as John Brown [1784-1858] came to term it) —these would be opposed to practices intended to have the reverse effect, most frequently, the prescription of opium.96 The rather indiscriminate type of treatment for Wollstonecraft corresponds with the generalized nature of her complaints—she does not name any specific illnesses, but simply describes a melancholic malaise regarding her physical and mental state. Such unspecified but perpetual health uncertainties contributed to her developing interest in medical, scientific, and philosophical fields of inquiry.

As noted above, Barker-Benfield suggests that Wollstonecraft sought to embody a particular ideal of sensibility: the rational, healthy, woman of sensibility. Passages from her letters and autobiographical novels show, however, that Wollstonecraft struggled so acutely with understanding sensibility, in part because her own body refused to comply in modelling the healthy version. She explains in a 1786 letter, “If I was stronger, if my health was not so much impaired, I should have more power over myself, as it is I am

96 The practice of bloodletting or bleeding dates back centuries. Prior to the eighteenth century, however, it would have been done with the intention of restoring a balance to the body’s humours rather than the body’s excitability. See note 129 below for further information on humoral medical theories.
The metaphorical term “unstrung” refers to the dysfunction of the nervous system, the workings of which were then understood only very vaguely. According to one 1798 source, “The use of the nerves is to convey the principles of motion and sensibility to the brain from all parts of the system, and from the brain to every part of the system .... [T]he manner in which this operation is effected, is not yet determined.”

John Leake’s discussion of nervous disorders echoes Wollstonecraft’s metaphor but is as unspecific as the description above; he argues that “impressions” are “made on the brain, and the heart, like a faithful companion, suffers by sympathy; but whether the Nerves act as tubes; or vibrating chords, like the strings of a musical instrument, or whether they serve as conductors to some subtle fluid, similar to that of electric fire, we are wholly ignorant.” The understanding of nerve function was limited until the mid-nineteenth century, and left ample room for the outlining of unsubstantiated but potentially credible theories. Wollstonecraft seems to feel this lack of knowledge as a lack of “power over” herself: power over how her body feels corporeally, but there is also the suggestion that in being unwell, she is forced to relinquish power over herself to those in positions of authority—namely physicians.

Throughout years of uncertain health, despite repeated medical assessments, medicinal waters, and travelling, evidence suggests that Mary Wollstonecraft was never given a diagnosis more conclusive than a “nervous fever.” However, her letters show quite unstrung.”

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97 Wollstonecraft to Everina Wollstonecraft, November 17, 1786, Letters, 90.
99 John Leake, Medical Instructions towards the Prevention and Cure of Chronic or Slow Diseases Peculiar to Women (London, 1777), 241.
100 Wollstonecraft to Everina Wollstonecraft, March 14, 1787, Letters, 112. In Domestic Medicine Buchan posits that nervous fevers were on the rise due to a “different manner of living, and the increase of sedentary employments.” He explains that they “commonly attack persons of a weak relaxed habit, who neglect exercise, eat little solid food, study hard, or indulge in spirituous liquors” (139).
that she continually attempted to self-diagnose, frequently arriving at the conclusion that she was melancholic—significantly, a condition more often ascribed to men than women. She writes to a friend: “Nature will sometimes prevail, ‘spite of the reason, and the thick blood lagging in the veins, give melancholy power to harass the mind; or produce a listlessness which destroys every active purpose of the soul.” Recalling Leake’s claim that “Hysterical and hypochondriac affections are of the same nature, for both proceed from a weakness and too much sensibility of the nervous system: The symptoms are only diversified by the difference of sex.” The figure of the melancholic, associated in both history and literature with male learning and genius (e.g., Milton’s “Il Penseroso”) fell within the broader category of nervous disorders during the late eighteenth century, and was seen as the counterpart to female hysteria. Despite the fact that several of her symptoms would readily have been identified with hysteria, Wollstonecraft refuses that designation. One of her letters, for instance, recounts a visit to church which “discomposed” her spirits. She recalls returning home and falling into a “violent fit of trembling.” As she writes, she describes herself as “very near fainting and hav[ing] almost always a rising in my throat, which I know to be a nervous affection.” She concludes: “I am ... satisfied to bear these disorders—(though as they seem to attack the mind, they are doubly distressing) if I can fulfil the duties of my station.”

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102 Leake, Medical Instructions, 247-8.
103 Wollstonecraft to Everina Wollstonecraft, February 12, 1787, Letters, 104.
eighteenth-century physicians are almost unanimous in attributing this symptom, the sensation of something rising in one’s throat, to hysterical affections, and this symptom of hysteria was relatively common knowledge. As far as I can tell, Wollstonecraft never uses this term, choosing instead to say, “I only am melancholy and alone.” Andrew Elfenbein agrees; “The role of genius, to which ... Wollstonecraft aspired, encouraged [her] to toss out conventional sexual roles.” In arriving at a diagnosis of melancholia, she therefore makes a very deliberate choice; Wollstonecraft diagnoses herself with—and limits the potential diagnoses of others to—conditions which are at worst only physically debilitating, and at best intellectually fortifying.

Wollstonecraft’s letters indicate the extent to which she was personally invested in clarifying the links between bodily causes and effects. Though she pinpointed her nerves as the source of her unease, she remained undecided on whether the origin of the trouble was in her body or her mind, as though unable to determine from which type of

104 Compare with, for instance, William Buchan discussing hysterical fits in *Domestic Medicine*: “The approach of the fit is foretold by a feeling, as if there were a ball at the lower part of the belly, which gradually rises towards the stomach, where it occasions inflation, sickness, and sometimes vomiting; afterwards it rises into the throat, and occasions a degree of suffocation, to which quick breathing, palpitation of the heart, giddiness of the head, ... succeed” (212).

105 Wollstonecraft to Everina Wollstonecraft, October 30, 1786, *Letters*, 85. While there is no explicit identification of either melancholy or hysteria in the letter in which she recounts the classic symptoms of hysteria, throughout her correspondence, melancholic is the term with which she consistently self-identifies.


107 Citing William Bynum in his essay “The Art of Diagnosis,” Malcolm Nicholson explains that for much of the eighteenth century, “the patient’s own description of his illness was the pivotal point in the diagnostic process” ([*Companion Encyclopedia of the History of Medicine*, 2: 801-825], 809). The diagnosis, however, remained in the hands of the physician. Guenter Risse adds that the post-revolutionary climate saw a disparagement of authority through an ideology that emphasized “citizens’ self-government in health matters, individual autonomy, and domestic healing.” Towards the dawn of the nineteenth century, he continues, “a new plan for the promotion of ‘the people’s health’ emerged, which sought to include professionals into a national policy of medical care” ([“Medical Care,” *Companion Encyclopedia of the History of Medicine*, 1: 45-77], 63). This, alongside increasing professionalization of medical practitioners and the standardization of medical practices, means that Wollstonecraft is writing during a particularly liminal period in which the diagnostic roles of doctor and patient are by no means clear.
affliction she would rather suffer. In early letters she proposes that her bodily failings arise from mental anxiety. She explains in October 1786: “A whole train of nervous disorders have taken possession of me—and they appear to arise so much from the mind—I have little hopes of being better.”

Eighteenth-century physicians, however, were wont to connect mental failure in a woman with hysteria: “the most susceptible minds, being the greatest victims to this disorder, demonstrate clearly the surprising effects of the mind on the body.” Perhaps with this in mind, when Wollstonecraft resumes her pen, only weeks later, she is unwilling to attribute her afflictions solely to mental failings: “To tell the truth I hope part of my misery arises from disordered nerves, for I would fain believe my mind is not so very weak.”

Wollstonecraft here subscribes to a different but equally prevalent understanding of health, one in which bodily health depends on mental fortitude. In the words of William Buchan: “A sound mind depends so much upon a healthy body, that where the latter is wanting, the former is rarely to be found.”

A lengthier passage from a later 1786 letter illustrates Wollstonecraft’s repeated vacillations and a renewed attempt to acquit (or blame) both body and mind:

I am indeed very unwell, a kind of melancholy languor consumes me—all my active spirits are fled—everything is tasteless—and uninteresting—I am grown beyond measure indolent, and neglect the few comforts, which are within my reach—I find exercise fatiguing and irksome—In short my nerves have been so much injured I am afraid I shall never be tolerably

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108 Wollstonecraft to Everina Wollstonecraft, October 9, 1786, Letters, 80.
110 Wollstonecraft to Everina Wollstonecraft, October 30, 1786, Letters, 85.
111 Buchan, Domestic Medicine, 331.
well—These disorders are particularly distressing as they seem entirely [sic] to arise from the mind—and that an exertion of the reasoning faculties would banish them and bring it to a proper tone—but slackened nerves are not to be braced by arguments physical as well as mental causes have contributed to reduce me to my present weak state.\footnote{112}{Wollstonecraft to George Blood, December 4, 1786, \textit{Letters}, 92.}

She begins with the diagnosis of melancholia and its attendant symptoms, languor and indolence, thereby suggesting a mental or psychological culprit manifesting itself through physical symptoms. Within a few lines, however, she begins wavering between mental and physical bases, discussing her “injured” and “slackened” nerves and other “physical” causes while still claiming that her disorders “arise from the mind” and “mental causes.” Tilottama Rajan reads Wollstonecraft’s malaise as resulting from the \textit{mind} preying on the body, not the body unsettling the mind.\footnote{113}{Tilottama Rajan, “Framing the Corpus: Godwin’s ‘Editing’ of Wollstonecraft in 1798,” \textit{Studies in Romanticism} 39. 4 (Winter 2000), 522.} This passage from Wollstonecraft’s letter, however, reveals that neither her body nor text can be read that simply. The ascription of both physical and mental causes makes treatment for her impracticable or even impossible. This is again both productive and debilitating: Wollstonecraft never achieves a satisfactory degree of health, but she can continue to display the symptoms of melancholia—among them genius and creativity—indefinitely and be under no immediate threat of being “cured.”

Wollstonecraft was unable to arrive at a satisfactory diagnosis for herself. For her literary characters, many of whom critics read as autobiographical representatives, however, she makes deliberate, even experimental efforts at examination, diagnosis and treatment. Her writings are working in concert with the increasing popularity of
preventative medicine, and are both didactic and prophylactic, displaying the influence of several medical writers, most particularly her contemporary John Brown. Neil Vickers argues that Brownian medicine (or Brunonianism) “envisaged the possibility that habit might check the effectiveness of the exciting powers” of the body. This allowed “for a capacity in the mind that could have a more determining effect than excitability.” In other words, Brown believed that the nervous system could be controlled through the development of careful habits. In almost all of her fictional and didactic writings Wollstonecraft challenged herself to create heroines whose self-knowledge enables them to understand, develop, and maintain healthy habits, and through these, sound physical and mental health. Only she then found that a second challenge lay in the difficulty in reconciling female literary heroism with what popular medical authors asserted were exclusively masculine habits of body and mind.

**Wollstonecraft and ‘Medical Knowledge’**

Almost all Wollstonecraft’s fictions signal an interest in the broader medical questions of the day. As shown in my Introduction, physicians publishing domestic guides to health during the late eighteenth century were, at least implicitly, asking a number of significant questions: What kinds of information should women be able to access regarding their own bodies and their own health? Who has the authority to treat female patients? Who has access to women’s bodies? A form of authority and self-diagnosis is precisely what Wollstonecraft urges in her writings. Vivien Jones asserts that

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Wollstonecraft struggled against a culturally accepted “internalized pathology,” and suggests that Wollstonecraft is as “concerned with the constructions of femininity in medical advice literature as she is with those in books of moral advice.”115 Indeed, Wollstonecraft is almost constantly attempting to determine whether or not a woman can be both healthy and feminine; or, put another way, whether or not feminine sensibility can coexist with physical and mental health.

While women in general were becoming gradually more aware of physic through an increase in popular guides to health and medicine, Wollstonecraft’s own knowledge would likely have been more extensive and explicit than many of her female contemporaries. Her publisher, Joseph Johnson, was responsible for printing a number of scientific and medical tracts of which Wollstonecraft would have no doubt been aware. Between 1791 and 1800, for example, Johnson published *Medical Facts and Observations*, consisting of “the best medical writings” both original and reprinted, as well as an “unusually complete list of medical books both domestic and foreign.” His other medical publications included *Transactions of a Society for the Improvement of Medical and Chirurgical Knowledge* (1792) and *Experiments on the Nervous System* (1793).116 Furthermore, in addition to reviewing fiction and poetry for the *Analytical Review* which Johnson also published, Wollstonecraft is believed to have authored reviews of scientific and philosophical texts including Samuel Stanhope Smith’s *Essay on the Causes of the Variety of Complexion and Figure in the Human Species* (1788).

George Adams’ *Essay on Vision, briefly explaining the Fabric of the Eye, and the Nature of Vision* (1790), William Smellie’s *Philosophy of Natural History* (1790), and *Physiognomy; or the Corresponding Analogy between the Conformation of the Features and the ruling Passions of the Mind. Translated from the Original Work of J.C. Lavater* (1792) by Samuel Shaw.¹¹⁷ Wollstonecraft herself also spent several years during the 1780s preparing Lavater’s writings for translation into English.¹¹⁸ This work was never published, but her interest in physiognomy nevertheless afforded an opportunity to explore many factors impacting human health and behaviour. In the seventh chapter of the *Vindication of the Rights of Woman* Wollstonecraft explains, “I have conversed, as man with man, with medical men, on anatomical subjects; and compared the proportions of the human body with artists.”¹¹⁹ There is no doubt that Wollstonecraft’s interest in, and knowledge of, human science and health were beyond those of an average lay person. Her specific invocation of issues surrounding physical health and medical treatment for women have been largely overlooked in critical conversations, but are an integral part of her broader interrogation of gender as a social construct.

¹¹⁷ The editors of Wollstonecraft’s collected works, Janet Todd and Marilyn Butler, discuss the debate surrounding the attribution of various reviews to Wollstonecraft in their prefatory note to volume 7—all those under consideration were published anonymously but are signed with various initials. Todd and Butler join Ralph Wardle in ascribing to Wollstonecraft all reviews signed ‘M’, ‘W’, and ‘T’. Eleanor Flexner and Derek Roper have argued against such attributions. However, all of the reviews I discuss have been signed “M.,” the initial most widely agreed to have been used by Wollstonecraft. See Todd and Butler in *The Collected Works*, 7: 14-18.

¹¹⁸ This work was never published and the first English translation of Lavater’s work to appear was done by Thomas Holcroft in 1789. In her “Physiognomy as Science and Art,” Martina Reuter examines the validity of claims that Holcroft’s version was based on the work done by Wollstonecraft, but concludes that his reliance on her earlier work seems unlikely (See Vol. 8 of *Psychology and Philosophy: Studies in the History of the Philosophy of the Mind* [Helsinki: Springer Netherlands, 2008], 160).

Wollstonecraft’s concerns with health manifest themselves in two ways: firstly, throughout her literary works, she is concerned with the sleight of hand physicians use that makes it difficult to distinguish between bodily causes and effects. She also questions the general influence of medical practitioners as well as their broader claims to prescriptive authority. The frequent attempts of medical practitioners and writers to assert medical “truths” (via oral diagnosis and published text) despite very real lacunae in medical knowledge, inspire Wollstonecraft to engage in her own experimentation, diagnosis, and prescription, both medical and literary. In concerning herself in the early writings especially with education and childhood development, she grapples with the idea of cause and effect, seeking to determine how unhealthy bodily habits are formed and how they may be altered or avoided.\textsuperscript{120} This type of engagement can be seen in her first works, namely “The Cave of Fancy” (c.1787), \textit{Thoughts on the Education of Daughters} (1787), and \textit{Original Stories from Real Life} (1788).

In these texts, Wollstonecraft considers the impact of the present on the future, prescribing what actions characters might perform now to produce particular effects later. She moves beyond simple analysis of cause and effect to its application to the future—through preventative medicine—using particular causes to prevent certain effects. She remarks in her preface to \textit{The Female Reader}, a 1789 anthology she compiled, “parents are often led astray by the selfish desire of having a wonderful child to exhibit; but these monsters very seldom make sensible men or women: the wheels are impaired by being set in motion before the time pointed out by nature, and both mind and body are ever

\textsuperscript{120} In this case, poor educational practices are the main “causes,” producing bad habits (effects), which in turn produce more bad, unhealthy habits.
Thus rather than seeking to treat feeble minds and bodies, she works to address how and when the wheels might be more properly “set in motion” so as to avoid producing such deleterious effects in the first place. Her particular emphasis on this forward-looking perspective naturally produces significant implications for mothers, both real and literary, as well as for early childhood development, the results of which we will begin to glimpse in Wollstonecraft’s final incomplete piece of fiction, *Maria, or, The Wrongs of Woman* (published posthumously in 1798).

In *Mary* and *Maria* Wollstonecraft further explores ideas of authority, most particularly, prescriptive authority. The term “prescription” denotes an act of writing beforehand; by the sixteenth century, it referred to “a direction … written by a physician for the composition and use of a medicine. ... [M]ore widely, any course of hygiene ordered by a physician, ‘doctor’s orders’” (a phrase which, we will see, has resonance for Wollstonecraft’s *Mary*).¹²² Wollstonecraft investigates the ways in which female characters are able to participate in the direction, development, even composition or narration, of their own stories. This participation may occur through narrative acts, composed texts within the larger work, and aural voices heard (read) via quoted or indirect speech. According to Susan Lanser, in literature particularly by women authors, such “formal practices are neither arbitrary nor simply representational,” but are in fact “responses to situational imperatives produced by the relations of power that acts of telling entail.”¹²³ Narrative technique, she goes on to say, can therefore be seen not

simply as a product of ideology, but as ideology itself; a narrative voice, situated at the juncture of “social position and literary practice,” can embody the social, economic, and literary conditions under which it has been produced. The narrative voices of Mary and Maria reflect how women’s acts of telling and prescribing are often curtailed or significantly affected by the voices of other medical authors and authorities.

Thus in her fictional writings Wollstonecraft begins with an interest in medical causality, but gradually begins to interrogate more specifically the relationship between medical and prescriptive “authority,” seeking to determine who has the right to speak for women’s bodies and why. By imbuing her fictional writings with the discourse of medical diagnosis, treatment and prescription, as well as dialogues which sought to promote preventative medicine, Wollstonecraft works to legitimize her own prescriptions for the female condition. Nicola Watson argues that Wollstonecraft made a continued effort to disassociate herself from the disempowered and eroticized heroine of sensibility. One strategy she employed for this distancing, I argue, is the co-opting of authority offered and legitimized by the discourses and topics of preventative medicine, including self-awareness and self-control. Through experimentation with the causes and effects of her literary characters’ habits, Wollstonecraft attempts to conceptualize and narrate her own and other women’s self-diagnoses, while also inquiring into the narrative logic, or lack thereof, frequently offered by physicians. Her novels can therefore be read

ideological validity, and aesthetic value claimed by or conferred upon a work, author, narrator, character, or textual practice” (6). My concept of “prescriptive authority” is indebted to her conceptualization, though differs in its engagement with a medical context, and in its insistence on a directorial / authorial / pre-scriptive voice.

124 Ibid., 5.
as experiments within the evolving novelistic genre,\textsuperscript{126} making claims to legitimacy for the genre, for women’s writing, and for the prescriptions for women’s bodies contained therein. While her broad interrogation of social authority is a well-established aspect of Wollstonecraft criticism, I examine her specific engagement with medical authority as she works from within a successful medium—prescriptions, doctor’s advice, preventative medicine—in order to more effectively interrogate how and why men maintain prescriptive authority over women. In other words, she perceives medical dialogues as a key operative within broader social and political discourses.

\textbf{Physiognomy and ‘The Cave of Fancy’}

In 1787 Mary Wollstonecraft began composing “The Cave of Fancy,” a fictional fragment never published during her life.\textsuperscript{127} Drawing on a knowledge of physiognomic theory, the text’s narrator explores the relationship between characters’ external appearances and behaviours. The main character in the text is a hermit sage, Sagestus. The narrative begins as he surveys the dead who have washed ashore following a shipwreck and draws conclusions about their lives based on their physical features: “He was perfectly acquainted with the construction of the human body, knew the traces that virtue or vice leaves on the whole frame; they were now indelibly fixed by death”


\textsuperscript{127} “The Cave of Fancy” was first published by Joseph Johnson in 1798 in \textit{Posthumous Works of the Author of ‘A Vindication of the Rights of Woman’}, edited by William Godwin.
(110). The hermit’s diagnoses throughout “The Cave” register Wollstonecraft’s engagement with human health and suggest a keen interest in physiognomic theory, the practice which seeks to determine connections between people’s external appearances, particularly facial features, and their inner characteristics and behaviours. Sagestus surveys the victims and remarks knowledgeably upon them all; his gaze lingering on a particular man, for example, he observes: “If a brutal cunning had not marked the face, it might have been mistaken for an automaton, so unmixed was the phlegmatic fluid” (116). Wollstonecraft here employs both physiognomic and humoral theory, evincing an understanding of changing theories of medicine and human biology, while underlining the idea of health as an equilibrium (whether, as in this case, a balanced “mix” of humours, or, as we will see in later cases, a balance of excitement in the nervous system). Her main interest in this text, however, lay with physiognomy. It is perhaps the obtrusive physiognomic theory throughout “The Cave” which contributes (at least in part) to its identification by scholars as an “apprentice effort” from Wollstonecraft, and its subsequent neglect in critical conversations. Yet it is an important text to

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128 I am using the 1972 facsimile edition of the original edition edited by Godwin, with four volumes in two (Clifton, NJ: A. M. Kelley). The pagination is not continuous within and across the two volumes. “The Cave of Fancy” is in Volume II and spans 99-155. All subsequent references will be given parenthetically in the text.

129 Humoralism is among the oldest of western medical theories and asserts that the body is comprised of four humours (black and yellow bile, phlegm, and blood,) the predominance of one or another of which would lead to variations in temperament, and the disturbance of one or more of which would produce illness. The shift from humoralism to anatomical and physiological paradigms was gradual, and physiognomic theory worked alongside both schools of thought. See Vivian Nutton, “Humoralism,” in *Companion Encyclopedia of the History of Medicine*, 1: 281.

acknowledge as it evinces Wollstonecraft’s developing interest in contemporary theories relating to human health and development.

Sagestus spends much of the narrative describing characteristics people once possessed, as he examines the dead bodies of those cast from the ship. Indeed, towards the end of the eighteenth century, physiognomists and physicians alike became increasingly interested and invested in examining the dead, rather than the living. David Wooton explains that, contrary to expectations which look to symptoms displayed by the living to determine a diagnosis, physicians at that time focused increasingly on the dead:

In the past doctors had sought to alleviate symptoms as described by the patient: what mattered was that the patient should feel better. ... But now, in the first decades of the nineteenth century, doctors were seeing patients in considerable numbers, and when these patients died (as a high proportion of them did) their bodies were routinely autopsied. … What the doctor now sought to do was predict, on the basis of his inspection of the patient, what would show up at autopsy. The doctor’s task was to read the symptoms he could perceive in the living as indicators of a hidden condition that would only be exposed to view in the dead.  

Physiognomists had an equal interest in the characteristics of the deceased. Lavater explained: the “settled features are much more prominent than in the living, and the sleeping. What life makes fugitive, death arrests; what was indefinable, is defined.”  

By Lavater’s standards then, Sagestus is highly skilled: “Whoever forms a right judgment of the character of man, from those first impressions which are made by his

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132 Thomas Holcroft trans., Essays on Physiognomy: Translated from the German of John Casper Lavater, 1789 (London, 1878), 149.
exterior, is naturally a physiognomist. ...; the philosophic physiognomist is he who is capable of developing the principles of these exterior traits and tokens, which are the *internal causes of external effects.*“\(^{133}\) As I have established, medical case studies are necessarily concerned with the sequencing of cause and effect and the provision of a judgment. “The Cave of Fancy” thus consists almost entirely of Sagestus’ case studies, his post-mortem diagnoses of internal causes based on his reading and interpretation of external effects / symptoms, including any visible signs of sensibility.

Physiognomy’s place within the realm of medical science is debatable: its basic operation involves classifying—“taking a particular expression as the exemplification of a general kind” —and then using this information to describe the character of an individual. However, the mid-century writings of James Parsons (1705-1770), and the publications of Johann Caspar Lavater (1741-1801) during the late eighteenth century made claims for physiognomy as a more creditable scientific practice, the result of which was a rapid increase in its popularity and legitimacy.\(^{134}\) Parsons read emotions and their expression as a product of the nervous system, with the diaphragm in particular conveying impulses and impressions to the face.\(^{135}\) While physiognomy traditionally read bodily features as indicators of moral and religious as well as corporeal health, Lucy Hartley argues that Parsons and especially Lavater refined the “claim that muscular

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\(^{133}\) Ibid. 12, my emphasis added.


\(^{135}\) Hartley, *Physiognomy*, 16.
action was directly related to mental processes, and that this relationship was repeated so often it became habitual.” This connection of mind, body, and habit was “consistent with the physiological principles” emergent during the second half of the eighteenth century. Wollstonecraft’s main character, Sagestus, shares the physiognomist’s “vision of the interrelation of body and mind” and sees a mechanistic process “work[ing] backwards from the movement of a part of the body, and a corresponding response in the muscles and the nerves, to the circulation of spirits and blood and their influence on the brain.”

By incorporating the nervous system into physiognomic theory, eighteenth-century practitioners increasingly medicalized the practice, and placed renewed emphasis on bodily habits, both healthy and unhealthy.

In an earlier review of a text by Samuel Stanhope Smith, Wollstonecraft had explained that physiognomy could indicate one’s sensibility because facial features could reveal the effects of both the “great and sudden impressions,” and also “continual and almost imperceptible touches” on the human constitution. These “touches,” she explained, quoting from Smith, impact the “habits of the body”; and, “of habits both of mind and body, nations are susceptible as well as individuals.” Note the hint of a language of disease and contagion here: if people, nations, are susceptible to habits, precautions must be taken to prevent them succumbing to bad ones. She notes Smith’s conclusion that said “habits” are “transmitted to offspring, and augmented by inheritance. Long in growing to maturity, national features, like national manners, become fixed, only after a succession of ages.”

136 Ibid., 24, 17.
137 Wollstonecraft, review of Samuel Stanhope Smith’s An Essay on the Causes of the Variety of Complexion and Figure in the Human Species, Analytical Review, December 1788, Works, 7: 51.
(or alternatively, the potential to resist them), and the “almost imperceptible” forces that shape them, are of particular interest to Wollstonecraft and focus her interest in physiognomy. When Sagestus first explains the concept of sensibility to his protégée, a young girl, the lone survivor from the wreck (whom he later names Sagesta), he explains that it is “the result of acute senses, finely fashioned nerves, which vibrate at the slightest touch, and convey such clear intelligence to the brain, that it does not require to be arranged by the judgment” (135). The implication here is that sensibility is no mere abstraction; rather, it has a very real foundation in human anatomy. Whether this foundation is biologically inherent or is socially developed, however, is another question. The idea of nerves being “finely fashioned” does cast a shadow of doubt on the biological basis for sensibility implied by “acute senses” as fashion implies transience and changeability, and the idea of something deliberately constructed, or fabricated.

In the “Cave,” Wollstonecraft has Sagestus echo Lavater’s writings almost verbatim, emphasizing that habitual behaviours often result in the determination of physical features. Lavater argues, for instance, “joy and pain still have each their peculiar expression; they act according to peculiar laws on peculiar muscles and nerves, ... and the oftener the passion is repeated, or set in motion, the more it becomes a propensity, a favourite habit; the deeper will be the furrows it ploughs.”¹³⁸ By “reading” the facial features of the dead before him, Sagestus comes to understand their characters and habits. Of one man he notes, “some perpendicular lines pointed out that melancholy had predominated in his constitution; yet the straggling hairs of his eye-brows showed that

anger often shook his frame” (111). In Sagestus’ examination of the dead men, Wollstonecraft has him consistently concur with Lavater’s teachings; however, when he comes to examine the two female passengers from the ship, Wollstonecraft steers Sagestus away from Lavater’s theories in interesting and telling ways.

Lavater devoted several sections in his writings to women in particular, explaining the differences (both physiognomic and otherwise) between men and women, and asserting the inherent or biological nature of these differences. Wollstonecraft agrees with Lavater’s account of sexual difference, yet modifies his theory slightly but significantly to suggest that these seemingly inherent and biological characteristics are, in fact, learned habits that require a revised educational plan to alter or prevent altogether. Lavater describes women’s tenderness and sensibility as emergent from the “light texture of their fibres and organs” and concludes: “by the irritability of their nerves, their incapacity for deep inquiry and firm decision, they may easily, from their firm sensibility, become the most irreclaimable, the most rapturous enthusiasts.” For Lavater, it is women’s fibres, nerves, and organs that lead to their apparently pliant and submissive nature: “this volatility of feeling render them so easy to conduct and to tempt; so ready of submission to the enterprise and power of the man. ... The man was not first tempted, but the woman.”

At first glance, Sagestus seems to concur. In examining a female attendant from the ship, he remarks that her body indicates an “affectation of gentility” and concludes with “the same thought that the sight of the sailors had suggested ..., Men and Women are all in their proper places—this female was intended to fold up linen and nurse the sick” (122). The remark on men and women in their “proper

139 Ibid., 400, 401.
places” might be read as a comment on categories of gender. But the observation of the nurse’s “affected gentility” and the analysis of the nurse alongside the sailors suggest that “proper places” in this context have more to do with categories of class than those of gender.

When Sagestus comes upon the orphan’s dead mother, “the lily that had been so rudely snapped,” he describes her in terms recalling Lavater’s; carefully observing, Sagestus “traced every fine line to its source. There was a delicacy in her form, so truly feminine, that an involuntary desire to cherish such a being, made the sage again feel the almost forgotten sensations of his nature” (Ibid.). He describes her features and then diagnoses, but reveals in an almost ludicrous passage, that her physical features are formed by habit, and not the other way around:

He discovered that her natural delicacy had been increased by an improper education, to a degree that took away all vigour from her faculties. And its baneful influence had had such an effect on her mind, that few traces of the exertions of it appeared on her face, though the fine finish of her features, and particularly the form of the forehead, convinced the sage that her understanding might have risen considerably above mediocrity, had the wheels ever been put in motion; but, clogged by prejudices, they never turned quite round, and, whenever she considered a subject, she stopped before she came to a conclusion. Assuming a mask of propriety, she had banished nature; yet its tendency was only to be diverted, not stifled. (122-3)

Thus while there is some “natural” delicacy to this woman, it has been heightened by her “improper education.” Furthermore, it is the “baneful influence” of her inadequate education that results in physical signs indicative of obstinacy, prejudice, and indolence. When Sagestus decides to adopt the dead woman’s daughter, it is in order to protect her from the evils of another improper education. The implication then, as he begins to instruct the young girl, is that unlike her mother, she will possess a true sensibility thanks
to his improved instruction; she will not be one from whom “fictitious, unnatural distress” draws tears (124). This equation of “fictitious” and “unnatural” offers a signal of Wollstonecraft’s continued discomfort with the fictions being produced, and consumed by her female contemporaries.

By proposing to equip young women (characters) with new and hardier habits, Wollstonecraft explores the possibility of overriding women’s supposedly “natural” (biological) nervous reactions with learned and acquired responses. Wollstonecraft does not deny the physical differences between men and women, but rather suggests that through education and training, women might come to “learn” and acquire some of men’s hardier habits. Indeed, Claudia Johnson observes Wollstonecraft’s repeated assurances in the second Vindication that “men’s physical superiority will guarantee their deserved pre-eminence no matter how strong or ‘masculine’ women should ever become.”

Thus when Sagestus begins instructing the young girl, he proposes that her “goodness” and feeling should be always “reined in by principles. ... The senses of children should be the first object of improvement” (130). It is Wollstonecraft’s very confidence in the physical distinctions between men and women that licenses her to encourage women in the fortification of their nerves and the subsequent reduction of their bodies’ nervous responses.

Throughout the text, Wollstonecraft offers an answer to Lavater’s larger question: “Shall not motive and action, shall not the correspondence between the interior and the exterior, the visible and the invisible, the cause and the effect,” be understood?

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Sagestus makes clear in his account of the orphan’s mother that while internal emotions do produce external symptoms, for women at least, external factors (education and social conditioning) are responsible for leaving the most telling, legible signs of sensibility. “The Cave of Fancy” shows not only Wollstonecraft’s interest in Lavater’s teachings, but also her deliberate determination to interrogate and revise particular tenets of his philosophies.

As she continued writing, Wollstonecraft persisted in incorporating medical and scientific thought into her work, albeit in more nuanced ways. In the next section I consider her didactic texts, designed to assist with the education of young children and to refine the instructive methods of their teachers. Therein her interest in health and sensibility continues to be evident in her attempts to understand and modify human, particularly female, “habits.”

Learned Habits and Literary Heroines

Wollstonecraft’s Original Stories from Real Life; with Conversations Calculated to Regulate the Affections, and Form the Mind to Truth and Goodness (1788) and her earlier Thoughts on the Education of Daughters (1787) are works intended, according to their author, for the education of children. Wollstonecraft begins Original Stories by emphasizing the importance of encouraging healthy habits in children. In her prefatory remarks she suggests, “good habits, imperceptibly fixed, are far preferable to the precepts of reason; but, as this task requires more judgment than generally falls to the lot of
parents, substitutes must be sought for, and medicines given, when regimen would have answered the purpose much better” (iii).142 The language here recalls that of Beddoes, Leake, and Buchan in their efforts to promote preventative medicine. Where Wollstonecraft differs, however, is in her rationale for why young children, especially girls, should seek to develop healthy habits.

