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The Names of Sickness: Writing Disability and Revising Diagnosis in Nineteenth-Century America

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The Names of Sickness:

Writing Disability and Revising Diagnosis in Nineteenth-Century America

A dissertation submitted in partial satisfaction of the

Requirements for the degree of Doctor of Philosophy

in English

by

Vivian Delchamps

2022

ABSTRACT OF THE DISSERTATION

The Names of Sickness:
Writing Disability and Revising Diagnosis in Nineteenth-Century America

by

Vivian Delchamps

Doctor of Philosophy in English

University of California, Los Angeles, 2022

Professor Helen E. Deutsch, Co-Chair

Professor Christopher J. Looby, Co-Chair

While the word “diagnosis” can be traced back to the seventeenth century, the verb “to diagnose” does not appear in written works until 1861, when American writers began to contend with new methods of medical examination. Literary texts soon resonated with an underlying fear of “undiagnosable” conditions (1873) and condemned the “evil” of “self-diagnosis” (1883); they began to mimic emergent medical techniques used to define discrete “Names of Sickness,” to use Emily Dickinson’s phrase.

This dissertation, “The Names of Sickness: Writing Disability and Revising Diagnosis in Nineteenth-Century America,” analyzes texts by women writers from the Civil War through Reconstruction to argue that literature transforms diagnosis from an alienating process of labeling into a tool for social critique. Drawing upon contemporary scholarship in critical feminist and intersectional disability studies, I assert that literature articulates disability even if we cannot—or will not—diagnose authors themselves. The dissertation asks how diagnostic methods can be redirected away from individual bodies and minds and towards systemic issues such as racial prejudice and gender violence—a question that attests to the value of humanistic inquiry during times of political and medical crisis.

This first book-length study of disability in American women's writing is divided into three primary chapters. I first argue that Emily Dickinson defied diagnostic labels while she shaped pain's expansiveness into poetic form. Chapter Two asserts that Charlotte Perkins Gilman's story "The Yellow Wallpaper" embraces the chaos created by patriarchal medicine to energize collaborative resistance. Finally, Chapter Three argues that Frances E.W. Harper's novel *Iola Leroy* figuratively "diagnoses" systemic conditions, such as the "virus of slavery and injustice." Significantly, Harper does not advocate for the eradication of disability; instead, she asserts the power of community for disabled and chronically ill women. My project thus emphasizes the transformative power of writing and community as it explores the ways women resist and revise diagnostic methods to challenge ableist violence. Ultimately, I assert that literary inquiry is imperative to grappling with crisis for which there is no immediate cure, and advocate for a humanistic approach to interpreting the names we give to sickness.

The dissertation of Vivian Delchamps is approved.

Anurima Banerji

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2022

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I am exceedingly grateful to all the family members, friends, and cats who have offered support and encouragement through the years. To Brian, for everything.

PREFACE

Emily Dickinson famously punctuated with dashes. See, for example, her coconut cake recipe: “1 Cup Cocoanut / 2 Cups Flour – / 1 Cup Sugar –”. In one poem, “There is a pain – so utter –”, she writes of pain:

> It has no Future – but itself –
> Its Infinite contain
> Its Past – enlightened to perceive
> New Periods – of Pain. (Fr650)

When Dickinson uses a period, its finality contrasts sharply with the breathy pauses that characterize her recipes and poems alike. The full stop at the end of this poem does not put an end to pain’s permanency, for the poem warns us of pain’s infinite “New Periods.”

At thirteen, I was diagnosed with rheumatoid arthritis and received my first accommodation: I was allowed to take examinations by computer, since I temporarily could not hold a pen. When other students complained about my accommodation, I learned what “ableism” is, though I did not have the vocabulary to describe it. Being diagnosed gave me the chance to write differently, but people around me stared when I wrote differently. I went back to writing with a pen as soon as my medications made that possible. Years later, I felt a surge of recognition reading Dickinson’s words, penciled after she began undergoing eye treatments:

> The physician has taken away my pen. (L290)

There was finality to her use of a period: a sentencing and the end of a sentence. In graduate school, I finally learned about disability studies and stopped worrying about whether I wrote in pen or by computer.

At eighteen, I was diagnosed with a rare genetic disorder, Hypermobile Ehlers-Danlos Syndrome. EDS, "a group of disorders that affect connective tissues supporting the skin, bones, blood vessels, and many other organs and tissues," is rare: it affects perhaps 0.02 percent of people worldwide (Armstrong para. 8). Symptoms "range from mildly loose joints to life-threatening complications, and virtually anything involving your connective tissue can be impacted by EDS" (Armstrong para. 10). Using the Beighton score,[1] my physician checked to see:

1) whether my neck and hand skin can stretch like I'm a freakshow performer from the nineteenth century (my skin is very stretchy)

2) whether I can touch my tongue to my nose (I can)

3) how soft my skin is by petting my arms (my skin was declared "velvety")

4) whether I can touch my palms to the floor with straight legs (as a ballet dancer, I have long been able to do this. Yet a total lack of muscle or joint resistance is a sign of EDS. This explains why I sometimes look like I'm dancing on a moving boat)

5) whether I have bruising or scarring (I do)

6) whether my limbs and fingers can pull "out of joint" (this happens often—it does not hurt until a few days later, when pain emerges, seemingly out of nowhere)

This (rather bizarre) examination process led to a diagnosis that explains some of my chronic fatigue, pain, and injuries. It also explained why some of my joints are stiff (RA) while others goop out of place (EDS). Once I was diagnosed with EDS, I could call myself a "zebra" if I wanted to. This slightly juvenile nickname comes from a saying taught to medical students:

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[1] For more on the Beighton score, see Bouwien Smits-Engelsman et al, "Beighton score: a valid measure for generalized hypermobility in children."

"when you hear hoofbeats behind you, don't expect to see a zebra." When you have EDS, you can expect the unexpected. I feel very lucky to have been diagnosed at all; many people with similar symptoms search for answers for years. There's no cure for my conditions— to paraphrase Dickinson, they have no futures but themselves—but there are coping tools, and I go to physical therapy and make routine appointments to check up on my heart, eyes, and other various organs.

A few years ago, I uncovered information about EDS that disturbed me far more than knowledge about risks to my own bodymind. From 2011 until 2018, Dr. Michael Holick testified as an expert witness in over three hundred child-abuse cases around the world. Holick never concluded that a child was being abused; rather, he diagnosed the child with EDS, often without performing examinations in person. "I already know on the phone they have EDS" he said, adding, "I almost don't have to ask. I know the answer" (Armstrong para. 12). I have never been abused, but my skin bruises easily. Perhaps some of these children were not being abused; perhaps they just have conditions like mine. But Holick used a period, not a dash or question mark. Parents who should have been questioned were not questioned. I think about those children and wonder about diagnosers and the diagnosed, power and the abuse of power.

Being diagnosed with RA and EDS gave me letters to my name—names of sickness I could use or ignore as I saw fit. These terms changed my life and yet sometimes mean very little. They paved the way for me to acquire medications that help, that come with cruel side effects, that render me immunocompromised in a pandemic.

Most significantly: being diagnosed helped me envision my role in incredible disability communities. Just two years ago, I discovered that another literary disability scholar also has

EDS and writes about her hypermobility. I felt a new surge of recognition: *she is like me.* I am not alone in experiencing chronic pain, in knowing what dislocation feels like.

Sometimes I do not think about my conditions at all. I think about the disability scholars and advocates who taught me to imagine possible futures where the funding that goes towards finding a cure for my conditions goes towards access and justice and inclusion and care and –

VITA

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"'The Names of Sickness': Emily Dickinson, Diagnostic Reading, and Articulating Disability." *The Emily Dickinson Journal,* vol. 28, no. 2, 2019, pp. 106-132.

"'A Slight Hysterical Tendency': Performing Diagnosis in Charlotte Perkins Gilman's 'The Yellow Wallpaper.'" In *Performing Hysteria: Images and Imaginations of Hysteria*. Edited by Johanna Braun. Leuven UP, 2020, pp. 105-122.

“Teaching Poetry Through Dance.” In *Poetry and Pedagogy Across the Lifespan: Disciplines, Classrooms, Contexts*. Edited by Sandra Lee Kleppe and Angela Sorby. Palgrave Macmillan, 2018, pp. 37-55.

INTRODUCTION

a diagnosis is an ending
to the idea that
we are not human.[1]

It is impossible to name all the ways in which diagnosis is useful.

It propels eradication and affirms what we know about our own body-minds. It extends the reach of genocide and makes meaning of the pain that keeps us up at night after night. It allows for violence in the name of care and creates access to medical technology, human services, and essential care. It sets in motion social control and guides treatment that provides comfort. It takes away self determination and saves lives. It disregards what we know about our own body-minds and leads to cure.

Diagnosis is useful, but for whom and to what ends?[2]

The Physician says I have "Nervous prostration."
Possibly I have – I do not know the Names of Sickness.
The Crisis of the sorrow of so many years is all that tires me –
(L873, late 1883).

The above letter by Emily Dickinson inspired my research project, *The Names of Sickness: Writing Disability and Revising Diagnosis in Nineteenth-Century America*—the first book-length study of disability rhetoric in nineteenth-century American women's writing. After

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[1] Bettina Judd, *Patient* (82).

[2] Eli Clare, *Brilliant Imperfection* (48, emphasis original).

reading the letter, I stumbled upon innumerable scholarly and not-so-scholarly articles claiming that Dickinson had depression, schizophrenia, epilepsy, lupus, and much more. This diagnostic gaze is also leveled at other famous authors.[3] Like Dickinson, "I do not know" the name of Dickinson's sickness, though various other scholars have sought to discern what might have sickened her. Dickinson's own poetry warns us to think about a clinical gaze. She wrote: "From Science – and from Surgery – / Too Telescopic eyes / To bear on us unshaded – / For their – sake – Not for Ours –" (F522). My project thus began with the question of how diagnostic readings of women like Dickinson might determine the limits of an author's subjectivity and reinforce stigmatizing ideas about disability.

Because "diagnosis" originated from a stem meaning "to know thoroughly" (*OED*), it seems to have much in common with literary interpretation. Yet there are abundant ways to study diagnosis in literature without conducting a study of diagnostic data, the influence of impairments on authors' lives, or diagnosing authors and characters themselves. Poet and gender studies scholar Bettina Judd writes that "A diagnosis / is an ending / to the idea we are not human" (Judd 82). Perhaps this is a reminder that being free of illness is to be invulnerable and therefore inhuman. Literature such as this poetry complicates our understandings of "bodyminds"—the entwining of the mental and physical—in the context of race, gender, and disability.[4] I ask: how does diagnosis grant us humanity? What does diagnosis foreclose? What

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[3] Louisa May Alcott's last known words as she was on her sickbed were "Is it not meningitis?" leading to extensive speculation about the author's death. See "Louisa May Alcott: Her Mysterious Illness" (Hirschhorn and Greaves). Hirschhorn has also asked: "Was It Epilepsy?: Misdiagnosing Emily Dickinson (1830-1886)."

[4] "Bodymind" is a feminist disability studies concept developed by Margaret Price in "The Bodymind Problem and the Possibilities of Pain" and Sami Schalk's book *Bodyminds Reimagined.* "Bodymind" refers to the enmeshment of the mind and body, refuting the Cartesian notion of Western philosophy that the mind is separate from the body.

does it empower? Like Eli Clare, above, I ask: "*Diagnosis is useful, but for whom and to what ends?"* (48). What names do writers give to sicknesses, not in the individual body alone but also in the collective body politic? How are analogies that figure racism as cancer and slavery as virus world-changing? How do women writers turn to embodied experience to shape their writings and empower their communities? Such questions energize my thinking.

I do not diagnose any author or any character in this dissertation with any physical or mental condition, a choice that is frustratingly unusual in some circles.[5] Instead, I argue that literature articulates realities of disabled life, often supplementing the confines of diagnostic language. I grapple with diagnosis as a source of knowledge and explore how literature might transform diagnosis from an individual label into a tool for social justice. Some medical humanists suggest that literary interpretation has much in common with medical diagnosis—after all, "diagnosis" originated from a stem meaning "to know thoroughly"—and claim that studying literature might help physicians become better diagnosticians. While I don't disagree with this statement, I push forward with a disability-oriented argument: that because literary analysis involves reading between the lines, it can help us figure out what needs to be done to make our world a more just, accessible, and equitable place. Literary interpretation might make us not just better at diagnosing; it might help us learn to notice systemic issues, challenge discrimination, and foster communities of care.

The Names of Sickness is the first project of its kind: a study of disability and American women writers of the nineteenth century, one that uniquely focuses on the assertion that

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[5] There are too many examples to list here. Physicians diagnose Anne of Green Gables with ADHD (Edison and Clardy); neurologists diagnose Poe with Schizophrenia (Teive and Munhoz), and literary scholars diagnose Bartleby with Autism (Pinchevski).

literature articulates disability even if we cannot—or will not—diagnose authors or characters.[6] Ambiguous utterances of symptoms in literature reveal disability to be a complex web of embodied and social relations. This web prompts imaginative expression which bewilders and shapes medical categorization. With this claim, I revise histories of medicine that celebrate the elimination brought about by diagnosis and cure—scholarship that fails to consider the many women writers who diagnosed *diagnosis* as a potentially flawed and dangerous method of knowing. I treat literature as a generative site for learning about disability as a lived experience, and furthermore assert the centrality of ableist discrimination to the legacies of gender and racial violence.

I take an intersectional approach to literary disability scholarship, exploring race, gender, and disability and challenging racism, sexism, and ableism. As scholars like Susan Schweik have demonstrated, ableist discrimination also has everything to do with class.[7] Like literary scholar Sari Altschuler, I find that disability "does not describe a stable set of somatic or cognitive variations; rather, it articulates a way of understanding the varieties of human experience"

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[6] I take up literature and disability scholar Michael Bérubé's playful goal: "to cure disability studies of its habit of diagnosing fictional characters" (20), while at the same time, I also put pressure on what disability scholar Eli Clare calls the "ideology of cure." In a study of intellectual disability in literature, Bérubé suggests that both literary criticism and disability studies have reinstated normalcy by scanning characters for disability diagnosis. He therefore directs us away from "diagnostic reads" that determine the limits of a character's subjectivity (Jones 234). He alters our "readerly focus," (234) so we are leaning less on intellectually disabled characters as *characters*, "than with the question of these characters' relation(s) to narrative" (Bérubé 37).

[7] In *The Ugly Laws,* Susan Schweik explains that starting in San Francisco in 1867 (and ending in Los Angeles in 1913), municipalities and states passed laws making it illegal for a person with a disability to solicit alms in public places. Disability definitions ranged from targeting those who exhibited "physical and mental deformities" (55) to those who have a body that is "deformed, mutilated, imperfect or has been reduced by amputations, or [being an individual] who is idiotic or imbecile" (56). Exploring issues of class and space as well as bodily variation, Schweik asserts that "unsightliness was a status offense, illegal only for people without means" (16).

(“Touching,” 2020, 91). Disability studies usefully focuses on the social aspects of embodied experience and challenges ableist discrimination. I also draw on crip theory, which reclaims a term historically used to stigmatize and oppress disabled people. Crip theory is a merging of queer theory and disability studies that prioritizes intersectionality and challenges the notion that one must receive a diagnosis to be included in disability communities.

I shift attention from diagnosers to the diagnosed and also explore the possibilities of undiagnosability. When a person or character is deemed or makes themselves undiagnosable*,* they thwart the diagnostic gaze in a way that frustrates medical science that also puts them in a precarious bodymind position. In Chapter Two’s discussion of Charlotte Perkins Gilman’s history and writing, I consider the contradictions and absences of knowledge in this author’s works, then consider more deeply how these texts produce knowledge of disability without diagnosis or other claims to certainty. Becoming undiagnosable can be a source of rebellion and imaginative experimentation for writers who do not want to be diagnosed or pathologized. This concept of undiagnosability is imperative for critical disability studies because it is most often women and people of color, especially women of color, who encounter diagnostic bias and must self-advocate to be diagnosed *correctly*. As many disability scholars, including Margaret Price, Eli Clare, Allison Kafer, Ellen Samuels, Sami Schalk—as well as health humanists such as Nicole Lee Schroeder—have argued, diagnosis is political and fraught; it is often required for accommodations, and is wielded to control marginalized populations. I add to their analyses the idea that to become undiagnosable might be empowering, if one is hoping to avoid being handed the world’s most heavily stigmatized conditions.

In exploring how literature articulates disabled life (and history, and culture) I assert that that disability studies-informed reading methods bring valuable new insights. One such reading method is Sari Altschuler's "historical cripistemology," which demonstrates that "particular disability histories—and the experiences, epistemologies, and cultures of ability associated with them—can be used to read characters without diagnosable disabilities" (120). [8] I take up Altschuler's claim that "literature is one of the richest sites for excavating disability histories and the cultures of ability in which they occurred because the thorny complexities, conflicting positions, and speculative possibilities with which cultures grapple can be explored—particularly in fiction—without requiring resolution" (98).[9] I similarly explore all that disability teaches us about the expansiveness of knowledge, rather than fixed, resolved knowledge.

Of course, in the nineteenth century, "disability" did not mean what it means today. However, disability scholars have shown that historicizing disability in literature is possible and productive. Altschuler and Cristobal Silva observe that "the concept of disability was inchoate in early America," (Altschuler and Silva 1) and Ellen Samuels writes that "there is less of a 'before and after' to the modern, institutionalized definition of disability than an ongoing tension between efforts to codify disability's meaning and the resistance posed by the messiness of impairment, as lived and represented through bodies, minds, and texts" (2017, 170). Altschuler states: "We cannot uncritically import contemporary disability experiences and epistemologies into other times and places" (96) and asks, "How, then, ought we to recover, understand, and

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[8] "*Historical cripistemology* is a method through which to examine the historical experiences and epistemologies, rather than representations, of disability in particular times and places and emphasizes the vast and varied entanglements of those experiences and epistemologies with mainstream US culture" ("Touching," 91). Historical cripistemology also "uses disability's history, and the distinct ways of knowing that emerged from that history, to examine literature and culture" (100).

[9] Altschuler notes that her term is indebted to Merri Lisa Johnson and Robert McRuer's (2014) term cripistemology—a critical approach that "combines the process of 'cripping,' which 'spins mainstream representations or practices to reveal able-bodied assumptions[,]' . . . with a philosophical commitment to 'standpoint epistemology,' which acknowledges that the subject positions from which we produce knowledge matter" (Patsavas 205).

incorporate disability-informed historical experiences and ways of knowing?" (96). She asserts that we must

> mine the past for instances of disability experience and knowledge and connect them to the broader social and cultural contexts in which they occurred. Only when we attend to specific disability histories and ways of knowing and to the broader cultures of ability…that helped fashion them can we understand how disability worked historically….[a]chieving this broader perspective requires some anachronism, strategically marshalled.…[D]isability does not describe a stable set of somatic or cognitive variations; rather, it articulates a way of understanding the varieties of human experience….[D]isability enables scholars to bring the long, rich, and varied histories of impairment, ability, and capacity together and into focus. This kind of strategic anachronism is useful because, as Cristobal Silva (2011: 12) explains, it helps illuminate new historical patterns that "[defamiliarize] narrative histories" and "[transform] our relation to the materials of literary [and cultural] history." It provides alternatives to existing methods that, it turns out, are already steeped in anachronism, although less consciously so—emerging, as so many do, from contemporary paradigms and disciplinary structures. ("Touching," 96-97)[10]

Cautiously leaning on anachronism's possibilities, I read women writers from the nineteenth century as disability theorists while drawing on the work of modern literary and

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[10] "Crucially, the formulation of disability history…relies on a twentieth- and twenty-first-century paradigm developed by disability scholars and activists" (Adams, Reiss, and Serlin 2015: 5). Disability encodes an identity category "produced as much by environmental and social factors as it is by bodily conditions" that links "a broad range of bodily, cognitive, and sensory differences and capacities" through shared experiences of exclusion and oppression (5). It is "more fluid" than other identity categories because it can be situational and can happen to anyone anytime (5) (Altschuler 97).

disability scholars, intersectional feminist disability scholars, and crip theorists. *The Names of Sickness* analyzes texts written from the Civil War through Reconstruction. Three women writers energize this project: Emily Dickinson (1830-1886), Charlotte Perkins Gilman (1860-1935), and Frances E. W. Harper (1825-1911). The chapters are focused on poetry, short story, and novel, in that order; I also read many journals and letters. For example, I consider Gilman's letter requesting a diagnosis for her "brain troubles," Dickinson's letter stating, "The Physician says I have 'Nervous prostration'" (L873), and Harper's letter that she is "not very strong physically" (Still 761). Whether or not we consider these writers as "disabled," we can appreciate that their forward-thinking experiments with diagnostic rhetoric do not merely advance medical knowledge—they also challenge discriminatory systems, including patriarchal medicine itself. These women each wrote about some ability-based discrimination bound to their womanhood; significantly, Harper additionally survived and critiqued racial prejudice that was also connected to ableism. These women described, in writing, symptoms that scholars might still try (fruitlessly) to pin down; they all illuminate the diverse ways nineteenth-century Americans revise diagnostic approaches to disability; and they all voiced their thoughts on medicine, men, motherhood, violence, prejudice, education through their writings. By exploring their works, I also explore literature's critique of racial, gender, and ableist violence.

As the above suggests, my project grapples with, but does not reject, diagnosis as a source of knowledge; rather, I ask what literature teaches us about embodied experiences and social change. The diagnostic act and "diagnosis" (the label) are distinct in some ways. One requires an agent (the physician or patient, if a self-diagnosis) and one seems to "occur," as if through the fabric of history. By diagnosing, doctors limit access to, or patrol the boundaries of, a protected class of citizenship. And by executing the action of diagnosing, they allow their patients to enact the historical subjectivity of "diagnosis." I celebrate what diagnosis does to give name to symptoms and validate a person's experiences—but I criticize occasions when diagnosis is a requirement for basic human rights, or when a diagnosis leads to violent or stigmatizing treatment. Eli Clare's book *Brilliant Imperfection: Grappling with Cure* (2017) has inspired much of my thinking. Of diagnosis, Clare writes,

> I want to read diagnosis as a source of knowledge, sometimes trustworthy and other times suspect. As a tool and a weapon shaped by particular belief systems, useful and dangerous by turns. As a furious storm…Simply put, diagnosis wields immense power…. It unleashes political and cultural forces. (41).

I also want to read diagnosis "as a furious storm," one that does not necessarily change or correct disorders. A single word or phrase attached to a person can offer relief to someone in pain, searching for bodily identity; yet diagnosis can also be used to justify oppression and violence.

In the nineteenth century, insurance policies did not demand that a physician or psychiatrist come up with a specific label, and patients were not passive recipients of diagnoses.[11] They participated in, critiqued, and revolutionized categories of disease, writing literary texts that articulated the power of receiving diagnostic labels for the purposes of self-reinvention. Some diagnostic categories were a marker of privilege, reserved for white patients. For example, in the 1880s, the conditions neurasthenia and hysteria became essential to the construction of dominant ideologies of white womanhood.[12] Such names of sickness were written and revised, explored in literature, offered, claimed, and abandoned.