Physicians promised beauty and fertility as the rewards for good, healthful women; these were the desired effects of medicine, both preventative and restorative. Doctors in their publications explicitly sought to establish an aetiological relationship between a woman’s health, beauty, and fecundity. In his tract intended particularly for female readers, for instance, Buchan packs it all into one frightening declaration: woman, he claims, must “seek for beauty in the temple of health; if she looks for it elsewhere, she will experience the most mortifying disappointment: her charms will fade; her constitution will be ruined; her husbands [sic] love will vanish with her shadowy attractions, and her nuptial bed will be unfruitful, or cursed with a puny race, the hapless victims of a mother’s imprudence.”143 The narrative sequence is very clear—should a woman seek beauty by any means other than health, the effects will be disastrous. Leake expresses a similar belief: “the great secret in the art of preserving or maintaining beauty consists in the art of preserving health.”144 Wollstonecraft offers a markedly different rationale for seeking to promote women’s health.

142 Mary Wollstonecraft, Original Stories from Real Life; with Conversations Calculated to Regulate the Affections, and Form the Mind to Truth and Goodness, 1788 (London: J. Johnson, 1791). All references provided parenthetically in the text. As noted in n.58 in my Introduction, regimen is intended as a preventative measure to arrest the onset or worsening of ill health.
143 William Buchan, Advice to Mothers on the Subject of their own Health and on the Means of Promoting the Health, Strength, and Beauty of their Offspring, 1803 (New York, 1812), 8.
144 Leake, Medical Instructions, 18.
To begin with, Wollstonecraft works to establish a connection between a girl’s ability to tolerate pain, and her “greatness of mind.” While the capacity to tolerate pain cannot necessarily be equated with health, there is still a connection between one’s ability to tolerate discomfort and one’s ability to resist disease (or dis-ease). Influential Swiss anatomist and physiologist Albrecht von Haller (1707-1777) determined that there was a crucial distinction to be made between “nervous irritability” and “sensibility”: the former referred to the contraction of a body part when touched by a foreign object, whereas the latter resulted in a “sign of pain in the feeling soul.” The paradox with women was that they were thought to possess a refined sensibility but with a frail bodily constitution. Lavater explains: “women feel more. Sensibility is the power of woman”; but he also observes, “all their organs are tender, yielding, easily wounded, sensible, and receptible.” In Original Stories, Wollstonecraft’s fictional educator, Mrs. Mason, indicates her belief that if a woman’s nerves could become more tolerant of pain or irritants, she would theoretically be able to benefit from her sensibility—through refined morality, and artistic superiority and appreciation—without being hampered or hindered by her overly delicate physicality. Throughout her texts then, Wollstonecraft urges

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146 Holcroft trans., Essays on Physiognomy, 400. Cf. Jane Austen’s heroine, Anne, in Persuasion (1817). Responding to Captain Benwick’s belief in a “true analogy between [men’s] bodily frames and our mental; and that as our bodies are the strongest, so are our feelings; capable of bearing most rough usage, and riding out the heaviest weather,” she argues, “Your feelings may be the strongest, ... but the same spirit of analogy will authorise me to assert that ours are the most tender. Man is more robust than woman, but he is not longer-lived; which exactly explains my view of the nature of their attachments” (Persuasion, ed. James Kinsley, [Oxford: Oxford University Press, 2004], 187-88).
women to learn fortitude. In so doing, however, her resolute stoicism occasionally becomes tinged with erotic, even masochistic undertones.

Wollstonecraft’s *Original Stories* involves the prudent Mrs. Mason offering two young girls a number of life lessons. Mrs. Mason admonishes one of her charges who persists in uttering the “loudest and most silly complaints” following a wasp’s sting: “I am sorry to see a girl of your age weep on account of bodily pain; it is a proof of a weak mind, a proof that you cannot employ yourself about things of consequence” (156). Mrs. Mason repeatedly asserts the connection between strength of mind and strength of body:

Children early feel bodily pain, to habituate them to bear the conflicts of the soul, when they become reasonable creatures. ... Those who, when young, weep if the least trifle annoys them, will never, I fear, have sufficient strength of mind, to encounter all the miseries that can afflict the body, rather than act meanly to avoid them. Indeed, this seems to be the essential difference between a great and a little mind: the former knows how to endure—whilst the latter suffers an immortal soul to be depressed, lost in its abode; suffers the inconveniencies which attack the one to overwhelm the other. ... Believe me, it is the patient endurance of pain, that will enable you to resist your passions; after you have borne bodily pain, you will have firmness enough to sustain the still more excruciating agonies of the mind. (157-9)

The implication is that all children, regardless of gender, have the promise of becoming “reasonable,” rational adults. Thus children, particularly young girls, who can withstand the “miseries that afflict the body,” will be able to develop a “great,” “patient,” and “firm” mind.147 While suggesting that “strength of mind” is needed to conquer bodily

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147 There are undoubtedly currents of Christian stoicism running through this passage—we see similar moments in *Mary* as well. There is, however, more at stake: in her articulation of the mind-body connection; such stoicism arguably borders on perversion. Katherine Binhammer notes that “by the close of the eighteenth century, the sweet sensations of pain as sentimental sympathetic identification in the
weakness, and asserting that only great minds can endure significant bodily pain,
Wollstonecraft also sees benefit in undergoing bodily pain in order to develop a great
mind. Here she recalls Adam Smith’s chapter on self command in his *Theory of Moral
Sentiments*: “We esteem the man who supports pain and even torture with manhood and
firmness; and we can have little regard for him who sinks under them, and abandons
himself to useless outcries and womanish lamentations. [He] is alone the real man of
virtue.”¹⁴⁸ For Wollstonecraft there was an absolute connection between virtue and
suffering; as she explained in a 1790 letter, “If I were to give a short definition of virtue I
should call it fortitude.”¹⁴⁹ Within the context of her educational texts, Wollstonecraft
argues that such virtuous fortitude is possible; by asserting the idea that the female body
can learn to withstand nervous impressions, she strives to impart a knowledge that, once
learned, will no longer have to be remembered; it will be *habitual*.

In her first published work, *Thoughts on the Education of Daughters, with
Reflections on Female Conduct, in the More Important Duties of Life* (1787),
Wollstonecraft illustrates the importance of having been indoctrinated in, or perhaps
more aptly, having incorporated healthy habits. She begins by explaining the most
important tenet of her educational principles: “the first thing to be attended to, is laying
the foundation of a good constitution” (3).¹⁵⁰ “Constitution,” according to Samuel

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¹⁵⁰ Wollstonecraft, *Thoughts on the Education of Daughters, with Reflections on Female Conduct, in the
in the text.
Johnson, could be one’s “state of being; texture of parts; natural qualities,” one’s “corporeal frame” or “temper of body, with respect to health or disease,” as well as one’s “temper of mind.”\footnote{Samuel Johnson, \textit{Dictionary of the English Language}, s.v. “constitution.” 1755.} It is little wonder that Wollstonecraft’s insistence on fortitude and self-discipline contributes to all aspects of human health—physical, mental, moral, and spiritual. She notes in her \textit{Thoughts}, for instance, “health of mind, as well as body, must in general be obtained by patient submission to self-denial, and disagreeable operations” (65). Thus it is not necessarily pain that she wants women to avoid, but rather its display and (re)presentation. She suggests that for women, all too frequently, “Painful feelings are \textit{prolonged beyond their natural course}—, to gratify our desire of appearing heroines, and we deceive ourselves as well as others” (86). Wollstonecraft here explicitly declares that female literary heroism, at least as it has been represented so far, is not a virtuous—and in her mind, healthy—model for emulation. She argues that women should not aspire to be, or to create heroines whose sufferings are audible and visible, because such heroism is in fact, unnatural.

A woman’s ability to tolerate her own pain and discomfort, alongside the ability to remove or alleviate the pain of others, are what Wollstonecraft envisions as a model of feminine literary heroism. In \textit{Thoughts} Wollstonecraft recommends to young women some course of education in medicine (104), as does William Buchan who notes that “sensible nurses” often “foresee the patient’s fate sooner than those who have been bred to physic,” provided they closely observe their patients, “both in distinguishing their symptoms, and in the application of medicines.”\footnote{Buchan, \textit{Domestic Medicine}, 111.} Wollstonecraft significantly sought to
add reason to a nurse’s practice, arguing that sensibility alone is insufficient. She writes: “nothing is more useful in a family than a little knowledge of physic, sufficient to make the mistress of it a judicious nurse. Many a person who has had a sensible physician to attend them, have been lost for want of the other; for tenderness, without judgment, sometimes does more harm than good” (104). It is a crafty move on Wollstonecraft’s part to emphasize that sensibility is natural to physicians, implying that it is not necessarily inherent or “natural” to only women, but rather can also be found in men, doctors, et cetera. The implication is that tenderness is insufficient, even potentially harmful without discerning reason to even the balance. It is therefore both for the care of others as well as themselves that Wollstonecraft advocates a medical education for women. In composing Mary and Maria then, she begins experimenting with new forms of literary heroism; and she works to illustrate the effects of her recommendations of women studying physic and nursing, so that they might be better equipped to understand what exactly constitutes a “natural course” of pain, illness, and bodily health.

Mary

In the introduction to her first novel, Mary, A Fiction, Wollstonecraft announces her intention to create a protagonist markedly different from her literary predecessors, as she explains, “a heroine ... different from those generally portrayed” (3). Andrew Elfenbein has discussed the extent to which Mary is depicted as a figure of genius, whose

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“positive masculinity” is presented as a contrast to more feminized, passive characters in the text. Claudia Johnson also suggests that in *Mary*, Wollstonecraft “treats the female body as the body to be overcome.”¹⁵⁴ These scholars and others have considered the afflicted female body in *Mary*, but have not really remarked on how Mary’s health is related to her interaction with the several physicians in the text. Mary’s authority, borrowed from doctors throughout the narrative, combined with her perceptive but hardy sensibility, enables her to achieve a degree of prescriptive authority. Mary writes and speaks freely throughout the text and to a large extent directs her own movements—literally through her travels and her day-to-day conduct—because within this fictional realm, she is able to embody characteristics previously thought to exist exclusively in either men or women. While the novel is written using third person narration, Wollstonecraft grants Mary a great deal of speech, both in dialogue and in included letters, and this narrative presence is available to her, I argue, because she is free from the physical limitations which hamper the novel’s other female characters.

Wollstonecraft composed *Mary* while employed as a governess in the Kingsborough family. While writing she suffered from a “constant nervous fever” that had been diagnosed by the Kingsborough’s family physician.¹⁵⁵ Furthermore, according to William Godwin, much of the text was composed during her residence at Bristol Hot Wells where the family had journeyed to sample the medicinal waters.¹⁵⁶ Gary Kelly


¹⁵⁶ William Godwin, *Memoirs of the Author of ‘The Rights of Woman,’* 1798 (London: Penguin, 1987), 223. “Taking the waters” refers to both the consumption of water thought to have medicinal properties, as well as the submersion in, and application of, said waters externally. Spas and baths were particularly
joins other scholars in identifying *Mary* as “manifestly and purposefully autobiographical, showing that afflicted female sensibility is the result of internalizing social contradictions of class and gender.”¹⁵⁷ It is therefore worth considering the significance of the invalids who appear in quick succession almost as soon as the text begins. Wollstonecraft was surrounded by sufferers in her daily life; the text is preoccupied by illness and ill-health; and all of the novel’s events are driven by or are in response to such afflictions. To summarize, characters in this novel suffer from milk-fever, consumption, melancholy, hysterical fits, hectic coughs, inflammatory blood, false spirits, and putrid fever. The text begins with the death of the heroine’s brother from a violent fever, her mother from an unspecified lingering complaint, and her father from complications and fever following a fall from a horse. Mary then journeys to Portugal with her invalid friend, Ann, in the vain hope that the climate there will afford her a cure. Once arrived, she meets the consumptive Henry, who dies following their return to England. The fictional Mary is the only mostly healthy character in the text. She suffers a brief moment of sickness but otherwise remains in good health until her implied death at the narrative’s conclusion.

In the prefatory remarks to the novel, Wollstonecraft indicates that this protagonist will differ markedly from earlier literary heroines. She elaborates:

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In an artless tale, without episodes, the mind of a woman, who has thinking powers is displayed. The female organs have been thought too weak for this arduous employment; and experience seems to justify the assertion. Without arguing physically about possibilities – in a fiction such a being may be allowed to exist. (3)

It is important to acknowledge her ambivalence here regarding the supposed weaknesses of the female body (“organs”). Claudia Johnson reads the thematizing of genre in Wollstonecraft’s choice of subtitle as somewhat limiting: “while Wollstonecraft’s ‘fiction’ on one hand testifies to her power to think for herself, on the other hand it allows that the status of that fantasy is subjunctive at best and figmentary at worse.”

Johnson reads Wollstonecraft’s statement that “experience seems to justify” female physical inferiority as a concession she is able to work around through her use of fiction. I would add that Wollstonecraft’s use of “seems” results in a claim that is not terribly convincing, and that might even imply her belief that the opposite could be true. Such tentative wording implicitly undermines the very proposition she lays out. Yet in reminding readers of the fictional nature of her text, Wollstonecraft leaves herself at liberty to create a female protagonist who is not confined by physical weaknesses.

Wollstonecraft begins by establishing the incontrovertible authority granted to physicians, and then gradually places the eponymous heroine in a comparable role. For starters, significant events in the narrative occur only following and in agreement with the diagnoses of physicians. Mary’s mother, for instance, suffers from a “lingering complaint” and “her decline was so imperceptible, that they were not aware of her

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158 Johnson, Equivocal Beings, 49-50.
approaching dissolution.” It is only when the physician, “observing the most alarming symptoms,” notifies Mary and her father that her mother finally dies. Similarly, when her father falls from his horse, the narrator informs us that “his recovery was not expected by the physical tribe;” he dies shortly after this prognosis (8, 14, 17). The depiction of the “tribe” of doctors conjures visions of a primitive clan, towards whose authority the narrator seems almost contemptuous. The same occurs in the case of Mary’s friend Henry. When his physician declares that “he never knew a person with a similar pulse recover,” Henry is as good as doomed (50). Despite the narrator’s apparent scorn of the medical profession, there is nevertheless an awareness of its power and authority.

In response to her feelings of helplessness, Mary begins by studying. While caring for Ann, she reads books on medicine and physic. This equips her with a degree of diagnostic skill enabling “her to foresee what she could not prevent.” During a conversation with Ann’s physician, Mary assumes “an authoritative voice” and “insisted on knowing his real opinion” (16, 17). This “authoritative voice” is persuasive enough for her to obtain the desired information. When she learns that her friend requires a change of climate, she immediately assumes the role of diagnostician both for herself and Ann. Eighteen pages into the novel, she writes to her absent husband, and this letter, marking only the second occasion in which the reader hears Mary’s voice in the text, oddly begins in quoted speech in the third person, but ends as first person narration as she assumes greater authority and assurance. She begins composing a letter addressed “to the man she had promised to obey.” She goes on: “The physicians had said change of air was necessary for her as well as her friend. She mentioned this and added,” and here begins Mary’s quoted speech, still from within the letter itself: “‘Her [own] comfort,
almost her existence, depended on the recovery of the invalid she wished to attend; and... should she neglect to follow the medical advice she had received; she should never forgive herself, or those who endeavoured to prevent her.’’ She concludes: ‘‘Continual attention to [Ann’s] health, and the tender office of a nurse, have created an affection very like a maternal one—I am her only support, she leans on me—could I forsake the forsaken, … No—I would die first! I must—I will go.’’ It is, ironically, Mary’s fierce devotion and dedication to the role of nurse that enables her to resist what should be a more binding role, that of a wife. She considers asking her husband’s consent, but “her heart revolted” and the letter is therefore “sealed in a hurry, and sent out of her sight” (18). Thus within this highly significant letter, Mary places herself in the dual role of both patient and caregiver, and craftily argues that her own well-being—“comfort, almost her existence”—depends on her ability to attend or treat her friend. She legitimizes her self-prognosis with the advice of another physician, and the result is her husband’s acquiescence: “‘As the physicians advised change of air, he had no objection’” (Ibid.).

From the moment she sends this letter, the reader hears Mary’s voice through quoted speech, letters, and written musings. Whereas formerly the narrator had described Mary’s thoughts and activities from a remove, the reader is now granted much greater access to her voice, particularly through conversations with her new friend Henry and through samples of her writing. While Ann never speaks, Mary articulates her thoughts clearly and frequently. She is able to inhabit this autonomous role, at least in part, because she remains healthy. And this good health is not simply fortuitous; it is the product of the same self-discipline and regulation Wollstonecraft advocates in her
Original Stories and Thoughts on the Education of Daughters. Mary regulates herself: she “practiced the most rigid oeconomy, and had such power over her appetites and whims, that without any great effort she conquered them so entirely, that when her understanding or affections had an object, she almost forgot she had a body that required nourishment” (12). An unsettling degree of disembodiment seems necessary for her to achieve both narrative and medical authority. Peter Logan argues that for astute diagnoses and prognoses, a physician must ultimately possess “the same sensibility, or nervous condition, he seeks to cure in the world;” it must, however, be strictly controlled.\textsuperscript{159} In Mary’s case, she disregards her own physicality, leaving herself largely unhampered by physical vulnerabilities, able to speak and write freely, and, as noted above, direct and assist others. Thus while on an outing with Henry, whom Mary soon after grows to love, Ann faints; “Henry would have supported her; but Mary would not permit him; … she feared sitting on the damp ground might do him a material injury. … As to herself, she did not fear bodily pain; and, when her mind was agitated, she could endure the greatest fatigue without appearing sensible of it” (27). Again Mary demonstrates personal fortitude, commanding authority, and an inner strength capable of controlling the outward expressions of her sensibility.\textsuperscript{160}

Yet Mary is not invincible. She does become ill twice during the novel. On the first occasion she becomes sick while caring for a poor family. Wollstonecraft’s class prejudices might be seen emerging here as she clearly depicts Mary’s bout of putrid fever as a contagious illness, one transmitted via “poisonous air” in an environment of

\textsuperscript{159} Logan, Nerves and Narratives, 41.
\textsuperscript{160} Mary’s fortitude, it must be noted, does not preclude her having sensibility. In fact, she celebrates her sensibility as “the most exquisite feeling of which the human soul is susceptible” (43).
“nastiness,” the “consequence of dirt and want.” At this time Mary is attended by a physician, “but the disorder was so violent, that for some days it baffled his skill” (41). As with the other physicians in the text, he effectively accomplishes nothing. It is therefore not necessarily the physicians’ practices, but the prescriptive and narrative authority they possess that Wollstonecraft seems to value. Mary recovers gradually only as the fever runs its course. Thus while she is not entirely immune to illness, because of her healthier, hardier habits, she is resistant to the nervous disorders that hinder the text’s other female characters. Mary goes through a “natural” course of illness, but Wollstonecraft does not allow it to extend beyond that.

A comparison of Mary with the novel’s other ailing ladies is useful. We are told that Mary’s mother “had, to complete her delicacy, so relaxed her nerves, that she became a mere nothing” (5). Resembling Austen’s languid Lady Bertram, the problem with Mary’s mother appears to be biological—her nerves are faulty. Yet this is also apparently a matter of choice: she had relaxed her nerves. Physician William Buchan remarks: “weak nerves are the constant companions of inactivity. Nothing but exercise and open air can brace and strengthen the nerves, or prevent the endless train of diseases which proceed from a relaxed state of these organs,”161 and Mary’s mother, indolent, and fond only of lounging with her lapdogs and reading romance novels, does not care for activity. The three female invalids who share the ladies’ home in Lisbon are, we are told, also “fashionable women.” Their illnesses, like that of Mary’s mother, are revealed to be of their own creation, or at least their own fault: “hurrying from one party of pleasure to another, occasioned the disorder which required the change of air” (22). Of Ann we are

told that disappointed love and poverty combined to produce her illness: she “had not the fortitude enough to brave such accumulated misery; and besides, the canker-worm was lodged in her heart, and preyed on her health” (13). The image of the canker-worm is a recurring one in Wollstonecraft’s writings and generally evokes grief and its attendant symptoms in women.\textsuperscript{162} The aetiologies of these other ladies’ illnesses are worth noting. The ills of these women are very clearly not the product of contagion or infection. Rather, all the women excepting Mary suffer from afflicted nervous systems and the attendant symptoms of sensibility.

The end of the text shows Mary finally succumbing to illness, the second bout to which I alluded above. We are told that “she visited the continent, and sought health in different climates; but her nerves were not to be restored to their former state. … Her delicate state of health did not promise long life” (53). It is not coincidental that Mary’s ill health—significantly a weakness emergent from faulty nerves—coincides with her reunion with her husband: “Mary fainted when he approached her unexpectedly.” She weakens further when forced to engage physically with him: “she gave him her hand—the struggle was almost more than she could endure. … When her husband would take her hand, … she would instantly feel a sickness, a faintness at her heart, and wish, involuntarily, that the earth would open and swallow her” (52-3). Reading her narrative

\textsuperscript{162} The canker-worm has a lengthy literary history with one of its most memorable appearances occurring in Hamlet. Laertes warns Ophelia about the fragility of female virtue: “The canker galls the infants of the spring / Too oft before their buttons be disclosed, / And in the morn and liquid dew of youth / Contagious blastments are most imminent.” (I.iii. 39-42)

In one of her literary reviews Wollstonecraft refers to grief as “beauty’s cankerworm” (See n. 78, above). Twice in her letters she describes the canker-worm in her bosom while referring to her separation from Gilbert Imlay (Letters 280, 307). There is an additional mention in Original Stories when Mrs. Mason cautions her young charges against negligence as a result of grief (97).
as a medical case reveals that Mary is healthy while she is autonomous; she possesses sensibility, is enlightened, and is very deliberately not debilitated by it. When forced to reunite with her husband, and no longer able to retain authority over her own body, her nerves become a source of affliction and Mary cannot restore them “to their former state” (53). A passage in Wollstonecraft’s later Vindication of the Rights of Woman more clearly articulates the causal relationship between marriage and women’s health that she begins to diagnose here: “The obedience required of women in the marriage state,” Wollstonecraft declares, weakens their minds, leaving them fragile and indolent.\textsuperscript{163} Mary, no longer able to authorize or prescribe the methods necessary for her own recovery, is unable to convalesce through this final illness. Her independent habits and the habits of society are too much at odds with one another. Mary thus contains case studies of several women, all serving as a reminder of the need to cure the habits of society in order to more effectively treat, or even prevent from developing, the diseased habits of the female patient.

Though Wollstonecraft later discredited Mary as “a crude production,” there is no denying her efforts at literary innovation. Claudia Johnson describes her intention to represent “the mind of a woman who has thinking powers” as “stunning both in its simplicity and its ambition.”\textsuperscript{164} I read Wollstonecraft’s attempt to establish a connection between a heroine’s health and her prescriptive authority as an example of literary and medical experimentation intersecting, and as setting the stage for her final piece of


\textsuperscript{164} See Claudia Johnson’s discussion of Mary in The Cambridge Companion to Mary Wollstonecraft, 190.
fiction, *The Wrongs of Woman, or, Maria*, in which women’s mental health becomes her main area of concern.

*Maria; or, The Wrongs of Woman*

Through the fictional *Mary*, Wollstonecraft explores the possibility of a sound mind and sensibility in a healthy independent female body. Society’s habits, however, which demand the sacrifice of women’s “strength of body and mind,” finally prove to be incompatible with such a figure.\(^{165}\) Her second novel, however, features a much less hardy, much more sensitive or “feeling” heroine right from the outset. In fact, Elizabeth Dolan notes that the fragmentary *Maria* features more than twenty-five portraits of “suffering women.” *Maria* can therefore be read as a text which illustrates Wollstonecraft’s personal investment in questions concerning women’s (inclusive of her own) mental health.\(^{166}\) The narrative begins with the eponymous heroine imprisoned by her estranged husband in a madhouse or “mansion of despair,” where, on the significant pretence that she suffers from a “hereditary” malady, she is only accessible to “the

\(^{165}\) Wollstonecraft, *A Vindication of the Rights of Woman*: “It is acknowledged that they spend many of their earliest years acquiring a smattering of accomplishments, but strength of body and mind are sacrificed to libertine notions of beauty, to the desire to get themselves settled by marriage—the only way women can rise in the world” (13).

physician appointed by her family.”

Dolan reads the episodic text as a variant emergent from Wollstonecraft’s earlier genre of didactic children’s literature, noting that “the portraits of women’s lives are not gracefully woven into the plot, but rather enter the narrative in encapsulated form.” Yet Wollstonecraft’s narrative form also calls to mind individual medical case studies such as those offered in the Ladies Dispensatory or in other eighteenth-century medical texts. While Wollstonecraft focuses primarily on the literary, medical, and legal treatments of Maria, it is only by examining and considering the cases of other women that the protagonist comes to understand her own situation. As I have suggested, case histories extant from the eighteenth and nineteenth centuries show doctors spending vast amounts of time learning, documenting, and comparing patients’ medical histories in order to determine the best course of action for a patient’s future. Some of the “cases” mentioned by the narrator in Maria can be compared with the prose of the Dispensatory, which cautions that hysterical disorders in general “seldom endanger life; but in those who abound with humours, and whose habit of body is over-charged, they prove more violent than in thin constitutions.” The Dispensatory, in fact, insists upon offering “prescriptions of every kind, and suited to all habits, ... for, ... there is no other way of proceeding with safety, and proper hopes of success, whatever mistaken people may imagine, who depend on universal medicines.” And Thomas Beddoes maintained that “to observe well and to connect well the phaenomena occurring in a single case only, may be followed by the effect of saving many lives.”

Maria’s

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169 Ladies Dispensatory, 74, 78.
170 Beddoes, Contributions to Physical and Medical Knowledge (Bristol, 1799), 15.
hospital setting alone encourages a broader reading of this text not only as autobiographical fiction, but also as a series of medical case studies presented as Maria comes to know the inmates kept alongside her. The women who inhabit this text are subjects of both medical and literary treatments as Wollstonecraft works to understand, diagnose, and prescribe for women’s nervous disorders.

In *Maria*, unlike the bodily ailments of Ann or Mary’s languid mother in *Mary*, the symptoms of excessive sensibility manifest themselves primarily as disturbances to women’s mental health. In *Mary*, the heroine is able to enjoy the benefits of her refined sensibility via literary production, musical appreciation, and spirituality. Mary, in fact, lauds sensibility as “the foundation of all our happiness,” and cites “this quickness, this delicacy of feeling” as that which enables her to “relish the sublime touches of the poet, and the painter” (43). *Maria*, however, is generally read as a fictionalization of Wollstonecraft’s *Vindications of the Rights of Woman*. By the time of the *Vindications* Wollstonecraft has come to lament that women’s “senses are inflamed, and their understandings neglected[;] consequently they become the prey of their senses, delicately termed sensibility, and are blown about by every momentary gust of feeling.”

Thus in *Maria*, Wollstonecraft illustrates the potentially hazardous consequences of female sensibility, both on an individual and a social level.

Wollstonecraft employs the larger narratives of Maria and her caretaker Jemima, as well as the smaller stories—case histories—of several minor characters in the novel to illustrate the multiplicity and the inevitability of the ills confronting women. Unlike *Mary, a Fiction* in which a healthy heroine is at least a possibility, the complete title,

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Maria, or, the Wrongs of Woman, signals the author’s disillusioned admission that women’s health (both physical and mental, but especially the latter) will continue to suffer as long as women are not permitted to diagnose and treat themselves, and as long as they continue to “learn” habits which predispose them to illness. As noted above, conspicuous tensions were produced by doctors urging the possibility of prophylactics and self-diagnosis while simultaneously asserting their own continued relevance and authority. The point Wollstonecraft illustrates in Maria is that though women are often capable of understanding and articulating their own diagnoses, very little change can be effected in a social context which instructs women on how to be patient(s), and which produces and applauds fiction continuing that instruction. Imprisoned in the madhouse, separated from her infant daughter, Maria “mourned for her child, lamented she was a daughter, and anticipated the aggravated ills of life that her sex rendered almost inevitable” (61). Her anguish at the separation from her child is heightened by the child’s gender, and her anticipation of “aggravated ills” suggests any number of noxious, harmful evils that may await a young girl lacking a wise mother’s care.

In the novel’s preface, Wollstonecraft notes that she seeks to “pourtray passions” rather than “manners” (prelims). According to John Leake’s Medical Instructions for women, the passions are “the very Elements of Life; but when perverted, or erring in extremes, become destructive to its existence. Thus ... Hope may be exalted into Enthusiasm little short of Madness; and excessive Fear may sink into despair.”172 As was often done by physicians, Leake here pathologizes women’s emotions, asserting that in extreme situations, even sentiment can pose a threat to a woman’s life. As Beddoes

172 Leake, Medical Instructions, 359-60.
reminds us, the passions and the nerves were thought to be intimately, if ambiguously, connected with each other: “the passions of the mind have no less power to deprive the nerves of their properties” than any other entity such as alcohol, a sedentary lifestyle, et cetera.\textsuperscript{173} Maria, Wollstonecraft’s most “feeling” heroine, is confined in a madhouse and it is her position there, alongside others with violent passions and disturbed fancies, that enables Wollstonecraft’s most trenchant critique of gendered social systems of authority. Leake argues in \textit{Medical Instructions} that for women, “So long as the fine, membranous covering of the nerves is sufficiently compact, they will remain in a sound state, but ... when from \textit{any cause} it loses its natural firmness, then the marrow or sensitive part of the nerves, being as it were thinly clothed and exposed, will feel, too strongly, such impressions as are made on the body or mind.”\textsuperscript{174} In \textit{Maria}, Wollstonecraft enumerates the very causes which lead women to “feel too strongly” and suffer adversely, or, as in certain other cases, in order to protect themselves, to develop the equally unnatural habit of not feeling at all.

As noted, nervous disorders were believed to emerge from and impact both the body and mind, and the more impressionable the nerves, the greater the impact the “passions” would have on one’s bodily and mental health. The undeniable resemblances between the other occupants of the madhouse and the novel’s heroine are therefore quite significant. We are told a short way into the novel, as Maria awakes to find herself a prisoner, that “one recollection with frightful velocity following another, threatened to fire her brain, and make her a fit companion for the [other] terrific inhabitants” (61). As she soon

\textsuperscript{173}Thomas Beddoes, \textit{Hygéia} (Bristol, 1802), 2:8, 131. See note 23 in the Introduction.
\textsuperscript{174}Leake, \textit{Medical Instructions}, 229, my emphasis.
learns, the melancholic and imbecile inmates are permitted to roam freely while others, the most “frantic,” are kept confined for, “so active was their imagination, that every new object which accidentally struck their senses, awoke to phrenzy their restless passions” (67). In the early stages of her imprisonment, Maria displays at various moments the same types of behaviour as the “melancholics” and those the most “frantic”: “Indulged sorrow, she perceived, must blunt or sharpen the faculties to the two opposite extremes; producing stupidity, the moping melancholy of indolence; or the restless activity of a disturbed imagination. She sunk into one state, after being fatigued by the other” (64). She later turns to reading to “escape from sorrow, and the feverish dreams of ideal wretchedness or felicity, which equally weaken the intoxicated sensibility;” but often the stories themselves lead her imagination to “conjure up and embody ... various phantoms of misery” (66, 65). Wollstonecraft, we know, deplored fiction that portrayed women as frail and “ductile.” That Maria’s imagination becomes inflamed by fiction illustrates both that her mind has not been trained in more serious subjects, and that there is very little “healthy” fiction available for her consumption.

Maria’s reading throughout the novel is by no means an innocent activity, and provides an ideal opportunity for Wollstonecraft to emphasize the importance, and yet relative scarcity, of healthy literary models of both femininity and masculinity. Maria borrows a fellow inmate’s copy of Rousseau’s Julie, or the New Heloïse, and subsequently comes to read the inmate himself, Darnford, as the embodiment of Rousseau’s hero, St. Preux. The choice of text here is key; as Nicola Watson points out, “Even the most passing allusion to Rousseau’s Julie might operate as shorthand for

175 See note 78, above.
anxieties of female sexuality, national identity, and class mobility.” The dangers of this type of reading are palpable for an imagination so easily affected; Maria bestows upon Darnford “all St. Preux’s sentiments and feelings, culled to gratify her own” (71). The narrator explains:

If reveries are cherished, as is too frequently the case with women, when experience ought to have taught them in what human happiness consists, they become as useless as they are wretched. Besides, their pains and pleasures are so dependent on outward circumstances, on the objects of their affections, that they seldom act from the impulse of a nerved mind, able to choose its own pursuits. (77-8)

Wollstonecraft suggests here that a “nerved mind,” without the benefits of a healthy education, is likely to persist in constructing narratives without any basis in reason or rationality. Women’s habits have been so corrupted that they are unable to act directly on what might otherwise be healthy “impulses.” Cora Kaplan rightly argues that Wollstonecraft’s strategy was to “accept Rousseau’s description of adult women as suffused in sensuality, but to ascribe this unhappy state of things to culture rather than nature.” Her earlier protagonist Mary very deliberately chooses to “study authors whose works were addressed to the understanding. This liking taught her to arrange her thoughts, and argue with herself, even when under the influence of the most violent passions” (14). Maria, however, lacks such texts to study, and consequently is wanting in self-discipline. Through Maria’s history as a reader, Wollstonecraft demonstrates the need for reading material to begin offering healthier life lessons, and the importance of

176 Watson, Revolution and the Form of the British Novel, 4.
women developing more knowing techniques for reading. She herself had already offered didactic works for children with the staunch Mrs. Mason to instruct; and *Mary* was an effort to produce a new kind of literature to demonstrate that reading fiction in itself was not an unhealthy act.\(^{178}\)

Mary and the patient who occupies the room beside her share a moment illustrating the fluid boundaries between sanity and insanity, ordered and disordered nerves. Maria hears the “lovely maniac” singing the ballad of old Robin Gray, a song lamenting the misfortunes of a woman forced to marry an old man to support her family. For a moment, the two characters, Maria and the madwoman, seem to merge into one:

“Jemima had half-opened the door, when she distinguished her voice, and Maria stood close to it, scarcely daring to respire, lest a modulation should escape her, so exquisitely sweet, so passionately wild.” While the most obvious meaning here suggests that Maria does not wish to miss a moment of the woman’s singing; another reading might imply that she seeks to prevent a similar expression or utterance from escaping her own lips. Maria’s imagination has her poised on the brink of delusion or fancy as “she began with sympathy to pourtray to herself another victim,” when the other woman abruptly erupts into a fit of maniacal laughter and the moment is broken. Maria retires to her room and inquires into the woman’s history. Her keeper, Jemima, informs her that the woman “had been married, against her inclination, to a rich old man, extremely jealous ... and that, in consequence of his treatment, or something which hung on her mind, she had, during her first lying-in, lost her senses” (70). While post-partum depression is implied, it is also the

\(^{178}\) The tragic irony of Godwin’s preface to his volume of her posthumous works of course has been oft-cited; his declaration that Volume three contained, for example, the “finest examples of the language of sentiment and passion ever presented to the world,” certainly undermined her didactic intentions for many, many years (2: prelims).
loaded idea of “treatment”—with all of its implications, medical, physical, and otherwise—at the hands of her husband which leads to her insanity. The narrator notes: “What a subject of meditation—even to the very confines of madness.” Even in contemplating her neighbour’s situation, Maria puts at risk her own mental health. As the “poor maniac’s strain was still breathing on her ear, and sinking into her very soul,” Maria laments, “‘Woman, fragile flower! Why were you suffered to adorn a world exposed to the inroad of such stormy elements?’” (70). Just as Wollstonecraft’s melancholy burdened her with difficult symptoms but endowed her with creative genius, Maria’s very impressionability, sensitivity, and sympathy are what render her simultaneously heroic and vulnerable.