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[11] For example, Lawrence Rothfield's *Vital Signs: Medical Realism in Nineteenth-Century Fiction* (1994), and Stephanie P. Browner, *Profound Science and Elegant Literature: Imagining Doctors in Nineteenth-Century America* (2013).

[12] The term "hysteria" was coined by Hippocrates in the 5th century BC. Hysteria was removed from the *Diagnostic and Statistical Manual of Mental Disorders* in 1980. It has been replaced

As I explore diagnosis, I also ponder cure and ask how literatures that speak to illness and disability express ideas beyond curative logics. I consider diagnosis as a part of the "ideology of cure." As Clare explains, the ideology of cure, which is "embedded in a network of five overlapping and interlocking medical processes: diagnosis, treatment, management, rehabilitation, and prevention" (Clare 70), seeks to normalize bodies and other forms deemed "abnormal." Clare argues that "Elimination of some kind–of a disease, future existence, of present day embodiments, of life itself—is essential to the work of cure…as a widespread ideology centered on eradication, cure always operates in relationship to violence" (28). This ideology and diagnoses themselves are socially constructed, racialized and gendered; they also have embodied consequences. The focus on cure resonates with Robert McRuer's scholarship in *Crip Theory.* While discussing compulsory heterosexuality and patriarchy, he asserts, "A system of compulsory able-bodiedness repeatedly demands that people with disabilities embody for others an affirmative answer to the unspoken question, Yes, but in the end, wouldn't you rather be more like me?" (302).

As I consider such issues, I suggest that nineteenth-century texts experiment with diagnosis-like narrative methods not just to grapple with individual conditions, but also to target *systemic* sources of mass debilitation through metaphor (the "cancer of slavery," to offer a prominent example from Harper's *Iola Leroy*). In thinking about how systems disable

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somewhat by "conversion disorder functional neurologic disorder," when a person experiences neurological symptoms not attributable to any medical condition. Women are also two to three times more likely to receive a diagnosis of conversion disorder than men (Stone et al.). Carol Smith-Rosenberg argues that hysteria was a sort of exit strategy for [white] women from gender-role conflict in that "it purchased her escape from the emotional and—frequently—sexual demands of her life only at the cost of pain, disability, and an intensification of women's traditional passivity and dependence" (207). Smith-Rosenberg seems to hint that hysteria almost became a way for women to obtain what we today call "accommodations."

individuals, I draw on the work of gender studies scholar Jasbir K. Puar. Puar's study evolves around the question, "What are the vectors for a politics of disability if debility marks the convergence of capitalism and slow death via its enfolding into neoliberalism?" (1). Puar usefully builds on the work of Lauren Berlant, a scholar of gender and queer studies. Of "slow death," Berlant writes: "The phrase slow death refers to the physical wearing out of a population and the deterioration of people in that population that is very nearly a defining condition of their experience and historical existence" (754). Though not explicitly a disability scholar, Berlant does situate their theories about chronic conditions in an American framework. As Puar writes in *The Right to Maim: Debility, Capacity, Disability*, debility

> foregrounds the slow wearing down of populations instead of the event of becoming disabled. While the latter concept creates and hinges on a narrative of before and after for individuals who will eventually be identified as disabled, the former comprehends those bodies that are sustained in a perpetual state of debilitation precisely through foreclosing the social, cultural, and political translation to disability (xiv).

Puar finds that disability is something largely denied to historically marginalized communities, and that for people who are marginalized and historically marginalized, *not* working is not an option; being "disabled" (a state which is often defined around an inability to labor and work) is therefore not an option. While "disability" is a marginalized category, it can also be a marker of privilege.

Today, white supremacy and heteropatriarchal capitalism still limit the category we know as "disability" by making some diagnostic labels ("schizophrenic" for example) highly stigmatizing and by rendering diagnosis inaccessible when it is desired.[13] Biases that lead to the diagnosis of transgender people as mentally ill and that depict black people as more likely than white people to have schizophrenia remain pervasive.[14] They not only reinforce injustice, but also reinforce beliefs that disabled people are inferior to the nondisabled.[15] People trying to self-diagnose are sometimes dismissed; the idea that patients have knowledge about their conditions and diagnoses is not new, but today it is still undermined by assumptions about physician authority.[16] This is especially significant for female patients[17] and patients of color, as we can see from the long history of bias in health care.[18] Thus, a diagnosis can be imperative for people who might yearn to situate their conditions within the cultural category of "disability" and is crucial for access to modern-day accommodations, healthcare, and legal protections.

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[13] This echoes Puar, who argues that "disability" is a privileged category and that American disability scholars often fail to recognize that privilege.

[14] Gender Identity Disorder remains a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders. Homosexuality was removed from the DSM in 1987. See Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis*. Also see Jonathan Metzl, *Protest Psychosis.*

[15] See Douglas C. Baynton, "Disability and the Justification of Inequality in American History" in *The New Disability History: American Perspectives.*

[16] In 1889 the renowned diagnostician William Osler famously stated, "Listen to your patient, he is telling you the diagnosis" (Sanders 11). Today, patients' opinions are still undermined; as Lisa Sanders argues, "far too often neither the doctor nor the patient seems to appreciate the importance of what the patient has to say in the making of a diagnosis" (7). See *Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis.*

[17] A recent commercial campaign called "SpeakEndo" features women with painful periods whose confident doppelgangers help them explain pain to gynecologists. The commercials, produced by the Abbvie pharmaceutical company, encourage women to communicate with their doctors to receive an endometriosis diagnosis and receive medication (presumably Abbvie's new endometriosis drug, Elagolix). This exemplifies the difficulty of speaking about pain, the importance of practicing narrating intimate pain to receive a diagnosis, and the ways these narratives are dictated by the capitalism of American health care. See https://bloominuterus.com/2018/02/03/have-you-seen-the-endometriosis-commercials-on-tv.

[18] See Irene V Blair et al, "Unconscious (implicit) bias and health disparities: where do we go from here?"

Intervening in more humanities scholarship, I further challenge ableist notions such as the "overcoming narrative."[19] A medical model[20] approach to literature relies on an overcoming narrative. Activist and scholar Simi Linton shows that overcoming rhetoric "emphasizes 'personal triumph over a personal condition' and fails to attend to the social circumstances that perpetuate ableism or the privileging of bodily and mental capacity" (Mullaney 50).[21] Literary scholarship too often anticipates a linear narrative of diagnosis-to-cure, without resting with or grappling with the undiagnosed, incurable, and chronic. For example, many literary scholars claim Dickinson "overcame" eye impairments;[22] celebrate that Gilman was cured of mental illness thanks to her writing;[23] or suggest Harper's character Iola was cured of a nervous condition because she married a physician.[24] These claims impose a wishful medical model onto

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[19] Other overcoming narratives—for example, the phrase "You are a credit to your race"—suggest that anyone who continuously faces discrimination is failing if they are not routinely succeeding.

[20] "The medical model, also called the deficit or individual model, has held and still holds a firm grip on society's current conception of disability. This perception of disability places the problem with the individual and sees disability as a direct consequence of an impairment" (Anderberg para. 1).

[21] The "restitution narrative" is also relevant here: "The medicalization of disability… refers to how individuals with disabilities have been categorized as 'sick' and placed under the jurisdiction of the medical establishment and medical professionals. This model views disability solely through the lens of impairment and is undoubtedly related to what sociologist Arthur Frank (1995) has critiqued as medicine's investment in the 'restitution narrative': the belief that all conditions are 'treatable' through medical intervention, which then returns the 'sufferer' to the condition of 'health' and 'normalcy'" (DasGupta 120).

[22] For example, Mary Jo Dondlinger asserts, "The enormous amount of artistic expression, over three hundred and sixty poems in one year, was a means of dealing with and *overcoming* this anguished period of her life" (101, my italics).

[23] Herndl says "Gilman managed to cure herself…. Gilman's writing proved to be restorative. She claims to have recovered from her nervous breakdown by writing, directly disobeying the directions of her doctor. She was probably right" ("The Writing Cure" 74).

[24] Michele Birnbaum argues, "The sentimental angst of [Iola's] 'condition' is scrutinized, diagnosed, and finally cured by marrying the doctor treating her" (10).

the lives of women and their characters, assuming that cure or death are the two possible futures for disabled life. I turn to literary texts that, I suggest, supplement diagnostic and curative approaches to disability and offer diverse and crucial ways for us to understand disability as a lived experience.

Feminist Disability Studies

> The man who does not know sick women does not know women.
>
> ---S. Weir Mitchell

> I try to describe this long limitation, hoping that with such power as is now mine, and such use of language as is within that power, this will convince any one who cares about it that this living of mine has been done under a heavy handicap…
>
> ---Charlotte Perkins Gilman

> A Word dropped careless on a Page
> May stimulate an eye
> When folded in perpetual seam
> The Wrinkled Maker lie
> Infection in the sentence breeds.
> We may inhale Despair
> At distances of Centuries
> From the Malaria–
> ---Emily Dickinson

I copy the three passages above from the first three epigraphs of "Infection in the Sentence: The Woman Writer and the Anxiety of Authorship" by feminist scholars Susan Gilbert and Sandra Gubar. Like Gilbert and Gubar, I study Mitchell, Gilman, and Dickinson (not in that order). Gilbert and Gubar use Bertha Rochester, the "madwoman" of Charlotte Brontë's *Jane Eyre,* as emblematic of female anxiety, and argue that the

> female anxiety of authorship is profoundly debilitating…It is debilitating to be any woman in a society where women are warned that if they do not behave like angels they must be monsters…Social historians…have begun to study the ways in which patriarchal socialization literally makes women sick, both physically and mentally. Hysteria, the disease with which Freud so famously [investigated]…is by definition a 'female disease'…Sufferers from anorexia…agoraphobia…are usually female…as are sufferers from crippling rheumatoid arthritis. (51-53).[25]

While Gilbert and Gubar aren't wrong when they say that patriarchy makes women sick—using the term "debilitating" like Puar later does—they clearly wrote this before the rise of disability studies began. Calling these women "sufferers" is a bit pitying, and the idea that these conditions are only due to patriarchy and have no other corporeal reality puts too much space between the social and the embodied.

After Gilbert and Gubar, we saw a rise of "feminist psychiatric disability studies, or the 'What about the *real* madwomen in the attic?' strand of feminist disability studies, starting

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[25] Like Gilbert and Gubar, Diane Price Herndl analyzes nineteenth-century literary representations of ill and insane women in women's fiction. Herndl "argues that illness, as a literary trope, reconciles or collapses the contradictory discourses of nineteenth-century womanhood…. Herndl does not explore the way that the incoherency of illness produces these discrete-though-contradictory explanations, informed by political and social mores, that the women's fiction she examines then deploys as coherent models (1993, 49)" (Horvath Williams).

with Elizabeth Donaldson's idea that madness as a metaphor of female rebellion obscures the lived experience of mental illness" (Johnson para. 5). I join other scholars in melding feminist theory with disability studies, which does important work we might call anti-ableist work in tandem with challenges towards heteropatriarchy and racism. Mitchell's quotation could be thought to acknowledge the reality of illness in contemporary women's lives or rudely imply that ill women show sides of themselves that are otherwise better off hidden. Gilman's writing about her "heavy handicap"[26] must now, certainly, be situated not just in feminist scholarship but in disability scholarship as well. Her prayer that she can "describe this long limitation" with her "use of language" speaks to the desire to articulate disabled experience to "convince" others of her reality. Dickinson's profound expression—"A Word dropped careless on a Page / May stimulate an eye"—opens opportunity for us to think about reading and interpretation. Further, the lines "Infection in the sentence breeds. / We may inhale Despair" do not invite us to consider illness as *merely* metaphor for feminine marginalization, but also to ask how metaphor and embodiment relate to each other and how stories of illness are told through the centuries.

Critical disability studies[27] usefully focuses on the social aspects of disability (and connected experiences of illness and pain) rather than uncritically accepting symptoms and diagnoses represented in texts.[28] The field has been shaped by disability justice, a framework

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[26] Today, "'handicap' refers to people with physical or mobility disabilities, but is usually a euphemistic phrase to avoid saying 'disability' or 'disabled'" (Brown, "Ableism/Language").

[27] Critical disability studies explicitly challenges the normative assumptions of more traditional disability studies and also focuses more on intersectionality (Hall).

[28] See Tobin Siebers' *Disability Theory*, which analyzes the tension between the "social model" of disability and the material details of impairment, and Alison Kafer's *Feminist, Queer, Crip*. For another foundational disability studies work that asserts disability studies' place at the center of such literary and cultural inquiries, see Ellen Samuels' *Fantasies of Identification.*

that examines disability and ableism as it relates to other forms of oppression and identity (race, class, gender, sexuality, citizenship, incarceration, size, etc.).[29]

I see my work furthering research arguing that disability studies should embrace scholarship of embodiment and pain. Most early significant works of disability theory begin by defining the "medical model" (and its problems), then the "social model" (and its virtues)—a necessary act that migrates disability into non-medical understandings. However, as Sharon L. Snyder and David T. Mitchell argue, "Disability studies has strategically neglected the question of the experience of disabled embodiment in order to disassociate disability from its mooring in medical cultures and institutions."[30] More recent studies complicate understandings of disability, medicine, and embodiment. For example, Tobin Siebers developed a "theory of complex embodiment," a theory "that values disability as a form of human variation…to raise…awareness of the effects of disabling environments on people's lived experience" (2008, 22). Representations of pain can be read not only as metaphorical, but also as signifying the knowledge of chronic pain and other aspects of complex embodiment.[31]

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[29] See Leah Lakshmi Piepzna-Samarasinha, *Care Work: Dreaming Disability Justice*. Disability justice frameworks were developed starting in 2005 by the Disability Justice Collective, a group of "Black, brown, queer and trans" people including Patty Berne, Mia Mingus, Stacey Milbern, Leroy F. Moore Jr., Eli Clare, and Sebastian Margaret" (Piepzna-Samarasinha). In disability justice, disability is not defined in "white terms, or male terms, or straight terms" (Piepzna-Samarasinha). Disability justice activists acknowledge that "ableism helps make racism, Christian supremacy, sexism, and queer- and transphobia possible" and that all those systems of oppression are intertwined. The disability justice framework is being applied to the intersectional reexamination of a wide range of disability, human rights, and justice movements.

[30] Sharon L. Snyder and David T. Mitchell, "Re-Engaging the Body: Disability Studies and the Resistance to Embodiment" (370).

[31] For a foundational explanation of the social model, see Tom Shakespeare, "The Social Model of Disability." He explains, for example, how individual impairment "differs from the social construction of disability that might surround that impairment" (197-204).

To expand the scope of disability studies and the health humanities, I also draw upon crip theory, which expands disability studies by “including within disability communities those who lack a ‘proper’ (read: medically acceptable, doctor-provided, and insurer approved) diagnosis for their symptoms” (Kafer, *Feminist, Queer, Crip* 18).[32] Alison Kafer’s point, that diagnosis has contributed to assumptions about who can identify as disabled and participate in the disability studies community, underlines diagnosis’s significance to both crip theory and disability studies. I appreciate that crip theory opens up the possibility of centering the contributions of undiagnosed people, Neurodivergent people, and people who do not wish (for cultural and professional reasons) to identify as “disabled.” While disability studies in general seems to frown upon people refusing to “come to terms” with certain identities, it’s important to remember that there are myriad reasons why a person, for cultural and professional reasons, might never “come out crip” to borrow Ellen Samuels’s expression. Samuels does intersectional work between disability studies and queer studies to better convey that we know that people might need to remain in “the closet”—so we must respect any who do not have crip pride, or wear their diagnoses on their sleeves. To become undiagnosable is in some ways like invisiblizing one’s own disabled identity, and this might be done to preserve a person from the ableism which we know can bring about slow death and debility (now borrowing phrases from Lauren Berlant and Jasbir Puar again). We can critique the violence that occurs when physicians do not or will not believe symptoms, while also acknowledging that becoming undiagnosable or hiding diagnosis can be lifesaving and empowering acts.

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[32] “Crip” “is most often embraced by educated disabled people who have some understanding of the historical and political significance of their experiences as disabled and who want to reclaim a stigmatized term” (Lewis 46).

This project takes an intersectional approach, exploring blackness, womanhood, and disability and racism, sexism, and ableism, for example, while also centering disabled black women writers.[33] Blackness, indigeneity, queerness, and femininity have all been essentialized, in different ways, as disability. Disability studies offers tools to critique the oppression engendered by such essentialization. Scholars of disability and Indigeneity point out that "Ableism, via Western biomedical diagnosis, has been a potent weapon disconnecting Indigenous and disabled peoples from their places. It has aided in the theft of Indigenous lands and the confinement of Indigenous and disabled people. Indigenous-disability studies spells out the inextricable links between medical treatment, confining institutions, and stolen lands." (Larkin-Gilmore, Callow, and Burch). Dennis Tyler Jr.'s new book, *Disabilities of the Color Line*, shows how

> Black writers and activists live through, recount, and avow…discursive and material disablement without unequivocally disclaiming disability or the lived experiences of disabled people. In doing so, they conceive or create dynamic new worlds that account for people of all abilities through a variety of ways: their acts of writing…radical traditions and performances, activism and defiance against ableism and racism (1).

Like Tyler, I am curious about how Americans from an earlier time continuously denounced forms of prejudice such as ableism, racism, and sexism, even though they did not share our

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[33] Writer and activist Audre Lorde is frequently referenced as inspirational to the disability justice movement, for works such as her essay "A Burst of Light: Living with Cancer," which addresses disability, illness, and racial justice, emphasizing that "We do not live single issue lives" (96). Writers such as Jina B. Kim draw upon disability justice and "crip-of-color" critiques in an attempt to develop an intersectional critical disability methodology which emphasizes that all lives are "enriched, enabled, and made possible" through a variety of means of support (Kim para. 3). I write about Lorde in relation to literary disability studies in chapter three.

modern vocabularies surrounding justice work. I am also fascinated by nineteenth-century America's imagining of "dynamic new worlds" that moved beyond a medical approach.

Revising Diagnosis (and Cure)

Diagnosis is currently "having a moment" in literary criticism and history (Mendelman).[34] Scholars are fascinated, for good reason, by diagnosis—as an act of knowledge production; as a method of reading; and as a tool for social oppression. In America, some of this fascination relates to the necessity of a diagnosis for healthcare. Volumes such as the *Diagnostic and Statistical Manuel* have led to diminished interest in the social and psychological context of mental disease, in favor of biological aspects.[35]

Cultural histories of diagnosis trace human efforts to narrate experiences and then classify them. The word "diagnosis" was first used in medical science in the seventeenth century. Originating from a stem meaning "discern, distinguish," literally "to know thoroughly" (*OED*), diagnosis was defined in 1681 as "dilucidation, or knowledge."[36] "Diagnostics" was soon defined as a practice with the goal to "discerne…the sick and infirme from the whole."[37] Diagnosis aimed to produce knowledge about the body and to help maintain distance between "the whole," or healthy, and the sick. Discovering, classifying, and diagnosing diseases are ambiguous and simultaneous processes.[38] Treatment almost always helps a doctor establish a

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[34] See the work of Lisa Mendelman, "Diagnosing Desire: Mental Health and Modern American Literature, 1890–1955" and Lindsey Grubbs, "A Wasted Sympathy": Undiagnosing Winifred Howells.

[35] See Bassam Khoury et al. "The DSM: mindful science or mindless power? A critical review" and Martyn D. Pickersgill, "Debating DSM-5: diagnosis and the sociology of critique."

[36] Thomas Willis, *The Remaining Medical Works of Dr. Thomas Willis*, transl. Samuel Pordage (1681).

[37] James Hart, *The Anatomie of Urines: Containing the Conviction and the Condemnnation of Them* (1625).

[38] Modern medical practitioners demonstrate that "diagnosis" has two primary meanings:

diagnosis—so before a patient is diagnosed, they may have to first undergo body-mind altering treatments (Albert 184). Cultural histories of diagnosis draw attention to the social constructedness of medical authority and the ranges of patient experiences that are undermined due to racism, sexism, and classism.[39]

For my project, I try to preserve a definition of "diagnosis" as a claim about a condition in a person's bodymind that is a disorder—i.e., something that impacts that person's reality almost every day. A "diagnosis" is the voiced "name of sickness" given by a physician to a patient; a "self-diagnosis" refers to a medical term claimed by the patient; and "to diagnose" refers to the moment when someone has recognized, by signs and symptoms, a condition or disease. "Diagnosis" is not just an equivalent of "label," which has more to do with stereotyping. Diagnosis as a form of *identification* is distinct from the term *identity*—a term which allows us to think more about disability studies' approach to identity. Identity is "the means by which the person comes to join a particular social body" (Siebers, *Disability Theory,* 15).[40] To be diagnosed with a condition does not necessarily result in identifying as disabled or in any way combining one's personal identity with that condition. In addition to "diagnosis," I consider "a naming of systemic ills that cause mass debilitation," drawing back to Puar's work, which we

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"First of all, *Diagnosis* is the name for the process a doctor goes through to arrive at a conclusion about the state of health of a patient. Diagnosis, in this sense, is…an activity or action…As such, it can be done well or poorly, hastily or carefully. Diagnosis in the second sense refers to the outcome of the diagnostic process….in this sense involving a labeling of the patient…that classifies a patient, provides an explanation of symptoms, and leads the clinician to create a prognosis" (Daniel A. Albert et al, *Reasoning in Medicine*, 184, original italics).

[39] See new cultural histories of diagnosis such as Danielle Spencer's *Metagnosis: Revelatory Narratives of Health and Identity*.

[40] Understanding disability "as a social construct and disability identity as politically constituted are foundational for disability theory and culture, baseline concepts upon which all other thinking and writing about disability identity must be measured" (Rodas 103).

might call a *metaphorical diagnosis,* which moves diagnosis past medical frameworks and more overtly into the realm of the literary.

While writing about the so-called "epidemic" of obesity in the twentieth century, Berlant writes, "The epidemic concept is not a neutral description; it's inevitably part of an argument about classification, causality, responsibility, degeneracy, and the imaginable and pragmatic logics of cure" (754). Like Berlant, I am curious about classification and how narrative might emerge from and through it. Physicians in the nineteenth century sometimes sidestepped diagnosis and moved right to treatments that could do harm—the famous rest cure, for example. While exploring that history, I mainly consider the relationship between diagnosis and stigma. American medical history is full of wild, marginalizing labels. A label—of "drapetomania" to offer one dramatic example—could serve as a tool of white supremacy and heteropatriarchy.[41] A label like "insane" might bar a person from many kinds of care while confining them to an asylum. I mostly explore psychiatric diagnosis (of hysteria, insanity, and nervousness, for example). However, I resist the idea that mental illnesses are or were considered distinctly from physical disabilities. "Phantom limb pain," a nervous disorder, is directly caused by physical amputation; Dickinson's ophthalmologist diagnosed "hysteria of the retina." In other words, classifications of body, mind, and emotion often blend together, especially for female patients. Hysteria takes up space in this project; still today, people (especially women, especially women of color) who are undiagnosed and desperate for diagnosis are dealt with as "hysterical" in the colloquial sense; they are subsequently barred from accessing medical treatment.