There are moments in the narrative when both the readers and other characters, especially Jemima, question Maria’s narrative reliability, that is to say, the degree to which the narratives she constructs about herself are credible. Wollstonecraft ensures that it will be up to the novel’s reader to determine, assess, or diagnose the degree to which Maria’s narrative is to be trusted. Jemima is told, for instance, by the physician, that Maria’s “malady was hereditary, and the fits not occurring but at very long and irregular intervals, she must be carefully watched; for the length of these lucid periods only rendered her more mischievous, when any vexation or caprice brought on the paroxysm of phrensy” (63). While she does not credit the physician’s report, Jemima, who briefly focalizes the narrative, is wary of trusting Maria too implicitly for, “the very energy of Maria’s character made her suspect that the extraordinary animation she perceived might be the effect of madness” (66). Wollstonecraft’s language used here to describe Maria and her thought processes echoes that used to describe the other inmates of the asylum.
In Maria’s initial assessment of Darnford, for example, we are told that Maria is belied by “fancy, treacherous fancy”; and in other instances that she must turn to writing to help soothe what she recognizes as her own “feverish fancy” (68, 73). The reader never doubts Maria’s sanity, in part because we are allowed access to inner dialogic, diagnostic techniques, and we come to understand, alongside her, the causes productive of her own, and other women’s conditions.

We are, however, at times led to question her judgment. Elizabeth Dolan, for instance, sees the heroine’s embroilment with Darnford, particularly her imposition of heroic attributes on an otherwise imperfect character, as Wollstonecraft’s warning about the “dangers of seeing sentimentally.” The Darnford narrative can be read as a misdiagnosis on Maria’s part, thanks largely to her improper education. Dolan continues: “Showing not just the disease of sentimentalism but also the cure, Wollstonecraft dramatizes for readers Maria’s movement from seeing the sentimental subject (herself) to seeing the social context.”179 In other words, Maria’s growing ability to see others more clearly—particularly from an elevated, authoritative, and possibly medical perspective—and to understand the role her daughter will come to occupy in society, is what distinguishes her from her neighbours who are trapped alone inside their diseased fancies and imaginations.

Maria’s perception and awareness of her physical and emotional state prevent her from lapsing into madness, and assure the reader of her sound mind. Her consciousness of the precariousness and fragility of health, of the fine line between sanity and insanity,

assures the reader of her narrative reliability, and, though to a far lesser extent than Mary, grants her some prescriptive authority. In surveying her fellow inmates she comments:

The view of what has been done by man, produces a melancholy, yet aggrandizing, sense of what remains to be achieved by human intellect; but a mental convulsion, which, like the devastation of an earthquake, throws all the elements of thought and imagination into confusion, makes contemplation giddy, and we fearfully ask on what ground we ourselves stand. (67)

The earthquake metaphor invokes the tremors and quakings of nerves, the very same afflictions with which Wollstonecraft was diagnosed. Comparing the passage above with Leake’s description of this class of illness: “Those disorders may be deemed nervous, where from an original fault, or infirm texture of the nerves, they become disagreeably affected by such slender causes as would not produce the like sensations in others, whose nerves were in a natural state.” Maria is aware of her own excessive sensibility and precarious state. Peter Logan unreservedly reads her as a nervous narrator, and the “distinguishing feature of the nervous body,” he explains—its high “responsive[ness] to cultural conditions”—was what “made it particularly useful for social criticism.” Indeed Wollstonecraft offers Maria as an example of how the nervous disorders of women need to be more appropriately “treated,” or, in the spirit of didactic literature and prophylactic medicine, how they might be avoided altogether.

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180 Leake, Medical Instructions, 230.
181 Logan, Nerves and Narratives, 45, 6.
Wollstonecraft’s explanation in the Preface to the novel, that this “history ought rather to be considered, as of woman, than of an individual,” suggests that Maria’s case can be understood as typical (59). The treatment that Wollstonecraft will recommend for nervous disorders such as Maria’s is therefore not unique to her situation; it is prophylactic, and is intended to first work on Maria’s daughter, and then on future generations of women. John Leake’s statement quoted earlier is worth repeating: “Whoever purposes to … cure Nervous or Hysteric Disorders, must do it by general means, which uniformly and permanently act on the general habit of body; and not by directing a new medicine for every new symptom, which … can only produce a momentary relief, but will never effect such a change of constitution as to end in a lasting cure.”

182 Using Maria, Wollstonecraft illustrates that treatment lies in changing the habits and early education of women in order to effect more permanent alterations. Maria makes clear the importance of implementing preventative measures to protect women’s health, through improvements to education, on both an individual and social level. 183

Mary is Wollstonecraft’s heroine who can exist “without arguing physically about possibilities.” She is endowed with greater physical, mental, and emotional fortitude than had previously been allotted to most female literary heroines. In Maria, however, Wollstonecraft presents a different type of heroine. She writes: “In many works of this species, the hero is allowed to be mortal, and to become wise and virtuous as well as

182 Leake, Medical Instructions, 254.
183 The particular remedies offered are given in more detail in the second Vindication, as well as in her earlier didactic texts where Wollstonecraft proposes specific methods to make women healthier and hardier. Mitzi Myers agrees: “Just as, in Mary, she takes the romantic narrative of self-education or self-invention and forms it about the growth of a heroine’s mind, so in the stories she converts another mutating genre—children’s literature—into a woman’s form, displacing the male tutors of Rousseau and Thomas Day with her female mentor, Mrs. Mason” ("Pedagogy as Self-Instruction," 210).
happy, by a train of events and circumstances. The heroines, on the contrary, are to be born immaculate; and to act like goddesses of wisdom, just come forth highly finished Minervas from the head of Jove” (59). Maria is a decided departure from both the knowledge and the traditional virginity associated with the goddess of wisdom. Maria feels sensually, nervously, and emotionally, and thus her strengths and weaknesses paradoxically emerge from the same visceral forces.

Extreme sensibility leaves women such as Maria and her maniacal neighbour vulnerable to illness, or alternatively, forces others, particularly those emergent from the lower classes, to over-compensate and protect themselves, in so doing disabling or even deadening not only their sensibility, but also the very qualities which supposedly render a woman feminine. Alongside Maria’s narrative, Jemima’s story illustrates the degree to which women of all social classes ought to avoid being overly sensitive. To protect herself, Jemima attempts to deny all forms of feeling; the result of this denial of sensibility amounts to an equivalent reduction in the depiction of her femininity. The narrator notes that Maria’s manner “made a slight suspicion dart into [Jemima’s] mind with corresponding sympathy, which ... the habit of banishing compunction, prevented her ... from examining” (63). As the reader comes to understand, Jemima has, out of necessity, developed habits which forestall what Wollstonecraft portrays as an otherwise natural sympathy. The nurse who cares for Jemima in her youth had also been similarly hardened: “Poverty, and the habit of seeing children die off her hands, had so hardened her heart, that the office of a mother did not awaken the tenderness of a woman” (80). The case histories included in the text suggest that, if unable to develop such hardened habits, women will eventually succumb to mental illness—insanity, anxiety, and
depression. Jemima’s mother, for instance, “grieved to the soul by ... neglect and unkind treatment, actually resolved to famish herself” (80). Similarly, a young, pregnant woman whom Jemima deprives of a home drowns herself with “desperate resolution” in a horse’s watering trough (89). Maria and her neighbouring inmate represent the opposite end of the spectrum from Jemima and her nurse. They suffer from nerves which damage their fragile mental health.

Through its emphasis on nervous disorders, eighteenth-century medicine continually pathologized the very biological composition of the female body. In *Maria*, Wollstonecraft admits to the existence of the nervous female body, but argues that neither the nervous body nor that which is overly hardened, or insensible, is woman’s “natural” state. Wollstonecraft agrees with physicians on the connection between body and mind; what she proposes, however, is that with an improved education, the body and mind can learn new, healthier habits. The process, she acknowledges, must be gradual. She argues in *Maria* that women are seldom able to act from the “impulse of a nerved mind”; instead their pains and pleasures are dependent on “outward circumstances.” The “cure” as Wollstonecraft offers it, is therefore not intended to save Maria, for she, we are told in an oft-quoted line, “appeared, like a large proportion of her sex, only born to feel; and the activity of her well-proportioned, and even almost voluptuous figure, inspired the idea of strength of mind, rather than of body” (77). It is too late to effect changes to Maria’s constitution. “Born to feel” suggests a predisposition to sensibility; and while Maria does demonstrate a marked strength of mind, throughout the text she is confined by her ultra-feminine corporeality. Images of

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her “burning bosom—a bosom burning with the nutriment for which [her] cherished child might now be pining in vain” emphasize the corporeal suffering of the female, particularly the maternal, body (61). By arranging for Maria to address her narrative to her infant daughter, Wollstonecraft implies that the remedy for women must be effected via preventative practices offered to and worked upon future generations of women. Wollstonecraft therefore urges women to develop and refine their understandings of their own physicality, recognizing that only through education could the habits of women be changed.

Maria particularly laments her absence from her daughter because she is prevented from preparing “her [child’s] body and mind to encounter the ills which await her sex” (92). She resolves to join forces with Jemima, in a maternal collaboration to offer her daughter a healthier education. Maria pleads with Jemima: “With your heart, and such dreadful experience, can you lend your aid to deprive my babe of a mother’s tenderness, a mother’s care? .... Let me but give her an education ... and I will teach her to consider you as her second mother” (Ibid.). While in Mary Wollstonecraft allowed herself to imagine a heroine whose body could, of its own strength, resist inscription, in Maria as in the Vindication, she intimates that this process of bodily change must be both gradual and learned, in order for it to become inherited and later inherent. Wollstonecraft sees an equalizing potential in human biology, illustrating the claim of her contemporary, physician John Brown: “Instead of the infinite difference of habits and temperaments, I have found every individual precisely the same as every other. Whatever produces [a
disease] in one, will produce it in another, prepared to receive its influence.” Sha concludes, “For Wollstonecraft, female nerves are not ontologically different than men’s. ... [W]omen do not have weaker nerves; rather, their nerves are insistently ‘enervated’” by a number of cultural culprits. He goes on, “Her preference for the verbal form—enervate—rather than the noun, nerves, deftly transforms any biological ground into cultural process.” Culture is changeable, often reflecting learned habits and tastes; Wollstonecraft thus seeks to teach women hardier, less feeling habits.

Maria’s sensibility is such that she seemed “only born to feel.” Within the novel Wollstonecraft goes to great lengths to illustrate the near impossibility of a woman feeling and not suffering, either mentally or physically. Such is her denunciation of the education (medical and otherwise) which has gradually sickened or poisoned women’s habit(s). In beginning a narrative addressed to her daughter then Maria attempts to begin a process of enlightenment and education:

The events of her past life pressing on her, she resolved circumstantially to relate them, with the sentiments that experience, and more matured reason, would naturally suggest.—They might perhaps instruct her daughter, and shield her from the misery, the tyranny, her mother knew not how to avoid. (66)

Maria’s resolution recalls Mary’s earlier determination to assume a knowledgeable and therefore “authoritative” role, implying determination, authorship and the creation of a narrative. Maria’s “circumstantial” narration is crucial, as it undertakes to clarify the confusion that could arise around cause, effect, and subsequent diagnosis. The narrative

185 John Brown, Elements of Medicine (Philadelphia, 1790), 166. Originally published as Elementa Medicinae in 1780; Brown translated the text into English in 1787.
186 Sha, Perverse Romanticism, 91.
she offers to her daughter promises to challenge the constitution of both individual women and the society in which they live, rallying against the “portion of the misery” which society “seems to have entailed” on all women. Maria instructs her daughter: “True sensibility, the sensibility which is the auxiliary of virtue, and the soul of genius, is in society so occupied with the feelings of others, as scarcely to regard its own sensations” (94, 130). While this may be read as an apparent contradiction of her aspirations for women to be free from the confines of sensibility, I read it as an urging for society to permit women to shed their culturally imposed habits of excessive feeling and nervous sensibility. Such an imperative lends urgency to Maria’s efforts, “gave life to her diction, her soul flowed into it” and she begins her memoirs with counsel: “Gain experience—ah! Gain it—while experience is worth having, and acquire sufficient fortitude to pursue your own happiness. ... For my sake, warned by my example, always appear what you are, and you will not pass through existence without enjoying its genuine blessings” (95). The imperative to “appear what you are” urges once again, the dismissal of false sensibility.

In his Advice to Mothers, William Buchan revealed the bizarre intermingling of education, medicine, and gender:

If a young man be intended for the army or navy, he is sent to the academy to be instructed in those branches of science which are deemed necessary. ... But a young woman, who has got a more difficult part to act, has no such opportunity afforded her. She is supposed to require no previous course of training,—to need no assistance but that of nature, to fit her for the discharge of her duties when she comes to be a mother. Did she live in a state of nature, that idea would not be far wrong, but, in society, every thing is artificial, and must be learned as an art. (83)
In this extremely popular medical text, Buchan makes clear medicine’s supporting role in teaching gender. Both men and women have “part[s] to act” within a social space where “every thing is artificial.” Women’s bodily conduct must therefore be “learned as an art.” In her writing, Wollstonecraft seeks to refine the messages offered—the important lesson is that gendered behaviour is learned, and can therefore be altered. Wollstonecraft frames Maria’s text as a cautionary tale, one intended to improve the habit(s)—reading, bodily, and cognitive—of her daughter, and the daughters of those to come. In enabling the case studies of several women to emerge within the span of the fragmentary novel, Wollstonecraft works to provide more instructive, if somewhat heavy-handed, fiction for female readers.

**Wollstonecraft’s Treatment and Textual Authority**

Wollstonecraft was aware of the difficult reception Maria was likely to face. The question of authority is raised throughout the text, beginning on the novel’s first page. She prefaces the work by defending herself and arguing that the novel is “not the abortion of a distempered fancy or the strong delineations of a wounded heart” (prelims.). Claudia Johnson’s reading is attuned to the significance of this statement: the text’s preface, she argues, “links it to the female body while refusing its pathology: this novel about women’s wrongs is *not* ‘an abortion of distempered fancy’ or the ravings of a ‘wounded heart’, but it does emanate from the specificity of womanhood.”\(^{187}\) Towards the novel’s end Maria articulates a defence of her conduct when Darnford is brought to

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trial on charges of adultery and seduction. She speaks in court “in earnest to insist on the privilege of her nature. The sarcasms of society, and the condemnation of a mistaken world, were nothing to her, compared with acting contrary to those feelings which were the foundation of her principles” (142). Despite the fact that Maria clearly attributes her conduct to the very sensibility so sought after in women, Wollstonecraft illustrates the extent to which her claims are found to be without authority, and ultimately ineffectual. In rendering the verdict the trial judge alludes to the “‘fallacy of letting women plead their feelings, as an excuse’” (145). Wollstonecraft here demonstrates the challenges arising from women’s emotional education; society encourages sensibility and “feeling” in women but then refuses to officially sanction the very habits they have instilled. The narration of both Maria and Jemima’s stories within the confines of a mental hospital, and later within a court of law, represents the voices of women against unchallengeable, and perhaps, unchangeable social authorities (namely medicine and law), and further asserts the value of the “case.” The judge presiding at Maria’s trial acts as both legal and medical authority as he decides that the “the conduct of the lady did not appear that of a person of sane mind” (Ibid.). With the delivery of this verdict, Wollstonecraft illustrates the effects produced by a society which lends little or no authority to women’s reading/diagnosis and narratives/prescriptions.

The impact of William Godwin’s *Memoirs of the Author of ‘The Rights of Woman,’* published the year following his wife’s death, has been well documented. Cora Kaplan dubs it the “book which undid her influence and reputation for almost a
century.”188 Godwin recalled Wollstonecraft “composing with rapidity” *The Vindication*, and described her as vehement, impetuous, contemptuous, and intemperate. He described her fits of “torpor and indolence” and concluded that she was “endowed with the most exquisite and delicious sensibility,” with a mind of almost “too fine a texture to encounter the vicissitudes of human affairs.”189 Such a description could not help but undo any claims to legitimacy and authority Wollstonecraft may have established for herself and her writings during her life.

As I have shown here, however, Wollstonecraft was deeply immersed in physiognomic, humoral, and neurological theory. She sought, via her didactic and fictional writings, to leave practical lessons for her readers (especially women), instructing them that they need not necessarily remain creatures of habit, or, perhaps more accurately, creatures confined by the habits of society and culture more broadly. Her early fiction offered somewhat programmatic illustrations of medical theory. Yet, as she delved more deeply into less didactic prose, something more exploratory and troubled began to emerge. In part, the difficulty lay in creating in fiction what she herself was not in life—a healthy woman of sensibility. Arguably, her success might have been undermined by her own unwavering, masochistic commitment to her project, as she was never able to separate her own story, her narrative, from those of her heroines. Unable to work through her own narrative, she was unable to explore the healing possibilities of fiction that Austen would later more fully realize. In the meantime, however, her desire

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to see a change in fiction, and her programmatic lessons, undoubtedly contributed to the discourses and methods of her friend and colleague, Mary Hays.
Ch. 2: Textual Remedies:

Diagnostic Memories in Mary Hays’ Memoirs of Emma Courtney

Introduction:

In 1796 the reviewer for the Monthly Magazine declared Mary Hays’ novel Memoirs of Emma Courtney to have been written “to show the danger of indulging extreme sensibility.”¹⁹⁰ Scholarly discussions of Hays’ work, however, have generally overlooked her treatment of her heroine’s afflictions, and the protagonist’s treatment of the afflictions of those around her—treatments both literary and medical. Hays is usually credited only with using the sentimental novel’s “standard conventions—acute sensibility, the distressed heroine, exhibitions of pathos, a plot of sudden reversal—as a medium for her feminist dialectics.”¹⁹¹ In fact, Hays’ “feminist dialectics” actually consist of a complex of discourses: philosophic, scientific, didactic, and political, and while certainly proto-feminist, should not be read only in this light. Throughout Memoirs of Emma Courtney, Hays employs a very specific type of rhetoric—one resonant with late eighteenth-century medical practices, dialogues, and treatments; one which was newly offered by the medical establishment, and gradually taking hold in the popular imagination at that time.

Memoirs of Emma Courtney tells the story of the eponymous heroine’s seemingly unrequited love for Augustus Harley; and more generally, the narrative maintains a

¹⁹¹ Eleanor Ty, Unsex’d Revolutionaries: Five Women Novelists of the 1790s (Toronto: University of Toronto Press, 1993), 43.
subtle but persistent interest in the health and treatment of women’s minds and bodies. Influential studies by Peter Melville Logan and Tilottama Rajan have begun the work of examining these treatments. Logan notes that Hays presents women’s “social condition” very generally as a “distemper,” and he argues that *Emma Courtney* illustrates “how late Georgian social conditions create a psychology unique to women that results in a debilitating form of romantic love.” “Hays’ representations of excess sensibility,” he continues, construct “female sexuality as a diseased product of women’s social condition.” ¹⁹² As Logan suggests, Hays indisputably depicts women’s sensibility as an affliction requiring treatment. What warrants further attention, however, is not only the verdict that Hays reaches—that the social body is diseased; that its symptoms have significant degenerative effects on women’s minds and bodies; and that it requires treatment—but also the narrative process through which she arrives at it. Using the form and logic of the medical case, Hays is able to articulate how women come to be afflicted and, subsequently, how such disorders might be prevented in the future.

Tilottama Rajan offers a valuable reading of Hays’ text as “autonarration,” which she defines as a narrative in which writers bring details from their personal lives into their texts, speaking in a voice that is recognizably their own or through a persona whose relation to the biographical author is obvious. Rajan suggests that for Mary Hays, the “transposition of personal experience into fiction recognizes that experience as discursively constructed.” ¹⁹³ Rajan’s reading of Hays’ text opens up multiple

¹⁹³ Tilottama Rajan, “Autonarration and Genotext in Mary Hays’ *Memoirs of Emma Courtney,*” *Studies in Romanticism* 32.2 (Summer 1993), 149, 159. Rajan’s concept of autonarrative is distinct from autobiography. She explains that the autonarrative works to locate ideology within a fictional rewriting of
possibilities for discursive analysis of the *Memoirs*. A decidedly medical strain is perceptible throughout the text if, as suggested in my introduction, we understand medicine to suggest an unstable field of inquiry during the eighteenth century comprising natural and moral philosophy, physic, surgery, pharmacy, anatomy, chemistry, and physiology—both then and now, concerned with the prevention, diagnosis, and treatment of mental and physical disorders. By employing the features I mentioned earlier, medical rhetoric and, more particularly, the diagnostic logic of the case history, Hays works to diagnose her own condition, social and biological, as well as those of women more broadly. Her use of this form and logic stands as another example of how late eighteenth-century novels by women engage the form of medical case histories, though Hays, like Wollstonecraft, is also somewhat stymied by her inability to separate her life and her fiction.

In attempting to diagnose her social and biological condition, Hays creates a narrative that is at once a recollection and an interrogation of her life’s events. It is the form of the narrative—particularly its chronology and structure, as well as its epistolary features—that enables her retrospective analysis. The bulk of *Memoirs* comprises detailed depictions of the eponymous protagonist’s mental, physical, and emotional sufferings; thus the assessment, diagnosis, and subsequent treatment of her condition, by herself and by others, must be considered as a significant aspect of Hays’ project. Other

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personal experience. The deliberate placing of the self within socially-constructed discourses of gender, class, etc. is what characterizes autonarration (i.e. the emphasis is on the way in which the self is constructed). While autobiography is a genre which typically purports to depict a life or character, Rajan suggests that autonarration “is written as a fictional narrative,” thus “consciously rais[ing] the question of the relationship between experience and its narrativization” (160). Hays’ *Memoirs of Emma Courtney* raises these questions particularly through its epistolary framing, as well as the narrator’s letters interspersed throughout the text, addressed exclusively to male recipients.
characters in the novel also undergo the narrating protagonist’s careful examination throughout the text. They suffer from an impressive list of physical and mental afflictions including internal disorders, jaundice, infirm and debilitated constitutions, internal mortifications, apoplectic fits, a broken leg, haemorrhaging, depression, morbid humours, contusions, a twice-ruptured blood-vessel, and bilious, nervous, and remitting fevers. Emma assesses and diagnoses many of these conditions and finally, in all but title, becomes a practicing physician by the end of the work. While scholars have remarked upon this fact in passing, it has been given little serious consideration.

Hays has Emma arrive at her diagnostic conclusions through narrative, through a rational consideration of cause and effect; and the text examines not only her personal condition, but also diagnoses and prescribes for the ills that plague the social body more generally. Hays’ decision to cast her heroine—and thus herself—as a physician illustrates her investment in determining exactly who has the authority to examine, diagnose, and prescribe for the general condition of women.194 The validity of Emma’s diagnoses is heightened by Hays’ deliberate doubling of Emma and her husband, Montague. Both are emotionally-charged, temperamental characters; both are practicing physicians; the husband, however, rashly kills himself near the novel’s end after harming several people, while his wife lives a long life, treating and caring for others.

Mary Hays and her “Mind’s Physician,” William Godwin

There are two reasons to begin an examination of *Emma Courtney* with a reconstruction of the novel’s compositional history. First, it is important to establish the chronology of the epistolary exchange between Mary Hays and William Godwin that led to the production of the novel itself—Godwin suggested the composition of the narrative, but its completion and publication occurred as the relationship between the two became strained and finally ended. Secondly, their letters reveal the use of medical designations and rhetoric. As close reading of both their correspondence and of *Emma Courtney* illustrates, Hays begins her writing as a therapeutic activity, casting Godwin as her supervising physician. As she progresses, however, she becomes aware that she and Godwin disagree, if not on the nature of her condition, at least on how it should be treated. While Godwin maintains that her affliction can be remedied through reason and philosophy, Hays argues the impossibility of changing habits that are so inveterate as to be corporeal, particularly within an endemic social system. She therefore writes against what she perceives to be an incomplete or improper prescription on Godwin’s part. To do so credibly and persuasively, she creates an authoritative fictionalized version of herself, effectively becoming her own physician. In other words, through the fictional character of Emma Courtney, Mary Hays rejects Godwin’s prescription (as it is voiced through the novel’s Mr. Francis), and is then able to articulate a second opinion—an alternate diagnosis for herself and a prescription for society.

Hays’ *Memoirs of Emma Courtney* must be read in light of the author’s life. As Julie Carlson notes in her study of the Godwin-Shelley circle (which for many years included Hays), for these authors, there is an “inseparability of biography and fiction,
Hays began composing the novel in 1795 at Godwin’s suggestion to help her work through her personal grief and melancholy following the termination of her relationship with Dissenter William Frend. Hays and Godwin maintained an odd friendship based on voluminous letters from Hays which generated short, terse responses from Godwin. These letters were interrupted by infrequent visits from Godwin to Hays. She had first contacted him as a fan of his literary and philosophical works, professing her admiration for his writings (particularly his *Enquiry Concerning Political Justice* and *Things as they Are; or, The Adventures of Caleb Williams*, published in 1793 and 1794 respectively); their subsequent correspondence suggests, however, that while they did develop a friendship of sorts, Hays always occupied a subordinate position. Mary Jacobus and Laura Mandell have read the Hays-Godwin relationship as one of psychoanalytic patient and therapist. Jacobus sees *Emma Courtney* as Hays’ “writing cure” and claims: “Hays’ letters to Godwin ... resemble the psychoanalytic encounter, in which the analyst’s reticence and self-control make possible the analysand’s self-disclosure and potential self-realization.” My own argument is supported by these readings of their relationship as psychologically therapeutic. As noted in Chapter One, during the late eighteenth century, the health of mind and body were perceived to be inextricable from one another. N. D. Jewson remarks that eighteenth-century pathology could be distinguished by “the absence of a sharp distinction between afflictions of the

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196 Mary Jacobus, *Psychoanalysis and the Scene of Reading* (Oxford: Oxford University Press, 1999), 214, 212. See also Laura Mandell’s essay, “The First Women (Psycho)analysts: or, the Friends of Feminist History,” *Modern Language Quarterly* 65.1 (March 2004), 69-92. Mandell also views the pair as analyst and analysand based on Hays’ candour, and the infrequency of Godwin’s visits and replies to Hays, which “corresponds to analytic neutrality” (81).
mind and of the body. Emotional temperament and physical disposition were believed to be closely related. The interaction between Hays and Godwin resembles both that of analysand and analyst and that of patient and doctor since Hays’ main point of concern in consulting Godwin is to have her disorders diagnosed and treated, and since during the eighteenth century, almost all disorders were treated by the same figure of medical authority.

Hays was interested in Godwin’s moral philosophy, and in particular, she seemed to appreciate his connecting of sound moral principles and good health. In his study on Samuel Johnson, John Wiltshire discusses the long-established connection between medicine and moral philosophy: “physic of the mind,” he notes, is a “traditional metaphor of moral philosophy. It is connected with the very origin of ethics which was a discipline modelled on medicine.” Indeed the metaphorical connection of flawed or corrupt philosophy with ill health and disease—on both personal and social levels—can be traced back through from the philosophers of Ancient Greece to the thinkers of the

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198 I am eliding the distinction between apothecaries, surgeons, and physicians in order to suggest that there was no distinction made in the kind of practitioner who treated mental and physical disorders. Both were incorporated in the practice of physic.


eighteenth century. Johnson, borrowing from Seneca, explains the palliative effects of philosophical thinking: “the antidotes with which philosophy has medicated the cup of life, though they cannot give it salubrity and sweetness, have at least allayed its bitterness and tempered its malignity; the balm which she drops on the wounds of the mind abates their pain, though it cannot heal them.” 200 Historian Charles Rosenberg notes that at this time, medical books for lay practitioners were found in two forms: pragmatic health manuals with recipes and medications, and works on “regimen and long life for the educated and leisured: as much moral philosophy as medical treatise.” 201 And while thinkers often portrayed philosophy as a balm or therapy, medical metaphors were also frequently used within works of moral philosophy.

Philosophical works concerned with examining the individual’s place within his or her society more generally were often invested in maintaining the health of the body politic, both on a literal and metaphorical level. Godwin claimed in Political Justice, for example, “man is in a state of perpetual mutation. He must either grow better or worse, either correct his habits or confirm them. … That which is today a considerable melioration, will at some future period, if preserved unaltered, appear a defect and disease in the body politic.” 202 Hays’ employment of medical rhetoric for her philosophical queries is therefore unsurprising.

Attention to her letters shows that Hays framed and understood her relationship with Godwin in several ways—as a relationship between teacher and student, brother and sister, parent and child, and, perhaps most frequently, as between doctor and patient. She initially proposes to be a “sister,” sharing with him “habits of strict friendship from a similarity of mind and principle.”203 She commits herself to studying and engaging with his works, and is particularly interested in his theories of causality in so far as they related to human—and literary—character. She praised Caleb Williams, Godwin’s novel in which the eponymous protagonist identifies himself as a “natural philosopher,” concerned with “tracing the variety of effects which might be produced from given causes.”204 As Godwin explained, causes—“antecedents” as he called them—would always produce particular effects (“consequents”) in political, social, and philosophical situations. In his discussion of “The Characters of Men” in Political Justice, Godwin claims:

An unknown cause is exceptionable, ... inasmuch as to multiply causes is contrary to the experienced operation of scientifical improvement. It is exceptionable, ... because its tendency is to break that train of antecedents and consequents of which the history of the universe is composed. It introduces an action apparently extraneous instead of imputing the nature of what follows to the properties of that which preceded. It bars the progress of enquiry by introducing that which is occult, mysterious, and incapable of further investigation.205

Causes can always be determined by following a “train of antecedents and consequents.”

The act of narrating such a chain of “natural events” can thus produce the “history of the

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205 Godwin, Political Justice, 1: 32.
universe.” It follows that since human “character” is determined through external impressions, for Godwin, one’s “character” should always be capable of improvement and change: “He that considers human life with an attentive eye, will not fail to remark that there is scarcely such a thing in character and principles, as an irremediable error.”

Hays shared this interest in the logic of causality, and began *Emma Courtney* with the intention of exploring the development of a woman’s character. She explains in the novel’s preface, “It has commonly been the business of fiction to portray characters, not as they really exist, but, as we are told, they ought to be—a sort of *ideal perfection*, in which nature and passion are melted away, and jarring attributes wonderfully combined.” Like Godwin with his “metaphysical dissecting knife,” Hays sought to portray a woman, as she “really exist[ed],” showing “things as they are.” Emma’s many errors, Hays explains, are “the offspring of sensibility” (36). That they are not easily remedied suggests Hays’ perception of the chain links in the “system” of social development as both confining and unbreakable.

Hays began studying Godwin’s work, and frequently made use of medical metaphors and analogies when seeking clarification as she grappled with what she dubbed his “system of intellectual … mechanism.” Where Godwin perceives social “evils,” for example, Hays refers to society as suffering from a “palsy” and as being in a “morbid state”; what Godwin terms “effects,” Hays equates with “symptoms.”

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207 In his account of the composition of *Caleb Williams* written in 1832, Godwin claimed to use such a tool. See Appendix II in the edition cited above, 339.
208 I will consider this term, “system” further, below.
209 Hays to William Godwin, 7 December, 1797, *The Correspondence*, 387.
210 Ibid, 385.
idiom produces a gradual slippage between the reasons for which she begins corresponding with Godwin—a greater degree of self-understanding arrived at via philosophical discourse—and what she finally seeks to gain from their correspondence: namely, a prescription and method of treatment to improve her personal condition. In her first letter to him she confesses to being “disgusted with the present constitutions of civil society,” but she adds that she has at last been “roused from a depression of spirits, at once melancholy & indignant” by the prospect of reading Godwin’s *Political Justice*. She goes on to describe to him her personal situation—living alone in lodgings—and explains, “having been disappointed in all my plans, having too much sensibility & too little fortitude to support the disappointment with equanimity, I was unwilling to sadden the declining age of a beloved parent ... by an habitual melancholy which I was unable to control.” Hays thus turned to Godwin in an attempt to understand the process that had led to this condition of “habitual melancholy”; for as she maintained, paraphrasing his own philosophy back to him, “every effect bespeaks an adequate cause!”

By 1794, the year in which they began corresponding, Hays had already experienced several traumas. Her hopes for marriage were ruined by the death of her

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211 Hays to William Godwin, 14 October, 1794, *The Correspondence*, 382. In this letter she writes to request a loan of his copy of *Political Justice* as it was too expensive for purchase, both by herself and by the circulating libraries she frequented.


213 Hays to William Godwin, May 6, 1795, *The Correspondence*, 391, 403. See Godwin’s *Political Justice*, for comparison: “Everything in the universe is linked and united together. No event, however minute and imperceptible, is barren of a train of consequences, however comparatively evanescent these consequences in some instances may be found.” Furthermore, according to Godwin, the mind consists of a “regular succession of phenomena, without any uncertainty of event, so that every consequent requires an antecedent, and could be no otherwise in any respect than as the antecedent determines it to be” ([*Political Justice*], 1: 42, 398-99). John P. Clark explains that Godwin’s “doctrine of necessity” mandated that “all the actions and thoughts of human beings are determined or occur according to law” (14). See John Clark, *The Philosophical Anarchism of William Godwin* (Princeton: Princeton University Press, 1977), 14, 40.
fiancé in 1780, when she was twenty years old. She later formed a friendship with William Frend that ended abruptly when he apparently rejected her romantic advances. She reportedly suffered further following his unexpected marriage some years later. Her letters reveal gradually worsening physical and mental symptoms which culminate in a breakdown following Frend’s marriage, shortly after she began corresponding with Godwin. Her symptoms, which worsened dramatically following Frend’s marriage, included a “depression of spirits,” “seasons of despondency,” weakness, fluttered spirits, an “exquisitely susceptible texture of nerves,” a “sickly” mind, “cold, morbid & phlegmatic sensations,” fevers, collected bile, disorder, and delirium, to name a few. Hays sought both philosophical and practical diagnoses. She had confidence in Godwin because of his methodologies: “It is because you are a philosopher that I can unfold my mind without reserve or apprehension: you are able to trace, & to investigate the sources of its disorders and its mistakes.” She employs a metaphor of dissection in expressing her wish to “unfold” her mind, to peel back the layers and reveal what lies beneath. The benefits of philosophical discourse were presumably to be twofold: in reviewing her personal history, she and Godwin might locate, and perhaps remove, the cause of her affliction; and second, but of equal importance, the very act of discourse would be beneficial, something of a “talking cure.” Laura Mandell suggests that “neurosis arises when for some reason a desire becomes inarticulable; neurotics cannot speak, because

214 Taken from selected letters in The Correspondence, 382, 391, 401, 403, 405, 438, 446, 454.
215 Hays to William Godwin, October 13, 1795, The Correspondence, 402. My emphasis added. Hays is anticipating both psychiatric and psychoanalytic practices in her desire for treatment of her “diseased” mind. See John Wiltshire’s discussion of Samuel Johnson’s writings in The Rambler in which Johnson “generates by metaphorical transference the role of psychological physician.” Wiltshire cites this as the “first time a writer ... addresses himself to the ills of the mind under the aegis of a metaphorical framework which legitimizes his activity as a form of therapeutics” (Samuel Johnson in the Medical World, 163).
they do not (consciously) know.”216 Hays explained to Godwin: “I have found in the exercise of my understanding the only means of stilling the importunate suggestions of a too exquisite sensibility.”217 She was able to find relief for the symptoms of her “exquisite sensibility” only through intellectual activity and discourse.

Thus Hays quickly and easily converts Godwin, the philosopher, into her “mind’s physician”—that is, she asks him to understand and articulate the workings of both her mind and body. She knew that in Caleb Williams he had delivered a “study and delineation” of the “existing constitution of society” through that novel’s abundance of trials, both personal and legal, which tested the constitutions of the text’s main characters.218 As noted earlier, “constitution” is a multivalent term; it can refer, for a start, to the way in which something is made up or comprised—hence Godwin’s literary trials to test his society’s mettle or composition. But “constitution” also signifies both a set of political principles and the “physical nature or character of the body in regard to healthiness, strength, vitality, etc.” 219 In turning to Godwin, Hays sought counsel on the nature of her personal constitution, and was undoubtedly aware of the ways in which this term could connect bodies to their environments and their societies.

Seeking a more profound understanding of her condition, Mary Hays comes to interact with Godwin as both her “mind’s physician” and her physician more generally. In this era of pre-psychiatry, the body-mind connection was thought to be so close, that

216 Mandell, “The First Woman (Psycho)analysts,” 90.
217 Hays to Williams Godwin, 7 December, 1794, The Correspondence, 387.
218 Godwin, Caleb Williams, 1.
treatment of one was usually attempted via treatment of the other. Physician William Rowley claimed, for instance, “It is easy to conceive the mind and body becoming reciprocally and alternately the cause and the effect; the effect and the cause of miserable sensations, bursting forth into violent passions.”

Thus while Hays requests help for her diseased mind, she is not necessarily making a distinction regarding the type of treatment she feels is needed: a healthy constitution requires health of both body and mind. Establishing a doctor-patient relationship between Godwin and herself seems to justify, for Hays, the length and intimate confessional tone of her letters. She writes, “I like your sincerity, &, to afford you a still greater proof of my own, I will give you a little farther insight into my character, though it will make yet more against me: but we cannot expect to have our disorders heal’d by the Physician, however skilful he may be, while we conceal any of their Symptoms.”

Hays here evinces an awareness of the possibilities, even the imperatives, of diagnosing through narrative. She is aware that, as the *Ladies Dispensatory* suggests, “words at length” are what enable a “true knowledge of indisposition,” but she does not yet see herself “able to cure it without applying” to a male figure of authority.

Kathryn Montgomery Hunter notes that physicians will take a patient’s opening story, “interrogate and expand it, all the while transmuting it into medical information. Sooner or later they will return it to the patient as a diagnosis, an interpretive retelling that points towards the story’s ending.”

Hays’ interaction with Godwin follows a similar trajectory. She recounts her symptoms at length, asking repeatedly for a diagnosis

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221 Hays to William Godwin, November 5, 1795, *The Correspondence*, 406.
223 Hunter, *Doctors’ Stories*, 5.
and even for prescriptions from Godwin.\footnote{Hays often treated herself, but more successfully with physical symptoms. She explains to Godwin in 1796, “I have been seriously ill, ... —the symptoms which I hinted, were the prelude to a fever, occasioned I believe by a collection of bile, which anxiety of mind has a tendency to generate in the constitution. Under this idea, I took medicines to remove the bile, their powerful operation convinced me, I was not mistaken. The disorder lay much in my head, & at one period a frightful confusion of thought made me very apprehensive of delirium. But the fever is now, I trust, entirely removed, & I feel only great debility—I am going to take some bark—(I have been my own physician, for I was formerly very injured by an ignorant apothecary)” \textit{(The Correspondence}, 454). In this instance she uses the narrative logic of the case, reading particular symptoms as signs (a “prelude”) of what will follow, and also displays the reason and rationality with which she later sought to imbue her heroine.} On May 10, 1795 she writes to him: “I shall in future, occasionally avail myself of your friendly invitation, & my bewildered mind shall seek from you, as its tutelary genius, a solution to the difficulties which entangle & the doubts which oppress it.”\footnote{Hays to William Godwin, 10 May, 1795, \textit{The Correspondence}, 393.} In November of the same year: “I have been much indisposed since I saw you, & being but little accustomed to bodily pain, bear it with a very ill grace. Nature (or circumstances) has given to me an exquisitely susceptible texture of nerves; both in mind & body I am alive to every passing event, the very air sometimes wounds me. ... These dispositions are too apt to generate selfishness, by absorbing us in our own feelings: I consider you as my mentor, teach me how to rectify them.”\footnote{Hays to William Godwin, 5 November, 1795, \textit{The Correspondence}, 405.} In her request for assistance she gradually casts herself as his medical apprentice as well as his patient—aspiring to learn from him and seeming to want to undertake the work herself, but not generally able to see it through to its conclusion. On October 13, 1795, for example, she writes, “Like a skilful physician, I can retrace the causes, the symptoms, the progress, & thoroughly understand the nature of my mind’s disorders, but the remedies are not within my power.”\footnote{Hays to William Godwin, 13 October, 1795, \textit{The Correspondence}, 401.} Hays was not seeking medication or a form of therapy necessarily familiar to contemporary readers; but she
does employ the narrative logic of the medical case. It is the narration of events in order, the “retracing,” she knows, that enables a diagnosis.

Hunter also suggests that a medical practitioner will examine a patient’s symptoms in order to work his way back to their causes; as noted above, Hays used Godwin’s term “effects” to signify both the results produced by a particular cause, as well as to invoke the more medical idea of “symptoms” produced by a condition. In her letter of 28 July, 1795, she writes, “after having from effects imagined a cause may be deduced, from that cause I again endeavour to infer effects, & wish to look beyond the disorders that now seem so inexplicable.” And a few months later, in October, she remarks, “my mind and constitution, some years since, received a shock, the effects of which I suspect I shall never wholly recover.” For Hays, it seemed, an important—perhaps the most important—part of the physician’s job was establishing a chronology or narrative sequencing of events that produced or effected disorder. Causes and effects, she felt, must be distinguished from one another in order to bring about a change in one’s condition. Popular medical texts at the time reiterated this line of thinking. Thomas Beddoes declared for instance in 1797: “As to our own countrywomen, I do not conceive how they can be rendered more hardy, or less nervous, if that term is preferred, otherwise than being seasonably taught the principles of self-management—its principles ... where we exhibit to sense that connection between cause and effect which constitutes the order

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228 Hays to William Godiwn, 28 July, 1795 and 13 October 1795, The Correspondence, 395 and 401.
229 Hays’ employment of medical metaphors stems, at least in part, from Godwin’s own style. Consider his argument: “There is but one perfection to man; one thing most honourable; one thing that, to a well organized and healthful mind, will produce the most exquisite pleasure. All else is deviation and error; a disease, to be cured, not to be encouraged” (Political Justice, 1: 240).
of nature.” Beddoes’ words are telling: only if cause and effect are operating within the “order of nature” can women become less “nervous.” The implication is that women are naturally robust, and are taught to become otherwise. In November 1795, Godwin offered a “hint” that a “fictional exploration of [Hays’] painful experience might help her come to terms with it.” According to Marilyn Brooks, he prescribed the writing project as “instructive rather than self-indulgent;” and Hays agreed that the narration would help her to better understand and represent how she came to be in her melancholy, nervous condition.

The Facts of “The Case”

Lectures published for physicians-in-training throughout the eighteenth century reveal the codification of the narrative methods of clinical practices. William Cullen, for instance, explains that the “method of proceeding” must be as follows “in every disorder”:

Enquire into the history of the patient before he was attacked with his disorder, in order to find out the remote causes of it. When these are ascertained, we shall make a full enumeration of the symptoms, shewing their quality and degree, observing what is peculiar in their series and succession, in what light they are to be viewed singly, but principally what judgment is to be formed from the concourse of them. After this, to understand which only a little attention is necessary, we shall endeavour to ascertain the species of the disorder.

230 Thomas Beddoes, A Lecture Introductory to a Course of Popular Instruction on the Constitution and Management of the Human Body (Bristol, 1799), 26.
232 William Cullen, Clinical Lectures, delivered in the years 1765 and 1766 (London, 1797), 4.
Knowing the “history” of the patient is crucial for assessing and understanding her current condition, as well as for predicting her future condition with any degree of accuracy. And focusing on the “series and succession” and “concourse” of events is what enables diagnosis. As I have shown, with the growth of public medical knowledge through periodicals, public lectures, and popular guides to medicine, both practitioners and patients were aware of the importance of accurate, detailed, chronological narratives. It is in this context that Hays corresponded with Godwin, and embarked upon her diagnostic writing project.

*Memoirs of Emma Courtney*, much of which is taken verbatim from the correspondence of Hays and Godwin, can be read as a case study illustrating what Hunter calls the “narrative structure of medical knowledge.” Successful practitioners, Hunter claims, are those who can create a coherent “narrative organization of the facts of illness.” In both her letters and in her turn to autonarration, Hays frequently and carefully reports on the changes in her personal condition, and she presents her situation to Godwin (and later Francis) in terms of a medical case: “I consider you as my mind’s physician, I ought therefore to give you an opportunity of forming a full & candid judgment of my case: my communications will be of a delicate nature, they must

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233 Cullen elaborates: “Many physicians, even of the most undoubted credit, who have observed diseases with the most diligent attention, ... have collected, not only those symptoms of a disease which are always present and inseparable from it, but those which accompany it in the whole course of its progress. They detail symptoms that seldom attend the disease, or are not necessarily connected with it, and many that are adventitious and accidental; while at the same time they entirely neglect to distinguish between those that are unusual and accidental, and those that are common and inseparable. Thus, in order to render the history of a disease as compleat as possible, they embarrass it by omitting to specify those circumstances that tend to distinguish it from every other” (*Synopsis and Nosology: Being an Arrangement and Definition of Diseases, by Classes, Orders, Genera, and Species*, 1769 [London, 1810], iv).

therefore be *held sacred*, to yourself alone!”235 At his suggestion then, Hays showed Godwin pages for assessment and evaluation as she progressed with her writings.

William Brewer notes that Godwin did advocate the experimental possibilities of fictional characters; they provided opportunities for “the observation of those particular effects, which result from [the mind’s] different circumstances and situations.”236 Godwin’s suggestion of a diagnostic narrative is therefore unsurprising.

Following Hays’ turn from fiction to more autobiographical writing, however, she and Godwin began to diverge. Initially forthcoming with her work, Hays welcomed Godwin’s input: “Assist me in a severe self-examination. ... You are a cool looker-on—your passions have not been engaged, you therefore are competent, to resolve this question—& you will resolve it with truth.”237 The details of Godwin’s responses to Hays’ writings are largely unknown since the terms of their “contract,” as he stipulated them, dictated that she “communicate her sentiments by letter” and that he would usually respond in person.238 We therefore have no way of knowing what his recommended

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235 Hays to William Godwin, January 1796, *The Correspondence*, 417. The semantic range of “case” is displayed here: beneath the obvious medical sense, the legal and also a residually casuistical sense of “case” may be in play. Hays’ confessional tone is worth noting. James Chandler explains, “the early novel itself, insofar as it can be identified as a recognized new form of writing in the early eighteenth century, was in part developed out of the literature of secular casuistry—i.e. advice literature and conduct guides for practical decision making in ordinary circumstances” (226). Roy Porter remarks on the intersection of religion and medicine at this time: “the general tendency of Christian theology to emphasize personal accountability and guilt was easily superimposed upon the ‘physiological,’ humoral aetiologies promoted by Classical medicine, which viewed an individual’s state of health as hinging upon personal life-style, constitution, and character” (2:1452). For physicians, as for priests, the narration of the patient’s case history has almost always played a crucial role in the diagnostic process. See Chandler’s *England in 1819: The Politics of Literary Culture and the Case of Romantic Historicism* (Chicago: Chicago University Press, 1998) and Porter’s “Religion and Medicine,” *Companion Encyclopedia*.


revisions were; it is safe to assume, however, based on Hays’ responses, that they were substantial. On February 7, 1796 she declared her “repugnance” towards his suggested alterations, and in May she addressed him as a “savage-hearted & barbarous critic!”

Godwin’s utilitarian philosophy meant that he was generally concerned with the laws of science and natural philosophy, not necessarily with the case-by-case distinctions called for by medical practice, let alone with one woman’s extreme case of sensibility. Utilitarian philosophy can be broadly understood as a theory suggesting that the best course of action should always maximize utility, ideally reducing suffering and maximizing happiness for the greatest possible number.

Thus Hays and Godwin came to differ on their understandings of the reasons for which she was composing her novel: while Godwin held that a wider readership might benefit from a different text (fiction), her letters suggest her belief that readers could not benefit if the facts did not adhere to the case (autonarrative). According to Brewer, for Godwin, fiction offered great possibilities for psychological experimentation: “In Godwin’s view, literary works can serve as ‘thought-experiments’ in the science of mental anatomy. They are imaginary laboratories in which writers can conduct psychological experiments on their characters, laboratories in which they can control the variables of environment, education, and situation, and attempt to determine their effects on a given personality.”

Seemingly uninterested in Hays’s actual life story (or the story as she chose to represent it), Godwin evidently made suggestions which would

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239 See The Correspondence, 454, 456. Hays’ responses suggest that Godwin found the text’s theme of hopeless romantic attachment to be uninteresting, the heroine to “have an austerity of character” and to have had no basis for her romantic aspirations.

240 Brewer, The Mental Anatomies, 19.
have taken the text of *Emma Courtney* out of the realm of autonarration and more into that of fiction.\textsuperscript{241} Hays, however, was suffering from very real symptoms, both bodily and psychological, for which she sought treatment and relief. She explains to Godwin: “I will not deceive you, unless I first deceive myself. My MS was not written merely for the public eye—another latent, & perhaps stronger motive lurked beneath—If this in some respects has spoiled my story, … it has also given to it, that ‘energy of feeling & ardour of expression’ which impressed you.”\textsuperscript{242} This latent motive, I suggest, is therapeutic and medicinal. Thus when he suggested modifications to the text, she rejected them, stating simply, “My story is *too real*, I cannot violate its truth.”\textsuperscript{243} For Hays, adjusting her narrative would alter the facts of the case and would be unproductive, possibly even harmful: in other words, the lesson or remedy Hays sought to discover was inextricable from the narrative from which it emerged.

While Hays initially sought Godwin’s reading or interpretation of her case history, she gradually became aware that while Godwin did concern himself with “the most desirable state of man,” his general principles were too broad to take into account the particular details of her case; her treatment could only be partial. She asks Godwin, “say not, that you are mortified to find how little impression you have made on my mind.—What influence would you wish to possess? Remember the different circumstances by which our characters have been formed … & then triumph, for you have

\textsuperscript{241} His critiques are consistent with views he expressed on other sentimental fiction. Katherine Binhammer notes that he panned Thomas Holcroft’s *Anna St. Ives* because he “disliked the interaction between the basic plot techniques of sentimental literature … and his own philosophy” (212). See “The Political Novel and the Seduction Plot: Thomas Holcroft’s *Anna St. Ives,*” *Eighteenth-Century Fiction* 11.2 (1999).
\textsuperscript{242} Hays to William Godwin, May 11, 1796, *The Correspondence*, 457.
\textsuperscript{243} Ibid.
cause, in the powerful diversion you have affected.”244 As Hays sees it, the different “circumstances” that led to the development of each of their characters will necessarily require different methods of treatment and therapy. Furthermore, the choice of the word “diversion” here reflects her belief that once formed, a character cannot readily be altered. She therefore represents Godwin’s prescription as consolatory, but not remedial. Moreover, she states that in writing *Emma Courtney*, “I searched into my own heart for the model, the possible effects of the present system of things, & the contradictory principles which have bewilder’d mankind.”245 Hays’ gradual realization of her own prescriptive authority would have been supported by medical practitioners whose publications were increasingly advocating preventative medicine, prophylactic practices, and consciousness of individual health. As William Buchan declared, it is “always in the power of the patient, or of those about him, to do as much towards his recovery as can be effected by the physician.”246

Hays began the novel that was to become *Memoirs of Emma Courtney* as part of Godwin’s experimental plan in 1795; its completion and publication a year later, however, occurred as their relationship ended. The particular terms Hays uses to soften her rejection of Godwin’s critiques are telling. She writes, “I am already more tranquil, more rational, than I had hoped or expected to be in so short an interval, & for much of this tranquility I feel myself indebted to you. Be not then discouraged—be not disgusted to find I have yet advanced no further—my malady was *too inveterate* to be easily or

244 Hays to William Godwin, May 11, 1796, *The Correspondence*, 457.
245 Ibid, 458.
quickly cured—it was a proof of strength, but strength ill directed.”\textsuperscript{247} She rejects any further assistance from him, knowing that his examining a narrative, a case history, that was no longer \textit{hers} could not result in a cure, or any relief for \textit{her} condition. Her use of the term “\textit{inveterate}” suggests something long-standing, deeply-rooted, habitual, or in the context of disease, something chronic, persistent, and resisting treatment.\textsuperscript{248} Her description of a “strength ill directed” furthermore indicates an awareness that, though she has arrived at the understanding of her disorder using Godwin’s method, her condition cannot be remedied by his prescriptions. Hays’ employment of medical terminology is significant, as she (through Emma) comes to assume a physician’s role, determining that her own diagnosis and prescription are likely to be the most accurate and productive. Following further disagreements in May, 1796, Hays continued to work on the manuscript alone and saw it published in November, six months later.\textsuperscript{249}

Thus while they shared a diagnostic logic, their methods of treatment and prescription differed significantly because Godwin’s policies for “man” did not necessarily consider the particularities of the individual female case. The distinction between their treatment methods might be considered in light of the distinctions between science and medicine more generally. Kathryn Montgomery Hunter’s delineation between the two is useful here: science “seeks to establish general truths, universal laws of nature. But medicine differs from physics or biology in its concern with general rules

\textsuperscript{247} Hays to William Godwin, May 11, 1796, \textit{The Correspondence}, 457.
\textsuperscript{249} Following the death of Mary Wollstonecraft (then married to Godwin) in 1797, communication between Hays and Godwin dwindled and finally ceased. Following his death, Mary Shelley returned their correspondence to Mary Hays, at Hays’ request.
that must at once be true and still apply usefully to the individual and variant case, often as that case is in the process of changing." If *Memoirs of Emma Courtney* can be read as a medical case study, Godwin’s *Caleb Williams* might be considered as a more general, scientific study working to determine absolutes, or as its title suggests, “things as they are.” The protagonist of that novel, for instance, tells the reader that he “could not rest till [he] had acquainted [himself] with the solutions that had been invented for the phenomena of the universe.” And, according to Godwin, he even composed the novel in reverse: “I invented first the third volume of my tale, then the second, and last of all the first.” Put another way, he determined the effects or the consequents of *Caleb Williams* before even conceiving of the causes. Hays, on the other hand, seeks to diagnose through narrative, to locate the causes of her condition by examining the effects that it created within herself.

Both Godwin and Hays were innovative users of first-person narration; Pamela Clemit argues that Godwin employed it to demonstrate the “psychological effects of systematized oppression.” Hays also employs the (autobiographical) retrospective first-person narrator to locate and identify the sources of the symptoms from which she suffered, in the hopes of preventing their recurrence in future generations. The difference between the two novelists, however, lies in the fact that while Godwin’s “I” was meant to represent a broad group, victims of social oppression, Hays’ “I” demonstrates the ways in

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251 Godwin, *Caleb Williams*, 4.  
252 Ibid.  
253 See Pamela Clemit’s discussion of Godwin’s fiction in which she argues that his “boldest innovation” is the “use of the first-person narrative to explore his philosophical interests” (*The Godwinian Novel: The Rational Fictions of Godwin, Brockden Brown, Mary Shelley* [Oxford: Clarendon Press, 1993], 6).
which the female condition was not yet included within the parameters of Godwin’s more universal “man.” It was the form of the medical case study that enabled the individual consideration and treatment sought after by Hays, and Wollstonecraft before her. As Hunter suggests, “clinical medicine must rely on the narration of cases for the preservation and advancement of its practical knowledge.”

Hays and Wollstonecraft’s works of autobiographical fiction number among the early case studies offered for the advancement of knowledge about women, and the advancement of women themselves.

“The Doctor is In”

Despite the author’s claims that the relationship between her life and text was “of little importance,” critics have been unanimous in their reading of Hays’ novel as autobiographical (37). Scholars agree that the eponymous heroine represents Hays, and the character of the heroine’s beloved Augustus Harley stands in as a loose depiction of William Frend. The bulk of the novel depicts Emma’s mental, physical, and emotional suffering due to her unrequited love for Harley. Godwin appears in the novel in the character of Mr. Francis, who starts out as a figure of influence for Emma but who disappears part way through the text. Hays’ fictional representation of her “mind’s physician” is particularly telling. Mr. Francis begins as a mentor figure, from whose “keen remarks” and “penetrating eye” the young orphaned Emma aspires to learn. When

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254 Hunter, Doctors’ Stories, xxi.
255 Mary Hays, Memoirs of Emma Courtney (Peterborough, ON: Broadview Press, 2000). (All references to this text will be provided parenthetically in the text.) See for example, Eleanor Ty, Unsex’d Revolutionaries and Georgina Green, “Fiction and Autobiography in Mary Hays’s Memoirs of Emma Courtney,” Literature Compass 4.3 (2007), 409-420.
he admonishes the young girl for weeping, she answers, “I thank you for your reproof, and solicit your future lessons” (69-70). But her admiration for his teaching is not unequivocal. Even in its early stages, she depicts their relationship with some ambivalence, recalling, “My understanding was exercised by attending to the observations of Mr. Francis, and by discussing the questions to which they led; yet it was exercised without being gratified: he opposed and bewildered me, convicted me of error, and harassed me with doubt” (72). In the absence of other companions, however, Emma continues to correspond with Francis, often seeking his advice.

Like the letters of Hays to Godwin, Emma’s letters to Francis, and her retrospective narration to Augustus Harley Jr. (with which the text is framed) describe the symptoms of her melancholic condition. Even before Emma begins her fraught relationship with Augustus Harley, signs of her melancholic constitution are evident. She writes to Francis, “Everything I see and hear is a disappointment to me;” and her symptoms are both physical and emotional. She feels inanity, apathy, “torpor and abhorred vacuity,” and a “thick and impenetrable darkness” clouding her mind (80). In awaiting a reply from Francis, the narrator begins to recast the nature of their relationship so that a teacher-student relationship comes to resemble instead the relationship of physician-patient, just as Hays had done with her relationship with Godwin. Emma recalls her impatience in waiting for a response: “My sickly mind required a speedy remedy” (81). When Francis replies, she does find comfort in his suggested prescriptions for her “excessive sensibility” and “fastidious delicacy” (81). He urges her to practice logic and philosophical thinking to improve herself as well as those around her—and there is for a time some improvement in her condition. The temporary recovery of her
spirits following his reply may be a consequence of the specific contents of the lengthy prescriptive letter, but may equally be attributed to her engagement with the letter itself and an awakening of her intellectual faculties. She notes that she had waited “impatiently” for the letter’s arrival as her “mind wanted impression” (84). She classes the letter as “kind” because it was “prompt,” and she reads it again and again, recalling how it had “awakened a train of interesting reflections” which brought tranquility to her spirits (84).

It is not long, however, before the patient resumes her complaints. Melancholy returns to plague her and is dramatically worsened when Augustus Harley rejects her. She recalls: “despair shed its torpid influence through my languid frame. Inquietude, at length, gradually gave place to despondency, and I sunk into lassitude” (114). Again, her symptoms are both emotional and physical. Emma turns to Francis once more, but this time his reply is simply “kind and consolatory, ... not unmingled with reproof.” The result is that Emma, in another compounding of emotional and physical health, “once more sunk into inanity; [her] faculties rusted for want of exercise, [her] reason grew feeble, and [her] imagination morbid” (118). She finally suffers a complete collapse when she learns that Augustus Harley has been secretly married throughout the entire course of their relationship, and in desperation she turns to Francis yet again. This leads to his final diagnosis of her condition: insanity. His reply to her letter takes into

256 “Impression” here suggests an “action of one thing upon another” or influence, as well as “the effect produced by external force or influence on the senses.” Oxford English Dictionary, s.v. “Impression.” Accessed August 18, 2010.
consideration the facts of her case as he understands them, and offers the following diagnosis:

Your narrative leaves me full of admiration for your qualities, and compassion for your insanity. ... The whole source of everything which looks like a misfortune was assiduously, unintermittedly, provided by yourself. You nursed in yourself a passion, which, taken in the degree in which you experienced it, is the unnatural and odious invention of a distempered civilization, and which in almost all instances generates an immense over-balance of excruciating misery.

Francis, though sympathetic, admonishes her for her insane behaviour: “Your conduct will scarcely admit of any other denomination than moon-struck madness, hunting after torture” (169). His diagnosis deliberately assigns blame to her. He acknowledges to a certain extent society’s role (as a “distempered civilization”) in contributing to her condition, and he is sympathetic; but he nevertheless maintains that her disorder was in fact “assiduously, unintermittedly, provided by” herself. Furthermore, while he does recognize her insane condition, he fails to perceive it as posing a serious threat to her health. He asks her to “make a catalogue of all the real evils of human life, bodily pain, compulsory solitude, severe corporal labour, in a word, all those causes which deprive us of health, or the means of spending our time in animated, various, and rational pursuits. Aye, these are real evils! But I should be ashamed of putting disappointed love into my enumeration” (170). Love, he maintains, is not a cause of “bodily pain,” and is not sufficient to “deprive us of health.” His only prescription for her is the continued practice of “enlightened reason” through which he believes she will come to learn that “the principle by which alone man can become what man is capable of being, is independence” (170).
Like Hays with Godwin, Emma initially agrees with her instructor before starting to doubt, and finally coming to reject his diagnosis and prescription. She admits to insanity, but—like Hays in her letter of 6 February, 1796—she maintains that she is a “reasoning maniac: perhaps the most dangerous species of insanity.”\(^{257}\) Her reason, in fact, leads to the rupture between her and her physician. She agrees with his diagnosis of their society as “distempered” and his assessment of her behaviour as insane, but then she rationalizes, as Wollstonecraft’s Maria had done before her, that her education has created a diathetic condition in her; that is to say, her education predisposes her to a state of excessive feeling or sensibility. She cannot be held responsible for her inappropriate conduct because, as she suggests, “while the source continues troubled, why expect the streams to run pure?” (171-2). And here Hays has Emma begin to trouble what she perceives as Godwin’s preoccupation with the restorative benefits of philosophical thinking: “Argue with the wretch infected with the plague—will it stop the tide of blood, that is rapidly carrying its contagion to the heart?” (171).\(^{258}\) Emma continues: “What does it signify whether, abstractedly considered, a misfortune be worthy of the names real and substantial, if the consequences produced are the same? That which embitters all my life, that which stops the genial current of health and peace is, whatever be its nature, a real calamity to me” (171). In other words, Emma reasons that the abstractions of Godwin’s utilitarian theory, his doctrine of necessity, and other philosophical tenets

\(^{257}\) Mary Jacobus points out that it is not clear whether “a reasoning maniac is someone who is mad about reason, or someone who deploys the tools of modern philosophy in the service of a delusion” (Psychoanalysis and the Scene of Reading, 219).

\(^{258}\) Julie Carlson notes that Godwin “objects to domestic affections because their privacy and partiality impede justice, and he spent his entire career seeking to disentangle family from feelings for and about it” (England’s First Family of Writers, 5).
might help to identify the problem, but they do not provide her with a solution that will remedy what she feels is a threat to the health of her mind and body.

In a second letter Emma goes further in disagreeing with Francis’ diagnostic conclusions. She declares, “My conduct was not ... so insane as I have been willing to allow” (175). Borrowing from Godwin’s own necessitarian logic, she defends the inevitability of her actions given life’s “chain of necessary events” (37). It is not her, but rather her society that is to blame:

Hemmed in on every side by the constitutions of society, ... [women] remain insulated beings, and must be content tamely to look on, without taking any part in the great, ... drama of life. Hence the eccentricities of conduct, with which women of superior minds have been accused ...! The strong feelings, and strong energies, which properly directed, in a field sufficiently wide, might—ah! What might they not have aided? Forced back, and pent up, ravage and destroy the mind which gave them birth! (116)

What Francis dubs “insanity” Emma comes to label as “eccentricity of conduct.” She furthermore asserts that it is the diseased social body (the “constitutions of society”) that resulted in the misdirection of female energies. Hays’ conclusion resembles Wollstonecraft’s in The Wrongs of Woman: it is not Maria or Emma who require

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259 In discussing human volition Godwin writes: “All the acts, except the first, were necessary, and followed each other, as inevitably as the links of a chain do, when the first link is drawn forward. But then neither was this first act free, unless the mind in adopting it were self-determined, that is, unless this act were chosen by a preceding act. Trace back the chain as far as you please, every act at which you arrive is necessary.” (Political Justice, 1: 378).

260 Cf. Wollstonecraft’s Vindication of the Rights of Woman: “I have been led to imagine that the few extraordinary women who have rushed in eccentrical directions out of the orbit prescribed to their sex, were male spirits, confined by mistake in female frames. But if it be not philosophical to think of sex when the soul is mentioned, the inferiority must depend on the organs; or the heavenly fire, which is to ferment the clay, is not given in equal portions” (Mary Wollstonecraft, A Vindication of the Rights of Woman, ed. Deidre Lynch [(New York and London: W. W. Norton, 2009], 38).
treatment. Emma’s prose becomes stronger and her stance more firm: “I feel, that my arguments are incontrovertible. ... I have acquired the power of reasoning on this subject at a dear rate—at the expence of inconceivable suffering” (177). This statement is crucial: her knowledge, her “reasoning” and her understanding of her own state of health come from her feelings, from her sensibility, and because of this, she claims, her arguments cannot be disputed.

Emma develops the authority to diagnose and prescribe for her condition using the diagnostic tools which Francis and the entire medical establishment acknowledge her to possess: sensibility and an excess of feeling. While Emma’s dependence on sensation might seem to go against her clear commitment to reason, the fact is that she persuasively combines the two lines of discourse—sensibility and rationality. She asks Francis, “Do you not perceive, that my reason was the auxiliary of my passion, or rather my passion the generative principle of my reason?” She elaborates:

You cannot resist the force of my reasoning—you, who are acquainted with, who know how to paint, in colours true to nature, the human heart—you, who admire, as a proof of power, the destructive courage of an Alexander, even the fanatic fury of a Ravillac—you, who honour the pernicious ambition of an Augustus Caesar, as bespeaking the potent, energetic mind!—why should you affect to be intolerant to a passion, though differing in nature, generated on the same principles, and by a parallel process. The capacity of perception or of receiving sensation, is (or generates) the power; into what channel that power shall be directed, depends not on ourselves. (172)

Her argument here suggests that bodily “sensations,” impressions, and “passions” (in her case generated by romantic love) can co-exist with reason, and she offers several male examples to illustrate her point. Indeed, Emma’s reason is finally proven to be sound at the end of the text when Augustus reveals his long-standing love for her. Her “feelings”
are acknowledged to have been right and reasonable all along, and she is vindicated. Where Emma does acknowledge herself to be at fault, is in her incapacity to exercise moderation. She recalls her pursuit of Augustus as an “extravagant” and excessive pursuit of pleasure. Thus Emma tells Francis that in attempting to deny her arguments, “you will endeavour to deceive either me or yourself” (177). From this point on, Francis, like Godwin, all but disappears from Emma’s narrative.