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[41] Drapetomania was a supposed mental illness that, in 1851, American physician Samuel A. Cartwright hypothesized as the cause of enslaved Africans fleeing captivity (White 41). For more on race and diagnostic politics, see Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease*.

When thinking about the network of diagnosis, treatment, and cure, I also challenge the idea that medicine is generally triumphing (if slowly) over disability and illness. Medical humanities projects too often forget that some conditions are undiagnosable and incurable and offer humanities scholarship as a useful way of envisioning a curative future, devoid of disability.[42] Some scholars assume that diagnosis and treatment, if done correctly, will unquestionably fix bodymind problems; in other words, some scholarship follows the triumphalist narrative of medicine over disability.

I join literary disability scholars such as Dennis Tyler Jr., who recently challenged the "triumphalist narrative of overcoming where both disability and disablement alike are shunned" (Tyler, back cover). Literary disability scholar and medical humanist Sari Altschuler also observes and questions the "triumphalist narrative of medicine" (2020 para. 1).[43] This triumphalist narrative is best defined in Michel Foucault's *The Birth of the Clinic* (1963), which remains influential for studies of the codification of institutionalized medical authority in the modern Western world. Foucault argued that the triumphalist narrative of modern medical progress should be regarded not as a history of scientific advancement, but as a discourse of power. As Tiffany DeRewal writes, the field of medical history has long been dominated by an "established, establishment" narrative, "thought to be written exclusively by physicians for other physicians, consecrated to heroic celebration of great doctors and their achievements, Whiggish and triumphalist, unapologetically internalistic and naively positivist" (Huisman and Warner 2,

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[42] I take inspiration here from Alison Kafer, who in *Feminist, Queer, Crip* imagines different futures for disability and disabled bodies (beyond cure and death).

[43] In an article about the coronavirus pandemic, "Learning from Crisis: Narrative and the History of Medicine," Altschuler writes, "Triumphal narratives about medicine are failing us" (para. 1).

quoted in DeRewal 23).[44] After the eighteenth century, Foucault contended, “the power of the state to manufacture subjects became dependent on the shift away from moral authority and religious tradition, to more normative and scientific understandings of the human body. ‘Biopower,’ defined as ‘a political technology that brought life and its mechanisms into the realm of explicit calculations and made knowledge/power an agent of transformation of human life,’ became the modern form of disciplinary power in the liberal state (*History* 134)” (DeRewal 23). I join Tyler and Altschuler in resisting an imagined future where medicine fundamentally overcomes disability, and instead offer a vision of a future where disabled people are everywhere and are welcomed everywhere.

There are times when care outweighs cure. Any attempt to understand or take up “care,” “in its lived, philosophical and political aspects is a slippery affair…It encompasses the intimate, fleshy and mundane exchanges between bodies engaged in everyday affects and acts—of giving and receiving, of living and growing, of teaching and learning—that are fraught with ethical complexity” (Douglas et al. 1). Recently, queer disabled writer Leah Lakshmi Piepzna-Samarasinha has explored “care work” as “a place where disability justice and queer femme emotional labor intersect” (35), asking, “What does it mean to shift our ideas of access and care…from an individual chore, an unfortunate cost of having an unfortunate body, to a collective responsibility that’s maybe even deeply joyful?” (41). Still today, much of the burden of care work falls upon women (especially mothers and women of color) and disabled people

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[44] According to Foucault, the rise of the Western medical establishment was not the result of science’s inevitable triumph over superstition (*Birth* 31). Rather, the positivist history of modern medicine was a myth, born of eighteenth-century liberal philosophies and shifts in political consciousness (DeRewal 24).

who provide care interdependently.[45] The medical cure/care dichotomy labels "cure" as the goal of the male physician and "care work" as the job of the female nurse, creating a hierarchy wherein men do the "real" work and women merely a domestic chore. Piepzna-Samarasinha's framing treats care as collective, moving away from individual models. Their work also expands upon Black feminist theorist Audre Lorde's representation of self-care as deeply political. As Lorde wrote, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (130). Like Jina B. Kim and Sami Schalk, I understand "the importance of self-care in our current political moment [as] deeply grounded in experiences of disability" (325).

When we ponder disability, it might be helpful to turn to a non-binary model of care and cure. Anthropologist Christina Giordano writes: "Suspending diagnosis gives the patient time to listen to the wounds of her being and to co-exist with them without removing their incommensurability by explaining them away through a diagnostic category. As Roger Gentis put it, what is needed is not so much to bring people back to norms, 'but to cure them from those very norms' (1978:6), and thus care for and cure life itself" (32-44). Giordano seeks a "care-cure": "A relation not punctuated by diagnoses and the eradication of disease, but by a holding, and the acknowledgment that others have their own words that need to be spoken and heard, and their own timing to be cared for" (32). As I demonstrate, Harper's *Iola Leroy* creates characters who perform interdependent care work to help each other grapple with the damage done by disabling institutions.

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[45] The fetishizing of productivity is also criticized in David T. Mitchell and Sharon Snyder's *The Biopolitics of Disability: Neoliberalism, Ablenationalism, and Peripheral Embodiment*, who point out that many disabled people cannot be productive in traditional ways that adhere to capitalist models.

The texts I study often gesture to a longing for care-cure; they seek to cure America of destructive political systems, and they also treat care work as a collective responsibility for anyone disabled by those systems. Moving beyond cure, literature reckons with conditions that defy diagnosis while examining social issues relating to gender and race that might be considered chronic. When the ideology of cure comes up short, narratives of symptoms that defy categorization and empower defiance against systems of classification fill the spaces within and excluded by empirical epistemologies. I assert that the realization that disorders might never be diagnosed or cured is not necessarily a depressing or pessimistic discovery. Rather, this knowledge may empower new ways of appreciating disorders that are chronic, undiagnosable, and incurable.

Methods of Reading

Close reading is invaluable for this exploration of embodiment. Like Michael Snediker, a poet and scholar of queer theory and disability theory, who studies chronic pain in American literature, I find that "the theory and practice of this present undertaking"—studies of the nuances of lived experience—"are unthinkable apart from their devotion to close reading" (21).

I analyze the formal features of texts to argue that a text might expose something about lived experiences with impairment even if, or especially because, a person struggles to narrate or define those experiences. Elaine Scarry argues in *The Body in Pain: The Making and Unmaking of the World* (1985) that pain is not narratable because it is invisible, unverifiable, and unpresentable, therefore often subject to misattribution or denial by those who are not experiencing it. By contrast, in *Hurt and Pain: Literature and the Suffering Body* (2013) Susannah B. Mintz argues that that the inarticulate aspects of pain become sources of connection, compassion, artistry, and knowledge in literature, and lead to experiments in genre. By demonstrating how particular disability histories—and the experiences, epistemologies, and cultures of ability associated with them—can be used to read characters without diagnosable disabilities, I open new avenues for thinking about literature and disability.

Representations of pain can be read not only as metaphorical, but also as embodying literal knowledge. This is much inspired by Snediker's argument that "figuration isn't external to the variable experience of lived embodiment: it *is* lived embodiment" (32). Snediker's close readings—of Dickinson's poem "A Pang is more conspicuous in Spring" (F1545B) for example—suggest that a poem might dissolve a fantasy of visualizable pain and replace it with felt intensity. Snediker counters criticism that "takes for granted that a poem's communication of pain is given from the position of a lyric self for whom that pain is centrally constitutive" (99). In contrast, the author suggests that the poem imagines pain's unsettling motion beyond the limits of a lyric self.[46] By paying close attention to the jingle of the "ng" digraph in the poem (in "Pang," "Spring," "things," and "sing"), Snediker suggests that the poem's opening lines "dilate and contract (*springlike,* in the manner of coils) from the sharpness of a pang" (100). With such observations, the author overtly finds a feeling—a pang—in Dickinson's poem. The book further suggests that Dickinson did not merely imagine or feel this pain but also inscribed it, translating it into the ways her poems might be read. This analysis productively demonstrates the dynamic overlap between reading, writing, and embodied experience.

Numerous disability scholars were long wary of metaphors, for they observed that disability is often metaphorized and disabled people themselves are reduced to metaphors for tragedy. Early works in disability studies trouble metaphors that turn disability into a stand-in for

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[46] Virginia Jackson also offers extensive analysis of the embodiment of Dickinson's lyric self. See *Dickinson's Misery* (2013).

other oppressions. Though not a disability scholar, Susan Sontag famously wrote in *Illness as Metaphor*: “It is toward an elucidation of those metaphors, and a liberation from them, that I dedicate this inquiry” (4). David T. Mitchell and Sharon L. Snyder argued that “through the corporeal metaphor, the disabled or otherwise different body may easily become a stand-in for more abstract notions of the human condition, as universal or nationally specific; thus the textual (disembodied) project depends upon—and takes advantage of—the materiality of the body” (50). They also write: “One might think of disability as the master trope of human disqualification” (51). Mitchell and Snyder usefully acknowledge that marginalization on the basis of ability is at the heart of other forms of marginalization. They critique specific kinds of “corporeal” metaphors, though elsewhere (in their section on Oedipus, for example) they explore the value of metaphors for writing new ways of thinking of disability in literature.

While these scholars usefully work to subsume race, class, gender, and sexuality into disability, an intersectional approach—one that both highlights ableism as a main issue for other forms of discrimination and simultaneously acknowledges that racism, for example, comes with discrimination that differs in major ways from ableism—is a useful way of moving Mitchell and Snyder’s work further. So, while we can consider disability as “the master trope of human disqualification,” we can also move towards intersectional methods that generously open up new ways of thinking about the overlaps between ableism, racism, sexism, and so forth.[1] Snediker joins a select number of scholars who have recently advocated for greater attention to analogy, metaphor, and figuration in disability studies. He praises recent works of disability scholar Ellen Samuels and literary scholar Todd Carmody, who open up ways for disability scholars to address analogy with more open-mindedness. Snediker observes that the field of disability studies has emphasized “the ontology of *is* at the expense of the no less phenomenal aesthetics of *like”* (11-

12) and asserts that “figuration brings us closer to the bafflements of phenomenal intensity than otherwise possible” (13).

New ways of reading provide us with various tactics for approaching such texts and their representations of embodied experiences. The reading practice called “symptomatic reading” assumes that a text’s truest meaning lies in what it does not say. Symptomatic reading has a history in psychoanalysis; it seeks to unmask hidden meanings, assuming that symptoms reflect larger issues within textual forms.[47] Eve Kosofsky Sedgwick’s critique of “paranoid reading” offers an example of reading that seeks specific, rather than broad, knowledge of an object.[48] Paranoid reading seems to have something in common with reading to diagnose, and yet the word “paranoid” is likened to “hypervigilance” and paranoid reading “is associated with a highly public and stigmatized manifestation of mental illness” (Love 237). While thinking beyond simple binaries—symptomatic or surface, paranoid or reparative— I consider attempts to move literary scholarship further away from the invasiveness of an authoritative critical gaze.

In Chapter One especially, I criticize what I call “diagnostic readings” of Emily Dickinson. When I write about “diagnostic reading,” which is a form of reading rather than a medical diagnosis, I attempt to make this non-literal way of looking at diagnosis clear. I consider the relationship between reading and diagnosing while maintaining a sense of the difference between the (possibly stigmatizing) consequences of a reader’s assumptions and the (possibly embodied) consequences of a physician’s diagnosis. When a doctor performs a diagnosis, they

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[47] See Stephen Best and Sharon Marcus, “Surface Reading: An Introduction,” 1. Symptomatic reading has a history in psychoanalysis; it seeks to unmask hidden meanings, assuming that symptoms reflect larger issues within textual forms.

[48] In “Paranoid Reading and Reparative Reading” Sedgwick defines paranoid reading as reading that anticipates bad actors and maliciousness, seeking out clues for them. Reparative reading, on the other hand, searches for the positive in even a deeply flawed work and seeks pleasure instead of avoiding pain.

use language that might dramatically, suddenly, and radically alter an individual's bodymind.[49] In his foundational work on performative utterances in *How to Do Things with Words* (1970), J.L. Austin distinguishes "verdictives" as a category of illocutionary acts in which a speaker gives a verdict, such as a diagnosis (147). I consider the idea that a physician's diagnosis, unlike some distant reader's interpretive practice, is embodied—an utterance that provokes physical, emotional, and mental responses as well as transformations of identity.

The Medical & Health Humanities

Because I consider representations of pain and illness in textual form, my study is informed by scholarship on illness and disability narratives. Numerous patient, illness, and disability memoirs have emerged recently in the past fifty years, each describing unique encounters with medical bias, mortality, and newfound identities and communities.[50] Ann Jurecic's *Illness as Narrative* (2012) inspires much of my thinking. She defends studying the illness memoir in academia, asking how personal, painful accounts of confusing and frightening experiences fit into literary studies as a genre for critical examination. Susannah B. Mintz offers a productive model. She argues that literature, such as Dickinson's poetry, articulates pain in complex ways, illuminating pain as something desirable, productive, and even erotic. Continuing the work of these scholars, I do not assume that literary texts by Dickinson, Gilman, and Harper

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[49] This phrase is often used in medical texts (Albert 119). Also see R. R. Ledley and L. B. Lusted, "Reasoned Foundations of Medical Diagnosis" (9). The phrase "perform a diagnostic test" is also used (Albert 38). I could not find the history of the phrase "perform a diagnosis," but the use of the word "perform" as in "perform a *cure*" has been in use since 1774 (*OED*).

[50] This includes Audre Lorde's *The Cancer Journals* (1997), which describes Lorde's turn to poetry to express her emotions and shifting identity through the course of her cancer diagnosis, surgery, and recovery. Other notable examples include Porochista Khakpour's *Sick: A Memoir* and Rita Charon's *Narrative Medicine: Honoring the Stories of Illness*.

only address diagnosis and pain autobiographically, for authors can write about pain in ways that are not necessarily dependent upon biographical claims to authenticity.

I also draw upon research in the medical and health humanities.[51] I believe disability studies does much of the same work as the medical/health humanities,[52] except that "medical humanists most often take the physician's medicalized point of view of bodies and disabilities."[53] However, many medical humanists succeed in breaking down barriers between disability studies and the medical field, a crucial move for the future of these fields. For example, Rebecca Garden argues that "the 'social model' of disability can be expanded to chronic illness and to the broader work of the medical humanities," and she writes to explain ideas from disability studies to medical practitioners.[54] Like Garden, I see my project as finding productive space between disability studies and studies of medicine and embodiment. And as I incorporate research from medicine and the medical humanities, I will not conform to ideologies that aspire to eliminate disability.

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[51] In *The Medical Imagination*, Sari Altschuler argues that during the eighteenth and nineteenth centuries, "doctors understood the imagination to be directly connected to health, intimately involved in healing, and central to medical discovery. In fact, for physicians and other health writers in the early United States, literature provided important forms for crafting, testing, and implementing theories of health. Reading and writing poetry trained judgment, cultivated inventiveness, sharpened observation, and supplied evidence for medical research, while novels and short stories offered new perspectives and sites for experimenting with original medical theories" (back cover).

[52] I use "medical humanities" and "health humanities," but generally prefer the term "health humanities," which questions notions about the cruciality of health See Therese Jones et al, "The Almost Right Word: The Move from Medical to Health Humanities."

[53] See Diane Price Herndl, "Disease versus Disability: The Medical Humanities and Disability Studies" (593-98) and Beth Linker, "On the Borderland of Medical and Disability History: A Survey of the Fields," (499-535).

[54] See "Disability and Narrative: New Directions for Medicine and the Medical Humanities" (70-74).

In Chapter Three, I specifically consider two other widely mobilized concepts in medical and health humanities today: "social determinants of health" and the concept of "structural competency." The first concept refers to the social conditions that structure health: the social conditions for Black women that can be, themselves, the cause of disability. Keisha Ray shows that we "see that social determinants of health—such as race and racism, access to safe housing and transportation—are major factors in how Black patients experience illness and how they experience care. We can "see just how instrumental a lack of access to key social determinants of health can be to proper health for Black people" (146).[55] Stories, in an earlier America and today, shed light on these social determinants of health and on the ways race relates to a person's experiences of health, disability, and care.

Regarding the second concept, I ask how literary structures train us in a kind of "structural competency"—which is, in Jonathan Metzl and Helena Hansen's framing, the ability to read for the structures that determine health beyond what the individual clinical encounter might reveal. Metzl and Hansen revise the term "cultural competency," arguing that "the clinical presentations of persons at both ends of the economic spectrum are shaped by 'cultural' variables, and also by the economic and political conditions that produce and racialize inequalities in health in the first place" (127). Their paper

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[55] See a chapter in *Contemporary Physician-Authors: Exploring the Insights of Doctors Who Write*, Keisha Ray examines Damon Tweedy's *Black Man in a White Coat*, which tells the stories of several of Tweedy's Black patients' experiences with poor health. Through his reflections on his patients, Tweedy also tells his own story of being Black and sick and his experience of healthcare as a Black physician and as a patient. Ray also defines Black bioethics: "Using the lens of Black bioethics, justice for Black patients may require giving Black patients priority in resource allocation as a matter of reparations for medicine's racist past and its current racist practices. Black bioethics forces us to think of justice, specifically as racial justice and those actions and practices required to once and for all attain racial justice in healthcare" ("It's Time for a Black Bioethics" 40).

> describes a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions…The paper ultimately argues that increasing recognition of the ways in which social and economic forces produce symptoms or methylate genes then needs to be better coupled with medical models for structural change (126).

In other words, Metzl and Hansen demonstrate how medicine must stop looking solely at individual experiences and begin examining structural issues and forces. This notion—of shifting from specific to general and back again—is of course also at the center of literary analysis, which uses close reading to move from detail to broad structural argument. My project likewise attempts to navigate between individual experiences of disability, and to think more broadly about systems that cause harm, without negating disabled experiences.

Why Nineteenth-Century America?

I study diagnosis in the nineteenth century—a century that attracts many literary disability scholars.[56] What makes the time between 1840-1901 so especially compelling?

My timeline encompasses what Cynthia J. Davis calls "the era of medical professionalization" (1).[57] The American Medical Association was founded in 1845, then "reorganized itself" and "assumed broad regulatory power" in 1901 (Schuster 142). Key works

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[56] Garland-Thomson, Davis, and other influential early scholars Snediker, Altschuler, etc. have proven this more recently.

[57] As Roger Cooter summarizes, the study of medical history today is necessarily intersectional, encompassing "wider interactions between self, society, and knowledge" than has been previously acknowledged, "all according to competing priorities and the different material constraints of everyday life": [The term "medicine"] invariably consists of more than merely the professional practice of licensed healers in all their economic, political, and social settings. It is more, too, than just the knowledge of diseases and processes affecting the body in sickness and health and the prevailing technologies for corporeal intervention" (DeRewal 23).

from disability studies show that ableist ideologies about normalcy emerged during the mid-nineteenth century. As Lennard J. Davis writes, "it is possible to date the coming into consciousness in English of an idea of 'the norm' over the period 1840-1860" (Davis 24). With the birth of "normalcy" emerged ableism, defined as "'discrimination in favor of the able-bodied'…the idea that a person's abilities or characteristics are determined by disability or that people with disabilities as a group are inferior to nondisabled people" (Linton 8). This idea is connected to normalcy, which "is constructed to create the 'problem' of the disabled person" (Davis 24).[58] In the 1840s, the word "normal" transformed from a descriptive definition, synonymous with "typical," to a prescriptive definition of the way a body should behave and function, "signaling a new social investment in regularizing objects and people" (Samuels 2014, 2). Protecting bodies deemed "normal" from the "abnormal" became a broad social and medical imperative that exacerbated the oppression of people marginalized due to gender, sexuality, race, and/or class.[59] As Foucault argues, medicine and law produced social controls that undertook to "protect, separate, and forewarn, signaling perils everywhere, awakening people's attention, *calling for diagnoses*, piling up reports, organizing therapies" (*The History of Sexuality* 31,

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[58] See Simi Linton, *Claiming Disability: Knowledge and Identity* and Lennard J. Davis, *Enforcing Normalcy: Disability, Deafness, and the Body*.

[59] See Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. For more information about the history of medicalization, see "Medicalization." Sayantani DasGupta writes: "The historical roots of disability's medicalization can be traced to nineteenth-century shifts from feudal to capitalist economies. The mid-1800s marked a change in how bodies were commodified and classified, with productive bodies distinguished from those that were considered less productive or nonproductive. Scholars including Michel Foucault (1979) have written about the rise of prisons, asylums, hospitals, workhouses, and poorhouses at this time as ways that those bodies perceived to be unproductive and/or nonnormative were sequestered, controlled, diagnosed, and otherwise administered to by the growing medical profession" (120).

emphasis added). Efforts were made to distinguish between categories such as black or white, able-bodied or disabled, and male or female.

The century saw a (nonlinear) progression towards public opinion that specific diagnoses are necessary—a shift that operated in tandem with broader efforts to understand what makes humans humans. Before the Civil War, diagnosis was largely considered a subjective process, linked to the doctor's imagination. Medicine was viewed with some suspicion and could be ridiculously unreliable.[60] Altschuler agrees that "until at least the mid-nineteenth century, medical knowledge was understood to be formed in the mind of the brilliant observer—not through depersonalized, objective observation" (9). Diagnosis of medical disorder in the nineteenth century was linked to other scientific practices, especially the characterization of genus and species.[61] William Whewell understood this science as subjective, writing in 1847, "The Diagnosis is an Artificial Key to a Natural System" (463). This representation of diagnosis as an "Artificial Key"—human-constructed—to a "Natural System" demonstrates his understanding of the science of diagnosis as subjective, dependent on human-made approaches.

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[60] The belief that diagnosis depended upon the imagination of a doctor sometimes led the public to turn to non-medical forms of healing and homeopathy. The public demonstrated concern about fake medicines and "quack" doctors (exemplified by stories such as Mitchell's "The Autobiography of a Quack" in 1831) as well as enthusiasm for spiritualism—the belief that the dead could interact with the world of the living through séances and mesmerism. As another example, Mitchell's "The Case of George Dedlow, Told by Himself" (1866) popularized the imaginative phrase "phantom limb." A work of creative fiction, Mitchell's story satirized the spiritual séance, helping to undermine this non-medical practice. See Emily Ogden, *Credulity: A Cultural History of US Mesmerism*. Mesmerism was devised by German Franz Friedrich Anton Mesmer, who believed magnets could be used to treat hysteria.