Francis’ final attempt at treatment for Emma is consolatory, not restorative. There is no further quoted speech from him, and she describes his attention to her to be only “humane and friendly.” She does concede that: “he judged right, that, by stimulating my mind into action, the sensations, which so heavily oppressed it, might be, in some measure, mitigated—by diverting the course of my ideas into different channels, and by that means abating their force” (178). But the notions of “mitigation” and “divergence” (which resonate with Hays’ letter above) suggest that he is merely treating her symptoms, not the underlying cause of her disorder. Her final response to his treatment is that she felt “soothed” and “flattered” (178). Emma mentions Francis once more; in a moment of crisis, she seeks him out, only to be told that he has left the country. News of his departure worsens her condition: “The intelligence,” she says, “was a new shock to me” (191). In his absence, Emma Courtney must attempt to treat herself using a combination of sensibility and reason. Like Wollstonecraft, Hays has Emma working toward what Carlson refers to as the “merger of reason and passion—and passion’s disassociation from sentiment.” Carlson argues that the combining of reason and passion was “crucial to facilitating ... the love of truth that drove [her] knowledge systems.” But sentiment on

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the other hand, is “passive” and, Carlson continues, “primarily tries to turn difference into sameness. The “I” of sentiment loves, identifies, and sympathizes with the other to the extent that the other can appear like one of us.”\(^{262}\) Thus Emma recognizes that while not without merits, the method of treatment Francis proposed is not suited to the needs of her particular case, her particular “I.” Her condition, and the female condition more generally, require alternate and individual consideration.

A Melancholy Diagnosis

If we judge by her correspondence, Hays’ health never really improved. Her letters suggest that she felt that treatment was difficult, almost impossible, since the formative impressions in her life had already occurred; that is to say, her early habits, education, and life events resulted in an irremediably melancholic constitution. Hays believed that bad habits were largely incurable. Though she initially seemed to weigh the merits of struggling against habits and education, she was for the most part, resigned to the near impossibility of ever really altering the self. July 28, 1795 she writes: “the habits acquired by early precept and example adhere tenaciously & are never, perhaps, entirely eradicated.” A few months later she adds, “My philosophy serves but to convince me of the inveterate nature of reiterated habits; I do not say that they are absolutely invincible; but, I believe, in some cases, the leopard may as well change his spots.”\(^{263}\) She found some consolation, however; as we have seen with Wollstonecraft, in the fact that

\(^{262}\) Ibid., 33, 16-17.
\(^{263}\) Hays to William Godwin, July 28, 1795 and Hays to William Godwin, October 13, 1795, *The Correspondence*, 394, 401.
melancholy was thought to heighten the body’s literary and artistic abilities. There was something to be gained then in diagnosing Emma (and thus herself) as melancholic.

Hays’ self-diagnosis of melancholy, throughout her letters and through her diagnosis of Emma, heightens her authority as both medical practitioner and novelist. As discussed earlier, scholars such as Peter Melville Logan, Dino Felluga, and Andrew Elfenbein argue that during the late eighteenth century, for astute diagnoses and prognoses, a physician needed to possess a degree of sensibility almost equal to that of his patients. Emma is explicit in her representation of the symptoms of melancholy; she explains to Mr. Francis: “The morning rises upon me with sadness, and the evening closes with disgust—Imperfection, uncertainty, is impressed on every object, on every pursuit! I am either restless or torpid, I seek today, what tomorrow, wearies and offends me” (117). She embodied Buchan’s understanding of melancholy as “that state of alienation or weakness of mind, which renders people incapable of enjoying the pleasures” of life.264 Emma reminisces that during her most severe struggles, “these painful and protracted conflicts affected my health, a deep and habitual depression preyed upon my spirits, and surveying every object through the medium of a distempered imagination, I grew disgusted with life.” Following her marriage she explicitly identifies her disorder as a “too habitual melancholy” (131, 197). Yet it is because of this depression that Emma, and through her, Hays, becomes even more astute in her self-diagnoses. As noted earlier, for physicians and artists, acute sensibility, and even melancholy, were key, but such sensibility needed to be strictly controlled.265 Thus in the

264 Buchan, Domestic Medicine, 277.
265 Hermione de Almeida offers another valuable study on this topic in Romantic Medicine and John Keats. In her discussion of Keats as poet and as physician she reminds us of John Hunter’s influential
preface Hays dedicates her work to “the thinking and the feeling few” as a “warning, rather than as an example,” of the dangers and possibilities of excessive sensibility (36, 38).

Hays presents Emma’s narrative as a case study, offering readers prophylactic medical advice to try and improve conditions for the future: hence Emma’s decision to explicitly address her narrative to a young man belonging to the next generation. Emma’s narrative is written for her foster son, the child of Augustus. Significantly, she writes him to try and subdue his “wild career of passion” as he pursues a woman who does not return his love. Within the novel, Hays includes two courses of action worth considering—one that is restorative for Emma, and one that is preventative, not for Hays, but for Augustus Jr. and the social body more generally. Hays grants Emma only a slightly more optimistic outlook than she found for herself. Emma claims: “There is no cure for me ... but by a new train of impressions, of whatever nature, equally forcible with the past” (177). Aware that she cannot change the events that have already taken place, or rewrite the beginning of her case history, Hays has Emma undertake a course of medical study to serve as a “new train of impressions” (177). As she explains to young Augustus, “Sensation generates interest, interest passion, passion forces attention, attention supplies the powers, and affords the means of attaining its end: in proportion to the degree of interest, will be that of attention and power” (42).

Thus “ever thirsting after knowledge,” like Wollstonecraft’s Mary before her, Emma embarks on a particular course of study: physic. She learns some sciences.

“teachings on the ‘sympathy’ between organs and parts commonly observed by clinicians in the hospitals [...which] led him in 1794 to address a parallel ‘sympathy of the mind’ vital to the study of life by the creative artist or physician” [(New York: Oxford University Press, 1991], 35).
astronomy and philosophy at a young age; but it is not until near the novel’s end that she really begins to develop an understanding of medicine. She opts to leave behind antiquated books featuring “great characters and heroic actions,” the chosen texts of her formative years, and turns instead to “physic, anatomy, and surgery, with the various branches of science connected with them” (196). Her marriage affords her even greater access to this kind of material. After learning that she and Augustus can never marry, Emma significantly resigns herself to marriage with a fiery and impetuous doctor, Montague. Her contentment with their marriage derives almost exclusively from their child, and from the pleasure she takes in assisting Montague in his medical practice. She recalls: “I rendered myself essentially serviceable to my friend; and, by exercising my understanding and humanity, strengthened my mind, and stilled the importunate suggestions of a heart too exquisitely sensible” (197). The study of medical texts provides Emma with both purpose and knowledge to help control her own sensibilities.

As the narrative progresses, Hays illustrates Emma’s increasing expertise and knowledge of physic in order to render her character’s self-diagnosis of her health and habits all the more persuasive. Here the work’s structure must be considered for how it guarantees the accuracy of her diagnosis. Just as medical guides increasingly offered women readers “an adequate idea of their own disorders, as well as the most gentle and effectual methods of treating them,” Hays has Emma present her own case history retrospectively to ensure that readers understand her qualifications for self-diagnosis and prescription. By the novel’s end Emma is, in fact, the only one qualified and able to

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diagnose and prescribe: Mr. Francis has disappeared and Emma’s husband, the physician Montague, has killed himself. The circumstances surrounding Montague’s death are worth noting. Following his act of marital infidelity, he becomes depressed and eventually suicidal. His letter to his wife explains: “Amidst the reflections which press, by turns, upon my burning brain, an obscure consciousness of the prejudices upon which my character has been formed, is not the least torturing—because I feel the inveterate force of habit—I feel, that my convictions come too late!” (216). There is some weight in the male physician’s recognition of the “inveterate force of habit,” as it adds legitimacy to Hays’ and Emma’s own views. Yet Hays represents the rational (if melancholic) temperament of his wife as a marked contrast to Montague’s. As far as physicians go, Montague harms far more than he heals—before killing himself, he also feeds his mistress toxic substances in an attempt to abort their unborn child.

The late acquisition of Emma’s medical knowledge might seem to discredit her self-diagnoses from earlier moments in the text. As Tilottama Rajan explains, however, the narrative’s epistolary framing—built through Emma’s letters to Augustus Jr.—“claims a presence and an immediacy that is impossible in narrative that is an account of the past.” 267 Emma’s first-person recollection of her life’s events ensures that she can narrate them with the accuracy and logic of the rational physician she has become. This is not to say that her narration is without feeling or sensibility; the narrating Emma is often swamped by the emotions of the narrated Emma. She admits, “As the enthusiasm—as the passions of my youth—have passed in review before me, long forgotten emotions have been revived in my lacerated heart” (220). The letters that frame the narrative,

however, assure her readers of a reasoning, rational author: “It is by tracing, by
developing, the passions in the minds of others; tracing them, from the seeds by which
they have been generated, through all their extended consequences, that we learn, the
more effectually, to regulate and subdue our own” (127). Almost as if recalling the
promise of the *Ladies Dispensatory*—“words at length, adapted to each particular
case”—Emma vouches for the importance of the narrative logic of the case. Only by
“tracing” the progress of “the passions” can the “consequences” be seen, understood, and
perhaps avoided.

The story follows Emma’s gradual education in medical matters and her
increasingly clear diagnoses and prescriptions; with each correct diagnosis from Emma,
she reasserts the authority of Hays’ entire narrative—that is, her personal case history,
diagnosis, and prescription. There are several examples of Emma’s medical savvy in
action throughout the text. Following a dangerous carriage accident, Emma refers to
herself as a nurse, with Augustus Harley (the accident’s victim) as her patient. Her
knowledge and care-giving efforts are later twice praised by other doctors.268 By the time
Augustus is injured a second time, Emma boasts having “acquired some knowledge of
surgery” and she feels subsequently qualified to “bleed” her patient, mix for him “cordial
and composing medicine[s]”, and watch his progress through the night (198-99, 203).
There is no doubt that she provides her patient with competent and thorough medical
care. Emma’s recollection of caring for Augustus for the last time is worth quoting at
length. She explains:

I neither trembled, nor shed a tear—I banished the *woman* from my heart—I
acquitted myself with a firmness that would not have disgraced the most

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experienced, and veteran surgeon. My services were materially useful, my solicitude vanquished every shrinking sensibility, affection had converted me into a heroine! The haemorrhage continued, at intervals, all the next day; I passed once or twice from the chamber to the nursery, and immediately returned. We called in a consultation, but little hope was afforded. (203) 269

Note the new model of heroism on display here. The figure passes easily from the medical “chamber to the nursery” to care for her infant. Her love, rather than disabling, is an enabling, empowering force. And while her “shrinking sensibility” is vanquished, there remains an “affection,” a feeling that renders her heroic. Emma’s transition from nervous patient to rational, authoritative physician—indicative of Hays’ own broader narrative and prescriptive authority—seems to be completed at the expense of Emma’s gendered identity. Yet this is not necessarily the case; in one moment she banishes the woman from her heart; but in the next she returns to the nursery. She is at once an “experienced and veteran surgeon” and a literary heroine, inspired by love. This paradoxical state, however, can only be short-lived. With the death of her patient and lover, she explains, “The spirits, that had hitherto supported me, suddenly subsided. I uttered a piercing shriek, and sunk upon the body” (206). Emma’s most powerful moment immediately precedes her weakest, as though her personal and medical failure are connected. In the spirit of preventative medicine, it remains for Hays, through Emma, to prescribe new educational practices which might fortify women’s sensibility without necessarily depriving them of the diagnostic capabilities of their feelings.

269 cf. Wollstonecraft: “Even women of superior sense, having their attention turned to little employments, and private plans, rarely rise to heroism, unless when spurred on by love! And love, as an heroic passion, appears but once in an age” (A Vindication of the Rights of Woman, 198).
As previously stated, by diagnosing herself as a melancholic, Hays / Emma is enabled and disabled, burdened with a physically debilitating, yet intellectually and artistically stimulating condition. And while in her letter to Godwin Hays laments that remedies are not “within [her] power,” in the novelistic rendering of her life, she is able, via Emma, to offer prescriptions for the health and happiness of Augustus Jr., and perhaps more importantly, for the anticipated readers—both male and female—of the broader published text. Shortly before the novel comes to a close she diagnoses “something strangely wrong in the constitutions of society—a lurking poison that spreads its contagion far and wide” (220), a conclusion strikingly similar to that reached by Godwin / Francis. She then shifts her gaze from individual constitutions to the broader constitution of the social body. The “cure,” she maintains, will come from those with enough “daring to trace, to their springs, errors the most hoary, and prejudices the most venerated, [to] emancipate the human mind from the trammels of superstition, and [to] teach it, that its true dignity and virtue, consist in being free” (221). Hays’ prescription for society is obviously not “medical,” per se, but it is reached through a carefully articulated consideration of cause and effect. By examining the constitution of her society, and by considering Emma Courtney as a symptom or effect of her society’s current distemper or bad habits, Hays reaches diagnostic and prescriptive conclusions that necessarily differ from those of Godwin. He argues that the human heart can be subjected to reason and that philosophical thinking is therefore the solution to her affliction; Hays maintains, however, that until women are educated to have a higher
purpose than love and marriage, their hearts can never be so stilled. Hays explains,  
“Philosophy, it is said, should regulate the feelings, but it has added fervour to mine.”

As a physician, Emma is qualified to articulate what she perceives to be the  
causes of the ill effects from which her society suffers. Like Wollstonecraft, Emma  
blames women’s weaknesses and ill health on the habits of society. Recall Emma’s  
claim: “The strong feelings, and strong energies, which properly directed, in a field  
sufficiently wide, might—ah! What might they not have aided? Forced back, and pent  
up, ravage and destroy the mind which gave them birth!” (116). Had the feelings and  
energies of women been “properly directed”—as in, perhaps through a course of medical  
study—she asks, “What might they not have aided?” Denied such an outlet, the result for  
Emma is mental, emotional, and physical suffering. Emma thus feels called upon to  
prescribe for women and society in general. The prescription Emma Courtney offers at  
the end of the text is legitimated in that she articulates it only after becoming a physician.  
And, in prescribing healthier habits for future generations, Hays attempts what William  
Buchan asserts to be the “last step” for the physician—analogical thinking. Emma’s

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270 Hays to William Godwin, 28 July, 1795, The Correspondence, 394.
271 William Buchan and physician and medical author John Gregory both discuss the importance of  
analogical thinking for physicians. An example from Gregory’s Observations illustrates: “I have a patient in  
an intermitting fever, which I propose to cure by the Peruvian bark. I shall suppose I have cured five  
hundred patients by this medicine formerly; but yet I know I never cured one whose circumstances, in  
respect of age, temperament, and every other particular, exactly corresponded to the one before me. If  
therefore I give the bark, I must reason, by tacitly adopting this principle, that the bark will universally  
cure agues, notwithstanding they differ in some circumstances. But this is a principle of which I have no  
direct and conclusive experience, but a principle which I have adopted, by a probable reasoning from  
analogy: and, indeed, it is not universally true, though physicians must proceed upon it in their practice,  
till such time as future observations shall ascertain the exceptions to it” (Observations on the Duties and  
Offices of a Physician; and on the Method of Prosecuting Enquiries in Philosophy [London, 1770], 110-  
111). See also William Cullen, Clinical Lectures delivered in the years 1765 and 1766 (London, 1797), 3.
conclusion marks an attempt to rationally transfer the experience of her own case to the current social condition, to help prevent the cases of other women.

“Fixing the System”

Hays asserts in the preface to the novel that “Every possible incident, ... might, perhaps, be rendered probable, were a sufficient regard paid to the more minute, delicate, and connecting links of the chain” (37). Her implication is that possibilities can become probabilities if we understand where they come from in the first place. Only by following a chain, or narrative, back to its beginning can we understand how it came to be, and therefore, how it might be altered. Emma Courtney begins with the author’s claim for the use value of her literary work and promises a logical, progressive narrative of events complete with an explanation for, and documentation of the causes and effects within her narrative. Thus far the novel resembles a medical case study. According to physician John Gregory (1724-1773), an ideal medical case report would include the patient’s “prognostic symptoms”; a distinction of the disease from others resembling it; an articulation of the condition’s “remote and proximate causes”; and the suggestion of a remedy and its possible effects. In this way, practitioners could readily share information, and even the most minute of circumstances could be tracked, ensuring that causes and effects could be clearly distinguished in each case. Beddoes too stressed the importance of documentation and evidentiary support. To ensure the “credibility of a narrative,” Beddoes insisted upon the patient’s name, designation, and most importantly,

the specifics of the method of treatment. He then usually attempted “to procure from the patient himself a description of his own feelings.”\textsuperscript{273} As we have seen, \textit{Emma Courtney} abounds in descriptions of this kind; and while critics (both early and recent) have poked fun at the heroine’s excessive sensibility, there may have been a use value for Emma Courtney’s seemingly immoderate description of feeling. Beddoes, for instance, discussed the need for a general “consciousness of health,” claiming that “the individual ... need only be taught to \textit{sympathise} with himself, if that term may be applied to the feelings, excited by different possible states brought strongly into contrast.”\textsuperscript{274} With the idea of self-sympathy and self-awareness in mind, Emma’s excess of feeling might then be read as a keen consciousness and articulation of the state of her emotional and physical health.

There was much at stake for Hays in her dual roles of patient and physician. Though unable to arrive at a cure for herself, there was some satisfaction for Hays in arriving at a diagnosis and cure for others. Placing Emma in the role of physician added legitimacy to her own discourse. Gregory’s depiction of the rational physician resonates strongly with Hays’ process of self-diagnosis. In discussing the importance of reasoning and analagical thinking for a physician, Gregory explains: “Without reasoning, or without trusting to certain principles, either fully established, or rendered highly probable, we could never be benefited by experience, because we could never transfer it from the case we have seen, to the case immediately before us.”\textsuperscript{275} Hays undoubtedly sought to benefit from her “experience,” and “transfer” this knowledge to the cases of others. Thus it is not through

\textsuperscript{273} Thomas Beddoes, \textit{Medical Cases and Speculations} (Bristol, 1794), xi-xii.
\textsuperscript{274} Thomas Beddoes, \textit{Hygëia; or Essays Moral and Medical} (Bristol, 1802), 1:1, 84.
license or accreditation, but rather particular ways and means of knowing that make Emma Courtney a legitimate physician by the text’s conclusion.

Throughout Emma Courtney Hays refutes Godwin’s “systematic” method of reasoning.276 In principle, Hays often agreed with the logic behind Godwin’s thinking, and so was doubly disappointed when it failed to produce a viable prescription or cure for the female condition. Hays, like Wollstonecraft, believed that women were differently constituted than men not because of inherent biological differences, but rather because of learned habits. Her argument was that a blanket cure for both men and women would be ineffectual so long as their educations continued to predispose them to different conditions. Gregory’s critique of “systems” in medicine has resonance here: “The hasty reduction of any science into a system, apparently full and perfect in all its parts, while, in reality, these parts are filled up and erroneous, is a bar to its further improvement. … Men are generally attached to systems, because they free them from the impatience of doubting, … and teachers find it contributes both to their interest and reputation.”277 Hays explained to Godwin in a letter dated March, 1796, that love is “necessarily made, with [women], a primary pursuit, their whole education has this tendency, & unless you cou’d make them wholly independent of circumstances, you cannot cure the effects which these trains of thinking & acting produce.”278 Hays suggests that women’s

276 My thinking here has been influenced by Clifford Siskin’s insightful essay, “Novels and Systems” in which he discusses the evolving relationship between these two genres of writing / thought during the late eighteenth century. He writes: “The Romantic-era novel helped to articulate one of the most distinctive features of European modernity: the notion of ‘The System’ — as in that which, in its most popular form, works both too well — ‘you can’t beat The System’ — and not well enough — it always seems to ‘break down,’” (Novel: A Forum on Fiction 34.2 [(Spring 2001), 202-215, 202].
278 Hays to William Godwin, March 1, 1796, The Correspondence, 437.
education predisposed them to tendencies, habits and symptoms of excessive sensibility; thus by Godwin’s own logic, hope for women lay in changing particular antecedents for future generations. In Mr. Francis’ early assurances to Emma he explained, “When the minds of men are changed, the system of things will also change; but these changes, though active and incessant, must be gradual” (83). Hays’ writings suggest that the “system” itself needs changing in order to offer new lessons to the minds of men.

Emma Courtney disagrees with Francis’ logic of applying a philosophical system universally; indeed Hays goes so far as to quote Godwin’s own writings back to him to demonstrate the hypocrisy of his diagnosis: “The ideas, the associations of each man are properly his own, and it is a pernicious system, that would lead us to require all men, however different their circumstances, to act in many of the common affairs of life, by a precise, general rule” (132). Clifford Siskin argues that Godwin gave the novel “a role in the work traditionally performed by system: the production and circulation of knowledge.”279 In resisting his proposed alterations to her text, Hays may have been doing her best to ward off what she viewed as a corrupt and toxic system. Her choice of “pernicious” particularly suggests the extent to which she believes his “system,” or perhaps any system, is harmful. When Francis scoffs at what she claims to be the underlying cause of her condition—namely the love to which her education predisposed her—Emma replies, “Ask your own heart—whether some of its most exquisite sensations have not arisen from sources, which, to nine-tenths of the world would be equally inconceivable? Mine, I believe, is a solitary madness in the eighteenth century”

279 Siskin, “Novels and Systems,” 209.
Her historical specificity here reminds the reader of the unique, “solitary” nature of her case. Her situation and plight may resemble those of others, but it is nevertheless due only to the particulars of her life—her own “chain of events”—that she has come to be in her current state of suffering; she therefore requires a personalized form of treatment. If, as she claims, “Habit daily produces this wonderful effect upon every feeling, and every principle,” then a treatment is necessary that primarily attends to her individual habits, and only secondarily glances outward to a universal condition (173).

The authors of both *Memoirs of Emma Courtney* and *Caleb Williams* declared their works to be diagnostic tools for their respective societies. In Godwin’s oft-quoted second preface to *Caleb Williams* (written some years after its original publication) the author explains that he wrote the text in “the first person, making the hero of my tale his own historian” as “it was infinitely the best adapted, ... [for] analysis of the private and internal operations of the mind.” He continues, explaining the use of the “metaphysical dissecting knife” to trace and lay “bare the involutions of motive,” and his recording of “the gradually accumulating impulses” which led his characters to “adopt the particular way of proceeding in which they afterwards embarked” (339). Given that we know he composed the work in reverse, however, Godwin’s technique resembles an autopsy more than a surgery; his process was intended to see what caused a particular state. While Hays has her heroine persist in a comparable rationale and methodology—“The science of mind is not less demonstrative, and far more important, than the science of Newton; but we must proceed on similar principles” (43)—she nevertheless takes a more proactive, than reactive position. From the very outset of the narrative Emma cautions

280 Recall that Emma briefly accepts Francis’ diagnosis of “madness” before refuting it altogether.
against a too close adherence to one particular system of beliefs: “I would warn you to be
careful in [the] particular application [of general truths]; a long train of patient and
laborious experiments must precede our deductions and conclusions” (92-93). In other
words, general truths might be applicable for the sciences, but for medical narratives,
attention to the recounting of the patient’s history must precede the diagnosis, the
prescription, and the overall prognosis. She explains to her “more than son,” Augustus
Jr., “I have unfolded the errors of my past life—I have traced them to their source—I
have laid bare my mind before you, that the experiments which have been made upon it
may be beneficial to yours!” (220). She seeks to encourage a level of preventative
medical awareness, and the fostering of an open mind with which to learn from
experiments and experience.

Mary Hays: A Victim of Circumstance

The “cure” that Hays proposed for the female condition was, like that proposed
by Wollstonecraft, an improved system of education for women so that they would learn
and incorporate healthy habits from the outset. In the 1795 letter in which she describes
herself as being “like a skilful physician,” it is the fact that “remedies are not within [her]
power” that prevents her from being a physician, limiting her instead to only
approximating one. She explains to Godwin:

I love action, but I have little to employ myself in; I love society, but my
sex & acquired delicacy, & still more the narrowness of my fortune,
derives me of this resource. I would travel, I would change the scene, I
would put myself in the way of receiving new impressions, I would sluice
off my thoughts into various channels, I would place myself in new
situations, I would propose to myself new labours, & engage with ardour in new pursuits—All this I should prescribe to another in my circumstances, but all this is, to me, unattainable. Oh! How impotent is mere reasoning!\textsuperscript{281}

Hays here reiterates that women’s habits are acquired, not inherent, and she argues that women are all directed into the same “channel” of life through their education. Her prescription is simple enough—change the impressions that the woman’s body receives in order to change her habit(s). The resources for such change, however, are for the most part denied to women. And this is Hays’ major source of complaint for herself and for Emma Courtney. Her \textit{Appeal to the Men of Great Britain in Behalf of Women}, published in 1798, but written throughout the 1790s, contains this same style of rhetoric, one which seeks to promote a “cure” for the condition of women.\textsuperscript{282} Hays lived until 1843, but following the publication of \textit{Emma Courtney}, as her letters and her second novel, \textit{The Victim of Prejudice}, show, her optimism concerning opportunities for women to develop new and healthy habits gradually waned.\textsuperscript{283}

The prescription offered in \textit{Emma Courtney} was directed to future generations and not in any way intended as a prescription for herself, as her own habits of sensibility

\textsuperscript{281} Hays to William Godwin, 13 October, 1795, \textit{The Correspondence}, 401 (The first two emphasis are mine).

\textsuperscript{282} See her \textit{Appeal} in which she laments those who are, “in the true pride of ignorance, ... too consequential to apply for elucidation to those, who, most undoubtedly were best able to detail their own grievances, and perhaps ... not least able, to point out an antidote or prescribe a cure” (\textit{An Appeal to the Men of Great Britain in Behalf of Women} [London, 1798], 216).

\textsuperscript{283} My discussion of \textit{The Victim of Prejudice} will necessarily be shorter and more focused on the health and habits of the text’s heroine. There is certainly more work to be done on the “medical” content of this text as Hays’ knowledge here seems to have become more extensive and refined. Among the conditions described the list includes: high fevers, overheated blood, scarlet fever, distempers and disorders, electric shocks impacting “quivering nerves,” melancholy, lassitude, languor, paroxysms, fainting fits, delirium, swoons, tertian ague, rheumatic pains, and a frame yielding to mephitic vapours.
were too indelibly fixed. Hays wrote in a melancholy 1802 letter to Henry Crabb Robinson, “I no longer care for authors, ... and I have done with systems. I am a complete and indifferent sceptic. ...[O]f what use is it to have the mind enlightened, when the habits are fixed?” 284 Again, as Siskin notes, “embedded in the novel, system becomes a vehicle not for rational explanation, but for habitual blame.” 285 The tragedy of her final novel then, the 1799 Victim of Prejudice, is that despite acquiring hardy habits through a healthy educational program, the heroine, significantly named Mary, remains unable to defeat the social “system,” or the “habits of society” which favour men, money, and certainly not a lone woman without rank, title, or fortune. 286

Mary begins her life, especially as compared to Emma Courtney, with promise. During Emma’s youth, she had been “vain and self-willed,” her “desires impetuous,” her affections “warm” and her “temper irascible.” “Stories” were her “passion, and [she] sighed for a romance that would never end” (49). Young Mary, in contrast, is “early inured to habits of hardiness; to suffer, without shrinking, the changes and inclemencies of the season; to endure fatigue and occasional labour; to exercise [her] ingenuity and exert [her] faculties, arrange [her] thoughts and discipline [her] imagination” (5). Mary’s education explicitly affords her the opportunity to learn hardy habits—she suffers,

284 Hays to Henry Crabb Robinson, February 27, 1802, The Correspondence, 554.
286 A brief summary of the novel’s plot: young orphaned Mary is educated alongside two young wealthy boys of good family (William and Edmund). Mary’s benefactor, Mr. Raymond, educates them using the same programs and they are all treated equally in his home. When Raymond realizes, however, that William and Mary love one another, Mary observes: “Painful suspicions assailed him; he began to doubt whether, in cultivating my mind, in fostering a virtuous sensibility, in imbuing my heart with principles of justice and rectitude, he had not been betraying my happiness!—Gracious God! What must be the habits of society which could give rise to such an apprehension?” Mr. Raymond also tells Mary that William will “imbibe the contagion of a distempered civilization,” echoing the very words of Emma Courtney (The Victim of Prejudice [Peterborough, ON: Broadview, 1998], 25, 32). All subsequent references will be given parenthetically in the text.
endures, exercises, and acquires self-discipline. When the heroine learns that she is not permitted to love her childhood friend William, she exerts mental strength to overcome her desires: “I devised means to interrupt and break the chain of habits and associations that was incessantly betraying my resolutions” (105). Even following her rape at the hands of a cruel neighbouring landowner, the “native vigour of [her] constitution ... gradually triumphed over the shock it had sustained” (123). But impoverished, friendless, and continually pursued by her attacker, even with such hardy, acquired habits, she is unable to survive. She fluctuates for a time, “between life and death; disappointment, confinement, unwholesome air, mental anguish had combined to exhaust and ravage [her] frame: ... the body survived, but the spirit was fled” (171). She dies shortly thereafter. The same question posed in Memoirs: “while the source continues troubled, why expect the streams to run pure?” reappears in the preface to A Victim, “Can the streams run pure while the fountain is polluted?” (2). The tragic fate of the novel’s heroine provides Hays’ troubled answer that the social “system” is irremediably damaged and damaging.

Memoirs of Emma Courtney might then be read, despite its despairing tones, as the expression of a moment of optimism for Hays, but perhaps more importantly, as exemplifying a unique moment in women’s literary history, when medical and literary narrative forms came to intersect. Hays, through Emma, narrates the symptoms of her sensibility, is never freed from them, but very notably does not die of their effects. At the novel’s end, her death is near—she recalls “the frost of a premature age sheds its snows upon my temples, the ravages of a sickly mind shake my tottering frame”—but she nevertheless lives long enough to pass on instructions to other young men and women
Rather than representing only the abstract symptoms of sensibility, Hays is explicit about the ways in which her condition is harmful to both her personal and the greater social constitution. Her final years were spent in occasional correspondence with Henry Crabb Robinson. Her letters to him reveal that while she is no longer optimistic about the possibilities for her own, and for greater social “improvement,” she remains firm in her identification of the very visceral causes of her condition:

All human happiness must have a physical foundation. In attending to the mental and moral education of man, this more important part seems to have been neglected and forgotten. The health, the animal spirits, the quantity of agreeable sensation, must make up the whole—real good of sensitive beings. ... The sensibility must be exercised, not exhausted, the appetites satisfied not jaded, & the mind and body preserved in that just and equal temperament that constitutes the health and vigor of both. Upon this principle, I would banish all intense studies & pursuits, all excess in sedentary occupation, all unnatural institutions and pernicious restraints. ... I would not have the nerves unstrung and the spirits saddened in their joyous season. ... The best things corrupted become the worst, so it may be said of extreme sensibility, or nerves too prone to vibrate. If such a disposition heightens pleasure, in the present state of European society, it but too frequently, to women more especially, aggravates pain. The cause of my habitual dejection, my friend, would not be difficult to trace.287

Despite her initial interest in metaphysics, Hays became increasingly invested in the “physical foundations” necessary for human happiness. She recognized that sensibility could be a source of pleasure, but only if “exercised, not exhausted.” And in suggesting that the source of her afflictions would not be “difficult to trace,” she reiterates the chain of events, beginning with a problematic education full of “sedentary occupations,” “unnatural institutions,” and “pernicious restraints.” John Gregory argued the importance of physiology to the study of physic, and therein he included: “the laws of the union between the mind and the body; ... the effects of culture and education upon the

287 Hays to Henry Crabb Robinson, February 27, 1802, The Correspondence, 554-555.
constitution; ... the power of habit, [and] the effects of enthusiasm, and force of imagination.” 288 Thus what began for Hays as a philosophic and even proto-psychoanalytic foray ends with the realization that the “cure” for her condition was to be found in concrete, rather than abstract terms, and that to improve the mental and physical health of women in general, it was the specific cases of women, and not the “system” of “man” that needed to be more closely examined. But Mary Hays, like Mary Wollstonecraft, was confined by the autobiographical nature of much of her fiction. Because she never experienced an improvement, or a lessening of her own sensibility—her “nerves” remained “unstrung” and her “spirits saddened”—she was unable to completely represent this healing in autobiographical fiction. However, the final author I consider, Jane Austen, recognized and explored the possibility of treatment through fiction, and thus sought to “cure” the heroine of sensibility once and for all.

288 Gregory, Observations, 73.
Ch. 3: Jane Austen’s Fictional Treatment of Sensibility

Introduction:

In Jane Austen’s final novel, *Persuasion*, the protagonist Anne Elliot talks of the importance of nurses, declaring: “What instances must pass before them of ardent, disinterested, self-denying attachment, of heroism, fortitude, patience, resignation—of all the conflicts and all the sacrifices that ennoble us most. A sick chamber may often furnish the worth of volumes” (126). Indeed, if Austen’s unfinished novel *Sanditon* might also be taken as evidence, by the end of her career, Austen was keenly and overtly attuned to the narrative potential and the narrative limitations of ill health and disorder, particularly as they related to the novel of sensibility. In her early novel, *Sense and Sensibility* (1811), Austen offers a treatment, both medical and artistic, of the symptoms of sensibility, revealing the extent to which past literary representations of these symptoms had been largely exaggerated by many of her literary contemporaries. Austen relies on the narrative logic of the medical case to interrogate the symptoms of sensibility in her novel’s two protagonists, Elinor and Marianne.

As noted in my Introduction, throughout the eighteenth century, literary and medical case studies suggest that people often suffered from the symptoms of sensibility. It is not easy to determine whether sensibility was an affliction in and of itself, or a bodily condition which left one more susceptible to other afflictions. Miranda Burgess characterizes sensibility as a “complex” of “emotional demonstrativeness and analysis,
aesthetic taste and empathic response.” Its multifaceted nature rendered it difficult to diagnose and treat. Thomas Beddoes’ medical interpretation is ambiguous: “Sensibility or openness to impression, which is one of the principle constituents of genius, has often been observed to accompany different diseases of debility.” The idea of “accompaniment” makes it impossible to determine which one arrived first; all that is known for sure is that “sensibility” and “diseases of debility” often make their entrance together. In Sense and Sensibility, Austen was responding particularly to the enfeebled, trembling characters of the sentimental novel: Rousseau’s Julie, Richardson’s Clarissa, and all subsequent spinoffs featuring heroines who “blush, swoon, or face unbearable social ostracism because of minor breaches of decorum.” As James Raven notes, the sentimental novel was the clear “fashion-leader of the period,” and frequently included characters of sensibility whose reactions to circumstances were, in turn, expected to evoke fine feelings in the reader. In turn, Austen undertakes to examine and treat the symptoms of sensibility, and succeeds in relieving her novels, at least, of painful conventions that all too often called for the death of the fallen heroine.

Several scholars have indicated Austen’s certain familiarity with literary discourses of sensibility. Thomas Keymer discusses a sentimental tale in a 1794 Lady’s

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290 Recall that treatment for sensibility was not always desired. Refined morality and aesthetic taste could be a good thing. Ann Jessie Van Sant reminds us that sensibility could offer “an organic sensitivity dependent on brain and nerves and underlying a) delicate moral and aesthetic perception; b) acuteness of feeling, both emotional and physical; and c) susceptibility to delicate passionate arousal” (Eighteenth-Century Sensibility and the Novel: The Senses in Social Context [Cambridge: Cambridge University Press, 1993] 1).
291 Thomas Beddoes, Hygëia: or, Essays Moral and Medical (Bristol, 1802), 2:6, 23.
293 Ibid, 31.
*Magazine*, likely familiar to Austen, in which the heroine (a Miss Brandon) finds “love when rescued from drowning by a dashing stranger named Willoughby.” In later years Austen wrote to her niece Anna, “I have made up my mind to like no Novels really, but Miss Edgeworth’s, yours, and my own.” Edgeworth’s novels were known for their didacticism, and Anna Austen’s writings appealed to her aunt for their “nature and spirit.” She clearly valued novels if they had spirit, or at least a lesson; it was the sentimental novel, whose heroines were burdened by their symptoms of sensibility, that Austen sought to resist. *Sense and Sensibility* reveals Austen’s awareness that while the symptoms of sensibility could be at least superficially treated in people and thus in characters, as a convention of the novel they presented a much greater threat to both readers and writers. Characters within this type of novel had been necessarily limited by predetermined disorders and symptoms; as John Mullan explains, “it was the pioneers of sentimentalism who themselves showed that the woman of sensibility and the man of feeling were made ill by all that they were able to feel.” In other words, Austen saw the novel of sensibility as an unfortunate trend for her chosen form, and the symptoms of sensibility as insufficient foundation around which to base the plot of a novel.

Illness can yield great possibilities for narratives, both in the eighteenth century, and today. In 1807, Beddoes cited the “records of medicine” as illustrating “more interesting and improving views of the human race, of the effects of our appetites,

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296 Ibid., 10 August, 1814, 269.
passions, of our ill-laid and too short trains of thought, than the meagre chronicles or the puffy narratives that are held in such unmerited esteem, under the title of history.” For Beddoes, medical records provide the most interesting “narratives”; they are personal and likely to honestly display human weaknesses and folly. The “records of medicine” refer most specifically to case histories, though they may also include more general studies as well. Daniel Tougaw, a contemporary scholar of literature and medicine, agrees; in his discussion of the genre of the medical case study he points out, “a healthy subject is a stable one, but pathology is a precondition for narrative and so a healthy subject has no story.” Indeed, afflicted subjects will always have a narrative. Though the conventions of the case study narrative may be strictly ordered and defined, there is nevertheless invariably and inevitably a narrative component to illness. Austen, whose “talent,” as Sir Walter Scott put it, lay in “describing the involvements and feelings and characters of ordinary life,” can also be considered as something of a character physician, concerned with her characters’ medical health and well-being.

This chapter contributes to the recent scholarly conversations that have begun to consider the significance of Austen’s representations of health, illness, and medical practices. Studies by Akiko Takei, Pamela Steele, Kenneth Moler, Toby Olshin, and Anita Gorman began by asserting the mere presence of sick people and medical practices in Austen’s writings, a departure from earlier readings of her fiction as “her work basket,

298 Beddoes, Hygëia, 1:2, 51.
her tapestry flowers,” done “in the spare cool drawing-room of other days.”

More recently, John Wiltshire’s important study, *Jane Austen and the Body*, examines her characters’ illnesses, aches and pains, blushes and trembles, broadly arguing that “illness features in her novels as a mode of social circulation.” Good health, Wiltshire suggests, is a social ideal; thus the ways in which healthy and unhealthy characters interact play a distinctive role in Austen’s careful depiction of her society’s norms and values. He considers the role of the sick body within Austen’s oeuvre, noting that “the body cannot be disentangled from thought about power relations, both within the family, and in the larger community.” In this examination of her major works, Wiltshire deepens and improves upon the earlier scholarly considerations of medical themes in Austen’s writings.

In his reading of *Sense and Sensibility*, Wiltshire wisely works to disrupt the longstanding tendency to read the Dashwood sisters, Elinor and Marianne, as a didactic and oppositional pairing representing good and bad sensibility respectively. Takei and Steele, for example, conclude that Austen viewed “severe illness as a way to moral enlightenment” for her characters, a way for the bad to become good. Thus Marianne’s fever in *Sense and Sensibility* and Tom Bertram’s illness in *Mansfield Park* (1814) are

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cited as prime examples of flawed characters becoming better. Fever, Steele argues, provides Austen’s characters with a “redemptive opportunity for remedial reflection.”

The implication of such readings is that Marianne suffers her crisis in health in order to become as “good” and as “healthy” as her sister Elinor. Such readings, however, risk oversimplifying Austen’s complex treatment of both Marianne and Elinor’s sensibilities.

The process of claiming Austen’s heroines and novels for one side or the other of a series of binary oppositions has generally proven to be unproductive. Wiltshire does trouble the binary between Elinor and Marianne by reading their mother, Mrs. Dashwood, as a “significant contributor” to the “psychological dynamics which produce the two sisters’ divergent personalities and attitudes.” However, this claim serves only to create a triangulation of the characters. In fact, we need to more deeply consider the decided similarities between Elinor and Marianne, particularly the ways in which their bodies both suffer, as well as the connections Austen establishes between their bodily symptoms and the ways in which their stories are told. An understanding of such resemblances offers access to Austen’s hitherto unexamined employment of the logic of the medical case study within the novel, as well as her interest in developing a healthier model of female literary heroism than those developed by her predecessors.

Austen is rumoured to have begun Sense and Sensibility as an epistolary work, first titled “Elinor and Marianne.” Given this early title as evidence, one can assume

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303 Steele, “In Sickness and in Health,” 156.
304 Wiltshire, Jane Austen and the Body, 25.
305 There has been some debate on this issue. D. W. Harding includes an appendix devoted to this question in Regulated Hatred discrediting the statement of Austen’s niece: “Memory is treacherous, but I cannot be mistaken in saying that Sense and Sensibility was first written in letters, and so read to her family” (quoted in Harding 212). The question is beyond the scope of my present discussion, though an epistolary origin would certainly be apt for the way in which I read the text. Regulated Hatred and Other Essays on Jane Austen (London: Athlone Press, 1998).
that this version might have been engaged with sensibility as a problem of character. The change in title signifies that Austen undertakes to examine and treat sensibility as a broad thematic concern for her novel. In undertaking such a treatment, however, Austen arrives at a double disappointment: not only is sensibility a condition that does not require substantial medical treatment (i.e. its symptoms are likely to go away on their own), as such, it does not warrant narrative treatment either. In other words, she shows the symptoms of sensibility, when examined closely, to have been exaggerated, rarely serious, and thus, not able to generate enough interest in the reader for a lengthy narrative. *Sense and Sensibility* is an interrogation of the novels of sentiment and sensibility with which her era was consumed.

In one early epistolary piece, “Love and Freindship” (1790), Austen reveals an already disparaging view of sensibility: of the work’s two heroines, Laura and Sophia, the latter perishes, and it is Sophia’s passive sensibility Austen mockingly holds to blame for her untimely death. Laura recalls the two women’s very different responses when confronted with the deaths of their husbands, “Sophia fainting every moment and I running mad as often” (96). Sophia dies as a result of being exposed to the “chilling damps of night” while “lying totally inactive on the ground” (98). On the other hand, Laura’s frenzy keeps her blood warm and she lives to tell their tale. Austen’s mocking moral—“run mad as often as you chuse; but do not faint”—can be read as evidence of her disenchantment with sensibility, and her awareness of the absurdity of ineffectual passive heroines and their too frequent demises (99). By the time she completes *Sense

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306 Jane Austen, “Love and Freindship” in *Catharine and Other Writings*, ed. Margaret Anne Doody and Douglas Murray (Oxford: Oxford University Press), 96. All subsequent references will be cited parenthetically in the text to this edition.
and Sensibility, Austen has ensured that her future works are effectively inured to the disabling symptoms of sensibility. To be sure, crises of health persist in her later writings, but these are limited to broken bones, fevers, concussions, *et cetera*, all conditions whose existence can be empirically proven. Those who do suffer from an excess of sensibility (Mr. Woodhouse and Mrs. Bennet), Austen comically dismisses as hypochondriacs.

Before looking closely at *Sense and Sensibility*, it is important to note the particular literary model of sensibility to which Austen was responding. The linking of nerves and physical reactions was, as Anita Gorman suggests, a “literary commonplace” at the end of the eighteenth century in novels by both men and women. Austen neither appreciated it, nor complied with such a model in her own writings. Sydney Owenson’s (later Lady Morgan) *Wild Irish Girl* (1806), for example, featured a sensitive and musical heroine of sensibility. As described by the man who loved her: “she was borne away by the magic of the art in which she excels, and the natural enthusiasm of her impassioned character: she can sigh, she can weep, she can smile, over her harp. The sensibility of temperament trembles in her song, and the expression of her rapt countenance harmonizes with her voice.” Austen voiced her response to such a heroine in a January letter to her sister: Lady Morgan’s “Irish Girl does not make me expect much.—If the warmth of her Language could affect the Body, it might be worth reading in this weather.” In other words, the trembling heroine of Lady Morgan left Austen feeling no strong bodily or emotional response. Miranda Burgess agrees, also citing evidence from

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Austen’s letters: “Austen playfully resists the claims that print, even in the special case of
the novel, is a medium able to ‘affect the Body’ by provoking feeling in its readers,
however receptive, even eager, they might be to surrender to its effects.” 310 Instead,
Austen might be said to have used the measured writings of Samuel Johnson as a model
for some of her characters. Wiltshire cites Elinor Dashwood’s moderation, judiciousness,
and careful conduct as evidence, and argues that Elinor’s “father” might have been Dr.
Johnson himself. Johnson was a self-proclaimed “dabbler in Physick” who emphasized
“clinical observation and experimental knowledge as the foundations of medicine.” 311
Austen too bears some resemblance, as she lays out her heroines’ symptoms of
sensibility for her readers’ observation so that they might arrive at a shared diagnostic
conclusion about the symptoms of sensibility.

Throughout Sense and Sensibility Austen presents and examines several cases,
the subjects of which are all potential heroines of sensibility. I suggest she uses the
model of the medical case study as a diagnostic tool for the disordered women in her
novel as she strives towards what might be called a “fresh application.” 312 Through
Elinor’s—and especially Marianne’s—narratives, she works to evaluate and reconsider
the conventions of the novel of sensibility. As noted above, the results of these efforts are
mixed: by the end of the novel, she offers evidence illustrating that medical treatment for
symptoms of sensibility is not really warranted. She does not deny that the symptoms of
sensibility can be quite persistent, and agrees that one can attempt treatment, applied like

311 Wiltshire, Jane Austen and the Body, 27, 3; Samuel Johnson in the Medical World: The Doctor and the
312 This phrase is used by Marianne’s physician, Mr. Harris, to describe his course of treatment during her
illness.
ointment on a scratch to soothe the sting. In the main though, the problems of sensibility are superficial, and as afflictions will gradually heal themselves if left alone. It is the very topic and conventions of sensibility that Austen finds to be unworthy of treatment within her novels. Sensibility burdens the novel, locking the conventions of its stories and characters into particular inevitabilities.

Marianne’s illness, I argue, is actually a symptom of the disordered novel of sensibility. Personally, she is relieved of her symptoms, but her story—and to a lesser extent, Elinor’s also—cannot be remedied as easily. The ending of Sense and Sensibility has left many readers dissatisfied, and I suspect this dissatisfaction derives from Austen’s reluctance to engage with the chronic conventions of the novel of sensibility, which would have dictated an overwrought conclusion for the two sisters, or at least for Marianne. William Galperin notes “Marianne’s eventual marriage to Brandon is more than an event that readers have long lamented in light of its compromised disposition, particularly following Willoughby’s tenth-hour disclosures. It is a figure as well of Austen’s marriage to a literary form and to an authority—or an hegemony ...—that forecloses on change in seeming to value it.”313 The possibilities for medical and artistic treatments of sensibility are limited and limiting, and thus Sense and Sensibility is both the first and last of Austen’s works to even offer an attempt.

Colds in the Head, Sore Throats, and Fevers

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In *Searching for Jane Austen*, Emily Auerbach seeks to locate the identity of the “elusive” Austen amidst a myriad of scholarly, popular, cinematic, historical and biographical accounts that have been, and continue to be, published on the early nineteenth-century novelist. Auerbach claims that the early recorded versions of Austen’s life—by brother Henry Austen in 1817 and nephew James Edward Austen Leigh in 1869—as well as the edits and excisions to her letters by her sister Cassandra, effectively sanitized the author, removing witty, sarcastic, materialistic, and bodily references, and leaving behind a “kinder, gentler” Jane, a “modest, delicate, saintly woman.”

Auerbach describes this as a careful and deliberate distancing of Austen from her body and bodily habits, suggesting that Austen-Leigh “needed to support his claim that his aunt knew nothing of medicine, so he [cut] sentences referring to bones, fractures, bile, and emetics.” Indeed, readers often consider Austen as an author of manners, of romance, and of social niceties, not of bodies, illnesses, and disease.

Despite these early depictions, and the excisions from her correspondence, sufficient material remains to indicate that Austen often cared for ill family members, and furthermore, that she herself was not a creature of delicate, easily fluttered nerves. There are regular instances in which Austen remarks upon circumstances that could have—or would have—produced discomfort in someone less hardy, or someone more closely resembling a typical heroine of the novel of sensibility. A few brief examples serve to illustrate the humour and nonchalance with which Austen could treat her own and others’ afflictions. In August 1796, for instance, she informs Cassandra of her safe

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315 Ibid., 10.
arrival at Staines “without suffering so much from the heat as [she] had hoped to do.”

Of her mother some years later Austen wrote, “She would tell you herself that she has a very dreadful cold in her head at present; but I have not much compassion for colds in the head without fever or sore throat.” On its own, a cold was a mere annoyance, to be briefly endured. For much of her life, Austen herself resisted succumbing to ill health, and was keenly aware of and derisive towards the cultural currency of modish illnesses.

Austen’s time spent living in and visiting Lyme and Bath reinforced the idea of illness as a fashion, impermanent, and subject to rapid change. While in Lyme with her parents she wrote, “It was absolutely necessary that I should have the little fever and indisposition, which I had;—it has been all the fashion this week in Lyme.” In 1807 she rhetorically asked, “What is become of all the Shyness in the World?—Moral as well as Natural Diseases disappear in the progress of time, and new ones take their place.—Shyness & the Sweating Sickness have given way to Confidence and Paralytic Complaints.” This comment is telling: neither one’s physical nor moral natures are innate. For Austen, bodily habits were never fixed. Rather, it was imperative that people work on changing and improving those that might be harmful. Thus while Mary Hays believed in the “inveterate nature of reiterated habits” and her final literary character died a “victim of circumstance,” Austen declared that “seven years” would be enough “to change every pore of one’s skin, & every feeling of one’s mind.”

316 Austen to Cassandra Austen, 23 August, 1796, Letters, 5.
318 Austen to Cassandra Austen, 14 September, 1804, Letters, 92.
319 Ibid., 8-9 February, 1807, 119.
320 Ibid., 8-11 April, 1805, 99. See note 263, Ch. 2.
For Austen, feigned afflictions could be sources of amusement or entertainment because they were caused by human folly. Beyond a gentle mocking, Austen’s tone implies that there is no point in expending energy or concern on a feigned disorder. Austen described a neighbour in 1813 as a “Honey—the sort of woman who gives me the idea of being determined never to be well—and who likes her spasms & nervousness & the consequence they give her better than anything else.” Feigned or exaggerated nervous afflictions, in particular, were treated by Austen with light humour (as Mrs. Bennet’s familiar lament that Mr. Bennet has “no compassion on her poor nerves” reminds us). The nerves, of course, were understood as the seat of sensibility. Austen generally rewarded the deliberate display of nervous disorders with a scathing send-up in both her life and her fictions. Her final, unfinished work, *Sanditon*, indicates that her treatment for hypochondriacs (as we currently understand the term) was a cutting dose of satire. One biographer queries: “What other fatally ill writer has embarked on a savage attack on hypochondria?”

When illness was genuine, however, as it appears to have been with several of her family members, Austen showed both knowledge and concern. Her brother Edward suffered from ill health in 1798 and Austen’s comments at this time indicate an

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322 From Robert Hooper’s *Compendious Medical Dictionary*: nerves “convey the principles of motion and sensibility to the brain from all parts of the system, and from the brain to every part of the system. The manner in which this operation is affected is not yet determined,” s.v. “nerve.” (London, 1798). William Buchan explains: “In all persons afflicted with nervous disorders, there is a great delicacy, and sensibility of the whole nervous system, and an uncommon degree of weakness of the organs of digestion. These may be either natural or acquired” (*Domestic Medicine* [London, 1790], 292).

understanding of, and adherence to humoral medical theory. When discussing his “Bowel complaints, Faintnesses & Sicknesses,” she remarked, “If his nervous complaint proceeded from a suppression of something that ought to be thrown out, which does not seem unlikely, the first of those Disorders may really be a remedy, & I sincerely wish it may, for I know of no one more deserving of happiness.” 324 The reference to something that “ought to be thrown out” signifies her equation of bodily health with balanced humours in the body and suggests her understanding of the narrative logic of the medical case (something needs to be “thrown out” before change can be effected). She comments similarly on her brother Henry’s illness: “What a turn he has for being ill! & what a thing Bile is! This attack has probably been brought on in part by his previous confinement and anxiety;—but however it came, I hope it is going fast.” 325 Bile was often the suspected culprit behind the afflictions of the Austen family members, including her own. In general, she balanced her concern for the ill health of others with activity, optimism, and a rational outlook.

In her letters Austen represents most real illnesses as temporary and treatable. Furthermore, their treatment would be facilitated by adhering to the logic of the medical case—what worked as treatment in one instance should work again in another provided the circumstances are enough alike. She was almost invariably optimistic when confronted with illness. In 1798 she wrote of her mother: “It is by no means wonderful that her Journey should have produced some kind of visitation;—I hope a few days will entirely remove it.” 326 Illness was a “visitor” who, after an appropriate amount of time,

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325 Ibid., 6-7 November, 1813, 253.
326 Ibid., 27-28 October, 1795, 16. Austen here uses “wonderful” as a term expressing surprise. “Visitation” refers to her mother’s being temporarily afflicted with an indisposition.
would absent itself or be removed. She also wrote of family friend Mary Cooke in 1809, “yesterday brought me a much better account from Mary; the origin of the complaint being now ascertained to be Bilious, & the strong medicines requisite, promising to be effectual.” Once the “origin” or cause was understood, a treatment could follow. Austen repeatedly demonstrates this understanding of a logical process for diagnosis and treatment of illness for her family, friends, and most tragically, for herself.

During her own final illness, Austen continued to emphasize the narrative logic of the case. She writes in 1817: “I have certainly gained strength through the Winter & am not far from being Well; & I think I understand my own case so much better than I did, as to be able by care, to keep off any serious return of illness. I am more & more convinced that Bile is at the bottom of all I have suffered, which makes it easy to know how to treat myself.” An “understanding” of one’s “case” is what enables self-treatment. She remained optimistic until shortly before her death, and when suffering from a renewed attack she deliberately articulated a cause: “A few days ago my complaint appeared removed, but I am ashamed to say that the shock of my Uncle’s will brought on a relapse, & I was so ...Ill on Friday & thought myself ... likely to be worse. ... I am the only one of the Legatees who has been so silly, but a weak Body must excuse weak Nerves.” Austen here acknowledges (without naming) the existence of symptoms of sensibility, yet she admits them only as emerging from bodily illness, and significantly not the other way around. Austen died four months after composing this

327 Ibid., 30 January 1809, 172.
329 Austen to Charles Austen, 6 April, 1817, Letters, 338. Austen here refers to the surprise of her wealthy uncle’s will which left the bulk of his property to his wife, instead of to his nephews (Austen’s brothers), as had been generally expected.
letter. Her treatments at the hands of others (she was nursed by her sister and was visited by at least three physicians) proved finally unsuccessful.\textsuperscript{330} Austen’s treatment of her literary characters, particularly \textit{Sense and Sensibility}’s Marianne, however, ensured a very different fate for her heroines.

**Sensibility**

The novel’s title page generates the expectation that sensibility will play one of two main roles. In an oft cited reading Marilyn Butler argues, “Austen conscientiously maintains the principle of a didactic comparison. ... The entire action is organized to represent Elinor and Marianne in terms of rival value systems.”\textsuperscript{331} Furthermore, the early associations of Marianne and sensibility in the text seem to present the latter as a problem requiring treatment. We are told by the narrator that Marianne is “sensible and clever; but eager in every thing; her sorrows, her joys, could have no moderation.” The meaning of “sensible” here is ambiguous; it might be a good thing, in its association with “clever” and in its seemingly being contrasted (through the conjunction “but”) with her immoderate emotions. Yet Elinor depicts it as a negative quality only a page later as she sees “with concern, the excess of her sister’s sensibility”; this sensibility, at least in its excess, is more clearly a flaw or shortcoming (4, 5).\textsuperscript{332} Unsurprisingly, Butler’s reading

\textsuperscript{330} The cause of Austen’s death has not been determined. Signs point variously to Addison’s disease, non Hodgkin lymphoma, and leukemia, among others.


contrasts Marianne and her immoderate emotions with Elinor, whose “feelings are strong but she knew how to govern them” (4). As noted above, in recent years, critics have credibly countered Butler’s interpretation by aiming to dismantle such a seemingly strict binary.

Thomas Keymer and John Wiltshire both question the natural desire to read the work as a presentation of binaries: sense versus sensibility, right versus wrong, Elinor versus Marianne, and, I will add, healthy versus unhealthy. Thomas Keymer points out that in general, “a properly flexible account of Sense and Sensibility [sees] it as a novel in which binaries break down.”  

In her correspondence Austen seems to use the term “sensible” as one that might broker between the sense and sensibility divide. One of the apothecaries who visited her brother serves as an example here. Austen describes him as a “sensible, intelligent man” capable of discerning that “the occasional particular glow in the hands & feet, which we considered as a symptom of [the Gout], he only calls the effect of the Water in promoting a better circulation of the blood.”

Here, Austen perceives Mr. Anderton as “sensible,” able to employ diagnostic narrative logic; he reads a particular symptom as being the result of a very particular cause, and offers a diagnosis based on these factors. Interestingly, the term “sensibility” does not appear frequently in her correspondence, and significantly never, as far as I can tell, is it used after 1799.

Marianne embodies sensibility; yet as critics note, Austen does not seem to dislike her. Claudia Johnson suggests: “Austen can, in a sense get away with a character like Marianne because she suppresses her antecedents—Marianne reads Scott and

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333 Keymer, “Northanger Abbey and Sense and Sensibility,” 35.
Cowper, not Hays or Wollstonecraft—and projects a fictive world that supports many of Marianne’s contentions.” Helen Small argues that the difficulty in interpreting Marianne’s sensibility lies in Austen’s language which “vacillates between presenting Marianne as actively cultivating a false sensibility and presenting her as the victim of a sincerely suffering sensibility.” According to Small, it is difficult to determine whether Marianne embodies—as in, has a sensitive and feeling body—and therefore genuinely suffers from her sensibility, or whether her sensible condition is more superficial—feigned or contrived—and therefore merely appears to be a case requiring treatment. This deliberate ambiguity, I argue, is part of Austen’s strategic treatment and subsequent dismissal of sensibility from her chosen form, the novel.

While both Elinor and Marianne can be described as having “sense” and “sensibility,” only Marianne is associated with affliction, or a bodily liability requiring treatment. Elinor consistently takes preventative measures—though often at great physical and emotional pains—to avoid displaying any signs of emotional or physical affliction: as Marianne remarks, Elinor’s “self-command is invariable” (33). While Austen uses the very same language of sensibility, irritability, and impressionability with both sisters, Elinor routinely resists the consequences of such impressions through deliberate and calculated effort, while Marianne generally gives voice to whatever she is feeling. When a gloomy Edward comes to visit, for example, his attitude “left an uncomfortable impression on Elinor’s feelings especially, which required some trouble and time to subdue. But as it was her determination to subdue it, and to prevent herself from appearing to suffer more than

what all her family suffered on his going away,” she adopts what the narrator terms as a “method” very different from Marianne’s (89). The employment of a particular “method” places Elinor’s conduct in the realm of rationality and reason, rather than feeling and sentiment. The use of “impression” implies that it is her nerves that were affected, but she disallows the display of any symptoms that might confirm this to other characters in the novel. Interestingly, the narrator also suggests that Marianne has “judiciously” chosen her own “method” of responding, thereby asserting that the conduct of both sisters is equally deliberate. Similarly, when Elinor learns of Edward’s prior engagement, “though her complexion varied, she stood firm in incredulity and felt in no danger of an hysterical fit, or a swoon” (111). Austen’s use of free indirect discourse is strategic here and enables us to see that Elinor knows the symptoms that might arise in situations similarly circumstanced, but also knows through feeling that she is in no danger. Elinor “feels” just as much as Marianne, but she is always conscious of the likely outcome following the full expression of these feelings, and so she consistently uses “resolve,” “fortitude,” “self-command,” and “exertion” to avoid their display.337

While the novel devotes equal time to both sisters, Marianne usually generates more narrative interest for the readers within the novel; in other words, characters seek to read and interpret Marianne’s body much more frequently than they do Elinor’s.338 Marianne’s sensibility and seeming susceptibility are what leave space for the stories that others tell about her. Marianne’s narrative forces itself upon readers (both within and outside the novel), while Elinor’s is more silent, subtle, but still interesting. Kathryn

337 See Sense and Sensibility, 112-113, 116, 121, 190, 211, 230, 312.
338 Consider, for example, her step-brother’s observation following Willoughby’s rejection of Marianne: she “‘looks very unwell, has lost her colour, and is grown quite thin. ... At her time of life, any thing of an illness destroys the bloom for ever! Her’s has been a very short one!” (198-99).
Montgomery Hunter explains, “Stories or case histories are themselves readings and interpretations of events as they have been represented in patients’ narratives or as they have left their marks on patients’ bodies.” Through her silences and omissions, Elinor continually resists narrative, and uses fortitude to resist having her conduct and mien be in any way remarkable. Having had Lucy’s confession of her engagement to Edward forced upon her, Elinor “thought she could even now, under the first smart of the heavy blow, command herself enough to guard every suspicion of truth from her mother and sisters” (121). The metaphor here is physical; the news is likened to physical violence, the evidence of which must be concealed from public view. When Marianne is devastated by Willoughby’s public repudiation of her, Elinor’s first words of caution are “Do not betray what you feel to every body present” (152). The reasoning behind this advice is, presumably, because a public, visible betrayal of feeling will inevitably lead to the generation of stories by others, true or not.

Visible signs of “feeling” include blushing, pallor, trembling, and, of course, tears. Such signs from Elinor, however, are almost always only given in sympathy with other people’s narratives, while Marianne’s are almost exclusively for her own. “Many were the tears shed by them in their last adieus” as they leave their beloved home, Norland. Both sisters cry in this instance (and naturally so, while mourning the loss of their father and family home), but only Marianne speaks, placing herself at the centre of the narrative of loss: “Oh! happy house, could you know what I suffer in now viewing you from this spot, from whence perhaps I may view you no more!” (23). For Marianne it is her suffering that

takes centre stage. A later incident results in Elinor weeping, but it is significantly as a result of her sister’s story, and not her own. Following the arrival of Willoughby’s final letter to her sister, Elinor enters the room, “eager ... to know what Willoughby had written.” She is as keen to learn the outcome of this narrative as the readers of the novel. She sees:

Marianne stretched on the bed, almost choked by grief, one letter in her hand, and two or three others laying by her. Elinor drew near, but without saying a word; and seating herself on the bed, took her hand, kissed her affectionately several times, and then gave way to a burst of tears, which at first was scarcely less violent than Marianne’s. The latter, though unable to speak, seemed to feel all the tenderness of this behaviour, and after some time thus spent in joint affliction, she put all the letters into Elinor’s hands; and then covering her face with her handkerchief, almost screamed with agony. Elinor, who knew that such grief, shocking as it was to witness, must have its course, watched by her till this excess of suffering had somewhat spent itself. (157-8)

Elinor’s conduct is in response to Marianne’s suffering. Though her tears are “scarcely less violent,” Elinor does not cry for herself, and she almost immediately resumes watching her sister’s “excess of suffering.” Later, Elinor will briefly shed “tears of joy” when Marianne recovers from serious illness, but for the most part she remains “silent and strong” (275). There is only one moment in the text when Elinor cries for herself, and yet it is hidden so that it is only through the complicity of the narrator that we are even told about it.

Austen reveals the fact of Elinor’s having had a story to tell only at the end of the novel—readers, but not characters, have been privy to her acts of self-control throughout. She gives a very small physical sign, and this is followed by a much larger one on the part of Marianne. When the Dashwood ladies receive what they believe to be the news that Edward is married, “Marianne gave a violent start, fixed her eyes on Elinor, saw her turning pale, and fell back in her chair in hysterics. Mrs. Dashwood, whose eyes, ... had
intuitively taken the same direction, was shocked to perceive by Elinor’s countenance how much she really suffered” (310). The sequencing is important here: Marianne is startled by the news, but it is not until she sees a physical sign at last revealed by her sister that she becomes truly alarmed. Her hysterics and Mrs. Dashwood’s concern are the result of Elinor’s pallor—an unusually visible sign from her—not the news itself. The narrator then offers a lesson in reading that might be considered in light of the novel as a whole:

[Mrs. Dashwood] now found that she had erred in relying on Elinor’s representation of herself; and justly concluded that every thing had been expressly softened at the time, to spare her from an increase of unhappiness, suffering as she then had suffered for Marianne. She found that she had been misled by the careful, the considerate attention of her daughter, to think the attachment, which once she had so well understood, much slighter in reality, than she had been wont to believe, or than it was now proved to be. She feared that under this persuasion she had been unjust, inattentive, nay, almost unkind, to her Elinor;—that Marianne’s affliction, because more acknowledged, more immediately before her, had too much engrossed her tenderness, and led her away to forget that in Elinor she might have a daughter suffering almost as much, certainly with less self-provocation, and greater fortitude. (312)

The lessons in reading, interpretation and narrative here are several. With Mrs. Dashwood’s “just” conclusion, Austen confirms that there have been two case studies of sensibility unfolding throughout the novel. We are told that Elinor has been consciously presenting a version, a “representation” of herself. Her having “misled” her mother is significant, as it suggests a very deliberate act, not only of encouragement, but of encouragement in the wrong direction. When Elinor learns that Edward is free to marry her, her fortitude finally crumbles; yet she still refuses to present signs for public consumption: “Elinor could sit no longer. She almost ran out of the room, and as soon as the door was closed, burst into tears of joy, which at first she thought would never cease”
Even at the height of her happiness, Elinor refuses to publicly share her body’s response with those around, thereby denying the other characters the opportunity to access and weigh in on her story.