[61] Because different races were sometimes characterized as different species, this was a development that had broad social implications. Scientists such as Carolus Linnaeus defined races and "monsters" as different species. See Helen Deutsch and Felicity Nussbaum, *Defects: Engendering the Modern Body*. Deutsch and Nussbaum write that in Linnaeus's *Systema Naturae, "homo sapiens* was divided into the wild man, American, European, Asiatic, and African. Another species, *homo montrosus,* included both natural and man-made monsters, classified by climate or manner" (7).

From the 1830s to the Civil War, Americans put each other into trances or fun and profit. Literary stories depicted public engagement with hard-to-believe medical disorders and these bizarre experiments. By the Civil War, the professionalizing forces of clinics and medical schools worked together to try to concretize a relationship between diagnosis and objective science.

In the 1860s, the Civil War and growing professional communities had a profound effect on the public view of American medicine. First, there was a dramatic shift from a fundamentally domestic diagnostic process, in which doctors visited patients in their homes and listened to them describe their symptoms, to a more clinical practice, wherein patients visited a clinic to receive a physical examination. Before the 1860s, medical consultations "rarely came with the kind of physical examination we consider routine today. Such exams were highly unorthodox and potentially offensive. Patients came to doctors to describe their medical *complaints,* not to disrobe" (Altschuler 12, emphasis in original). By 1861, use of the verb "diagnose" emerged, meaning "to make a diagnosis of (a disease), to distinguish and determine its nature from its symptoms; to recognize and identify by careful observation" ("Diagnose," v1). This definition emerged together with the physical examination—which involved taking pulses, listening to breathing, and performing acts of "careful observation." The exam still did not involve immodest disrobing; however, it incorporated more biological data, transforming representation of diagnosis into a science that seemed to penetrate surface illusions and discover hidden truths. The result was

> a medical culture that became less interested in words—particularly the patient's words— and more interested in objective evidence…. Patient history remained important and became incorporated into physician examination as another set of elicited signs and

> medical observations, thus producing two histories: a superficial, chaotic story presented by the patient…and another deep, 'true' history revealed by the skill of the physician (Verghese 307).[62]

Writing in 2010, physician Lisa Sanders adds:

> Until very recently, diagnosis was much more art than science…The physical exam—invented primarily in the nineteenth century—was the starting point…. The patient's story…is our oldest diagnostic tool. And, as it turns out, it is one of the most reliable as well. Indeed, the great majority of medical diagnoses—anywhere from 70 to 90 percent—are made on the basis of the patient's story alone.
>
> Although this is well established, far too often neither the doctor nor the patient seems to appreciate the importance of what the patient has to say in the making of a diagnosis. And yet this is crucial information…. Talking to the patient more often than not provides essential clues to making a diagnosis. Moreover, what we learn from this simple interview frequently plays an important role in the patient's health even after the diagnosis is made. (xiv; 6-7)

The relationship between doctor and patient was once mutually rooted in narrative. However, by this time, patients were no longer considered authorities over their symptoms, signifying a shift from previous practice. Patients told a "chaotic" story, while the well-trained doctor supposedly found objective truth; this revolutionized the power dynamic of diagnosis, granting more authority to the doctor and altering the narrative quality of diagnostic discourse.

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[62] Abraham Verghese, et al., "A History of Physical Examination Texts and the Conception of Bedside Diagnosis."

Next, as numerous historians and literary scholars have observed, the Civil War produced much new medical discourse. Discourse about amputation, infection, and nervous disorders became central in medical study and representations in literature.[63] For example, with "George Dedlow," Mitchell imagines the experience of coming up with new ways to describe phantom limb pain from the disabled man's point of view. The hospital became an imaginative space for authors and the public to ruminate about various topics, including democracy, sexuality and intimacy, notions of gendered and racial difference, and, of course, the multifarious impacts of impairment, illness, and medicine.[64] While methods for diagnosing infection and the need for amputation were available during this time, claims about how to diagnose war-related nervous disorders including neuralgia and nervous prostration, were met with debate, and both doctors and patients delved into questions of how the nervous system worked.

Americans writing about nervous disorders in particular articulated rich literary histories that teach us about systemic issues in medicine and beyond. "Insanity," "hysteria," and "neurasthenia"—which all have unique cultural histories—labeled individuals experiencing any number of symptoms. Americans then turned their attention to the nervous disorders of neurasthenia and hysteria, which produced new problems about diagnostic boundaries and patient agency and revolutionized interactions between doctors and patients.[65] Authors diagnosed

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[63] Jean Franzino has published articles that productively connect Black Disability Studies to the analysis of prosthetic limbs in the Civil War See "'Harmonies of Form and Color': Race and the Prosthetic Body in Civil War America."

[64] For more on Whitman and the hospital as liminal space, see Robert Leigh Davis, *Whitman and the Romance of Medicine*.

[65] In *Neurasthenic Nation* (2011) Schuster demonstrates that doctors struggled to describe distinctions between neurasthenia and hysteria during this time, writing, "the two conditions were intertwined while the medical community struggled to define its diagnostic boundaries" (5). Physicians and patients produced diagnoses together. Schuster argues that "the story of neurasthenia is one of reciprocity, wherein the medical profession, patients, and popular culture all interacted to help shape the disease in the imagination of one another" (2). My study develops

with nervous disorders discovered that treatments were profoundly gendered: women were often isolated at home while men were sent outdoors. Emily Dickinson wrote in a letter in 1884, “The Physician says I have ‘Nervous prostration.’ Possibly I have—I do not know the Names of Sickness. The Crisis of the sorrow of so many years is all that tires me—” (L873). Despite her concerns about this diagnosis, Dickinson’s doctor ordered Mitchell’s famous “rest cure” treatment that barred patients from physical exertion and intellectual stimulation.

Charlotte Perkins Gilman’s encounters with the neurasthenia diagnosis were complex: she diagnosed herself with “brain troubles” (Knight 267) after the birth of her child, then travelled west to Pasadena, California and reported that engagement with social life there improved her symptoms. This trip West imitated the treatment Mitchell used to help men such as Walt Whitman, whom he encouraged to travel.[66] However, Mitchell did not recommend this treatment to Gilman when she reached out to him, after returning to her baby and husband in Providence, Rhode Island. Instead, Mitchell put her on the rest cure.

In addition to reinforcing a gender binary, the hysteria and neurasthenia diagnoses contributed to the construction of hierarchies of racial difference. Diagnoses were both attributed to, and withheld from, black people depending on the racist discourse at hand, and as Sander L. Gilman argues, debates about hysteria at the close of the nineteenth century were rooted as much

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this depiction of reciprocity, and I remain attentive to the ways physician-patient relationships are unequal or unjust. Furthermore, self-diagnosis of neurasthenia became common, ushering in an era of patients bypassing the medical profession in ways that went beyond previous experiments with spiritualism. Doctors and pharmaceutical companies took advantage of those who self-diagnosed, prescribing and labelling medicines (sometimes made of alcohol and cocaine) as treatments for “nervousness” (62).

[66] Mitchell even endorsed western health spas and sent patients to them as part of an economic agreement (Schuster 132). For more about the cultivation of the West into a regional mythology of health in the late nineteenth and early twentieth centuries, see Emily K. Abel, *Tuberculosis and the Politics of Exclusion: A History of Public Health and Migration to Los Angeles*.

in stereotypes about race and mental illness as they were in the claims of its origin in the wandering womb.[67] Diagnoses were also used to demarcate racialized bodies as primitive *and* were withheld. If Black writers did not represent their heroines as ill, they not only risked the lack of sympathy such representations could evoke, but also fueled the ideology that black women's bodies were indestructible. Black authors such as Frances E. W. Harper articulated the contradictory qualities of this racial discourse by creating neurasthenic black characters and doctors. Late nineteenth-century American literary scholarship can thus illuminate the ways in which authors struggled with the dilemma posed by diagnostic politics.

After the end of my focused timeline, new transformations necessarily sparked new debates. Sigmund Freud's[68] influential work in psychology transformed approaches to the diagnosis and treatment of mental illness and hysteria, the Flexner Report transformed American medicine and led to the erasure of many Black medical schools,[69] and vaccines and antibiotics transformed approaches to infection and amputation. Before all that, when medical practice

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[67] The "wandering womb" was the belief that a displaced uterus was the cause of many medical pathologies in women. The continued withholding of diagnosis is reminiscent of a more modern issue: a recent article discovers that the withholding of the diagnosis of autism from women and girls (due to the notion that it is a "male" diagnosis) has adversely affected women. Race also is an issue with this diagnosis. See Phoebe Braithwaite, "The Underdiagnosis of Autism in Girls Is a Story of Gender Inequality." Today the word "hysterical" is often used to describe black people, especially black women. See Sander L. Gilman. *Diseases and Diagnoses: The Second Age of Biology*.

[68] I mostly do not engage with Freudian psychoanalysis in keeping with the historical work of other scholars in the field of nineteenth-century American literary disability studies. For more on disability and Freudian's concepts of the death drive and the ego, see Anna Mollow's writing—especially "Criphystemologies: What disability theory needs to know about hysteria."

[69] Abraham Flexner published "Medical Education in the United States and Canada" (1910), "a report that revolutionized medical schooling in the early twentieth century by insisting on empiricism" (Altschuler 2019, 6). This report incidentally led to the closure of many schools (including medical schools that were historically Black) that did not meet new expectations for scientific research.

transformed in America in the nineteenth century, diagnosis emerged as a volatile process and label that depended on the contributions of physicians and patients, and that shifted dramatically, depending on cultural systems and social norms of the moment. Diagnosis's complexity, and the responses it provoked, then became fodder for literary works that grappled with disability and found words to speak to experiences both painful and empowering.

Chapter Overview

This dissertation is divided into three primary chapters. Each chapter explores a constellation of stories of embodied experiences written by both men and women; women's poems, letters, and stories provide the gravitational pull. The chapters each address the woman writer's contemporaries: men and women whose thinking (especially about health, embodiment, and medicine) influenced the writers directly, or connects to their ideas. I provide each woman's historical context, then delve deep into disability-informed close readings.

To explore disability's articulation in literature, I begin with Dickinson's poetry, turn to Gilman's short story, and end with Harper's novel. In addition to offering a gradual progression in terms of the scale and size of each of these literary forms, this organization demonstrates literary shifts, such as dynamic contrasts between lyric poem, Gothic story, and sentimental novel. I spend almost as much time on nonfiction writings as I do on poetry and fiction, reading at length these women's letters, journals, and lectures. This demonstrates that it is perfectly possible to explore an author's biography and life without performing what we might call an "armchair diagnosis"[70] or what I have called "diagnostic reading," even while I try to situate these women in literary disability history.

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[70] "Armchair diagnosis" describes when professionals or nonprofessionals diagnose someone they have never treated. This can relate to a refusal to acknowledge context and can lead to

I situate each of these individual women writers within her medical and political context, in part by close reading works by some of her contemporaries. For example, writings by Dickinson's father, her ophthalmologist Henry Willard Williams, and her friend Thomas Wentworth Higginson shed light on Dickinson's particular patriarchal medical culture. Physicians Silas Weir Mitchell and Mary Putnam Jacobi offer new ways for us to approach the ways Gilman wrote about physician-patient dynamics. Finally, nurse Charlotte L. Forten Grimké and physician Martin Robison Delany made assertions about race and health that give us new ways of thinking about Harper's *Iola Leroy.* In addition to traversing this archive, I analyze texts such as the 1848 Code of Ethics of the American Medical Association, demonstrating that women writers engaged with and challenged many of its tenets. They took uniquely fascinating approaches to supposedly commonplace understandings of human health in their time.

In Chapter One, I first show that Emily Dickinson's poems weave together contradictory descriptions of visual impairments to toy with a reader's prying eyes. Her poems about pain meaningfully contend with "undiagnosable" aspects of disabled life (including encounters with prejudice) that fall outside the purview of the medical profession. In the 1860s, physicians began to use stethoscopes and ophthalmoscopes to collect biological data and diagnose symptoms. Chapter One analyzes the social impact of this new technology of "physical examination," arguing that, while Emily Dickinson has never been depicted as someone with medical knowledge, she tested epistemological practices of medical professionals of her day and engaged in contemporary debates about sensory perception. The chapter considers Emily's father, Edward Dickinson, and his views on mental illness, then analyzes the medical texts of Dickinson's

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stereotyping. Henrik R. Wulff writes in "Rational diagnosis and treatment" that "extravagant armchair reasoning" is irrational (125).

ophthalmologist, Dr. Henry Willard Williams, demonstrating that Dickinson wielded stethoscopes and ophthalmoscopes in her poetry, not to fix or resolve the beautiful messiness and contradictions of disabled life, but to thoughtfully explore them. Dickinson also questioned the diagnostic gaze of her poetry mentor, Thomas Wentworth Higginson, a homeopath deeply concerned with America's "feminine condition," who criticized poems he found to be "deformed."[71] The chapter revises pathologizing approaches to Dickinson's life, reading Dickinson as a proto-disability theorist, whose writings criticize the objectifying gaze wielded by white male interpreters who sought to diagnose. Her poetry represents the undiagnosable power of invisible pain beyond empirical perception and defends the value of disabled perspectives for human progress.

Dickinson's poetry explores the elements of disability that a diagnosis cannot capture, demonstrating all that literature can teach us about the complex realities of bodily and mental experiences. Dickinson's poetry addresses the problem of pain's lack of narratability by welcoming pain's contradictions, enfolding them into her poetic forms. With her poetry, she bridges the gap between bodymind pain and language without relying on diagnostic terms. Dickinson's embrace of paradox and contradiction stands in sharp relief against assumptions about diagnosing disorders made by the professional medical field of her day. We can situate her poetry against a possibly surprising non-literary source: the American Medical Association's 1847 Code of Ethics. This Code—which set a clear standard for professional medicine previously undetermined in American health culture—makes clear that the process of diagnosing a disease and understanding the theory of disease should be a harmonious process.

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[71] Brenda Wineapple, *White Heat: The Friendship of Emily Dickinson and Thomas Wentworth Higginson*, 39.

While medical men such as Dr. Williams attempted to pin down the causes, natures, and names of disorders, Dickinson took time to ponder pain as a chronic and sometimes unnamable force. This gave her poetry the power to reach readers in pain, and offer them care beyond the pharmaceutical—an approach that embraces rather than runs from pain's many unknowns.

Chapter Two asserts that many past studies of Charlotte Perkins Gilman's story "The Yellow Wallpaper" assume that illness is usually curable; correcting this assumption reveals how far Gilman is willing to go to unravel linear, diagnosis-to-cure narrative plots. Chapter Two analyzes feminist theories of hysteria to challenge the notion that diagnoses resolve and fix disabled lives.[72] Hysteria and neurasthenia were common, even "fashionable" diseases in the 1880s. Many (upper-class, white, and female) patients bypassed professional diagnosis and treated themselves to improve their conditions, wresting control of diagnosis away from medical professionals.[73] Charlotte Perkins Gilman self-diagnosed herself with "brain troubles," then sought treatment from Dr. Silas Weir Mitchell, who prescribed for Gilman and others a "rest cure," that wrecked "hysterical" women's bodies and minds. The chapter challenges scholarship suggesting that Gilman was *cured* after she wrote "The Yellow Wallpaper," a story that directly confronts Mitchell's diagnostic gaze. Mitchell both denied that Gilman was really ill, and at the same time treated her as if she had a nervous disorder, forbidding her to behave as a woman "should." This incident exemplifies one of the key points in my dissertation: at times, physicians skipped over the diagnostic step completely. Its absence then loomed large as physicians moved directly to body and mind-altering treatments and literary experimentation. The chapter asserts

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[72] The chapter reads through and against feminist critics of hysteria including Elaine Showalter, *Hystories: Hysterical Epidemics and Modern Media* and Sarah Nettleton, *The Sociology of Health and Illness*.

[73] On hysteria and nervousness as "fashionable," see Ann Douglas Wood's "'The Fashionable Diseases': Women's Complaints and Their Treatment in Nineteenth-Century America."

that Gilman experienced illness throughout her life and used her writing not to cure herself but to grapple with the constantly-shifting landscape of heteropatriarchal medical methodologies.

The chapter analyzes Mitchell's own short stories to complexify representations of him and think about his understandings of disability, masculinity, and race. After treating numerous men who experienced symptoms of neuralgia during the American Civil War, Mitchell published short stories that help us to better understand the role literature plays in crafting diagnostic categories. This chapter brings a disability studies and medical humanities lens to two stories: first, Mitchell's "Autobiography of a Quack" (1867), then "The Case of George Dedlow: Told by Himself" (1866). Mitchell's stories expose his underlying hatred of medical quacks and unreliable patient narratives, even as Mitchell himself created narrators that might be called unreliable. Stories by physician-authors such as Mitchell were filled by phantoms and mysteries, demonstrating that physicians used literature to explore unknown and even unknowable states of embodied existence. This chapter asks: how does literature—especially that written by a physician like Mitchell—represent discourses surrounding medicine, health, and disability? Ultimately, I find that while Mitchell's texts spread the damaging ideology that disabled people are better off dead than alive, the stories also demonstrate his willingness to imagine and sympathize with the pain of patients. His texts blur generic boundaries between fiction and nonfiction in a way that afforded them additional popularity and enabled them to reach greater audiences because they connect the fantastical to real and tangible experiences. Popular literary utterances of doctors in the nineteenth century demonstrate that fiction writing gave doctors the chance to at least try to comprehend the cultural issues, as well as the physical pains, that make life difficult (but not, as Mitchell might think, unlivable) for people with severe disabilities.

The chapter further reveals that Gilman eventually sought treatment from a female doctor, Mary Putnam Jacobi, who has been almost completely neglected in literary histories of Gilman's life. This chapter makes a necessary historical intervention by centering Dr. Jacobi, while arguing that Gilman's short story maintains canonical power because it represents diagnosis as both desirable and deadly—a contradiction that energizes ongoing efforts to theorize hysteria in American history and in our contemporary moment. Next, the chapter close reads Gilman's famous story "The Yellow Wallpaper." I argue that hysteria is never cured in the story; rather, hysteria—its wildness, its randomness, and its slippery diagnostic categorization—makes Gilman's most famous literary work possible. The story's narrator rejects a restoration or return to health. Instead, she produces something very new, an outcome completely at odds with her physician-husband's expectations. She has, in alignment with the story's many contradictions, cured herself of the rest cure. By making explicit the impossibility that the narrator could write this story down in the midst of the story's final moments, Gilman abandons a traditional form of narration, permitting chaos to reign over scientific order. Consequently, her story does not privilege diagnosis and cure and rather treats destruction and restoration as equally crucial parts of a human life.

Finally, Chapter Three argues that Frances E. W. Harper's novel *Iola Leroy* "diagnoses" systemic causes of debilitation—including the "virus of slavery and injustice," to use Harper's phrase. Harper seizes upon literature's figurative potential to address substantial threats to future wellness, yet significantly, her novel does not advocate for the erasure of disability. In making this argument, my project expands the work of critical disability studies and race studies by demonstrating that literature teaches us to grapple with, rather than simplify and resolve, biopolitical issues that must necessarily remain complex. Chapter Three reads diagnosis as a sustained method for reckoning with gendered and racial discrimination during the Reconstruction Era.

The chapter begins with analysis of the Civil War nursing memoir and poetry of Charlotte L. Forten. Forten's memoirs name disorder while stressing the necessity of social change, using diagnosis as a useful narrative tool for identifying the root causes of debilities—including slavery, racial prejudice, and war—and by stressing that racial ideologies are more contagious and dangerous than individuals' illnesses. I then read works of Martin Robison Delany, a black physician and author who challenged white physicians' depiction of "freedom" as a dangerous disorder for formerly-enslaved peoples. The chapter then analyzes Black woman writer Frances E. W. Harper's sentimental novel *Iola Leroy*, pointing to the historical connection between Delany and Harper (Harper named a character "Delany" in her story).

The chapter asserts that *Iola Leroy* represents disabled Black mothers, nurses, and physicians as exhausted by the labor of revising white physicians' approaches to disability, while they themselves live with traumas caused by racial prejudice. Harper writes as a proto-disability theorist, for she explores the embodied realities of disability while she criticizes debilitating institutions. *Iola Leroy* features abrupt leaps through history and genre, moving rapidly from Civil War nursing stories to political speeches to dialogue about education. With this pedagogical focus, *Iola Leroy* leads us through a complex epistemological history of disability and race. Like Harper's letters, the novel ponders the exhausting nature of care work for Black women. I argue that it uses writing to imagine vast communities and systems that approach disability in ways that radically differ from white patriarchal medical models.

The novel centers embodied experiences, such as Iola's illness; yet the novel is also fascinatingly *disembodied*, implying that we need to know about characters' political views first and their external appearances second. I further demonstrate that the novel uses analogy to take a medical approach not to individual bodies, but to systems of injustice. When literature explores the figurative in this way, it takes diagnostic tools beyond the clinic and use them to address social problems beyond the imagined boundaries of the human body. Further, in this novel, disability is not, in itself, a tragedy, for Harper does not treat disability as a problem in the way that she treats injustice as a problem. Unlike many other scholars, I find that Harper's novel does not insist that Iola was or needs to be cured for the fulfillment of her Black identity. The novel rather demonstrates the importance of Black maternal figures and communities of care.

With this last chapter, I suggest that literature can reside in and fathom the unknowns that threaten the well-being of medicine itself. Ultimately, I assert that literary inquiry is imperative for grappling with crisis for which there is no immediate cure, and advocate for a humanistic approach to interpreting the names we give to sickness.

CHAPTER ONE

Too Telescopic Eyes: Emily Dickinson, Diagnostic Reading, and Disability Poetics

Introduction

> The Physician says I have "Nervous prostration."
>
> Possibly I have – I do not know the Names of Sickness.
>
> The Crisis of the sorrow of so many years is all that tires me –
>
> (Emily Dickinson L873, late 1883).

Emily Dickinson was not a passive recipient of diagnostic labels. When she experienced illness and impairment (including visual impairment during the 1860s, and symptoms of fatigue in the 1880s) she questioned the wisdom of her physicians, and poetically tested the limits of diagnosis as a form of knowledge production.[74] In 1886, her physician, Dr. Orvis Bigelow, commented upon the only physical examination she would permit: "She would walk by the open door of a room in which I was seated—Now, what besides mumps could be diagnosed that way!"[75]

By shifting perspective, by only subjecting herself to its power while walking past distant doors, Dickinson dodged the diagnostic gaze that shifts power away from a patient and toward a medical practitioner. And, in the letter above, she questioned Bigelow's claim that she had "nervous prostration." Though the letter acknowledges she "does not know the Names of Sickness," she implies that Bigelow might not know either, nor does he understand "all that tires" her any more than she does. Dickinson, a poet without formal medical training, grasped that physicians' diagnoses are not universally helpful ways to approach problems of body and

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[74] Thank you to Dr. Jean Franzino for her invaluable thoughts on this chapter.

[75] Quoted in J. Leyda (provenance unknown), *The Years and Hours of Emily Dickinson,* xxix.

mind. Not only in her letters does she address diagnosis, however. Dickinson's poems offer nuanced perspectives on the complex lived realities of disability, perspectives valuable to literary disability scholarship. Dickinson's experience with Dr. Bigelow exemplifies a key issue to this dissertation: diagnoses are not neutral labels, helpfully bridging the gap between felt realities and language, but are in fact ambiguous naming practices that have complex, embodied consequences. The "Names of Sickness" (and the narratives and actions that precede them) possess an almost poetic ambiguity. In fact, the poems can shed light on the ambiguous nature of the poet's diagnoses by pointing to the contradictory aspects of embodied experience that are simplified in medical terms.

The historical moment in which Dickinson wrote is significant for the development of the physical examination used to diagnose patients. As discussed in the introduction, since the seventeenth century, *diagnosis* has been understood as a method of knowing and discerning between diseases—it originates from a stem meaning "discern, distinguish," literally "to know thoroughly" (oed.com). In the nineteenth century, the verb *to diagnose* emerged to mark an active performance of distinguishing between healthy and unhealthy individuals, and of protecting normal from abnormal states. Before the 1860s, medical consultations "rarely came with the kind of physical examination we consider routine today…Patients came to doctors to describe their medical *complaints,* not to disrobe" (Altschuler 12, original italics). As Michel Foucault claimed, "medicine has always been a social activity," involving the full power dynamics of a public, since the eighteenth century (Foucault 2004, 8). In the nineteenth century, however, a patient ceased to be seen as an active participant in determining the nature of an illness and became more of a passive object to be scrutinized, as "the medical gaze" separated a patient's body from their identity (Foucault 1973, 89). The physical examination began to include taking pulses, listening to breathing, and performing acts of careful observation; in 1861, the verb "diagnose" began to be used in relation to this medical practice (oed.com). Bigelow labeled Dickinson with "nervous prostration," a highly gendered diagnosis (commonly used when physicians were more or less stymied, as the next chapter will explain in further detail).

When Dickinson shied away from Bigelow's diagnostic gaze, she made herself, in his view, almost undiagnosable. The term *undiagnosable* emerged in the 1830s as a source of failure, particularly for people desperate for diagnosis and medical practitioners who read *inability to diagnose* as their own *failure*. Yet, while failure to diagnose or making a misdiagnosis can be deadly for a physician, becoming undiagnosable can also be as a method of rebellion for those who do not want to be pathologized in medical terms. Though Bigelow complained that he could not examine his patient, he performed a diagnosis, and this had real, immediate consequences: he ordered a "rest cure" treatment, one disproportionately ordered for contemporary women diagnosed with neurasthenia and hysteria, and that confined Dickinson to bed, forcing the poet to become "bereft of Book and Thought, by the Doctor's reproof" (L1042) in 1884. As I discussed in the introduction, Silas Weir Mitchell developed the rest cure in the late 1800s for the treatment of hysteria and nervous prostration; the rest cure often caused women further physical, emotional, and mental harm (Sharpe and Wessely 798).

Dickinson's distant encounter with Bigelow was not the first time she was scrutinized, nor is it the only moment when her work allows her to be read as undiagnosable. Dickinson, twenty years previous, experienced visual impairments, and was privileged to meet with the first American ophthalmologist, the renowned Dr. Henry Willard Williams, who likely literally put her under a microscope. We do not know what Williams diagnosed Dickinson with—a fact that has frustrated innumerable biographers, who speculate widely about Dickinson's eye conditions.[76] While the absence of a known diagnosis "isn't equivalent to there having been none, it's reasonable to surmise that for at least some span of time, Dickinson's debility eluded both her doctor's interpretive efforts and her own" (Snediker 88). Considering this, it is plausible that Dickinson had complex feelings about Williams's struggle to diagnose and her own undiagnosability, considering that diagnosis is fundamentally a method of knowing.

What we do know about Dickinson's diagnosis is that medical professionals of the nineteenth century often upheld stereotypical notions about gender, and that her Dr. Williams was no exception. In an editorial in *The Boston Medical and Surgical Journal*, Williams forcibly argued that women's "physical organization," especially "during a portion of every month, disqualifies them" from the medical professions (78). It has also been hypothesized that Williams diagnosed Dickinson with "hysterical hyperaesthesia of the retina" (Blanchard, *Diagnosis*, 20). "Hysteria" often signaled "a state in which ideas control the body and produce morbid changes in its functions" and hysterical hyperaesthesia was associated with a "hysterical temperament" (20). Whether this is the diagnosis Williams gave Dickinson or not, his beliefs about women undoubtedly influenced his practice. In his book *Recent Advances in Ophthalmic Science,* he writes that visual examination is necessary for accurate diagnosis (237).[77] The frontispiece of

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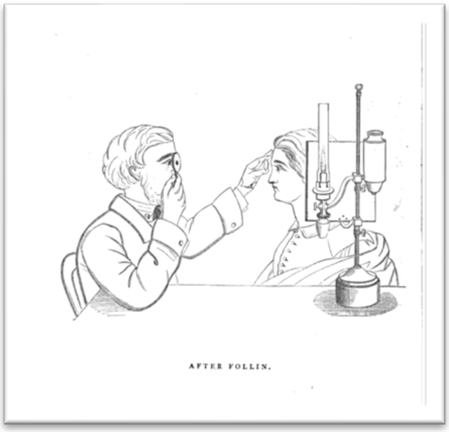
[76] Hirschorn and Longsworth claim that Williams diagnosed Dickinson with rheumatic iritis—a disease Williams described as "often severe, sometimes agonizing" that led to "intolerance of light," but which thankfully came with a "favorable" prognosis (Williams 133). Here I neither wish to confirm or reject the possibility that she did indeed have this or that exact condition (which today is more commonly known as anterior uveitis); rather, I want to acknowledge both the reality of Dickinson's physical hurt as well as the consequences of Williams' diagnosis. Antoine Cazé and Lyndall Gordon, among many others, continue to speculate.

[77] This volume is currently housed with the Dickinson Papers at Harvard. There is no evidence that the Dickinsons read the volume, as a staff librarian found it to be unmarked and unblemished (Blanchard 1592). However, I turn to Williams' book to shed light on his medical philosophies and approach to treating eye disorders in order to better understand what Dickinson's medical encounters with the doctor may have been like.

Williams's book depicts a white male physician using a magnifying lens to examine a white woman's right eye.[78]



Notions of female passivity dominate in the image—for example, by the patient's blanketed arms.[79] In every other depiction of physician-patient interaction in Williams's book, Williams interestingly assumes that both physician and patient are male. For example: "The patient should be seated in a darkened room…. Gas-light is placed, a little behind the plane of *his* forehead…The surgeon seats *himself* opposite, with *his* eye at about the level of that of the patient, or a little above it" (36). This assumption of male gender—or the use of he/him pronouns as universal in writing—was common and continues to be standard in much writing; nevertheless, it is interesting that Williams begins with an image of a woman when the rest of the book erases women and contains no she/her pronouns, possibly because his book was directed towards a mostly-male physician audience.

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[78] The image reads "After Follin." Follin was the author of Leçons sur L'application de L'ophthalmoscope au Diagnostic des Maladies de L'oeil (roughly translated to Lessons on the Application of the Ophthalmoscope to Diagnosis of Maladies of the Eye, published in 1859).

[79] For more on the subject of female passivity in medicine, see Carroll Smith-Rosenberg and Charles Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America."

Williams's depiction of the physician's gaze connects to Dickinson's "I tie my Hat – I crease my Shawl –" (1863, F522), a poem which reflects on what the boundless soul is doing while an individual is performing mundane domestic tasks. The poem includes a depiction of scrutiny:

> From Science – and from Surgery –
> Too Telescopic eyes
> To bear on us unshaded –
> For their – sake – Not for Ours –

Dickinson's poem represents eyes that are "Too Telescopic," that are "unshaded"—seemingly detached from modesty. These eyes gaze "For their – sake – Not for Ours –" signifying the unequal power dynamics that emerge in male-dominated scientific fields.

While Dickinson's lyric experiments—as I argue—unfurl the lived experiences of visual impairments and chronic pain, they open up the idea that contradictions and conundrums are *valuable* for human knowledge, whereas medical discourse characteristically represents "Telescopic eyes" as valuable for *resolving* contradictions (to avoid embarrassing ignorance). In the 1860s, the "clinical gaze" was used to expose the body before the judgement and interpretation of authority (Michel Foucault 1979). The "gaze" has been extensively defined as an oppressive act of disciplinary looking that subordinates its victim. Feminism has fruitfully elaborated the concept of the male gaze: "a position of privilege in social relations which entitles men to look at women and positions women as objects of that look" (Garland-Thomson 41). Although the clinician may aim a *diagnostic* gaze at many parts of the body, this visual scrutiny seldom encompasses the whole person, but rather focuses on the aspects that are suspected of revealing pathology. The medical expert probes a body and pronounces its fate; often, comments are made about the patient's mental and emotional state. Certainly, in our case Bigelow seemed frustrated by Dickinson's evasive actions, and Mitchell's "hysterical hypertensia" is grounded in the notion that a person's emotions control their vision.

While Dickinson suggests that being put under a microscope burns, as objectifying eyes stare "unshaded," many medical thinkers focused instead upon the frustration of *not knowing* the objects of their scrutiny. The condition *Amaurosis,* prior to the discovery of the ophthalmoscope, was indiscriminately applied to all conditions of blindness for which no cause could be seen with the unassisted eye; it therefore became a symbol for the frustrations ophthalmologists felt when they could not diagnose.[80] Williams writes that thanks to the ophthalmoscope, "The practitioner is not now obliged to include a large number of deep-seated diseases of the eye under the designation 'Amaurosis'…a condition where the patient sees nothing, and the doctor also—nothing'" (237).[81] Williams, here, quotes an amusing aphorism, one that exposes a real terror held by medical practitioners: that without the ability to see the problem at hand they will be as impaired as their patients. Literary scholars and biographers sometimes hint at a comparable terror at not being able to biocertify—to use Ellen Samuels's term—Dickinson's embodied social identities.[82] Rosemarie Garland-Thomson writes that the diagnostic gaze is "a form of

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[80] After the ophthalmoscope was invented, the name amaurosis was given only to "those hopeless states where the optic nerve has become atrophied from cerebral or spinal lesion" (Williams, *The Diagnosis* 237).

[81] Philipp Franz von Walther was a German surgeon and ophthalmologist. Walther's quote, which Williams cited, reads in full: "Amaurosis is said to be a condition where the patient sees nothing, and the doctor also—nothing (faults, abnormalities in the patient's eye). Thus both are blind, the patient outwardly, physically, the doctor inwardly, spiritually. In both cases, however, this failure to see has no objective, but a purely subjective reason. The patient as well as the doctor see nothing because there is nothing visible, and because both are unable to see in the same way" (translated by Brian Wolf: Walther, 1841).

[82] Samuels reveals that in the mid-nineteenth century in the United States, intense efforts emerged to biocertify racial, gendered, and disabled identities as biologically distinct and

institutional vision" that "can only be wielded only by those with the appropriate authority and credentials" (29). However, lack of medical or psychiatric credentials has not prevented scholars from performing diagnoses when reading Dickinson. One literary scholar[83] recently gave a talk entitled "Before I got my eye put out: Emily Dickinson's Eye Disease Seen from a Pathological Perspective," in which the presenter positioned Dickinson's poems over a zoomed-in image of the poet's right (supposedly disorderly) eye. As this literary scholar discussed the possible specifics of her impairment, he acknowledged his regret that we do not have access to Williams's examination notes. For literary scholars, this raises the question: what do we gain from further scrutiny, devoid of disability-informed methods? Why do we, as scholars, so fear being in a position wherein "the patient sees nothing, and the [literary] doctor also—nothing"?

These are imperative questions, because assumptions about Dickinson's seeming abnormalities have shaped much of her reception history. When Thomas Wentworth Higginson wrote the preface to the first edition of Dickinson's poetry, he remarked upon her reclusion, and elsewhere referred to her as a woman "partially cracked" (L570).[84] In 1925, critic Harold Monro then claimed that Dickinson "is intellectually blind, partially deaf, and mostly dumb to the art of poetry…Her tiny lyrics appear to be no more than the jottings of a half-idiotic school-girl" (121). While perhaps not as obvious as Monro's, contemporary diagnoses are accompanied by ableist,

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scientifically verifiable in a literally marked body. See *Fantasies of Identification: Disability, Gender, Race* (2014).

[83] Literary scholar Antoine Cazé gave this talk on April 16 2021 for the Emily Dickinson International Society.

[84] After reading Higginson's preface, one anonymous critic hypothesized that Dickinson had a "morbid mental condition or a latent mental disease" (Buckingham 161); yet another asserted that in Dickinson's poetry, we can find a "hardly human dumbness" and that "one pities deeply the suffering of such an incommunicative spirit" (276).

sexist remarks,[85] are often mainly attributed to queer people and women (especially unmarried women), and further figure Dickinson as a "madwoman in the attic."[86] Numerous contemporary critics diagnose Dickinson with specific disorders, seeking medical explanations for what they see as abnormal behavior and unusual poetry.[87] These interpretations (which I term "diagnostic readings") are often harmful, not just to Dickinson scholarship but to scholarship generally. Diagnoses are met with significant reader and viewer interest[88] because audiences are often fascinated by the pervasive image of the diagnostician as detective who identifies and fixes

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[85] For example, Russell R. Monroe patronizingly claims, "the schizophrenic dependency is a parasitic one, the patient extracting from the person depended upon without reciprocal giving, and it seems...that this characterized Emily's relationship to her family" (171). Critics who perform diagnostic readings often imply that Dickinson "suffered from" or "overcame" disability, language that casts disability as tragic. For example, Mary Jo Dondlinger asserts, "The enormous amount of artistic expression, over three hundred and sixty poems in one year, was a means of dealing with and *overcoming* this anguished period of her life" (101, my italics). As Mullaney helpfully points out, "Disability studies puts pressure on what it terms '*overcoming* rhetoric,' which—in the words of activist and scholar Simi Linton—emphasizes 'personal triumph over a personal condition' and fails to attend to the social circumstances that perpetuate ableism or the privileging of bodily and mental capacity" (50).

[86] In fact, for James C. Kaufman, who argues that women writers are likely to become mentally ill, writers exist "in a living hell," and "when people visualize writers, a number of images might come to mind: an isolated Emily Dickinson, writing poetry on the back of old envelopes while hiding in her attic" for example (37). The phrase, "madwoman in the attic" refers to Sandra M. Gilbert and Susan Gubar's influential work *The Madwoman in The Attic: The Woman Writer and The Nineteenth-Century Literary Imagination.*

[87] See my article, "'The Names of Sickness': Emily Dickinson, Diagnostic Reading, and Articulating Disability."

[88] For example, Lyndall Gordon made headlines in 2011 when she diagnosed Dickinson with epilepsy, a "handicap or whatever we want to call it" ("Biography"). Inspired by the image of a thrashing Dickinson, Terence Davies then inflicted kidney disease upon his Emily when he directed the biopic, *A Quiet Passion* (2017). Davies remarks that though he thinks Dickinson died of heart failure, he "thought it was more compelling that she died of kidney disease, which is how it unfolds in the film" (Radsken). While many critics recognize that their diagnoses are hypothetical, Davies openly confirms that he fictionalized Dickinson's medical history for the sake of drama.

abnormality.[89] Since (as Dickinson herself once suggested in a poem) “Medicine Posthumous/ Is Unavailable” (Fr1260A), modern critics’ diagnoses cannot be followed with corrective medical interventions; however, they do have consequences. That Dickinson’s writings speak to her lived experience of symptoms might invite scholars not to diagnose but, more productively, to self-reflect on academic approaches to disability. Analyzing how her writings speak to lived experiences of symptoms (without rushing to diagnose) also allows us to read her writing more slowly, allowing us to appreciate poetic articulations of embodied experience without jumping to interpretive conclusions.

Troubling diagnostic reading is significant to other questions about reading practices that scholars ask today. Even disability scholars sometimes use the methods of close reading to diagnose historical people and characters in order to rationalize the use of a disability studies framework. Michael Bérubé directs us away from such interpretations, since they demand that readers interpret texts about illness or impairment literally.[90] Additionally, another interpretive strategy, “symptomatic reading” (when critics assume that a text’s truest meaning lies in what it does not say, and examine “symptoms” in order to uncover truths about the text) relates to “diagnostic reading,” if we take “symptom” quite literally.[91] Eve Sedgewick’s critique of “paranoid reading” offers another example of reading that seeks specific, rather than broad, knowledge of an object. Paranoid reading seems to have something in common with reading to

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[89] For more on diagnosticians as detectives, see P. J. Accardo, *Diagnosis and Detection: The Medical Iconography of Sherlock Holmes* (1987).

[90] See Michael Bérubé, *The Secret Life of Stories: From Don Quixote to Harry Potter, How Understanding Intellectual Disability Transforms the Way We Read.*

[91] Symptomatic reading has a history in psychoanalysis; it seeks to unmask hidden meanings, assuming that symptoms reflect larger issues within textual forms See Stephen Best and Sharon Marcus, “Surface Reading: An Introduction.”

diagnose, and yet, as Heather Love writes, the word "paranoid" is likened to "hypervigilance" and paranoid reading "is associated with a highly public and stigmatized manifestation of mental illness" (Love 237). Alternatives offered for these reading methods (surface reading and reparative reading, respectively) attempt to move literary scholarship further away from the invasiveness of an authoritative critical gaze.

Moving beyond diagnostic readings, then, this chapter demonstrates that Dickinson's poems are far more significant to the production of knowledge about disability—and more critical of disabling social norms and dangerous treatments—than most previous criticism has indicated. I focus on the texts Dickinson creates, considering Dickinson as a poet who *theorizes* disability, whereas the previously mentioned scholars (who try to pin down her diagnosis) treat Dickenson herself as the text to be interpreted. I further argue that Dickinson can be studied as a proto-disability theorist, and that disability studies-informed reading methods bring valuable new insights on the poet. One such reading method is Sari Altschuler's "historical cripistemology," which demonstrates that "particular disability histories—and the experiences, epistemologies, and cultures of ability associated with them—can be used to read characters without diagnosable disabilities" (120). Historical cripistemology "uses disability's history, and the distinct ways of knowing that emerged from that history, to examine literature and culture" (100).[92] I draw upon this method, building on Altschuler's language to assert that neither characters nor authors need to be *diagnosed* for us to study disability in their texts as a form of human variation and as a focal point of cultural critique.

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[92] Altschuler notes that her term is indebted to Merri Lisa Johnson and Robert McRuer's (2014) term cripistemology—a critical approach that "combines the process of 'cripping,' which 'spins mainstream representations or practices to reveal able-bodied assumptions[,]' . . . with a philosophical commitment to 'standpoint epistemology,' which acknowledges that the subject positions from which we produce knowledge matter" (Patsavas 2014: 205).

Diagnoses of Dickinson often attempt to make sense of her articulation of pain, which itself exemplifies her contributions to the field of disability studies. Initially, disability scholars avoided discussing pain, as they first needed to draw attention away from the body and towards social discrimination; now, scholars contemplate embodied symptoms to more fully appreciate the diverse range of social, political, and bodymind experiences that make up disabled life.[93] Tobin Siebers developed a "theory of complex embodiment," raising "awareness of the effects of disabling environments on people's lived experience" (*Disability Theor*y 22). As Jamie Utphall explains, "While some disabled persons experience disability as more of a social factor, others may live daily with tangible, visceral sensations, such as atypical experience of time or debilitating chronic pain. All experiences are important and valid, and demonstrate the inextricable relationship between social and physical realities" (Utphall 6). Siebers' concept has influenced modern scholars' readings. For example: Clare Mullaney persuasively argues that Dickinson "was *a poet of disability*, meaning that she translated bodily constraints into her poems via their content as well as their textual forms" (53, original italics);[94] Michael Davidson claims that Dickinson's poetry might help disability scholars better acknowledge "the lived experiences of loss, frustration, pain and embarrassment" (para. 21); and Michael D. Snediker considers chronic pain's "profoundly recalibrative impact" on Dickinson's writing life, arguing that "a tendency among critics to understand [affliction] in terms of its jolting interruption of the quotidian has given short shrift to [Dickinson's] poetry's testament to incessant pain as the

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[93] "Bodymind" is a feminist disability studies concept that refers to the enmeshment of the mind and body, refuting the Cartesian notion of Western philosophy that the mind is separate from the body. See Margaret Price, "The Bodymind Problem and the Possibilities of Pain," 270.

[94] I also appreciate Clare Mullaney's 2019 chapter on making Dickinson's poems accessible to readers with disabilities, "Dickinson, Disability, and a Crip Editorial Practice" and am grateful to Jamie Utphall for her work in her essay "'Demur - you're straightway dangerous -': Emily Dickinson's Crip Theory."

quotidian' s own abiding texture" (31-32). These literary disability scholars demonstrate that close reading is inseparable from the study of the *lived experience* of disability, that Dickinson's embodied *and* social realities shaped her poems, and that her poems teach us to read disability complexly.

I expand on the work of these scholars, reading Dickinson's texts with the method of historical cripistemology in mind. I also read texts by three men in her life—her father, Edward Dickinson; her ophthalmologist Dr. Williams; and her editor, mentor, and friend Thomas Wentworth Higginson—who contributed to dominant narratives about health and represent a larger patriarchal medical culture that Dickinson thought about and critiqued. By making Emily the center of gravity and addressing her lived experience of disability—while also studying the medical culture of which she was a part—the chapter situates disability as an individual's lived experience and as a product of social and cultural relations. I first demonstrate that Dickinson was interested in, but skeptical about, her father Edward's views of the curability of the phenomena labelled insanity. Dickinson poetically explores states of physical and mental agony, not to diagnose herself or others but to articulate insanity as a productive site for an embodied poetic imagination. I then analyze her experimentation with the ophthalmoscopic methods Dr. Williams used while she experienced visual impairment. I draw upon Altschuler's claim that in nineteenth-century America, authors actively produced medical knowledge while performing "imaginative experiments" in literary form, by demonstrating that Dickinson's poems formally invite and yet challenge a diagnostic gaze (2). I then spend time with Higginson's writings, studying his beliefs about gender, race, and health to better understand his seemingly clinical approaches to Dickinson's body and body of work. After Higginson critiqued Dickinson's poems, she represented his analysis as surgery; I therefore take seriously the politics of surgical approaches to disorder in their time. Further, Dickinson sent Higginson poems that might act as what Margaret Price calls counter-diagnoses, where a writer "uses language . . . to subvert the diagnostic urge to 'explain' a disabled mind," and thus, "ruins [the conventional diagnostic story] altogether, attacks its foundations, queers it."[95] While Dickinson did not denigrate alienists,[96] physicians, and surgeons—indeed, Dickinson was fascinated by their medical innovations—she refused to grant them omniscient authority, and crafted poems that subvert explanation. She did not represent diagnosis as a predominantly useful method of interpreting symptoms, an assumption continuously made by modern scholars. On the contrary, she often suggests that diagnostic labelling leads to medical interventions that can be harmful, and that medicine cannot understand pain because it seeks only to label and eliminate symptoms.