Mrs. Dashwood’s description of herself as an “unjust, inattentive” and “almost unkind” reader provides a reminder that the just, attentive, and kind reader has known all along that Elinor’s quieter case was also worth attention. When Marianne admonishes her sister for her lack of feeling, Elinor replies: “The composure of mind with which I have brought myself at present to consider the matter, the consolation that I have been willing to admit, have been the effect of constant and painful exertion; they did not spring up of themselves;—they did not occur to relieve my spirits at first” (230). Elinor might have taken a lesson from Wollstonecraft’s Mrs. Mason who recommended the “patient endurance of pain” in order to resist the passions.340 Here is a reiteration of the narrative logic of cause and effect, as well as a reminder of what the reader has known all along, that Elinor’s suffering has been as great as that of her sister; it was simply more contained, and thus only sophisticated readers perceived it and sympathized with it.341 The sisters’ narratives are quite similar, a fact which will become increasingly important as we consider Austen’s dismantling of the heroine of sensibility and her gradual construction of a more introspective and sympathetic model of female literary heroism. “Sympathy,” in this


341 Mrs. Jennings, a kind but unrefined reader, misinterprets Elinor’s narrative as well. When she sees Elinor in conversation with Colonel Brandon she observes that the young lady “changed colour, attended with agitation, and was too intent on what he said to pursue her employment” (245). She believes that a proposal is taking place when in fact Colonel Brandon is trying to enable Edward Ferrars to marry Elinor’s rival, Lucy Steele.
context, should suggest both feeling for others, and the capability of generating sympathy in the reader.\textsuperscript{342}

Unlike Marianne, whose charged emotions lead her to reckless conduct resulting in illness and fever, Elinor is never in any danger of dying. Even when suffering from more minor afflictions, through her resolution, governance, exertion, composure, and firmness, she takes preventative measures to ensure that no one need care for her; she knows that she can and so she does care for herself. In reality, Elinor endures a plight comparable to that of Marianne; she is suffering “almost as much” (312). Yet she prefers the small “consolation” produced by “constant and painful exertion” to the histrionics of Marianne. She tells Marianne, “I owed it to my family and friends, not to create in them a solicitude about me, which could not be in my power to satisfy” (230, 228). It is no surprise then that Marianne’s “affliction” is “more acknowledged” by Mrs. Dashwood, as well as by the other characters throughout the work. Narratives of sensibility, unless deliberately silenced like Elinor’s, are often presented by authors and witnessed by other characters and readers through bodily signs. Peter Melville Logan cites the writings of eighteenth-century physician Thomas Trotter and claims that “the nervous temperament is unique in demanding the ‘sympathy and attention of others to the narration of their own sufferings.’”\textsuperscript{343} Marianne embodies this temperament to an extreme: not only does she display the bodily signs—she becomes pale and she weeps—but she also speaks clearly, narrating the connection between what she feels and what she says. In other words, there

\textsuperscript{342} John Mullan notes that “sympathy” was described by David Hume in \textit{A Treatise of Human Nature} (1739-40) as “the faculty by which ‘the passions and sentiments of others’ become our own” (“The Sentimental Novel,” 249).

is a clear link between her physical, emotional, and mental health and the way she presents her own narrative; this is a marked contrast to her sister’s almost continuous suppression of narrative.

Not only does Marianne display the physical symptoms of sensibility, but she also articulates them verbally. The narrator informs us: it “was impossible for [Marianne] to say what she did not feel” (105); similarly it seems impossible for her not to say what she does feel. Thus from the novel’s beginning, Marianne commands attention, both physically and verbally. She and her mother suffer “the agony of grief,” giving themselves up “wholly to their sorrow, seeking increase of wretchedness,” and resolving “against ever admitting consolation” (5). The language here indicates the degree to which their emotional pain is excessive, yet encouraged by themselves and by each other. And it seems that for Marianne, her indulgent emotional excesses frequently lead to her physical discomfort. The morning after Willoughby’s abrupt departure:

She would have been ashamed to look her family in the face the next morning, had she not risen from her bed in more need of repose than when she lay down in it. But the feelings which made such composure a disgrace, left her in no danger of incurring it. She was awake the whole night, and she wept the greatest part of it. She got up with an headache, was unable to talk, and unwilling to take any nourishment; giving pain every moment to her mother and sisters, and forbidding all attempt at consolation from either. Her sensibility was potent enough! (71)

Even when unable to verbally convey her suffering, Marianne does not conceal it. Her “sensibility” in this instance is layered. She feels that she ought to respond in a certain way to the situation; and her cognisance of this, both mental and emotional, is sufficient to generate the appropriate bodily responses. Following Willoughby’s unexplained
departure she displays a “violent oppression of spirits,” “violence of affliction,” and “effusions of sorrow” before settling into a “calmer” though no less visible “melancholy” (71-2).

Many Austen critics have observed that the novel is, especially after Willoughby’s departure, almost entirely focalized through Elinor: we see her watching Marianne. Deidre Lynch explains: “Austen’s handling of point of view and use of free indirect discourse ... render the real story of *Sense and Sensibility* the story of Elinor’s inner experience. Yet Austen makes us work if we want straightforwardly to correlate psychological effects with individuality or to correlate what is most private with what is most personal.”344 I agree: I want to emphasize, however, that all the novel’s characters, even the savvy one (Elinor), get swept up in Marianne’s narrative of sensibility. Elinor focalizes her sister’s experience, not her own. Part of Austen’s project, I suggest, is getting the reader to understand which other kinds of narrative might be worth closer attention, which other heroines might be worth reading about. Mary Favret argues that Elinor “is an anti-epistolary heroine: the inner world of her thoughts and feelings finds no direct expression in the novel,” while Marianne “insists on making explicit her innermost thoughts.”345 In some ways, Austen’s “treatment” of the novel of sensibility might be akin to her “treatment” and dismissal of the epistolary novel: Elinor’s letters, Favret explains, “never enter the novel—they disappear uninspected. Instead, Austen’s reading lesson persuades us to accept the intervention of the narrator, in order to protect

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the interest of the heroines.”⁴³⁶ After having started within the conventions of the novel of sensibility, Austen finds herself at a loss as to how to get out.⁴³⁷ Elinor keeps her symptoms to herself; she does not display them or describe them; and as such, she requires a different kind of narrative representation. It is Austen’s use of free indirect discourse with Elinor that enables her to become a richer, more complex character. Clara Tuite suggests that Sense and Sensibility institutes a “mechanism of sympathy, through the technique of free indirect discourse, which mainly focuses the sympathetic character of Elinor. Austen’s text transforms the suspect, contagious principle of sensibility into a more sober principle of sympathy through free indirect discourse.”⁴³⁸ While Marianne’s perceptible symptoms attract the attention of the novel’s other characters, Elinor’s silent sufferings garner the readers’ sympathy.

Home Remedies: Lavender Water, Constantia Wine & Apricot Marmalade

Marianne’s most audible moment of suffering, her near scream of “agony,” follows her rejection by Willoughby in London. Tony Tanner has commented on this “muffled scream ... at the heart” of the novel, and he reads it as “a symptom” of Marianne’s sickness (which is discussed at length below).⁴⁴⁹ There is, however, another

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⁴³⁶ Ibid., 152.
⁴³⁷ Favret also notes, “Unlike her fictional predecessors, ... the letter-writing Marianne does not die; instead, the threat of the letter is continually revealed and overcome in the novel. Although the institutionalizing power of letters does temporarily silence and debilitate both Marianne and Elinor, Austen’s narrative technique rescues them both, weaning both them and her readers away from a tragic epistolary closure” (152).
⁴⁴⁹ Tony Tanner, Jane Austen (Houndsmills, Basingstoke: Macmillan, 1986), 75.
moment of shrieking in the text, a scream not at all muffled, though for all its volume, much more frequently overlooked. As Elinor and Marianne sit visiting Lady Middleton and the Misses Steele, their host holds and caresses one of her daughters, a young girl named Annamaria:

Unfortunately in bestowing these embraces, a pin in her ladyship’s head dress slightly scratching the child’s neck, produced from this pattern of gentleness, such violent screams, as could hardly be outdone by any creature professedly noisy. The mother’s consternation was excessive; but it could not surpass the alarm of the Miss Steeles, and every thing was done by all three, in so critical an emergency, which affection could suggest as likely to assuage the agonies of the little sufferer. She was seated in her mother’s lap, covered with kisses, her wound bathed with lavender-water, by one of the Miss Steeles, who was on her knees to attend her, and her mouth stuffed with sugar plums by the other. With such a reward for her tears, the child was too wise to cease crying. She still screamed and sobbed lustily, kicked her two brothers for offering to touch her, and all their united soothings were ineffectual till Lady Middleton luckily remembering that in a scene of similar distress last week, some apricot marmalade had been successfully applied for a bruised temple, the same remedy was eagerly proposed for this unfortunate scratch, and a slight intermission of screams in the young lady on hearing it, gave them reason to hope that it would not be rejected.—She was carried out of the room therefore in her mother’s arms, in quest of this medicine.

In responding to Miss Steele’s lament that “It might have been a very sad accident,” Marianne replies, “Yet I hardly know how, ... unless it had been under totally different circumstances. But this is the usual way of heightening alarm, where there is nothing to be alarmed at in reality” (104-105). This blunt comment from Marianne is hardly surprising. She almost always voices her opinions for better or for worse, leaving Elinor, Tanner notes, to erect the appropriate social “screens.” Marianne here provides another interpretive

350 See Tony Tanner, especially Ch. 3, “Secrecy and Sickness: Sense and Sensibility,” 86.
key for the text: each person’s case history is different, but, particularly for those suffering from the symptoms of sensibility, their endings are not usually tragic (or even all that interesting), unless in the most extreme circumstances.

There are several useful points of comparison between Annamaria, this most minor character (literally and figuratively), and Marianne, one of the novel’s heroines, aside from the near anagrammatic nature of their names. A brief description of their similarities: Lady Middleton’s “consternation” at Annamaria’s minor injury “was excessive”; and when Mrs. Dashwood learns of Willoughby’s conduct towards her daughter, she too feels a “disappointment hardly less painful than Marianne’s” (185). As discussed above, early in the text, when mourning the death of Mr. Dashwood (which of course must not be equated with the scratch of a needle):

Elinor saw, with concern, the excess of her sister’s sensibility; but by Mrs. Dashwood it was valued and cherished. They encouraged each other now in the violence of their affliction. The agony of grief which overpowered them at first, was voluntarily renewed, was sought for, was created again and again. They gave themselves up wholly to their sorrow, seeking increase of wretchedness in every reflection that could afford it, and resolved against ever admitting consolation in future. (8)

Marianne’s voluntary renewal of excessive affliction, and her deliberate yielding to sorrow, resembles the little girl’s calculated decision to continue crying. While grief is natural, it is the deliberate prolongation of emotion that seems problematic for Austen. Though spontaneous at first, both young ladies (and Mrs. Dashwood) make an intentional resolution to continue displaying emotional symptoms. Lavender water is given as an

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351 John Mullan quotes an anonymous sentimental novel: “Grief ... improves the heart; it humanizes, it renders us more fit for society” and notes that such an equation of feeling and virtue was becoming “platitudinous” by the end of the eighteenth century (“Sentimental Novels,” 248-9).
antidote for the “hysterics” of both; and while Annamaria receives sugar plums, Mrs. Jennings offers Constantia wine, a sweet dessert wine, to heal Marianne’s broken heart.\(^{352}\) Annamaria kicks her brothers for offering consolation while Marianne, in response to Elinor’s “quiet and unobtrusive attention” entreats her, “with all the eagerness of the most nervous irritability, not to speak to her for the world” (155, 166). Thus far they may be said to resemble one another. Though neither lady’s condition warrants it, the narrator discusses both using medical language and case analogies—“critical an emergency,” “assuage the agonies,” “wound bathed with lavender water,” “distress,” “remedy,” and “medicine.” Austen uses this language, however, to show its extravagance, and to suggest that it might be out of place in terms of “treating” the symptoms of sensibility.

The means through which their situations are remedied are also comparable. Possible solutions for both young women are determined using the logic of the case; that is to say, other characters determine and offer treatments for them through a consideration of the circumstances that led to their particular conditions, and via comparisons between these and similar past experiences—or as Kathryn Montgomery Hunter refers to it, a “narrative taxonomy of similar cases.”\(^{353}\) Lady Middleton’s recollection of a “similar distress last week” is what finally helps remedy her daughter’s situation (through the application of apricot marmalade). Colonel Brandon offers Elinor a narrative of a woman who “bears a strong resemblance” to Marianne “as well in mind as in person;” Elinor’s retelling it to Marianne has a temporarily restorative effect on her while she is mourning

\(^{352}\) Elinor accepts the wine instead, and “as she swallowed the chief of it, reflected that, though its good effects on a cholicky gout were, at present, of little importance to her, its healing powers on a disappointed heart might be as reasonably tried on herself as her sister,” reminding the reader again of their similar plights (172).

\(^{353}\) Hunter, *Doctors’ Stories*, 5.
the loss of Willoughby. Colonel Brandon hopes the “comparison must have its use with her” and though it does not effect a permanent cure, Elinor does observe Marianne’s “spirits less violently irritated than before” and “her mind become settled” (185). In both instances a method of treatment is determined by comparing case histories. In both cases, however, the treatments are only able to alleviate the symptoms of sensibility, not to cure sensibility itself—because, as Austen determines, sensibility does not warrant substantial medical treatment, or artistic, for that matter.

The realization that there are two shrieking females in the midst of an otherwise demurely quiet Austen novel calls for a reconsideration of the significance of such utterances. Given the similarities between Annamaria and Marianne, the latter’s comment to Miss Steele that the situation could have only been problematic if it had taken place under different circumstances is worth considering. “This is the usual way of heightening alarm, where there is nothing to be alarmed at in reality,” says Marianne (105). Marianne offers a signal here, one easily missed. Through the progress and outcome of Marianne’s story, Austen points out that no one should die from of a scratch, just as no one should die from a broken heart, unless in the most dire of circumstances. As Claudia Johnson observes, novels of sensibility are full of heroines dying from this very cause (broken hearts, not needle scratches): death is the only “culturally recommended” way through which a fallen woman can clear her name. In general, Johnson adds, “the

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354 It is worth noting that Mrs. John Dashwood also screams when she hears of her brother’s prior engagement to Lucy Steele: “She fell into violent hysterics immediately, with such screams as reached [her husband’s] ears, as he was sitting in his own dressing-room down stairs.” Mr. Donavan, a physician, is called for her care and his response indicates Austen’s sentiments towards such feigned affliction: ”he smirked, and simpered, and looked grave, and seemed to know something or other, and at last he said in a whisper, ‘...I think it advisable to say, that I believe there is no great reason for alarm; I hope Mrs. Dashwood will do very well’” (224).
operations of sensibility require the suppression of women’s health and resilience,” and death is therefore the usual outcome for heroines of sensibility.\textsuperscript{355} Austen does not rule out the insights the culture of sensibility had into the interconnectedness of the mind and body—in fact Persuasion’s Anne Elliot will make a strong claim for the existence of such a connection by modelling genuine feelings of sympathy—yet Austen does employ the case study model to illustrate the more likely causes behind the deaths of such women, demonstrating the high improbability of romantic circumstances ever directly leading to actual death. A close examination of the narrative of the one woman who does die indicates the degree to which Austen seeks to undermine the narrative logic of such tales.

It is Colonel Brandon who first paints a likeness between the woman he once loved, Eliza, and Marianne Dashwood. According to Brandon, there is a “very strong resemblance” between the two women. He cites their “warmth of heart, [and...] eagerness of fancy and spirits” as points of similarity (178). He then provides the details of Eliza’s history to Elinor: Eliza had been forced to marry against her will, Brandon’s brother, a man of dubious (personal and sexual) character. Her husband’s mistreatment of her, and her lack of “fortitude” (179), Brandon suggests, lead to her infidelity, divorce, and finally, death. We are told that when Brandon finds her she was “so altered—so faded—worn down by acute suffering of every kind! Hardly could I believe the melancholy and sickly figure before me to be the remains of the lovely, blooming, healthful girl, on whom I had doated” (180). Brandon is there to witness Eliza’s death from “consumption.” This narrative by Brandon is frequently read as setting the stage for Marianne’s fate, outlining

the dangers that may await her through her liaison with Willoughby. Brandon then reaffirms this narrative trajectory through the story of Eliza’s daughter (also named Eliza) who is seduced and abandoned by Willoughby. As Mary Poovey suggests, “it is from the fate of the two Elizas we learn to be wary of Marianne’s quick feelings.”

Indeed, the immediate force of the Elizas’ cautionary tales is palpable.

Yet it is important to note the many differences in narrative “circumstances” between the Elizas and Marianne. There are similarities of character, but their situations are so different, that it is difficult to imagine their fates being the same. The first Eliza is married, and is badly mistreated. When she dies, it is not from shame, a broken heart, or embarrassment, though these may have been contributing factors. Colonel Brandon is a self-admitted “awkward narrator” and cannot be unilaterally blamed for the reader’s assumption that this was the case. But if it is death by broken heart, it is a slow death indeed since Brandon is not able to locate her until almost four years after her first illicit affair.

Presumably, her death is as likely to have been brought on by the perils of poverty (he finds her living in a “sponging house”) as by the wounds of love. Brandon cites “consumption” as the cause of her death. Depending on the consulting physician, consumption could be caused by “violent passions, exertions, or affections of the mind; as a grief, disappointment, anxiety.” But it might just as easily be attributed to inactivity and the “warm, close rooms” of the sponging house. John Leake even suggests that there is a “particular habit of body” that may be “original or acquired which renders women more

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357 Austen is careful to provide a chronology here. Brandon does not come back to England for three years, and then it is almost another “six months” before he locates her.
immediately subject” to consumption.\textsuperscript{358} In other words, any and all of the circumstances surrounding a consumptive woman’s case history were relevant—since consumption could be either “original” or “acquired.” Consumption was a handily vague disorder with which heroines of sensibility could be diagnosed.\textsuperscript{359}

Brandon ends his narrative of the first Eliza with the admission that the circumstances between Marianne and Eliza are wildly different: he admits that he may have “fancied” a resemblance between the two and concludes, “their fates, their fortunes cannot be the same; and had the natural sweet disposition of the one been guided by a firmer mind, or a happier marriage, she might have been all that you will live to see the other be. But to what does all this lead? I seem to have been distressing you for nothing” (181). Thus here is another moment to remind the reader of Marianne’s own earlier words of wisdom. The “circumstances” of the two women are acknowledged even by the teller of the tale to be different enough that no alarm should be raised; presumably, the same treatment (or lack thereof) will not produce the same effects in Marianne. Brandon seems to fit within John Gregory’s description of dangerous physicians who, he explains, “upon the experience of the success of a remedy in some particular cases, they venture to prescribe it indiscriminately in all others, where some of the most remarkable symptoms correspond, without any farther enquiry into the circumstances in which they differ.”\textsuperscript{360}

Such medical practices, he notes, invariably harm more than they help.


\textsuperscript{359} Roy Porter remarks: “It is important not to assume that a single, fixed, specific ‘ontological’ disease was meant by the word ‘consumption,’ its synonym ‘phthisis’—or, in fact, by most other diagnostic labels. Diseases were rather \textit{sui generis}, marking states and symptoms, not things” (\textit{Doctor of Society: Thomas Beddoes and the Sick Trade in Late Enlightenment England} [London: Routledge, 1992], 115, n.101).

The circumstances of the second Eliza, which Brandon goes on to narrate, do seem to more closely resemble Marianne’s, in that both women are the objects of Willoughby’s attentions. But Eliza is an illegitimate orphan, placed first at a school and then in the care of inattentive strangers. Even Brandon admits that he shares her story not as a cautionary tale, but rather as a narrative intended to generate sympathy from Marianne: “she will feel her own sufferings to be nothing” (183). As noted above, Brandon’s narration does have a briefly restorative effect on Marianne. But due to her deliberate refusal to abandon the role of sentimental heroine, this tale effectively only serves to deepen her melancholy. When Elinor tells her of Eliza, though she

Saw [Marianne’s] spirits less violently irritated than before, she did not see her less wretched. Her mind did become settled, but it was settled in a gloomy dejection. She felt the loss of Willoughby’s character yet more heavily than she had felt the loss of his heart; his seduction of Miss Williams, the misery of that poor girl, and the doubt of what his designs might once have been for herself, preyed altogether so much on her spirits, that she could not bring herself to speak of what she felt even to Elinor. (185)

Marianne here becomes intensely melancholic. Wiltshire suggests that this is not because of “disappointed love,” but rather because she is “made ill by a disturbance given to the moral foundations of her world, by a denial of what, through the senses, she is sure she ‘knows.’” Since we later are persuaded of Willoughby’s love for her (through his convincing the rational Elinor of this fact), this claim has merit. But her acquaintance with Miss Williams’ story is only a part of the problem. As she has done throughout the novel, Marianne persists in trying to place herself at the heart of a narrative of sensibility. That

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the “loss of Willoughby’s character” impacts her more than “the loss of his heart” indicates the degree to which she is invested in him as a character type. His seduction and abandonment of Eliza disqualify him from fulfilling the role of the “man of feeling” who typically requires a “constant supply of pitiable objects in order to arouse the benevolent meltings that validate their moral status.” Marianne sees that one man alone cannot both create the object of pity and then pity it, and it is this disappointment that affects her most of all.

“An Heavy Cold”

Like Eliza before her, Marianne does become ill, and does, while mourning her separation from Willoughby, appear to be near death. It is therefore essential to look closely at this incident to determine whether her illness threatens to undermine Austen’s resistance to conventional trajectories for the novel of sensibility, or whether, as I argue, Marianne’s succumbing to illness is what enables Austen’s most trenchant critique of such novels, and her interrogation of the legitimacy of the heroine of sensibility as a source of narrative interest. Kimberly Braddock argues that the “medical case study was needed within the profession to verify pre-determined diagnoses.” Indeed, Elinor and Marianne serve as Austen’s most significant case studies, affirming her belief that the pre-determined literary diagnosis for heroines of sensibility (i.e., death) was, in fact, often erroneous.

362 Johnson, “‘A Sweet Face as White as Death,’” 169.
363 Kimberly Braddock, “The Medical Case Study as Rhetorical Form for Nineteenth-Century Literature and Art” (PhD Diss., Idaho State U, 2005), 19.
When Brandon narrates the story or case of the first Eliza, he omits the middle of her narrative; we know only the circumstances in which she started, and the tragic ones in which she died. This is perhaps because narratives of sensibility, as Claudia Johnson reminds us, often emphasize the “feeling of the onlooker, not the feeling of the sufferer, who indeed is only there so as to occasion the sentimental displays of the watchers.”

John Gregory notes that too often a “love of the marvelous is very conspicuous in most writers of medical observations. We find them recording extraordinary cases, such as having nothing similar to them, ... with a tiresome minuteness of description.” Thus Brandon’s sentiments, and those of Elinor and the readers, are awakened by Eliza’s extraordinarily tragic fate.

Readers become similarly alarmed for Marianne in large part because Austen allows Elinor, through whose very rational perspective much of the novel has been presented, to become alarmed for her sister. Elinor’s transition from self-command and restraint to fear and apprehension is what alarms the reader, as it seems that this tragic fate may be a very real possibility. When Marianne first starts to become ill, Elinor “then really believed” that the affliction would be short-lived (270), and, she persists for several days in “making very light of the indisposition” (270). Soon after, however, she witnesses her sister’s feverish delirium, and feels for herself a quickening and lowering of Marianne’s pulse. Her reading of these physical signs indicates her heightening alarm as she “fancied that all relief might soon be in vain” (273). While it may be nothing more than a “fancy,” at last Elinor has become complicit in placing Marianne at the heart of a narrative of

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364 Johnson, “‘A Sweet Face as White as Death,’ 159-74, 169.
sensibility. Surrounded by those (Colonel Brandon, Mrs. Jennings, the absent Mrs. Palmer) who believe that they already know what Marianne’s tragic fate will be, it is difficult for her to resist such an interpretation, such a diagnosis: “her apprehensions once raised, paid by their excess for all her former security; and the servant who sat up with her, for she would not allow Mrs. Jennings to be called, only tortured her more, by hints of what her mistress had always thought” (273). All those attentive to Marianne’s narrative, including Colonel Brandon, who has “no courage, [and] no confidence” in her recovery, feel certain of its outcome, perhaps no one more so than Marianne (272).

Despite Marianne’s wish—or belief in her wish—to die, it is the wish of the author that she should live. The possible cause(s) of Marianne’s illness is / are clearly stated, and following the causal narrative logic of Marianne’s case history, Austen cannot allow such a death for her heroine: “Two delightful twilight walks ... all over the grounds, and especially in the most distant parts of them, where there was something more of wildness than in the rest, where the trees were the oldest, and the grass was the longest and wettest, had—assisted by the still greater imprudence of sitting in her wet shoes and stockings,” given Marianne a cold (267). In other words, wanting to walk in the most wild, romantic scenery, and stubbornly refusing to come in from the cold and wet, led to Marianne’s illness. Dying of a cold brought on by walking in the wet woods would be bad. Even worse, however, would be Austen’s crediting the diagnosis and prognosis offered by Mrs. Jennings. Mrs. Jennings “scrupled not to attribute the severity and danger of this attack, to the many weeks of previous indisposition which Marianne’s disappointment had brought on” and she grieved for the “rapid decay, the early death of a girl so young, so lovely” (274). Had Marianne succumbed to this fate, this “decline,” Austen makes clear that it
would have been her own fault for so stubbornly adhering to the role of sentimental heroine—though perhaps implicitly the fault also lies in Marianne’s having no other literary heroines on which to model her conduct. When Marianne does recover, she tells Elinor:

My illness has made me think. ... I saw that my own feelings had prepared my sufferings, and that my want of fortitude under them had almost led me to the grave. My illness, I well knew, had been entirely brought on by myself, by such negligence of my own health, as I had felt even at the time to be wrong. Had I died,—it would have been self-destruction. (303)

Marianne admits that her “feelings” are culpable; and that furthermore, she deliberately and knowingly cultivated them in the hopes that her life would end. There is an admission here from Austen of the power of feeling and grief; but it is accompanied by Marianne’s judgment that to allow emotions such power is “wrong.”

Austen is careful to provide accurate details for Marianne’s case history, affirmed by a credible figure of medical authority, in order to demonstrate the improbability of death in Marianne’s case. The apothecary, Mr. Harris, effectively acts on the author’s behalf, refusing Marianne the death everyone seems to expect. When Marianne first becomes unwell, it is said to be a “violent” cold accompanied by “a pain in her limbs, a cough, and a sore throat” (267). She gradually becomes “more and more indisposed” and, after a

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366 Kenneth Moler reads the events surrounding Marianne’s illness as a criticism of “‘sense’ and of Elinor Dashwood.” He argues: “It is only Elinor who belittles the possibility of dying of love; Jane Austen grants Marianne a genuine decline—giving it an air of probability by having Marianne catch a cold as a result of her grief-stricken wanderings in inclement weather, and having the cold take a serious turn because of her despondency and her already weakened state of health” (66). I disagree. Elinor’s gradual turn to fear and even grief is natural. What is unnatural, what is the real object of critique, is Marianne’s wilful negligence of her own health. See Kenneth Moler, *Jane Austen’s Art of Allusion*. It is worth noting that Marianne particularly admires the works of Cowper, Shakespeare, Scott, and Pope.
particularly “restless and feverish night,” is unable to sit up (268). When the apothecary is summoned, he declares that “a very few days would restore” Marianne to health. Yet his use of the term “infection,” and his pronouncing the disorder to have a “putrid tendency,” cause general alarm (268). Indeed, such words were good cause for distress. Beddoes notes in his discussion of putrid fever, “When any local stimulus continues to act upon any part of the system, the circulation becomes more rapid, and a fever is the consequence. Is the stimulus weak, a slow fever ensues, which will by little and little exhaust the irritability of the system and the patient will die of a consumption.”367 Thus there is a way in which Marianne may have been on the path traced by Eliza before her. As noted above, consumption was thought to sometimes occur as the result of passions, affections, and disappointments; however, it was just as frequently attributed to prolonged exposure to the cold and wet. Buchan elaborates: “more consumptive patients date the beginning of their disorders from wet feet, damp beds, night air, wet clothes, or catching cold after the body had been heated, than from all other causes”;368 Eliza may have died from sleeping in a damp bed in a close room. Had Marianne succumbed to her disease, she might have been said to die from a consumption—one which would have been widely attributed to her grief and broken heart; in reality, however, her death might just as easily have been brought on by her wet socks. Without necessarily denying the powerful impact that grief can have on a person’s health, Austen is interrogating the validity of the popular diagnostic belief that people could die from broken hearts. She is invested in clearing up the order of events—illustrating that if this seems to be the case, there was likely another event (self-neglect)

368 Buchan, Domestic Medicine, 176.
that was a more “proximate cause” of disorder (to borrow a term from John Gregory). Even Sophia in Austen’s early “Love and Friendship” dies as a result of her inactive state, lying in the grass amidst the “chilling damps of night,” and not from grief at the death of her husband (98).

According to the apothecary, however, death is never expected for Marianne. Claudia Johnson states that “the operations of sensibility require the suppression of women’s health and resilience, and Austen’s writings refuse to indulge the hankerings of sensibility so defined.” Thus the physician first “talked boldly of a speedy recovery” and “then declared his patient materially better” (270). When she visibly worsens, he acknowledges this as an “unexpected and unpleasant alteration,” but he still does “not allow the danger to be material,” and he speaks confidently of the “relief which a fresh mode of treatment must procure” (273). Thus while there are obstacles to her recovery within the narrative of her illness, he “will not allow” any material danger. When Marianne persists in illness, adhering to the role of sentimental heroine, her condition continues to deteriorate; she is significantly “only more quiet—not more herself” (274). Marianne continues to occupy a role, the role of sentimental heroine. The irony is that when Marianne recovers, Austen seems to discover that there is no new role for Marianne to occupy, no new “herself” to become, until she becomes a wife.

Despite the prognostications of those around, and the wishes of Marianne herself, the physician serves the author here in not “allowing” Marianne’s death. Just as Wollstonecraft and Hays before her had lamented a lack of strong literary heroines, Austen too finds herself at an impasse with what to “do” with Marianne, with what her fate should

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369 Johnson, “‘A Sweet Face as White as Death,’” 164.
be. Despite her sickness, the apothecary remains confident: “he had still something more to try, some fresh application, of whose success he was almost as confident as the last” (274). Austen’s “fresh mode of treatment” saves Marianne’s life, but as already noted, her survival presents a problem for the novel itself. Ironically, only impending death keeps interest alive when sensibility is the main problem. Wiltshire rightly suggests that an unhealthy body in the narrative is a “source of events, of narrative energies.”

It is Willoughby’s belief in Marianne’s illness, for instance, that leads to his dramatic re-entry into the novel. He admits that his reappearance is conditional on his belief in her illness. Following his entrance into the Palmers’ home he vehemently asks Elinor, “For God’s sake tell me, is she out of danger, or is she not?” To her assurances that she is, he replies, “Had I known as much a half an hour ago--”, and leaves his sentence unfinished (278). The implication of course is that Willoughby has arrived expecting a dramatic deathbed scene, and is almost disappointed to find that Marianne is improved. Claudia Johnson’s reading of this scene, her discussion of Willoughby’s rapture with the image of Marianne’s “sweet face as white as death,” requires little enhancement.

What I would emphasize, however, is the continued energy that exists in the novel while Willoughby believes her to remain ill. When her survival is assured, the reader begins to feel mixed sentiments, as the narrator tells us are also felt by Elinor, with regards to the options for Marianne’s future.

370 Wiltshire, Jane Austen and the Body, 9.
371 Claudia Johnson argues that Austen defies the eighteenth-century literary convention requiring women who had been seduced and abandoned to die in order for their honour to be restored. She writes: “The physical degeneration of the injured heroine, far from being profoundly regretted, is profoundly wished. By dying, the heroine does not defy social codes governing the conduct of good girls; ... rather, those codes themselves insist upon and anxiously collude in an enfeeblement that leads to her decease” (“A Sweet Face as White as Death,” 162).
Austen’s employment of the case study for Marianne makes ending her novel of sensibility problematic. According to Kathryn Hunter, in medicine “narrative closure is achieved by the diagnostic resolution of crisis,” and here Austen has established that the symptoms of sensibility need not be fatal. The prognosis is good, and Marianne “continue[s] to mend every day” (294). Hunter also notes, however, that the “physicians’ own subjectivity as well as the subjectivity of the patient is controlled by the fixed conventions of medical narrative.”\(^{372}\) Just as with a patient’s case history, there are only so many endings available for each character. Marianne had been afflicted with a condition that enabled / forced her to feel keenly and to voice her feelings. Having been “cured” of this affliction, her subjectivity is significantly diminished. If Marianne is not the heroine of a novel of sensibility, neither she nor her creator seem to know who she should be instead. Thus she adopts a posture of “reclining weakness” and demonstrates towards Colonel Brandon, who has been especially kind during her illness, a “warm acknowledgment of peculiar obligation” (298). Elinor, who “had seen [Marianne] week after week so constantly suffering, oppressed by anguish of heart which she had neither courage to speak of, nor fortitude to conceal, now saw ... an apparent composure of mind, which, in being the result she trusted of serious reflection, must eventually lead her to contentment” (299). The wording here is tentative and founded on a logic of probability, not a firm empirical knowledge. Elinor “trusts” in Marianne’s “apparent” composure of mind; and the reader is given to understand that Marianne has a fate—contentment—which she “must eventually” achieve. When she begins to waver, sentimentally recalling memories of Willoughby, Marianne must deliberately renew a determination to display

\(^{372}\) Hunter, *Doctors’ Stories*, 127, xx.
“resolute firmness.” The narrator continues to monitor her “happy symptoms” (300). Unhappy symptoms would have ended in death; happy ones end in marriage.

In medical narratives, when a patient is cured, the case study has ended; the physician restores the narrative to the patient. For Marianne, however, a financially dependent unmarried woman, the plausible possibilities for narrative closure are limited. Hunter explains, the “narrative act of healing” is the “return of the story to the patient, an acknowledgment that no medical story—not even chronic illness or impending death—is a life story.”

Returning the narrative to Marianne, however, proves to be an exercise in futility. Upon recovering she at first declares: “I have formed my plan, and am determined to enter on a course of serious study” which involves reading for six hours a day. Marianne makes her plan, Elinor notes, with her usual “eager fancy,” and threatens to introduce “excess into a scheme of ... rational employment and virtuous self-control” (301). Marianne then promises to live “solely for [her] family,” declaring to her sister, “From you, from my home, I shall never again have the smallest incitement to move” (305). Paradoxically, however, for Marianne to make good on her promise to live for her family she must leave them to marry the wealthy Colonel Brandon. Throughout the work, Brandon’s kindness and generosity to the Dashwood family leave them “indebted” to him: “they each felt his sorrows, and their own obligations, and Marianne, by general consent, was to be the reward of all.” The narrator leaves room for doubt as to Marianne’s excitement about her fate, but “with such a confederacy against her—with a knowledge so intimate of his goodness—with a conviction of his fond attachment to herself—what could she do?” (333). If the narrator seems content with the novel’s ending, I would argue that it

373 Hunter, *Doctors’ Stories*, 141.
is because a relatively happy marriage is infinitely preferable to the senseless death of a young heroine of sensibility.