Poetry, with all its figurative language, pulsing rhythms, and microscopic details, is at the heart of the chapter, and I conclude by arguing that Dickinson's poems depict pain as *unnamable* in diagnostic terms. To do this, I first analyze the American Medical Association's Code of Ethics (1848), which emphasizes the importance of finding objective, uncontradictory ways of labeling the disorders that cause pain and illness. In contrast, I show, Dickinson's poetry grapples with the contradictions characteristic of bodymind disorder, often suggesting that there is little point in using language to try to pinpoint the nature or the cause of symptoms. In writing about medicine, illness, and pain as she does, Dickinson represents embodiment complexly, takes charge of discourses dominated by men, and questions diagnosis by suggesting it to be a singular, incomplete mode of interpretation. Embracing contradictions that frustrate

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[95] Margaret Price, "'Her Pronouns Wax and Wane': Psychosocial Disability, Autobiography, and Counter-Diagnosis."

[96] "Alienist" is the French term for a psychologist, a psychiatrist, or another practitioner who cared for the mentally ill, commonly used in the nineteenth century.

diagnosticians, Dickinson's poems capture the chaos of disabled embodiment with remarkable, and practically paradoxical, accuracy.

Dickinson's Contemporaries

Emily and Edward Dickinson: Insanity and the Asylum

Far in advance of Margaret Price's 2014 article "The Bodymind Problem and the Possibilities of Pain," which fosters an understanding of the terms "crip" and "bodymind" within a feminist materialist framework, Dickinson poetically explored the embodied realities of mental illness and the social stigmas that surround it. Price requests that greater attention be paid to mental disability and madness in feminist disability studies, suggesting that scholars engage the intersectional questions that arise when we think seriously about bodies and minds—or "bodyminds." Price defines "bodymind" as "a sociopolitically constituted and material entity that emerges through both structural (power- and violence-laden) contexts and also individual (specific) experience" (271). She turns to Alyson Patsavas's "cripistemology of pain"[97] to suggest that disability studies "needs to pay more attention to the place of pain in the world of disability—in fact, that such attention may help resolve the bodymind problem by enabling us to begin incorporating bodymind in ways that go beyond the gestural" (274). Emily's early letters and poems highlight her fascination with the epistemological possibilities of developments of her day concerning the ways insanity might be diagnosed and cured, and speak to Price's commitments to thinking through bodymind pain. Her poems of insanity are remarkable not because they self-diagnose or otherwise speak to autobiographical encounters with madness;

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[97] This refers to Alyson Patsavas, "Recovering a Cripistemology of Pain: Leaky Bodies, Connective Tissue, and Feeling Discourse."

rather, they grapple with contemporary debates about the topic while also signifying insanity as determined by outside forces who seek control the person labeled "mad."

From a young age, Dickinson learned much about physician authority from her father, Edward Dickinson, who served as a trustee for a local insane asylum and brought home numerous writings about the diagnosis of mental illnesses that argued that mental illness could, and should, be cured via medical means. Massive medical institutions aimed at reforming the mentally ill were also developed throughout the country, and especially in Dickinson's Massachusetts, in the mid-nineteenth century. According to Stefan Schöberlein, Edward served from 1859 to 1864 as a trustee for the Northampton Lunatic Asylum (Habegger 176; Annual Report 1877, 56). In this position, Edward was involved in making key decisions about the institution he once called "this most important + valuable public charity" (Schöberlein 49). He voted on the hiring of the lead physician and made improvements to the hospital's facilities; he was also expected to "make visits through every part of the hospital" frequently (Kirkbride 51).

Though not a physician—Edward was a lawyer and a politician—he also acted as something of a physician in the Dickinson household. In 1848, after her father withdrew her from college for a month because she developed a cough, Dickinson wrote, "Father is quite a hand to give medicine, especially if it is not desirable to the patient," drolly expressing desire for consensual treatment (L23). Dickinson also addressed her father's control over her medical treatments in early 1866: "I had promised to visit my Physician for a few days in May, but Father objects because he is in the habit of me" (L316). Dickinson's father seems to have controlled some aspects of her medical treatments, and she seemingly disliked these interventions.[98]

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[98] Dickinson's father also encouraged her to tend to her mother's health. Emily Norcross Dickinson was bedridden with various chronic illnesses from the mid-1850s until her death in 1882; it seems that Edward encouraged young Emily to help her mother after her stroke. Writing

Edward was also somewhat possessive of Emily's education, as he held traditional views about the dangers of women who read—and the dangers of reading for mental wellness. Emily told Higginson that her father ‘‘buys me many Books – but begs me not to read them – because he fears they joggle the Mind" (L 261, to Higginson, April 26, 1862).[99] Despite Edward's concerns about the fitness of her mind, Emily read avidly, learning about advancements in medical science.

Dickinson's impressive education gave her the tools to explore medical perspectives on bodyminds. Dickinson was assigned Calvin Cutter's 1847 textbook, *Anatomy and Physicality: Designed for Academies and Families* when she took an anatomy class at Mount Holyoke Seminary (Lowenberg 41-42). Barbara Baumgartner reads Cutter's text alongside Dickinson's poetry, demonstrating that Dickinson is intrigued by anatomical details of the physiological body. Baumgartner argues: "Significantly, Dickinson's depiction of the brain is in dialogue not only with Cutter's anatomy text but also with new developments and understandings of the brain that were being formulated in other disciplines (psychology, medicine, biology, physiology, and geology) in the nineteenth century" (57). With the mind identified as the expression of a physical

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to a friend in summer 1858, Emily said she would visit if she could leave "home, or mother. I do not go out at all, lest father will come and miss me, or miss some little act, which I might forget, should I run away – Mother is much as usual. I Know not what to hope of her." As her mother continued to decline, Dickinson's domestic responsibilities weighed more heavily upon her. Forty years later, Lavinia said that because their mother was chronically ill, one of the daughters had to remain always with her. Emily took this role as her own, and "finding the life with her books and nature so congenial, continued to live it" (Walsh 87). See John Evangelist Walsh, *The Hidden Life of Emily Dickinson* (1971).

[99] Dickinson also relates in a letter that her father failed to educate her properly in simple matters: "I never knew how to tell time by the clock till I was 15. My father thought he had taught me but I did not understand & I was afraid to say I did not & afraid to ask anyone else lest he should know" (L342b).

organ that can be damaged or diseased, alienism, or the study of mental insanity, turned toward hereditary theories to explain the etiology of madness.[100]

Emily's father also exposed her to discourses concerning the diagnosis and curability of mental illness.[101] Schöberlein reveals that Edward stayed in touch with the famous alienist and writer Pliny Earle, who believed physicians should learn to diagnose insanity rather than rely on the anecdotal evidence of family and friends. In 1844, when Emily visited her aunt and uncle in Worcester, around 40 miles east of Amherst, Edward urged her in a letter to "see the Lunatic Asylum & other interesting places" of the area (Habegger 176, quoted in Schöberlein 50). If we consider "Edward's intrusive proclivity to manage even minute details of his family's health," this explains why some "biographers read such an incident as a more or less veiled comment about mental instability" (Schöberlein 49). Alfred Habegger, for instance, wonders whether Edward might have hoped that "his overwrought females would regain their balance if they inspected the behavior and treatment of the insane" (176, quoted in Schöberlein 50); Connie Ann Kirk reads Edward's remark as telling Dickinson that "there are places where people can go if they cannot manage to get a grip on their emotions" (63, quoted in Schöberlein 49). Schöberlein points out that to accept these biographers' comments would be to omit an important detail:

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[100] Pliny Earle, for example, saw a suggestion of hereditary causes when looking at insanity as a whole, arguing that "the number of physical causes…is about three and a half times as large as that of the mental or moral causes," which in his nosology includes insanity following disease and physical damage to the head as well as "hereditary insanity" (in Bucknill and Tuke 104).

[101] For more on Dickinson's father's work with asylums, see Stefan Schöberlein, "Insane in the Membrane: Emily Dickinson Dissecting Brains." For more on asylums and insanity in nineteenth-century American culture and literature—as well as the social construction of an insanity diagnosis—see Dale Peterson, *A Mad People's History of Madness* (1982) and Benjamin Reiss, *Theaters of Madness: Insane Asylums and Nineteenth-Century American Culture* (2008).

lunatic asylums in the mid-nineteenth century were attractive buildings viewed as symbols of modernity and empathy (50).

The buildings symbolized modernity via the notion that mental illness could be cured; however, many housed within them were plausibly not insane but merely *read* as insane, and were institutionalized unwillingly. Despite new knowledge about the mind, the diagnosis of insanity was highly disorganized—and prejudiced. As Bainbridge writes, “However comfortable the alienists may have been with diagnoses [of insanity] …these judgments were usually made first by family and friends of the afflicted, with the doctors often merely accepting these lay diagnoses. Indeed, the enumeration instructions for the 1860 census assumed that most causes of insanity would be readily apparent to household members” (223). In other words, insanity was quite literally constructed by family and friends, and doctors’ expertise lay more in finding ways to control and potentially fix the patients. It was generally believed that in institutions the vast majority of patients *could* be permanently cured, an idea that contrasted with former beliefs that the insane would be perpetually insane (Schöberlein 48). The elegant building of the asylum itself was meant to have a curative effect, as “a special apparatus for the care of lunacy, [whose grounds should be] highly improved and tastefully ornamented” (Kirkbride 51, quoted in Schöberlein 50).[102] This was known as the “building-as-cure” approach—the idea that a well-designed building could correct those diagnosed with insanity.

Edward believed, as many others did, that the curative confines of the asylum signaled modern advancement. A prime example of Edward Dickinson’s admiration both for Pliny Earle and for alienism in general can be found in a letter from 1870, in which, after congratulating

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[102] See Kirkbride, T.S, “On the construction, organization, and general arrangements of hospitals for the insane” (1854).

Earle on the positive outcome of a recent investigation over illegally detained inmates, he ties the progress of psychiatrics to the spiritual ascension of humanity:

> When men in high position, give their names to mountebanks + moonstruck idlers, asking for the investigation of . . . public officers, whose garments are white as snow, + whose lives are a shining light to all about them—it need not surprise, even a casual observer, that depravity has not yet [had] its perfect work—and that there is yet [a] considerable distance between us + the Millennium. (Letter to Pliny Earle 1870, quoted in Schöberlein (51)

When Edward Dickinson considered alienists, he saw demi-gods in white[103]; as Schöberlein emphasizes, for Edward, men like Earle are not just medical professionals, but harbingers of the millennium (51).

Emily Dickinson may well have learned of her father's interest and enthusiasm in the topic of treating insanity, as it is likely that it came up often in her home. However, in Dickinson's many poems about the brain, she does not diagnose mental illnesses in herself or others, nor does she repeat some of these optimistic views of the curability of mental illness or celebrate men who offer healing. Dickinson suggests that madness is hard to distinguish from "divinest Sense":

Much Madness is divinest Sense – To a discerning Eye –
Much Sense – the starkest Madness – 'Tis the Majority

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[103] Typically, men like Pliny Earle wore black formal wear in the asylum—which included black coats and white lapels. It is unclear whether they would have worn white coats, which seem to not have grown popular for American physicians until the 1880s. Alienists did sometimes put patients into white straightjackets. See Heidi Johnson's *Angels in the Architecture: A Photographic Elegy to an American Asylum*.

In this, as all, prevail –
Assent – and you are sane –
Demur – you're straightway dangerous – And handled with a Chain –
(Fr620)

From a contemporary disability studies standpoint, we might read madness here as a social construction. As Schöberlein writes:

> Besides—quite ahead of her time—underscoring the social constructedness of the label "mad" ("'Tis the Majority / In this, as all, prevail –"), Dickinson here presents insanity as a way to "discern" the truth about that "awful stranger – Consciousness" (Fr1325). Operating with two nuances of the word "sense"—namely, rationality and perception—the concept of madness allows Dickinson to enter a state of disordered reason (Webster's "madness") that disrupts the "daily mind" (Fr1325), permitting her to penetrate what "mind" itself is. (63)

Now, rather than presenting madness as a lack of knowledge, Dickinson suggests that madness offers the power to "discern" new knowledge, because only one labeled "mad" can see this state of affairs. One who is labeled mad is presumably the one who also has the "discerning eye" to see that these labels are inaccurate. Schöberlein adds: "By analyzing, through madness, what being a self means, Dickinson points us back toward a biological force that society needs to have 'handled with a Chain': the brain—the implied subject that rhymes with the poem's last word" (63). Dickinson acknowledges that a mind that stands out is one willing to "demur," and is marked as "straightway dangerous," controlled by others—alienists perhaps. This interestingly recalls disability scholar Garland-Thomson's words: "Medical-scientific observation as diagnosis brings home the alien in chains, converting the unusual into the monstrous, sick, polluted, contagious, mad, queer, and deviant" (49). The insane were literally handled with chains (Reiss 160).[104] And so Dickinson's poem becomes a reflection on actual practices against people labeled insane, a commentary on the knowledge produced by madness, and a more metaphorical interrogation of the Majority's reasoning.

Dickinson further questions the value of sense and reason for both minds and brains, challenging the privileging of minds that function in a seemingly rational way. A poem like "I felt a Funeral, in my Brain" (Fr340), for example, invites the breaking of sense as a way of gaining impossible knowledge over innumerable Worlds:[105]

I felt a Funeral, in my Brain,
And Mourners to and fro
Kept treading – treading – till it seemed
That Sense was breaking through –

And when they all were seated,
A Service, like a Drum –
Kept beating – beating – till I thought
My Mind was going numb –

Dickinson places the sensation of a funeral within the organ of the brain, rather than locating the deathly service within the more abstract space of the mind. The mental pain represented by the

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[104] In *Theaters of Madness: Insane Asylums & Nineteenth-Century American Culture* (2008) Benjamin Reiss examines how asylums shaped American culture and notes that many alienists who promised to unchain the patients in asylums in fact never did and maintained chains as a symbol for control (160).

[105] Dickinson writes poems with alternative words included in margins/at the bottom of the page. These alternatives are included in parentheses.

funeral is so intense that it evidently requires a physical setting. Corporeal mourners, who "tread" and give the speaker what seems like a headache, cause "sense,"—or bodily sensation—to violently "break through," into the speaker's head. The drumming service is painful, physically and audibly.[106] The "beating" is boldly sensational. And now the speaker's mind, not brain, is in danger of going numb, in danger of losing sensation. Dickinson found a way to convey the intensity of mental anguish: the brain is no longer a mere organ but is a conceptual space that both analyzes and can be analyzed. The mind receives physical agony so intense it causes numbness. Dickinson oscillates between physical and conceptual terms, creating a complex vocabulary that expresses deep anguish.

Dickinson's articulation of the very real danger of a physical/mental/emotional break posits that the brain, mind, and self all conflate, because the action of one redefines the experience and survival of the others. The poem ends when the speaker's disembodied self loses comprehension:

And then I heard them lift a Box
And creak across my Brain (+Soul)
With those same Boots of Lead, again,
Then Space – began to toll,

As all the Heavens were a Bell,
And Being, but an Ear,

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[106] As Davidson argues about this poem in his essay on Dickinson, disability, and hearing loss: "Instead of hearing the tolling bells through her ears, she becomes the bell; instead of not hearing, she becomes the Silence. There is no separation of sound and sensory organ; both are conjoined in the awe-filled word, 'Being.' And where silence had marked the space between one peal and the next, it is now one with the sounds that give it form" (para. 8).

And I, and Silence, some strange Race
Wrecked, solitary, here –

And then a Plank in Reason, broke,
And I dropped down, and down –
And hit a World, at every plunge,
And Finished knowing – then –

Reason physically “breaks,” then the speaker experiences the action of “dropping down.” The pain of the drop is dramatized, for at every plunge the speaker’s identity hits an entire world. That “world” might signify different planes of knowing or being, or even the many circles of Hell, if we read into the wretchedness of the speaker’s being. The “funeral”—a representation of some form of mental anguish—damages much more than just the brain it inhabits, wrecking even the most intangible planes. There is movement (“treading”) and pulsating sensation (“beating – beating”) as the nerves struggle to compensate. The mental pain affects entire worlds, and every part of the speaker’s self. Far from suggesting that the break described can be cured or fixed, Dickinson depicts the break as total, a complete mental disconnect from reality (“Finished knowing- then”) with little hope of recovery (“Reason, broke”) (Bucknill and Tuke 291, 208). Looking at this from the medical perspective of her time, Dickinson is describing an incident that disrupts or “overrides reason,” and unfolds as a “morbid process” (Bucknill and Tuke 238, 538). Rather than offer a solution to a problem—or any clear diagnosis of the mental break—Dickinson stops the poem with “And Finished knowing–then–” implying that something has happened that *finished* knowledge. This supplements my reading of the poem above, which suggests that madness *produces* knowledge. Here, an end has been reached, but whether that is because all possible knowledge has been obtained or because no more knowledge can be found is left obscure.

Similarly, in “I felt a Cleaving in my mind” (F867B) Dickinson portrays the mind/brain’s experience of physical suffering, and refuses to offer a simple solution:

> I felt a Cleaving in
> my Mind –
> As if my Brain had
> split –
> I tried to match it –
> Seam by Seam –
> But could not make
> them fit –

The speaker is aware of her own mind and brain, but seemingly exists outside of them. Despite the ravaging circumstances, it feels she is somehow empowered by her knowledge of internal events. The speaker senses “a cleaving” in her “mind,” yet it was her “brain” that split, and her experience is corporeal. However, the reason why the brain has split is ignored; the poem neither turns blame upon the brain, nor does the speaker blame her own self. Withholding a diagnostic view of the mind and brain, the speaker *does* look for a solution to this “cleaving.”

However, the speaker’s attempt to stitch the organ back together again with sutures, her urge to repair her train of thought with a medical surgery, do not feel desperate; we might note a calm, detached, curiosity on the part of the speaker toward the actions of the brain here. Moreover, she offers an image of brain that shows the speaker’s creative powers:

The thought behind, I
strove to join
Unto the thought before –
But Sequence ravelled
out of (reach) Sound –
Like Balls – opon a
Floor –[107]

The speaker tries to "match" the brain, "seam by seam," but this effort ultimately fails. Here, the "seams," the raveling, and the "balls," (presumably of yarn) allude to the stitching and unraveling that accompany sewing. The speaker does not successfully fix the brain, as her attempt at "sequencing" thoughts fails. We learn that the speaker cannot really be expected to repair her own internal agony. Mental agony, in other words, cannot be solved by sheer desperate willpower; a "cleaving" cannot be fixed by "mind over matter." However, though the speaker cannot "sequence" her thoughts rationally, she can come up with this powerful image—which shows her drawing on another of the mind's powers.[108]

As Dickinson uses poetry to explore all that madness offers and takes away, she further questions about whether the brain can be controlled by the will and whether madness can be truly perceived by one experiencing it. For example, "The first Day's Night had come –" (Fr423) depicts the resurgence of what appears to be a repressed horror that deeply unsettled the speaker's being. The poem concludes:

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[107] The alternate version of this ending that Dickinson wrote (F867A) reads: "The Dust behind/ I strove to join/ Unto the Disk/ before –." "Disk" could refer to a disk in a sewing machine. The spelling of "opon" is Dickinson's. The inclusion of "(reach) Sound" indicates the alternative words Dickinson put on the manuscript.

[108] Thank you to Jean Franzino for your thoughts on this interpretation.

My Brain – begun to laugh –
I mumbled – like a fool –
And tho' 'tis years ago – that Day – My Brain keeps giggling – still.
And Something's odd – within – That person that I was –
And this One – do not feel the same – Could it be Madness – this?

Ending the poem on a question shows both the desire for and futility of definition. Again, this suggests that Dickinson's poems formally invite and yet challenge a diagnostic gaze. The final question, "Could it be Madness – this?" attends to the desire to define madness, but, in remaining unresolved, implies that one scrutinizing her own laughing, giggling brain cannot necessarily label her own state of being. The poem moves rapidly across time since some major event, (And tho' 'tis years ago – that Day –), lending us a sense of the scope of the speaker's experience without concrete details. While the poem invites the idea that the speaker cannot necessarily label herself, it also may challenge the idea that anyone (including doctors) can fully determine madness. The speaker mumbles "like a fool," as Dickinson uses the stereotype of the inarticulate fool to describe a struggle to express an inner struggle with self. The poem uses such imagery to explore how madness shapes one's sense of being and perceiving. In doing so, the poem almost renders the idea of resolving that madness into a laughable endeavor.

Thus, Dickinson formed her own ways of thinking about mental illness as something explorable in poetic language. Her poetry about insanity illuminates her understanding of mental illness as embodied, renders diagnosis a fallible way of portraying intense bodymind experiences, and points to the knowledge that can be gleaned from positions labeled as insane.

Dickinson and Dr. Henry Willard Williams: Poetics of Blindness

While wildly diagnosing Dickinson is a problematic and speculative form of interpretation, Dickinson *did* experience disability, illness, and pain which can be discussed without the language of overcoming, inspiration, and pathos resisted in disability studies scholarship. While the debilitating Civil War raged on, Dickinson wrote almost a poem a day and circulated her poetry widely among friends. She began to experience eye problems in the fall of 1863, and her father set up appointments for her with the eminent ophthalmologist Dr. Williams (Guthrie 9). Dickinson did not merely narrate her symptoms to Dr. Williams; instead, she underwent a physical examination (which had only recently been adopted as a widespread practice) that undoubtedly taught her something about the ways physicians perform investigations.[109] Most scholarship on Dickinson and her ophthalmologist is written by critics who attempt to puzzle out the exact nature of Williams' diagnosis. I focus more on the fact that when Dickinson met with Dr. Williams, she encountered innovative medical techniques and technologies that she wove into her poetry. Uncovering Williams's opinions about the diagnosis and treatment of eye conditions provides useful context for reading the poems about visual impairment that Dickinson wrote while she was receiving his treatment and reveals Dickinson's dual commitments to thinking through bodily limitations and ethical debates about medicine. Rather than accepting medical professionals as omniscient or relying on the comforting assurance of cure, Dickinson questioned her doctor's methods and used poetry to explore the aspects of illness and pain that might be considered undiagnosable.

In letters, Dickinson shows as much curiosity about the work of physicians as that of alienists. Exposed as she was to knowledge about medical science, Dickinson toyed with the idea

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[109] For more about the evolution of the physical examination, see Abraham Verghese's "A History of Physical Examination Texts and the Conception of Bedside Diagnosis," 290–311.

of becoming a healer when her friends and family became ill; however, she assured her "patients" that she would not always use medical interventions to help them but would find productive alternatives. For example, Dickinson sent her brother Austin a particularly striking letter when he became ill in December 1851:

> May I change places, Austin? *I* don't care how sharp the pain is, not if it dart like arrows, or pierce bone and bone like the envenomed barb, I should be twice, *thrice* happy to bear it in your place.... I am glad to know you are prudent in consulting a physician; I hope he will do you good.... I think that warmth and rest, cold water and care, are the best medicines for it. I know you can get all these, and be your own physician, which is far the better way.... I do feel so desirous of a complete recovery! But lest I harm my patient with too much conversation on sickness and pain, I pass to themes more cheerful and reminiscence gay (L66, original italics).

The passage begins with Dickinson claiming she "would be twice, *thrice* happy" to bear pain in his place, colorfully describing pain while offering herself up as the recipient of pain. The image of the pain that may "dart like arrows, or pierce bone and bone like the envenomed barb" evokes both military and animalistic violence. The repetition of bone as in the phrase "pierce bone and bone" (which may bring to mind the line "Would drop Him – Bone by Bone" in "There is a pain so utter—" [Fr515A]) emphasizes the depth of the barb's invasion. She also takes up the role of healer herself, prescribing "warmth and rest, cold water and care" to help her "patient." Notably, these "best medicines," are not chemical; warmth, rest, and cold water are found naturally, while the general term "care" could indicate a physician's care, her own caring affection, or simply that he might take care of himself.

By stating, "I do feel so desirous of a complete recovery!" Dickinson indicates that she does hope to end Austin's illness via her own affectionate treatment; however, Dickinson's view of illness is not strictly curative, as she also explores ways to validate Austin's pain in her own imaginative language, such as with her "darting like arrows" metaphor. Dickinson later indicates she is afraid that this vivid "conversation on sickness and pain" could actually harm her brother. Sari Altschuler has argued that in nineteenth-century America, the imagination and narrative continued as they had in past centuries to be "intimately connected to corporeal well-being" (54) and that authors wrote about illness very carefully to avoid sickening readers by over-inflaming their imaginations. Here Dickinson stoppers her fascination with sickness and pain, turning to themes "more cheerful and reminisc[ing] gay," using hopeful language to inspire corporeal wellbeing. Her engagement of a cheerful imagination offers a poetic alternative to professional medicine and demonstrates that Dickinson viewed the health of body and mind as closely intertwined. Dickinson's letter criticizes professional medicine, which may erase patient autonomy; validates his decision to see a physician ("I hope he will do you good"); and underscores the embodied aspects of illness, describing pain in poetic language while suggesting that Dickinson's own supportive presence might help support her brother while he is in pain. While Dickinson attests that her brother's consultation with a doctor is "prudent," she quickly changes tack and claims that it is far better to "be your own physician." Dickinson contemplates the value of dependence, independence, and interdependence, much as disability researchers do today, and ultimately indicates that autonomy is preferable to yielding authority to a medical professional.[110] Dickinson's skepticism of physicians here aligns with a general skepticism

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[110] Feminist disability scholars explore dependency, independence and interdependence to challenge the idea that adults can and should be able to do everything for themselves. Nondisabled people often navigate a world which is already tailor-made for their bodyminds and

toward physicians in the early and mid-nineteenth century. Paul Starr's *The Social Transformation of American Medicine* explains, for example, how and why Americans were "wary of medical authority in the mid-nineteenth century" (ix). Dickinson does not just reflect a general suspicion of doctors as bunglers, but targets in particular their questionable authority and treatment methods.

When in other instances Dickinson offers to become a doctor for her ill friends, she acknowledges her friends' pain, often using imaginative language to evoke pain's depth and animacy; she then keeps patients (including herself) company with poems. When Dickinson wrote to an ill friend in 1863, she remarked: "Tell the doctor I am inexorable, besides I shall heal you quicker than he. You need the balsam word" (L281). Prescribing, with some humor in her tone, her own "balsam" (healing) words, Dickinson dismisses the doctor's treatments in favor of her use of language. Again, language becomes a valuable alternative to medical authority in Dickinson's poetic imagination. When Dickinson's sister Vinnie took ill, Dickinson wrote to a friend: "She has borne more than she could, as you and I know more of, than her Physician does.... I shall try superhumanly to save her, and believe I shall, but she has been too lacerated to revive immediately" (L525). Critical of the "Physician" who "lacerated" Vinnie too often, and who does not know the magnitude of Vinnie's pain, Dickinson offers herself as a more sympathetic—even superhuman—interpreter of Vinnie's illness. She acknowledges the realities of pain and illness while also suggesting that people experiencing them may benefit from decidedly nonmedical forms of support. Further, she demonstrates that she seeks to save Vinnie

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abilities (Price 2015), and the idea of interdependence calls our attention to how both disabled and nondisabled people rely on other people for their everyday life in a range of different ways. Also see Nick Watson et al., "(Inter)Dependence, Needs and Care: The Potential for Disability and Feminist Theorists to Develop an Emancipatory Model."

not just from illness, but from the harm done by the doctor's violent and ignorant lacerations. Interestingly, Dickinson's so-called poetic surgeon Higginson used the term "superhuman" when discussing women's health in his 1858 essay "The Saints, and Their Bodies," (an essay Dickinson probably read). He asserts that "the mind has immense control over physical endurance…But for all these triumphs of nervous power a reaction lies in store, as in the case of the superhuman efforts often made by delicate women" (10). He laments, "The robust, healthy, hard-looking country-woman or girl is as rare now as the pale, delicate, nervous female of our times would have been a century ago" (11). Dickinson, herself a pale woman here caring for another pale woman, might have been seen as superhuman in Higginson's view, yet while Higginson indicates that "a reaction lies in store," Dickinson seemingly claims her power without concern about the possible consequences.

When Dickinson began to have problems with her eyes, she was unable to be her "own physician" and her father placed her in Dr. Williams' care. Whereas in earlier decades physicians might have made only house calls to speak with women about their ailments, women like Dickinson had to travel to their physicians in order to be observed and receive treatment. Dickinson travelled to Boston from April 1864 to the end of November, and then from April 1865 to sometime in October. As Donald L. Blanchard notes, "no record survives of any diagnosis of her condition during her lifetime" (1591). Nevertheless, Williams' written accounts of the methods of diagnosing eye disorders teach us about the medical culture of which Dickinson was a part.

As mentioned above, Williams sought accurate methods of diagnosing eye disorders. He enthusiastically endorsed Antoine-Louis Felix Giraud-Teulon's 1861 invention, a binocular stereoscopic ophthalmoscope, and praised what this device enabled doctors to learn:

> The ophthalmoscope has done more to increase our knowledge of diseases of the eye than had been accomplished during a century by all other means. The practitioner is not now obliged to include a large number of deep-seated diseases of the eye under the designation 'Amaurosis' to which the well-known remark of Walther was unfortunately but too apropos,—'a condition where the patient sees nothing, and the doctor also—nothing.'…He is relieved from many embarrassing *uncertainties in diagnosis*, painful to himself, and *more or less detrimental to his patient*,—and is no longer in the dark; but, in regard to the interior of the eye, can speak of what he knows and testify of what he sees (25-26, my italics).

Amusingly, commenting on the designation "amaurosis" (a condition of vision loss), Williams observes that the ophthalmoscope stops the patient and doctor from seeing—and knowing—nothing. The doctor is "no longer in the dark" thanks to the device; because he sees, the patient also sees, a claim that indicates his belief in technology's ability to mitigate disability. Further, he asserts that the new tool protects the physician from admitting to "embarrassing uncertainties in diagnosis" that are "painful" to the doctor and merely "more or less detrimental" to the patient. Even if Williams is interjecting humor here, his implication—that the physician is more greatly pained by a lack of certainty in diagnosis than the patient—emphasizes Williams' vantage point as a doctor on the objective side of the microscope. Williams suggests that a failure to learn more about a patient predominantly harms the physician, and is predominantly interested in this passage with how technology can prop up the practitioner as much as mitigate disability.

In Williams' depiction, the ophthalmoscope becomes almost a prosthetic device, one that helps the physician (and his self-conception) as much as it does the patient. This instrument allows the seer to better view the patient, judge the patient, and seek a cure. In light of this, the image of a doctor using an ophthalmoscope (as illustrated in the introduction above), shows that Williams is positioning himself, as a physician, as the one who understands and appreciates the wonders of technology while chiding lay people for being skeptical about assistive technology. Elsewhere, Williams argues that patients must accept prosthetic seeing devices (eyeglasses) when they become necessary: "When these symptoms of loss of adaptive power begin to be felt, the eyes should be aided by convex glasses of sufficient power to compensate for the deficiency; otherwise, they are fatigued by futile efforts, and yet more serious disability may result. It is useless to postpone wearing glasses, in the hope that the necessity for resorting to them may be overcome" (*Recent* 123).[111] This statement almost calls back to the idea that the ophthalmoscope prevents further disability; the physician sees so that the patient might see. He continues his book with a statement important to his overall philosophy about diagnosis: "As *accurate diagnosis* is and must be the basis of all successful treatment, the oculist can already point to brilliant therapeutic *triumphs* over diseases hitherto deemed incurable, which have directly resulted from the knowledge acquired by means of this instrument" (26, my italics). Again, Williams praises the ophthalmoscope for offering further acquisition of knowledge, leading to "accurate diagnosis" and triumph over formerly incurable diseases. This triumphalist language about medical power emphasizes Williams' faith in his own profession's approach to bodily difference. He believed that accurate diagnoses may make real the fantasy of the eradication of disease.

While Williams wielded the tools of objective observation to make a diagnosis, Dickinson used her pencil to express her opinions about his judgements. Letters show that even

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[111] On a related note, Dickinson "preferred not to wear reading glasses"; Blanchard speculates that she did not feel she needed them after her treatment with Williams (Blanchard 1597). It is not clear, though, where Blanchard found this information.

as Dickinson invited and consented to medical treatments, she rebelled against the medical authority's patriarchal handling. Williams's approach caused Dickinson additional pain: he gave Dickinson atropine, a drug used to dilate the pupil, relieving pain caused by inflammation of the eye. Dickinson wrote that her doctor was "very kind"; however, she also noted the painful side of effects of her treatments (L294). She wrote to her sister Vinnie: "the calls at the Doctor's are painful, and dear Vinnie, I have not looked at the Spring. Wont [sic] you help me be patient?" (L289). Dickinson's clever pun (help me be *patient*), suggests the position of the patient, who is supposed to be passive and patient (adjective) rather than assertive. Further, this letter shows that the doctor caused her pain and that she lamented not being able to look "at the Spring." She felt the lived realities of her impairment—caused by both embodied sensations and medical treatment—and became especially frustrated when Dr. Williams instructed that she cease reading and writing. She wrote to her sister in 1864, "I want to go Home…The Doctor is not willing yet, and He is not willing I should write. He wrote to Father, himself, because He thought it not best for me" (L289). Dickinson disliked that her doctor controlled her access to her home and patronizingly "wrote to Father, himself." Dickinson wrote a friend that her reading and even serious thinking were embargoed: "The medical man said avaunt ye [books] tormentors... He might as well have said, 'Eyes be blind, heart be still.' down, thoughts, & plunge into her soul'...So I had eight months of Siberia" (Sewell 76). Hinting that her eye doctor counterintuitively rendered her "blind," Dickinson openly vented.

As I discuss more robustly later on, Dickinson also creatively contests physicians' authority in her letters to Thomas Wentworth Higginson. She wrote Higginson after learning that he was wounded in the Civil War: "Dear Friend, – Are you in danger? I did not know that you were hurt...I was ill since September, and since April in Boston for a physician's care. He does not let me go, yet I work in my prison, and make guests for myself…Can you render my pencil? The physician has taken away my pen" (L290). Dickinson acknowledges the reality of physical hurt by asking about Higginson's injury and also addresses the frustrations of being in a physician's "care." While it is possible that Williams did not literally take Dickinson's pen, he probably prescribed reduced reading and writing. It is interesting that Williams's investigative examination practice often included pencils. He wrote:

> If a small object, a pencil for instance, is brought gradually very near the eyes, they at first converge normally towards it, but suddenly one or both eyes turn outward, as if wearied — denoting insufficient power in one or both recti interni. We can readily suppose that fatigue must here follow prolonged efforts to keep up the degree of convergence necessary for reading or other work requiring minute attention. (124)

Williams thus would bring a pencil close to his patient's eye to sense whether reading would fatigue the patient, thereby using the pencil not to write but to discern the degree of the eyes' "power." Dickinson is not referring to this examination exactly, but there are some interesting overlaps between her note to Higginson and Williams's passage. Williams sought to test whether his patients could "render" a pencil and function "normally"; Dickinson expresses that her writing may not be easy to decipher and that there are now forces preventing her from using a pen. Although Williams probably preferred that she refrain from writing entirely, pencil was sometimes thought to be easier on the eyes than ink.[112] Therefore, Dickinson used a pencil to conjure up "guests": poems that kept her company, providing her with community rather than pharmaceutical relief.

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[112] I had a source that suggested this but have not been able to locate it.

Dickinson's poems capture some of her own visual experiences. Clare Mullaney suggests this in her article "'Not to Discover Weakness Is the Artifice of Strength': Emily Dickinson, Constraint, and a Disability Poetics." Writing most of her poems in the 1860s with what James Guthrie calls "'covered' vision," Dickinson registers the presence of eyestrain in the text itself (Guthrie 17). When she wrote to Lavinia in 1866, "This is my letter – an ill and peevish thing, but when my eyes get well I'll send you thoughts like daisies, and sentences could hold the bees" (L301), Dickinson describes her text as "ill," asserting that her experience of eyestrain alters her capacity to write. She is still using striking imaginative language here, shaping a metaphor of the text as a sort of ill patient, and the simile of thoughts like daisies. Her embodied reality shapes her writing, and she fears that it may diminish it, even as it continues to proliferate new imaginative constructions.[113] Writing with pencil, conjuring guests, and representing her own writing as ill, Dickinson recognized the ways in which physical illness altered her engagement with the materials and processes of imagining and writing.

The poems Dickinson refers to serve a rebellious function. While Dickinson wrote poems to handle her confinement indoors, her imagination became a prized alternative to medicine. The poems she wrote grapple with the value of seeing and blindness, demonstrating that the lived reality of disability impacted her poetic imagination. Williams's notion (above) that *seeing* is the same as *knowing* is a concept that Dickinson also toyed with in her poetry. This idea may remind us, for example, of Dickinson's 1863 poem "I heard a Fly buzz – when I died –" (F591) in which she recalls that "The Eyes around – had wrung them dry –." The speaker's detached eyes became dry from being thrown around in search of the elusive fly:

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[113] Thank you again to Jean Franzino for your thoughts on this.

With Blue – uncertain – stumbling Buzz –
Between the light – and me –
And then the Windows failed – and then
I could not see to see –

Michael Davidson opens his study of Dickinson and disability with a reading of this poem, writing, “What is powerful about the poem is Dickinson’s understanding of the gap between sight as something one *has* and something one *is*” (1). He argues, “In this moment [Dickinson] is permitted to see, as it were, through a glass darkly; rather than conform the world to recognizable patterns and codes, she confronts raw consciousness itself. The repeated ‘see’ helps emphasize the filament-thin boundary between these two functions: doing and being, having and existing, seeing and knowing” (para. 1). Seeing and knowing are often thought to be synonymous; considering what blindness teaches us about knowledge revises this assumption. Suggesting that the “Windows,” rather than the eyes, failed, this poem recalls Dickinson’s 1865 poem, “Who saw no Sunrise / cannot say” (F1028A), in which she again references blindness. She concludes her first stanza with the lines: “Who guess at seeing, / guess at loss / Of the Ability –.” Here she universalizes impairment, suggesting that to “see” is only ever to speculate—to “guess.” Always already a flawed mode of perception, seeing constitutes inability. For Dickinson, as Mullaney persuasively argues, “Both seeing and being blind are equally deficient modes of perception” (2019, 70).

In 1863, Dickinson writes about impaired vision by contemplating the act of interpreting a scene:

I’ve seen a Dying eye
Run round and round a

Room –
In search of + Something –
as it seemed –
Then Cloudier become –
And then –obscure with Fog –
And then – be soldered
down
Without disclosing what
it be
‘Twere blessed to have
Seen –   + somewhat

As Mullaney reveals, the poem is fractured by the page the text is written on, as Dickinson’s manipulation of paper while she managed her visual impairment governed the poem’s unpredictable line breaks (69). The poem’s speaker scans “a Room” whose content, vaguely marked with an ambiguous “Something,” is never described nor defined. The “Dying Eye” becomes “cloudier” and obscured by “Fog” before it is “soldered down” by an unknown agent. The words “fog” and “soldered” have medical meanings: Williams used “chloroform or ether”—fog-inducing substances—writing in his book, “Should a suture be employed…its introduction will be facilitated by the *passiveness* of the eye” (Williams 36-37, my italics). Dickinson evokes the fogginess and metallic soldering that are involved in medical operations, demonstrating again her knowledge about medicine. Moreover, the poem itself obscures much about its own meaning; with the line “Without disclosing what / it be” the poem also defies diagnostic reading efforts. By the end of the poem, readers experience something like impairment, as the eye’s death puts an end to observation. Challenging notions about the necessity of seeing as a foolproof method of ascertaining information about an object, Dickinson’s poem brings the reader into the experience of visual impairment and alludes to the befuddling and physically violent processes physicians bring to that impairment.

Dickinson was thoughtful about her physician’s methods, and, in poems, tested the usefulness and ethics of diagnostic physical examinations. In “It knew no Medicine” (1862), for example, Dickinson offers a puzzle that could perhaps be solved through an examination and a process of deduction:

It knew no Medicine –
It was not Sickness – then –
Nor any need of Surgery –
And therefore – ‘twas not Pain –

It moved away the Cheeks –
A Dimple at a time –
And left the Profile – plainer –
And in the place of Bloom

It left the little Tint
That never had a Name –
You’ve seen it on a Cast’s face –
Was Paradise – to blame –

The speaker's deductive reasoning here is rather unhelpful, for reasoning does not reveal much more about "It." The speaker mimics a physician performing a diagnostic examination, observing that the subject displays certain symptoms: pale cheeks, and a "little Tint" on the face. The poem seems to have a tongue in cheek/sardonic tone. It openly makes a logical leap when it assumes that something untouched by medicine and surgery *cannot* be sickness or pain, highlighting the irrationality of its own diagnostic process. It says here that something medicine or surgery cannot treat must not then be sickness, even though, the poem implies, we all know that is not true; not only symptoms with recognized names can affect us.

The poem blurs lines between text and body as the speaker reads the body like a text as a way of testing the literariness and use value of a medical examination. Furthermore, the poem hints that medical examinations are dangerously foolish, for one can become sickened through close contact with an ill object of study. The last lines read:

> If momently ajar –
> Temerity – drew near –
> And sickened – ever afterward
> For Somewhat that it saw? (Fr567 A).

With that question, the speaker arrives at a diagnosis of a sort, though a different sort than medical professionals engage in. *Seeing* caused the subject's sickness. We then might think that the speaker's examination of the subject's face is reckless, since the act of looking can cause sickness. Asking "was Paradise – to blame –" the poem hints that what the subject "saw" was death. Now it seems that the line "Nor any need of Surgery –" could indicate that there really is *no need* of surgery, for a surgical intervention would unjustly stop this subject from seeing "Paradise." The poem tests the practicality of the physical exam and posits that medical efforts are unhelpful when a subject's sickness is caused by something beyond the scope of human understanding. The poem seems to suggest that the diagnostic mindset has no way to deal with symptoms that do not line up with particular known diagnoses and treatments.

When Dickinson reflected on blindness and the value of sight, she experimented with medical tools such as microscopes, asking how they obtain knowledge about bodymind states. This recalls Dickinson's poem "Faith' is a fine invention" (Fr202), which asserts, "Microscopes are prudent/ In an Emergency!" This poem is largely a dig at unexamined religiousness, but it also belittles scientific modes of inquiry. "I tie my Hat – I crease my Shawl –" (F522) critically investigates medical methods:

> To cover what we are
> From Science – and from Surgery –
> Too Telescopic eyes
> To bear on us unshaded –
> For their – sake – Not for Ours –

This poem observes that scientists and surgeons have eyes that are "Too Telescopic" and that gaze "unshaded," leading the speaker to wish she could "cover" herself. Most significantly, the poem recognizes that this gazing is done "For their – sake – Not for Ours –." Just as Williams implied that diagnostic accuracy provided by the ophthalmoscope is meaningful because it reinforces physicians' authority, Dickinson suggests that physicians practice of telescopic gazing is done for the "sake" of the physician, not that of the patient.

While Dickinson's poems reveal her fascination with visual sensation and engage her treatment for eye ailments, it is worth noting that Dickinson also thought about auditory debility and the power of sound for poetry. Because poetry is often designed to follow cadences and rhythms, Dickinson contemplated ways of listening to poetic sound. For example, she uses the term "soldered" in "I've seen a Dying Eye" above; this word has meanings relating to deafness. It means both "To remain obdurately deaf" and the opposite: "to bring or restore to a sound or unimpaired condition" (*oed.com*). This use of a contronym (a word that evokes contradictory or reverse meanings depending on the context) heightens the sense of the paradoxicality of both sight and blindness as ways of knowing. The word also provides for a human (or perhaps divine) agency—an action is done, by someone or something, ostensibly to "restore something to unimpaired condition," and yet this act itself is what does the damage. The idea that the eye could be "soldered down/Without disclosing what/ it be" suggests that the eye is silenced, unable to disclose "what it be"; the importance of hearing, speaking, and seeing are thus all raised by the poem. This interestingly recalls Williams's words in *The Diagnosis and Treatment of the Diseases of the Eye* that "It is very important that the eye should be kept quiet" (after trauma to the cornea) (42). Dickinson's poem represents ability and disability in synesthetic terms that, in our reading, might seem to contend with Williams's expression of the audible powers of the eye.

As Dickinson challenges dominant discourses about the necessity of seeing, she also tests the value of hearing for human knowledge. This is important topic, for again, some early critics associated Dickinson with disability (including Deafness) while disparaging her poetry. For example, Arlo Bates argued in 1890 that Dickinson "was a Laura Bridgman" (the first blind, deaf, and mute person to be educated) and that her poetry, "a case of arrested development," displays the poet's "pathetic dumbness" (Buckingham 48). In 1925, critic Harold Monro claimed that Dickinson "is intellectually blind, partially deaf, and mostly dumb to the art of poetry…Her tiny lyrics appear to be no more than the jottings of a half-idiotic school-girl" (121). By reading Dickinson alongside contemporary disability scholars who figure disability not as tragedy but as a central to humanistic knowledge, we can push back upon stigmatizing metaphors of disability while we appreciate that Dickinson's poetry captures a full range of embodied experiences. Many of Dickinson's poems auscultate, mimicking stethoscopic modes of listening to loud, pulsating, beating hearts. Like Mullaney, I suggest that Dickinson also poetically explored disability—in this case, auditory disability—and pondered whether hearing and Deafness are similarly defective for knowledge production.