Austen acknowledges that this is the best, and / or the most plausible, of the options available for her heroines—the same ending is given to both Elinor and Marianne—given the details of their case histories. Elinor has actually maintained control of access to her story the entire time (she was her own physician)—so there is virtually no change for her; she is quietly elated when she learns that Edward is free to marry her, and then, after a matter of “hours,” her spirits become sedate and her heart is made tranquil (319). It should be noted that Elinor is not more rewarded for her quieter sensibility. She does find a happy ending, but only because a far less “feeling” character, Lucy Steele, finds it more profitable to leave Edward to his own devices. In general, sensibility is simply not rewarded for its own merits in this text. With Elinor quietly content, Marianne might be said to resemble one of Austen’s own neighbours, of whom she wrote, “Mary Oxenden, instead of dieing, is going to marry Wm Hammond.”

For Marianne, the author actually provides an inventory of the ways in which her story could have ended, persuading the reader—and perhaps herself—that the ending she has chosen is the best of the possible options. Austen writes of Marianne:

Instead of falling a sacrifice to an irresistible passion, as once she had fondly flattered herself with expecting,—instead of remaining even for ever with her mother, and finding her only pleasures in retirement and study, as afterwards in her more calm and sober judgment she had determined on,—she found herself at nineteen, submitting to new attachments, entering on new duties, placed in a new home, a wife, the mistress of a family, and the patroness of a village. (333)

Austen selects this option as the most plausible, and the most palatable. That Austen and her readers are not entirely persuaded by it is clear: “that Marianne found her own happiness in forming [Colonel Brandon’s], was equally the persuasion and delight of each observing friend” (334). The dangers of easy “persuasion” are explored in one of Austen’s later texts; of course this might simply be coincidental, but, as is more often the case with Austen, the title for the later work may well be a subtle but deliberate moment of intertextual resonance.

Critics have argued that, despite appearances, sensibility is not really a major factor in this novel. Tony Tanner and Mary Poovey, for example, in their respective discussions of Sense and Sensibility, argue that Austen actually “avoids the systematic examination of ‘sensibility’ that the novel seems to promise.” 375 In his work, Sentiment and Sociability, John Mullan might be said to agree, as he limits his engagement with the novel to a slight nod via his title. Mullan does discuss sensibility’s “ambiguous status,” a “susceptibility which is part of the language of the physicians as much as that of the novelist.” 376 Austen does treat the novel of sensibility, but as a physician treats an affliction, in an attempt to cure it; and so she does, or at least its symptoms. Like a scratch, sensibility is shown to be superficial, something on the surface that only rarely causes lasting suffering. There might be immediate painful symptoms, but the application of something sweet and soothing—be it apricot marmalade, Constantia wine, or a new lover—can afford relief. No other heroine from Austen’s oeuvre can be said to unduly “suffer” from the symptoms of sensibility. She

375 Poovey, Proper Lady, 188.
has effectively inoculated the constitutions of her future heroines against this kind of affliction. Instead, her other works seem to draw more upon Elinor as a model whose “interiority,” as Mary Favret observes, remains “intact and independent.”377

The “Constitutions” of her Characters

Aside from Marianne, there are only two main Austen characters whose constitutions might require particular examination or treatment, or for whom the question of whether or not they suffer from the symptoms of sensibility might not be so easily answered: Fanny Price of Mansfield Park (1814) and Anne Elliot of Persuasion (1817). The healthy constitutions of Elizabeth Bennet, Emma Woodhouse, and Catherine Morland (of Pride and Prejudice, 1813, Emma, 1815, and Northanger Abbey, 1817) can hardly be questioned.

While illnesses of others occasionally generate narrative energy in the stories of the latter three, the afflictions are certainly not their own. Elizabeth Bennet is depicted as traipsing through muddy fields to visit her sister, and Mr. Darcy famously declares her “fine eyes” to have been “brightened by the exercise” (31).378 Emma Woodhouse is described as “being the complete picture of grown-up health,” and Catharine Morland as a child is “noisy and wild, hated confinement and cleanliness, and loved nothing so well in the world as rolling down the green slope at the back of the house” (2). As she grows up, her “love of dirt” dissipates, but she remains a healthy, hardy figure (3).379 Within these

377 Favret, Romantic Correspondence, 145.
three works, Austen does use illness, but either as a narrative device, leading to a change of location for principal characters, or as a source of comedy and satire when a character’s illness is exaggerated or contrived. Thus the illness of Jane Bennet takes Lizzy to Netherfield; the dramatic afflictions of Mrs. Churchill remove Frank Churchill from Hartfield to her bedside at (in)opportune moments, while Jane Fairfax’s poor health brings her to Highbury to vex Emma and to be loved by Frank, and it is Mr. Allen’s relocation to Bath for his gouty constitution that takes Catharine Morland out of her isolated country home. Mrs. Bennet and Mr. Woodhouse provide comic fodder with their various exaggerated complaints.

The way Mansfield Park’s Fanny Price and Persuasion’s Anne Elliot “feel,” however, is more complicated. Austen’s treatment of these two heroines is worth a brief consideration in order to illustrate that while they may seem to show symptoms of sensibility, neither of them suffer from them in the way that Marianne did (or seemed to) before them. In these two novels Austen moves towards embracing feeling, with the crucial difference being that good feelings—both moral and healthy—are those felt for others, that is to say—in sympathy. Sympathy becomes a middle ground that allows a heroine the beneficial features of sensibility without necessarily dooming her to death.

380 Jane Fairfax might be said to resemble Mansfield Park’s Fanny Price (discussed below) and Anne Elliot, whose bodies are genuinely affected by their emotions. The narrator notes that when the daughter of Jane’s guardians marries: “She had never been quite well since the time of their daughter’s marriage; and till she should have completely recovered her usual strength, they must forbid her engaging in duties, which, so far from being compatible with a weakened frame and varying spirits, seemed, under the most favourable circumstances, to require something more than human perfection of body and mind to be discharged with tolerable comfort” (106), Austen makes a valid point here that the economic realities of a woman who must support herself as a governess (as Jane needed to begin doing) do not coincide with the romantic notions of the novel of sensibility (Emma, ed. Stephen M. Parrish [New York: W. W. Norton, 2000]).

381 As do many of the characters in the unfinished Sanditon.
Mansfield Park

*Mansfield Park*’s Fanny Price may well be mistaken for a conventional heroine of sensibility. In comparison with her hardier cousins she is said to have “inferiority of strength” and a “more tender nature.” She is also described as having a “delicacy of taste, of mind, of feeling” (14, 28, 78). Furthermore, Fanny’s repeated bouts of exhaustion and suffering do resemble the tremblings and faintings of a heroine of sensibility. It is Henry Crawford, however, who alerts the reader to the fact that Fanny is most certainly not one such heroine. When he announces to his sister his intention of sporting with Fanny’s affections, she offers a brief caution: “she is as good a little creature as ever lived, and has a great deal of feeling.” He replies, with his usual caustic humour, “It can be but for a fortnight, ... and if a fortnight can kill her, she must have a constitution which nothing could save” (208). Fanny is meant to be apart from the vulnerable, “feeling” heroines who came before her, who indeed had constitutions vulnerable to the wounds of love.

Fanny has the same disciplined feelings as Elinor Dashwood, and she is equally prone to self-censorship. She is almost constantly attempting to suppress the expression of her feelings. Questions of class come into play here—Fanny does not feel herself to be a worthy subject for narrative in the context in which she finds herself. The narrator notes that she thought “too little” of her own claims to join a conversation on at least two occasions. If anything, her health suffers from these acts of self-censorship because she

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383 Austen is careful to indicate that Fanny’s physical weakness is genuine; when she walks with Henry Crawford: “Had she been without his arm, she would soon have known that she needed it for she wanted strength for a two hours’ saunter of this kind” (373).
never bothers to put her case forward or even consider it at length herself. Furthermore, she cannot dissemble (when asked to take on a role in the play she replies, “I really cannot act”); so she must disallow any expression of personal feeling (134). Fanny is “always more inclined to silence when feeling most strongly” (336). Like Elinor, she makes resolutions throughout the work “on the side of self-government;” unlike Elinor, however, who is often able to conceal what she is feeling, Fanny’s secrets are often nearly betrayed by her weaker body (240), and these physical weaknesses have a twofold effect. First, the plot of the novel is often furthered by Fanny’s bodily needs (her need to sit quietly, for example, affords others the opportunity to pair off); and secondly, these weaknesses and moments of suffering enable Austen to gesture towards a bigger message—that the proper way to “feel” is for others, via genuine sympathy and not selfish sensibility.

Returning to Daniel Tougaw’s point from earlier, it is certain that illness generates narrative interest and narrative possibilities. Thus when Fanny’s weakness forces her to sit down while the group explores Sotherton, she has no choice but to observe, and focalize for the reader, the actions of others. Mary Crawford and Edmund Bertram are allowed time together, as are Henry Crawford and Maria Bertram. Similarly, Tom Bertram’s serious illness leads to temporary but significant changes in character: Lady Bertram becomes almost motherly—giving us an example of what her conduct should have been all along—and more significantly, Mary Crawford begins to rethink her feelings for Edmund, in light of the fact that he may yet become the heir to the Mansfield estate. Indeed, illness and

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384 An incident in Chapter 4 illustrates this tendency: “The ensuing spring deprived [Fanny] of her valued friend the old grey pony, and for some time she was in danger of feeling the loss in her health as well as in her affections, for in spite of the acknowledged importance of her riding on horseback, no measures were taken for mounting her again.” Edmund must return from a trip away to notice and then rectify the situation, because Fanny refuses to present her case for consideration. (31) The other incident is when she is younger and thinks “too lowly of her own claims” to be injured by her cousins’ slighting her (17).
affliction afford the greatest opportunity to test people’s natures, both of those afflicted and of those around them. Tom Bertram improves substantially: he “regains his health without regaining the thoughtlessness and selfishness of his previous habits. He was the better for ever for his illness” (421). More subtly, and thus for Austen, likely more importantly, the illnesses and weaknesses of others provide the most opportunity for the display of genuine sympathy. In Mansfield Park, those who show compassion for the feelings of others are—whether we like it or not—the work’s heroes.

Fanny’s health deteriorates later in the novel, when her uncle makes her the subject of what he terms a “medicinal project”; yet it does so not because of her disabling sensibility, but rather, because she is exposed to conditions resembling those afflicting Sense and Sensibility’s first Eliza—confinement, poor air, and a lack of exercise. Like Eliza, there is something precarious about her dependent social situation. It is perhaps Fanny’s disregard for her dependent status, and her subsequent determined refusal to marry Henry Crawford that leads her uncle to note symptoms of “disorder” in her “powers of comparing and judging” and to his diagnosis of her “diseased” understanding. While not intentionally cruel, Fanny’s uncle suggests that she “does not quite know [her] own feelings” (286). The reader knows that Fanny is actually highly attuned to her feelings; they are, however, decidedly different from what Sir Thomas would have them be. Thus when he is unsuccessful in his attempts to reason with her on this matter, he adopts medical diagnostic logic in forming a plan for her “cure.” He “knew her to be very timid, and exceedingly nervous; and thought it not improbable that her mind might be in such a state, as a little time, a little pressing, a little patience, and a little impatience, a judicious mixture of all on the lover’s side, might work their usual effect on” (289-90). This logic is in concert
with eighteenth-century theories on women and their bodies. According to Lavater, for example, “this tenderness, this sensibility, this light texture of their fibres and organs, this volatility of feeling render them so easy to conduct and to tempt; so ready of submission to the enterprise and power of the man.” Lavater continues (as quoted in Chapter One): “Women feel more. Sensibility is the power of woman.”\(^{385}\) Ironically, it is Fanny’s strength of feeling that her uncle is not able to understand, to come to terms with. He has misdiagnosed the constitution of his patient; as such, the desired effects are not produced by his “medicinal project.”

Sir Thomas’ project consists of his decision to send Fanny back to Portsmouth, to visit her impoverished family: “Her Father’s house would, in all probability, teach her the value of a good income; and he trusted that she would be the wiser and happier woman all her life, for the experiment he had devised” (335). Though she is happy to return home, it is here that her health is the most threatened. Had Sir Thomas known of the excessive noise which “was to a frame and temper, delicate and nervous like Fanny’s, an evil,” and the “general fare” she is made to consume, “he would probably have feared to push his experiment farther, lest she might die under the cure” (357, 376). Again, Austen clearly makes her point. Though her body may be weak, and possibly made weaker by the luxuries of Mansfield, Fanny is never in danger of dying from her emotional sensitivities. Her feelings are strong, but governable, and perhaps most importantly, in spite of general mistreatment, are still capable of genuine sympathy. Case in point: despite Sir Thomas’

\(^{385}\) Thomas Holcroft trans., *Essays on Physiognomy: translated from the German of John Casper Lavater* (London, 1878), 400.
cruel “experiment” on Fanny, when his own children begin to disappoint him one after another, Fanny nevertheless “felt for him most acutely” (412, my emphasis).

The Crawfords, Maria Bertram, and Aunt Norris are all banished at the text’s end because they are unable to curb their own selfish impulses and learn to appreciate the feelings of others. Fanny resists Henry Crawford because, despite appearances, he lacks “regard for others” and for “humanity where his own pleasure was concerned” (297). When Mary Crawford borrows Fanny’s horse, indulging in lengthy rides for pleasure—depriving Fanny of the horse she needs to ride to improve her health—Mary charmingly begs for leniency, suggesting that “selfishness must always be forgiven, ... because there is no hope of a cure” (61). This refusal to amend, to work on personal improvement, signals that the Crawfords will not prevail, despite their charms. For Austen, there should almost always be room for improvement, almost always hope for a cure. When Edmund finally rejects Mary Crawford, it is because of her selfishness, but more importantly, her unwillingness to attempt improvement. Both Edmund and Fanny are shocked and appalled at the immoral liaison between the married Maria Rushworth and Fanny’s declared suitor Henry Crawford. When Edmund visits Mary, looking for sympathy, the problem becomes apparent: Mary displays a “total ignorance, unsuspiciousness of there being such feelings” as Edmund was experiencing. This lack of sympathy is problematic in and of itself; but it is through that, combined with her total unwillingness to improve herself that she is finally damned. Edmund recalls, “I saw her change countenance. She turned extremely red. I imagined I saw a mixture of many feelings—a great, though short struggle—half a wish of yielding to truths, half a sense of shame—but habit, habit carried it” (418). Austen differed from Wollstonecraft and Hays in her view that habits could be changed. Mary
Crawford’s unwillingness to try and remedy hers suggests the same flaw, self-indulgence, that Austen critiqued in sensibility.

Selfish habits, habits in which one’s own feelings triumph over those of others, are the problem for Austen. Henry Crawford had embarked on a course of self-improvement, and, according to Austen’s narrative logic, she notes that had he persisted, had he continued in his efforts, he would have been rewarded: “Would he have persevered, and uprightly, Fanny must have been his reward” (426). But in choosing immediate gratification over long term gains, he was fated to be unsuccessful. Those who choose their own pleasure or their own feelings over those of others, are generally condemned by Austen. Even Edmund (perhaps especially Edmund), who plaintively asks Fanny to “think of me!” when he has done with Mary Crawford, is acknowledged to be not quite deserving of his bride: “she was of course only too good for him” (430). But he is the best that can be found for her.

**Persuasion**

*Persuasion’s* Anne Elliot also feels; but for Anne, “feeling” is a means of moral perception and emotional sensitivity: there is less connection to her physical well being. Anne feels and thus is capable of both experiencing genuine sympathy and evoking it in the reader. During her early courtship with Captain Wentworth she is described as “an extremely pretty girl, with gentleness, modesty, taste, and feeling” (26). When she meets with Captain Wentworth again after their eight year separation, she “began to reason with herself, and to try to be feeling less” only to perceive that “to retentive feelings eight
years may be little more than nothing” (53). Her feelings are therefore shown to be lasting and real, and though acute, are not overly debilitating.

In comparison, *Persuasion’s* unsympathetic characters are all consistently described as “unfeeling.” Anne’s sister, Mary, “had no feelings to make her respect her sister’s in a common way.” Anne “must sigh that her father should feel no degradation in his change, should see nothing to regret in the duties and dignity of the resident landholder.” The villainous Mr. Elliot has many faults, the worst of which is that “there was never any burst of feeling, any warmth of indignation or delight at the evil or good of others. This, ... was a decided imperfection.” The characters lacking in feelings for others are condemned to varying degrees, either through satire, or more overtly, for Mr. Elliot and Mrs. Clay, through banishment. Even the benevolent Lady Russell must “learn to feel that she had been mistaken” before she is allowed to share in the happiness of the couple at the novel’s end (53, 112, 131, 200).386

Anne’s acute feelings are what enable her to sympathize with those around, to the extent that her very presence is often depicted as being medicinal or restorative. It is Anne who patiently tends to her young nephew after a serious fall, and who is able to tolerate and even amend her sister’s peevish spirits (Anne reminds her: “You know I always cure you when I come” [36]). There is also something of a resemblance between Anne and Elinor Dashwood in their self-command. Anne tries to help a grieving friend through “suggestions as to the duty and benefit of struggling against affliction” (84). When Louisa Musgrove falls and is seriously injured, “Anne, attending with all the

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386 See Alan Richardson “Of Heartache and Head Injury: Reading Minds in *Persuasion*” *Poetics Today* 23.1 (2002), 141-60. He suggests, “The novel’s most systematically ‘rational’ characters, Lady Russell and William Walter Elliot, are the very ones that cause the most pain and give the worst counsel. ... [And] men who fail to speak from feeling and to feel from the body are not to be trusted in *Persuasion*” (156).
strength and zeal, and thought, which instinct supplied, to Henrietta, still tried, at intervals, to suggest comfort to the others, tried to quiet Mary, to animate Charles, to assuage the feelings of Captain Wentworth. Both seemed to look to her for directions” (93). She generally puts the feelings of others before her own.387

If Anne can be said to resemble Elinor, the more minor character Louisa Musgrove might be compared to Marianne Dashwood in that they both share high spirits and a serious crisis of health. Louisa is introduced as a young, lively girl, Anne’s sister-in-law, and a rival for the affections of Captain Wentworth. When the group ventures to Lyme on a visit, Louisa takes pleasure in jumping off the sea wall into Wentworth’s arms. Louisa’s refusal to listen to direction, however, leads to a serious accident. Louisa falls: “there was no wound, no blood, no visible bruise; but her eyes were closed, she breathed not, her face was like death” (91). Her injury forces a series of events—there are changes in location for several characters and thus as a narrative device, her illness (diagnosed as a “severe contusion”) serves a particular purpose. Perhaps most importantly, however, Louisa becomes involved with, and engaged to another man—a “thinking,” mourning, sentimental man, rather than to Wentworth, as many characters had come to expect. In one sentence from Anne, Austen provides the story of sensibility which formerly would have taken an entire book to recount:

The idea of Louisa Musgrove turned into a person of literary taste, and sentimental reflection, was amusing, but she had no doubt of its being so. The day at Lyme, the fall from the Cobb, might influence her health, her

387 One notable exception is when she has an unexpected moment of contact with Captain Wentworth who physically removes a clinging child from her back when the child refuses to heed his Uncle Charles’s instructions. The narrator writes, “neither Charles Hayter’s feelings, nor anybody’s feelings, could interest her, till she had a little better arranged her own” (69). The implication here, however, is not that Anne is being selfish or self-interested, but rather, as Judy Van Sickle Johnson suggests, that the unexpected physical contact with Wentworth arouses unfamiliar sexual feelings. See her essay, “The Bodily Frame: Learning Romance in Persuasion” Nineteenth-Century Fiction 38.1 (June 1983), 43-61.
nerves, her courage, her character to the end of her life, as thoroughly as it appeared to have influenced her fate. (135-6)

Louisa’s narrative is therefore dismissed as largely uninteresting, and even lightly comical (Louisa’s brother remarks that “if one only happens to shut the door a little hard, [Louisa] starts and wriggles like a young dab chick in the water; and Benwick sits at her elbow, reading verses, or whispering to her, all day long” [176]). Anne comes to reason: “the conclusion of the whole was, that if the woman who had been sensible of Captain Wentworth’s merits could be allowed to prefer another man, there was nothing in the engagement to excite lasting wonder” (136). The implication is that Louisa’s feelings, unlike Anne’s, do not run sufficiently deep. She is pleasant and harmless, but her changeable emotions, and her narrative of sensibility cannot be privileged over Anne’s narrative of lasting feeling and deep-seated sympathies.

**Sensible Sympathy**

Austen chose to treat sensibility in one of her early novels. This treatment revealed to her the relative paucity of directions for novels of this kind; and her subsequent works therefore move away from sensibility as a source of narrative energy. Clara Tuite argues that in its move away from the conventions of narratives of sensibility, *Sense and Sensibility* “manoeuvre[s] towards sympathy as a synthesizing, stabilizing third term that...
lies between ‘sense’ and ‘sensibility.’”388 For Austen, sympathy, a relative conformity of feelings between people, can include sensibility but need not be subsumed by it.389 John Gregory argued that sympathy is “that sensibility of heart which makes us feel for the distresses of our fellow creatures, and which of a consequence, incites us to relieve them.”390 In her desire to help her sister, and in her own silenced pain, Elinor inspires a sympathetic interest in the reader. To quote Deidre Lynch: “Anne and Elinor each partake of something like a narrator’s invisibility, omniscience, and capacity to enter into others’ feelings and coordinate and harmonize others’ perspectives.”391

In many ways Austen herself was a physician of sorts. As Ian Watt suggests, Austen’s “analyses of her characters and their states of mind, and her ironical juxtapositions of motive and situation ... do not seem to come from an intrusive author but rather from some august and impersonal spirit of social and psychological understanding.”392 Austen’s novels promote sympathy over sensibility, and, one might argue, work to promote public health and the greater good. John Brown notes that “medicine is the science of preserving the good, and of preventing and curing the bad, health of animals.”393 Thus characters like Anne Elliot, Jane and Elizabeth Bennet, even Emma, are protected and upheld. Characters such as Kitty Bennet are able to become “by proper attention and management, less irritable, less ignorant, and less insipid” (343). All physicians, however, must recognize when a patient cannot be saved. Thus Austen

391 Lynch, Economy of Character, 233.
banishes *Mansfield Park’s* Maria Bertram and Mrs. Norris and, as the narrator notes, “Not even Fanny had tears for aunt Norris” (425).

*Sense and Sensibility* was a trial for Austen, enabling her to see which character types could (and should) live on, and which models could not progress or advance. Tuite argues that the “effect of this subtle indirect presentation of Elinor’s ‘tenderest compassion’ is to suggest that ‘sense’ of course can feel too, that feeling is not confined to sensibility. Such a ‘sense’ which can feel is precisely the kind of chastened, regulated, and regulating feeling which Austen cultivates in her readers through Elinor as the model of a new kind of female propriety and sensitivity.”

Austen’s subtle use of the logic of the medical case study enables her to offer a new perspective on the novel of sensibility. That both sisters achieve the same fate at the novel’s end—indeed, the work’s final paragraph refers to them as an inseparable unit—might seem to undermine the importance of Elinor’s silent strength. Marianne, however, can only find “happiness in forming [Colonel Brandon’s]” (334); she therefore remains confined to the pages of *Sense and Sensibility*. But when we look ahead to Austen’s other heroines, we are frequently rewarded with glimpses of Elinor’s—“my Elinor” Austen called her—quiet strength and sympathy in several of her other leading ladies.

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In Austen’s *Persuasion*, the happy and hearty Mrs. Croft offers an important lesson concerning women’s health as she explains the salubrious benefits of her travels at sea with her husband, Admiral Croft:

I can safely say, that the happiest part of my life has been spent on board a ship. While we were together, you know, there was nothing to be feared. ... A little disordered always the first twenty-four hours of going to sea, but never knew what sickness was afterwards. The only time that I ever really suffered in body or mind, the only time that I ever fancied myself unwell, or had any ideas of danger, was the winter that I passed by myself at Deal, when the Admiral ... was in the North Seas. I lived in perpetual fright at that time, and had all manner of imaginary complaints from not knowing what to do with myself, or when I should hear from him next; but as long as we could be together, nothing ever ailed me, and I never met with the smallest inconvenience. (61)

Not only does Mrs. Croft here register an argument for the health benefits of marriages based on genuine affection, but more importantly, she employs the logic of the case to illustrate her recognition that the specific cause of her ill health was inactivity. It is her “not knowing what to do with” herself that causes a number of “imaginary complaints.” Whether real or imaginary, these complaints cause “real” suffering in body and mind; she explains, however, that treatment and prevention are simple: activity is the answer. Thus in *Persuasion* Austen argues that not only is sympathy a healthy way to feel, but furthermore, activity and employment serve to ward off ill health. Mrs. Croft almost embodies the model described by Mary Wollstonecraft more than twenty years earlier in *A Vindication of the Rights of Woman*:

We should hear none of these infantine airs, if girls were allowed to take sufficient exercise and not confined in close rooms till their muscles are relaxed and their powers of digestion destroyed. ... If fear in girls, instead of being cherished, ... were treated in the same manner as cowardice in
boys, we should quickly see a woman with more dignified aspects. It is true, they could not then with equal propriety be termed the sweet flowers that smile in the walk of man; but they would be more respectable members of society, and discharge the important duties of life by the light of their own reason. ‘Educate women like men,’ says Rousseau, ‘and the more they resemble our sex the less power will they have over us.’ This is the very point I aim at. I do not wish them to have power over men; but over themselves.\textsuperscript{396}

No one would describe Mrs. Croft as a “sweet flower,” but she is a strong, respectable woman who capably “discharge[s] the important duties of life.” Mrs. Croft has effectively diagnosed and treated her own condition; in so doing she embodies the very trend my project has tracked, namely, the ways in which late eighteenth-century medical writings provided women with a discursive toolbox to further develop powers—physical, social, and psychological—“over themselves.”

This project has asserted that when read alongside popular medical texts, certain novels of sensibility by women during the late eighteenth and early nineteenth centuries manifest features previously unremarked upon: the logic of the medical case, medical rhetoric, and the prescriptive authority of the physician. The heroines studied in this project one by one become healthier, or at least more in control of assessing and treating their own health, and thus more capable of determining the course of their narratives. By the time of Austen’s final novel, a new model of female heroism emerges. And while the authors who wrote before her—Wollstonecraft and Hays—may have created female protagonists occasionally disabled by symptoms of sensibility, they did so in order to determine how these symptoms might best be treated, and perhaps, how they might be treated and even prevented in their own lives.

Mary Wollstonecraft struggled to negotiate between the lessons she offered for girls in her didactic writings—to patiently endure pain in order to resist the passions—and the emotional and physical sensitivities of her fictional heroines Mary and especially Maria, who was “born to feel” (77). *Mary* offered her a space of exploration in which to imagine a character who did not have to be limited by the forces that had weakened heroines before her. As I have shown, the eponymous heroine is even able to adopt the diagnostic authority of physicians in the text. In the end, however, the very qualities that rendered Mary uniquely healthy could not be reconciled with social norms—namely her arranged marriage and her dislike for her husband’s authority over her. The work ends by foreshadowing death for the unhappy Mary. In the unfinished *Maria*, Wollstonecraft offers a series of case studies of female patients within a mental hospital. The dedication of the text to Maria’s daughter suggests the extent to which these case studies are being offered as knowledge to help ensure the health of women in the years to come. Wollstonecraft’s final work, in which the heroine’s mental health is diagnosed by a judge in a court of law, recognized the difficulty in treating the condition of women—physical, legal, and social—and thus offered educational prescriptions and suggestions for future generations. Even so, it was in the prescriptive tenets of her non-fiction writings that Wollstonecraft was most clearly able to advocate for the implementation of preventative medical and educational practices.

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397 It is well worth noting that the *OED* cites the term “case study” as first being used in 1762, and as referring to “the attempt to understand a particular person, institution, society, etc. by assembling information about his or its development; the record of such an attempt.”

398 Recall her introductory note to *Original Stories from Real Life*: “good habits, imperceptibly fixed, are far preferable to the precepts of reason; but, as this task requires more judgment than generally falls to the lot of parents, substitutes must be sought for, and medicines given, when regimen would have answered the purpose much better” (iii).
Like her friend Mary Wollstonecraft, Mary Hays had a keen interest in medicine. Hays likewise sought to diagnose her personal condition through fiction. She tried to treat her “case,” first with William Godwin as her supervising physician, and then, perhaps in the belief that Godwin had more interest in the universal condition of “man” than in the specific condition and cases of women, she opted to treat herself. Through her autonarration in *Memoirs of Emma Courtney*, Hays effectively makes her protagonist, and thus herself, into a physician, qualified to diagnose the conditions of those around her. *Memoirs* ends on a slight note of optimism, with the suggestion that through improved educational practices, the health and habits of women and society might be improved. Yet by the time her final novel, *A Victim of Circumstance*, is published, Hays has determined that the condition of women is diathetic—that is to say, constitutionally predisposed—because of the habits of their society. Both Hays and Wollstonecraft employed the narrative logic of the medical case, but in the end their diagnoses for women were not overly optimistic. In the main, this is likely due to the semi-autobiographical nature of both of their fictions. They were not healthy and hardy in life. How then to credibly make their heroines be so?

Austen also relied upon the narrative logic of the medical case. Her use of that logic, without any hints of autobiography, enabled her to see in her first novel, *Sense and Sensibility*, that sensibility itself was not worth any further treatment, medical or artistic. As a condition it might generate irritating and even occasionally disabling symptoms, but it was not something one was born with, and if one worked on improving one’s habits (as Elinor did), one could almost do away with it all together. Using the logic of the case first for Marianne and Elinor, and later for *Mansfield Park*’s Fanny Price and
Persuasion’s Anne Elliot, Austen determined that the healthy, productive way to “feel” is through sympathy for others, transcending the confines of selfish sensibility.

The investigation of medical discourse within certain novels enables a more complex engagement with the kinds of heroines being imagined and the kinds of narratives being crafted. Alexander Wenger examines the “function of proof” that case studies bring to medical treatises during the eighteenth century. He explains, “that proof may be rhetorical: the case gives authority to the discourse in which it appears. It may also be exemplary: the case becomes the illustration of a general idea.” But, he continues, when medical cases appear in works of fiction, the proof functions yet another way: “it is based on the fiction’s force of persuasion. The narrative becomes proof because it may be felt by every reader.” In Hays’ Emma Courtney, I would argue, the case serves all three purposes. Emma’s status as physician gives authority to her diagnosis for herself and her society; her case is intended to serve as a lesson for future generations; and there is an affective dimension as well. Hays writes in her preface to the novel, “Let those readers, who feel inclined to judge with severity the extravagance and eccentricity of her conduct, look into their own hearts; and should they there find no record, traced by an accusing spirit, to soften the asperity of their censures, yet—let them bear in mind, that the errors of my heroine were the offspring of sensibility; and that the result of her hazardous experiment is calculated to operate as a warning, rather than as an example” (36). The authors I have considered employed medical cases to varying degrees within their novels to produce all of the effects cited by Wenger—authority, didacticism, and

emotional resonance. They may not have been credited as such because of the very prevalence of the issue they were trying to treat, namely sensibility and its symptoms. To return to the point raised by Nicola Watson—discussed briefly in my Introduction—women authors struggled to claim public authority for a female narrative premised on sensibility: Wollstonecraft, Hays, Austen, and others, thus worked to legitimize the ‘feelings’ of women by treating them through the logic of popular medical practice. And this innovation in the form and content of certain late eighteenth-century novels is worth considering both for feminist literary scholars and scholars of narrative medicine alike.

Mary Brunton is a now relatively obscure eighteenth-century author whose work found its way onto Austen’s reading list. In Brunton’s 1811 novel, *Self-Control*, the extremely moral heroine, Laura Montreville, is pursued by a rakish villain whom she unfortunately loves. The novel, which celebrates piety above all, also embraces sympathetic and useful sensibility. The heroine models the habits of self-control and discipline so desperately sought after by Mary Wollstonecraft and Mary Hays. In the heat of a conflict between two suitors, one of them shoots the other and Laura is left alone in the garden with the victim:

Laura’s terror was not the passive cowardice of a feeble mind. She was left alone to judge, to act, for herself—for more than herself. Immediate momentous decision was necessary. And she did decide by an effort of which no mind enfeebled by sloth or selfishness would have been capable. She saw that loss of blood was the cause of De Courcy’s immediate danger. ... Such remedy then, as she could command, she hastened to apply.

To the plants which their beauty had recommended ..., Laura had added a few of which the usefulness was known to her. Agaric of the oak was of the number, and she had often applied it where many a hand less fair would have shrunk from the task. Nor did she hesitate now. The ball had entered near the neck; and the feminine, the delicate Laura herself

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400 *Discipline* is Mary Brunton’s other, aptly-named novel, published in 1814.
disengaged the wound from its coverings; the feeling, the tender Laura herself performed an office from which false sensibility would have recoiled in horror. (394)

In this instance Laura is able to assume the duties of a physician. She models the same type of heroism as that shown by Emma Courtney, who “banished the woman from” her heart in order to care for her beloved patient. And Laura is able to do so of course thanks to her habits of “self-control.” Unlike Hays’ final heroine, she is not a victim of her circumstances, but rather one who is able to assess and take charge of those around her. It is indeed worth remarking upon the works in which heroines are able to, as the Ladies’ Dispensatory suggests, come at a true knowledge of not only the indispositions of others, but more importantly, of their own conditions, and to cure them “without applying ... to any person living.” The self-knowledge, “self sympathy” (as Beddoes called it), and self-direction tried experimentally on characters in fictions by women may well have enabled further learning and autonomy for authors and readers alike at the end of the eighteenth and start of the nineteenth century.

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