Other critics have explored sound, hearing, and Dickinson's voice. For example, Jefferey Simons ponders Dickinson's use of sound in his article "Dickinson's Ear." Beth Staley also explores aurality:

> Dickinson's manuscripts, especially the fragments, demonstrate and interrogate techniques of hearing practiced across the nineteenth century, and attention to their visuality is never distinct from attention to their aurality when we consider how they witness and respond to voice, how they reproduce sound, and thus how they engage a crisis of variables and misrecognition [...]. (21)

Staley adds that "Dickinson's techniques of hearing align with those practiced across the nineteenth century and enhanced by technology" (21). This history was mapped by Jonathan Sterne, who studies how "hearing has helped to construct the modern gaze; he explains how the modern medical gaze has been tailored by listening as enhanced by the stethoscope and how modernity's emphasis on vision has been tailored by listening as enhanced by sound telegraphy (95)" (Staley 21). Physicians began to rely upon the senses rather than a patient's narration of symptoms, grounding the revolutionary physical examination in the acts of inspection, palpation, percussion, and auscultation. This last term, *auscultation*, refers to the close listening to a patient's heartbeat or stomach. Voluntary, narrated symptoms, offered by the patient, became supposedly unreliable when compared to the rhythms a physician found through such empirical observation. The stethoscope transformed techniques of listening, and functions as an assistive device for listeners. Dickinson explores this tool while simultaneously hinting that hearing is one, flawed method of learning about interiors, whether bodily or spiritual.

For example, in Dickinson's poem "I felt a Funeral, in my Brain," (F340) she imagined "Being, but an Ear" and described a powerful "Beating – beating –" felt within the mind and brain. Davidson writes about this poem in his essay on Dickinson, disability, and his own hearing loss: "Instead of hearing the tolling bells through [Dickinson's] ears, she becomes the bell; instead of not hearing, she becomes the Silence. There is no separation of sound and sensory organ; both are conjoined in the awe-filled word, 'Being.' And where silence had marked the space between one peal and the next, it is now one with the sounds that give it form" (para. 8). The poem supports Davidson's argument that while Dickinson recognized the difficulties resulting from losing her vision, she also "thought hard about what is gained from losing sight, not from the tragedy that it implies" (para. 2). Davidson develops the concept of Deaf Gain, offered by Deaf scholars Dirksen Bauman and Joseph J. Murray, which argues that lived realities including Deafness must be recognized as part of the fabric of human diversity.

In other poems, Dickinson explores this lived reality of Deafness while she also connects the visual and auditory elements of poetry through language, asking whether sight and sound are necessary for knowledge. While Dickinson often uses four-line stanzas, her poem "A Pit – but Heaven over it –" (F508) alters her typical visual and audible form. This poem about mortality features stanzas that are four, five, eight, then four lines long, a variation that effectively encourages a way of feeling the poem rather than just seeing or hearing it. The first two stanzas read:

A Pit – but Heaven over it –
And Heaven beside, and Heaven abroad;
And yet a Pit –
With Heaven over it.

To stir would be to slip –
To look would be to drop –
To dream – to sap the Prop
That holds my chances up.
Ah! Pit! With Heaven over it!

In this Pit, it is suggested that "to stir ''and even to sense would lower one's "chances" of survival. The repetition of the terms "Pit" and "Heaven" and the strong end rhymes, "it" "pit" "drop" "prop" (different from the slant rhymes found in many of Dickinson's other poems) help to create the sensation of falling into the "fathoms" of the pit. Replacing "A Pit" with "Ah! Pit!" in the ninth line, Dickinson plays with sound and visual cues, bringing both forms of sensation together. No lone sense can capture the experience of existing within this mortal Pit. Moreover, the line "to look would be to drop," suggests that sensation itself can be dangerous. The poem continues:

We – could tremble –
But since we got a Bomb –
And held it in our Bosom –
Nay – Hold it – it is calm – (1863, F508)

The final stanza (which includes the famous lines about the "Bomb" in "our Bosom") suggests the desire to measure the pounding of a heart to sense if it is "calm" or trembling, alive or in danger. This has often been read to indicate the dangerous potential of a woman writer, or to signify Dickinson's ongoing interest in the subject of mortality.[114] While it may be a stretch to suggest that these lines refer to the stethoscope—a device invented in 1816 by René Laennec because Laennec was not comfortable placing his ear directly onto a woman's chest to listen to her heart—the pounding "Bomb" in the "Bosom" does capture the idea of auscultation, the medical technique of listening to uncover a heartbeat. Dickinson contemplated what sensation does for knowledge, toying with diagnostic tools and contemplating the limits of sensation for producing understanding about the world. Her poetic imagination thus crafts modes of expressing visual impairment that fill in gaps left by empirical perception.

Dickinson uses poetry to experiment with the diagnostic methods typically used to approach illness, hinting that acute experiences of pain can be worsened when a person is exposed to that diagnostic gaze. Williams believed sight to be a way of knowing and found that new microscopic tools gave physicians greater authority over biological states. Dickinson's poems do not parrot this perspective, nor do they accept her physician's methods as accurate. They often suggest that the tools that enhance sight in order to diagnose disorders, are not foolproof, for seeing and hearing are bound to fail to perceive empirical truths about lived realities, at least in the comprehensiveness of a particular approach to understanding. Though Dickinson has rarely before been presented as an author with any sort of medical knowledge, she engaged with diagnostic tools and contemplated the limits of sensation for producing understanding about the world. Her poetic imagination crafts modes of expressing visual impairment that fill in gaps left by empirical perception.

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[114] The idea that Dickinson is speaking to her power as a woman in this poem is referenced, for example, in Camille Paglia's *Sexual Personae: Art and Decadence from Nefertiti to Emily Dickinson*.

“Thank you for the Surgery”: Dickinson and Thomas Wentworth Higginson

Thomas Wentworth Higginson—editor, writer, health enthusiast, abolitionist, and the first officer to lead an official all-black regiment for the Union Army—became Dickinson’s lifelong friend after she reached out to him with a request for his readership. He played a major role (alongside Mabel Loomis Todd) in revising Dickinson’s poetry after her death. He also significantly shaped her legacy, both helping to make Dickinson famous and painting a picture of her as a recluse, a woman “partially cracked.”[115] Dickinson reached out to Higginson after reading his essays (on literary publishing, fitness, gymnastics, women’s health and education, and race) published in *Atlantic Monthly* in the 1850s.[116] When Higginson then examined Dickinson’s poetry and offered corrections, Dickinson remarked, sardonically, “Thank you for the surgery” (L261). While many critics assume Dickinson was speaking metaphorically, I use this phrase to analyze Higginson’s involvement in the medical world, Dickinson’s representation of the damaging consequences of surgical operations, and the understanding of poems as embodied specimens that breathe with life, that can be diagnosed and operated upon. While other scholars have thought about Dickinson’s engagement with Higginson’s views (about nature, for example[117]) none have studied Higginson’s racially and sexually charged writings about health and ability while thinking about the two writers’ relationship. I suggest that Dickinson saw

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[115] Higginson’s relationship to Dickinson and her poetry is often interpreted as either heroic or villainous. Brenda Wineapple reevaluated the Higginson/Dickinson relationship, painting “a far more nuanced portrait…presenting a Higginson who defended Dickinson’s idiosyncratic poetics against his coeditor Mabel Loomis Todd’s aggressive alterations” (Dietzman 44). While I hope to draw attention to Higginson’s influence on the larger tradition of ableism in Dickinson criticism, I do not wish to vilify Dickinson’s longtime editor and friend.

[116] Dickinson wrote: “I read your Chapters in the Atlantic –” (Wineapple 7).

[117] See, for example, Midori Asahina’s “‘Fascination’ is absolute of Clime’: Reading Dickinson’s Correspondence with Higginson as Naturalist.”

Higginson's reading as a diagnostic method of reading that could result in dramatic reshaping of their bodies. She extends the implications of his surgical metaphor further, and presented her poems as living specimens that both needed, and were threatened by, a diagnostic gaze and corrective editorial efforts. For Higginson's part, he hated many Civil War surgeons, and preferred (female) homeopathic physicians to allopathic ones. Dickinson, meanwhile, often poetically resided within the *unhealthy* to explore new ways of knowing and meaning. Dickinson acknowledges that surgery was sometimes necessary and implies that Higginson's methods were helpful, and *also* suggests that diagnostic and surgical methods are insufficient, sometimes even imprudent, approaches to difference.

Higginson was not a doctor, but because he was a "feeble, sickly infant" (Wineapple 19) and his wife Mary was described as "an invalid" who had rheumatism (24), he seems to have been self-conscious about being perceived as ill. He compensated for this possibility by becoming "the local authority on physical fitness" (3). Higginson mimicked physicians: in one essay, he scolded a fictional friend with dyspepsia, saying, "At forty, it is said, every man is a fool or a physician. We will wait and see which vocation you select as your own, for the broken remnant of your days" ("A Letter to a Dyspeptic" 74-75). Though his commentary about his fictional friend's impairment was judgmental and humorous rather than helpful, Higginson clearly preferred to be thought a physician rather than a mere reader. He represented health as physical and mental, corporeal and spiritual; suggested that a person's good health had much to do with a person's race, gender, and ability; and popularized burgeoning notions about the relationship between physical ability and a person's worth.

Higginson thought a great deal about female health in essays such as "The Health of our Girls." In "Barbarism," he argues that the "most momentous health-problem with which we have to deal" is "to secure the proper physical advantages of civilization for American women" (725). He adds, perhaps thinking of his own "invalid" wife:

> In this country it is scarcely an exaggeration to say that every man grows to maturity surrounded by a circle of invalid female relatives, that he later finds himself the husband of an invalid wife and the parent of invalid daughters, and that he comes at last to regard invalidism, as Michelet coolly declares, the normal condition of that sex, —as if the Almighty did not know how to create a woman (725).

Higginson's views about the weakness of women would likely play into his later representation of Dickinson as partially "cracked." After visiting Dickinson in 1873, he attests that Dickinson exhausted him, confirming his wife Mary's sentiments: "I'm afraid Mary's other remark, 'Oh why do the insane so cling to you?' still holds" (Wineapple 193). When he met Dickinson, he seemed to fit the pale female poet into the category of unhealthy—mental and otherwise—women who "cling" to those who are healthy.

Higginson went so far as to assert that invalids are lazy about protecting their own health. He admonishes a fictional ill friend in "A Letter to a Dyspeptic," writing, "I suspect that all rational advice for you may be summed up in one prescription: Reverse instantly all the habits of your previous physical existence, and there may be some chance for you" (472). To this "prescription," he adds, "There is something very noble, if you could but discover it, in a perfect human body. In spite of all our bemoaning, the physical structure of man displays its due power and beauty when we consent to give it a fair chance" (474). Similarly, in "Gymnastics," Higginson conflates spirituality and physical illness: "There are spiritual diseases which coil poisonously among distorted instincts and disordered nerves, and one would be generally safer in standing sponsor for the soul of the gymnast than of the dyspeptic" (289). His opinions about invalids, bemoaning, the "perfect human body," and the superiority of the "soul of the gymnast" resonate with claims about the birth of ableism with the concept of the "normal" in nineteenth-century America.[118] Higginson concludes that physically healthy bodies are stronger mentally and spiritually and that perpetual invalids are lazy and weak. While Higginson contributed to the physical fitness movement in America, he also contributed to the rise of ableism that depicts people with disabilities as inferior. In his essays, Higginson ponders (as Dickinson does) the relationship between mental, physical, and spiritual health. Unlike Dickinson, Higginson concludes that physically healthy bodies are also stronger mentally and spiritually and that perpetual invalids are lazy and weak.

While Higginson pondered the usefulness and power of able-bodied men and women, he thought about the diagnosis and treatment of disorder in individuals and America as a whole. In "Saints, and their Bodies,"[119] Higginson studies the qualities of "able-bodied" men and women, asserting that "Physical health is a necessary condition of all permanent success" (9). He claims,

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[118] The concept of normalcy emerged in this time: the words "normality" and "normalcy" appeared in 1849 and 1857 respectively. As Davis writes, "it is possible to date the coming into consciousness in English of an idea of 'the norm' over the period 1840-1860" (Davis 24). Before that, the concept of the "ideal" body prevailed. Higginson could be said to be participating in this social-cultural shift. In Higginson's writings, he refers to both ideal and normal bodies, and positions them as superior to ill, weak, and disabled ones. Ableism, defined as "'discrimination in favor of the able-bodied'…the idea that a person's abilities or characteristics are determined by disability or that people with disabilities as a group are inferior to nondisabled people" (Linton 8) is connected to normalcy, which "is constructed to create the 'problem' of the disabled person" (Davis 24). See Simi Linton, *Claiming Disability: Knowledge and Identity* and Lennard J. Davis, *Enforcing Normalcy: Disability, Deafness, and the Body*.

[119] He argues that few saints were "able-bodied men" (1) because "The mediaeval type of sanctity was a strong soul in a weak body; and it could be intensified either by strengthening the one or by further debilitating the other" (2). He adds, "There is in the community an impression that physical vigor and spiritual sanctity are incompatible…. The poets have probably assisted in maintaining the delusion" (2).

“Perhaps the best diagnosis of the universal American disease is to be found in Andral’s famous description of the cholera…’symptoms, characteristic; diagnosis, easy; treatment, very doubtful’” (“Saints and Their Bodies” 586). Suggesting that the diagnosis of American disease is “easy,” Higginson spends time concocting treatments, recommending gymnastic exercises outdoors for both men and women. Higginson asserts that gymnastics would help Americans, stating that “the one great fundamental disorder of all Americans is simply nervous exhaustion, and that for this the gymnasium can never be misdirected…the problem is, how to make the whole voyage of life perpetually self-curative” (“Gymnastics” 286). This statement illustrates Higginson’s desire to diagnose disorder while demonstrating that he gestured towards medical diagnosis in order to philosophize about the state of a nation as a whole. As Higginson pondered the power of individual men and women, he also thought about disorder in the nation and wondered how America could be perpetually cured. Deciding that the voyage of life should be “self-curative,” he places responsibility in the hands of individuals to find their own paths to health.

The discussion of race in Higginson’s *Atlantic Monthly* essays furthermore reveals that he worried that white Americans were falling behind in healthiness compared to nonwhite men. When he laments that white men have seemingly lost bodily vigor, he upholds ideas about body/mind distinctions, writing: “Supposing the fact still true, that an average red man can run, and an average white man cannot, – who does not see that it is the debility, not the performance, which is discreditable?...There is a melancholy loss of self-respect in buying cultivation for the brain by resigning the proper vigor of the body” (“Barbarism and Civilization” 59). However, he ultimately contradicts this claim to argue that white men are physically dominant. Higginson concludes that “the result is, that the civilized man is physically superior to the barbarian.” He insists: “The traditional glory of the savage body is yielding before medical statistics: it is becoming evident that the average barbarian…is small and sickly and short-lived and weak, compared with the man of civilization” (58; 60). Relying on “medical statistics”—scientific processes of defining the “normal” that took hold in this time period—Higginson makes clear his efforts to sustain white supremacy while also suggesting that bodily health is prolonged by mental and intellectual superiority.

While Higginson feared for the health of white Americans, his main concern was with slavery, which he saw as a rapidly-spreading sickness. Higginson fought for abolition well before the onset of the Civil War, and saw this fight as related to health.[120] Many of his early abolitionist speeches and essays depict America as a body afflicted with the “disease” of slavery, something he called “a gangrenous excrescence.”[121] In early writings, he prescribed an indirect treatment for this problem; though Higginson was an energetic abolitionist, he wanted to avoid direct, violent confrontations. In this regard, Higginson promoted what he called an “allopathic” method to the treatment of slavery. This method put faith “in curing by contraries” and aimed “at the suppression of agitation in the system.”[122] However, by 1854 Higginson had changed his strategy, and began to argue that only a “homeopathic” approach could eradicate the disease of slavery. As Ethan J. Kytle claims, the homeopathic approach, which “gives for any symptom the medicine that would produce the symptom, and cures the disease by helping it to do its work in the shortest possible time” meant matching agitation with agitation (334). In my final chapter on

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[120] That Higginson saw slavery as a “cancer” is a significant claim that I discuss later in my dissertation in the chapter on Frances E. W. Harper’s *Iola Leroy*.

[121] Newburyport *Union*, 6 Nov 1850, quoted in Kytle (343).

[122] *Liberator*, 2 Feb. 1854, quoted in Kytle (343).

Frances E. W. Harper, I will return to this concept: that literary thinkers pondered "cures" for enslavement by imagining various solutions with varying degrees of violence.

Just as Higginson supported a metaphorical homeopathic treatment to the problem of slavery, he also supported literal homeopathic treatments when pondering what he perceived of as weakness in American individuals. Though Higginson was involved in the medical field, he himself represents rebellion against professional medicine and the American Medical Association because he advocated for homeopathic medicine and hydropathy. The AMA Code of Ethics made it impossible for physicians to consult homeopathic medical providers—something that not so coincidentally made life harder for women who wanted to be physicians, because "most homeopathic medical schools welcomed women into their ranks" whereas many medical schools rejected women (Jonathan Davidson 27).[123] The founding constitution of the AMA stipulated that admission could be offered to all "regular" physicians, "excluding all Homeopathic, hydropathic" physicians. During the war Higginson often praised his regiment's surgeon, Dr. Seth Rogers, a hydropath who treated the black soldiers in the regiment and the proprietor and resident doctor of the Worcester Hydropathic Institution. In 1863, Higginson also received treatment for malaria from homeopathic physician Laura Towne. He supported Towne in a letter to his wife, describing her as "the homeopathic physician of the department, chief teacher and probably the most energetic person this side of civilization…I think she has done more for me than anyone else by prescribing homeopathic arsenic as a tonic, one powder every day on rising, and it has already, I think (3 doses) affected me" (*The Complete Civil War Journal*

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[123] The AMA Code of Ethics reads: "But no one can be considered as a regular practitioner, or a fit associate in consultation, whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession, and of the aids actually furnished by anatomy, physiology, pathology, and organic chemistry" (100). This statement actively targeted homeopathic medical schools, which were not recognized by the AMA.

and Selected Letters of Thomas Wentworth Higginson 316). Overlooking for now the fact that Higginson was probably not aided by arsenic, his letter suggests that he wanted to validate the intellect and skill of the rare female homeopath who treated him. Higginson's fondness for homeopathy did not necessarily come from great faith in the practice; rather, it derived from his concern that allopathic medicine and surgery were dangerous and deadly, and not effective at ridding body and nation of their "gangrenous excrescence." Moreover, during the Civil War, homeopathic professional organizations and individual providers were barred from helping their communities during the crisis of war. Higginson resented that omission because he found it illogical.[124]

When Higginson fought in the Civil War, he put his theories about liberation and reunification to practice while he oversaw the health of his soldiers and did his best to ensure that only the best possible physicians were involved with the regiment. From 1862-1864, he served as colonel of the First South Carolina Volunteer Infantry Regiment (Colored), the first authorized regiment recruited from freedmen for Union military service, described in *Army Life in a Black Regiment* (1870). Higginson shares his beliefs about the health and ability of black soldiers, often perpetuating white supremacy and ableism. He admired black soldiers, but his expression of that admiration was marred by racist and patronizing commentary. He complained of his soldiers: "their weakness is pulmonary; pneumonia and pleurisy are their besetting ailments; they are

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[124] Higginson critiqued allopathic medicine and the actions taken by the American Medical Association numerous times. When homeopaths treated symptoms with harsh deadly compounds, the theory was to affect an opposite of the disease state. Botanic, mild therapies appeared successful, as they did not blatantly harm patients. Allopaths offered "heroic" therapy treating patients with bloodletting, blistering, purging and emetics, essentially treating symptoms with harsh deadly compounds. For more on allopathic and homeopathic medical conflicts during this time, see Shauna Devine, *Learning from The Wounded: The Civil War and the Rise of American Medical Science*.

easily made ill" and here he reemphasized that he felt the black soldiers had weak pulmonary systems (*Army Life* 198). He seems to generalize their susceptibility to illness as something innate to their (different) bodies, rather than to the environment. His primary concern was that issues of health endangered vital missions that might well help cure the American country. He worked hard to provide the soldiers with excellent health care and made an effort to challenge his readers' racist views. Higginson vehemently argued that black soldiers were fit for service and indeed deserved the chance to fight for freedom in a rapidly-changing America. In occasional moments, Higginson also suggests that he himself would like to be black,[125] demonstrating a rare racial fluidity. As Christopher Looby argues, Higginson's "longstanding interest in male health and bodily fitness fed into his military experience…this interest reflects the reform culture of his time…but it also reflects Higginson's aforementioned engagement with the questions of racial and gender identity, and the fungibility of identities" (Looby 26). Though he reinforced patronizing views about black people, Higginson also played an important role in fighting slavery and fought the racism of his time. He consistently emphasized that America must work towards robust health at all costs—even if it meant violently attacking the system of slavery that sickened it. In other words, Higginson held somewhat contradictory and ever-changing views on health and how he valued people based on race, gender, and ability.

Significantly, Higginson rigorously criticized most of the surgeons he met, often finding them inadequate. In one letter, he complained that "Surgeons are by far the worst class of officers" because they drank too much whiskey. He complained that surgeons "hv. more opportunity" to drink, "as they always hv. liquor among their supplies" (undoubtedly to dull pain

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[125] Higginson wrote that the black soldiers "Look magnificently often, to my gymnasium trained eye & I always like to see them bathing" (*Journal* 87). He also wrote to his mother, "If I don't come home jet black you must be very grateful" (*Journal* 248).

and sterilize) (*Journal* 351). He added generously, “There are however marked exceptions & some of the most agreeable officers whom I hv. met are Surgeons & of the highest character—but these are exceptions” (352). Higginson’s concern that the surgeons were drinking signifies his fears that they would not be able to adequately help the soldiers of the regiment when they needed care. Instead, Higginson shows his faith in hydrotherapy and other “alternative” medical methods from his time. Just as Higginson felt that a homeopathic approach to the problem of slavery would help cure America, he also believed that homeopathic and hydrotherapeutic approaches to individual sicknesses were more effective than allopathic efforts. When Higginson himself fell ill, he relied on homeopath Dr. Rogers because he found his diagnostic and examination methods to be accurate and reassuring. He wrote in a letter to his wife Mary:

> No new symptoms develop, only the same ‘General Debility’…. Of course I am eager to have Dr. Rogers come, because I have much faith in his diagnosis of disease and none at all in that of Drs. Hayden and Minor, whom I see. Theirs consists of ‘How are you today? Can I do anything for you?’ more friendly than searching. Of course every patient, of well regulated mind, wants to be pulsed & thumped & ausculated [sic] a little, & to think that somebody else knows what’s what. (*Journal* 313)

Higginson was unsatisfied by the work done by Drs. Hayden and Minor,[126] seemingly finding the diagnostic label of “General Debility” to be inaccurate and unsatisfying. Higginson looks forward to Dr. Rogers’ visit because he anticipates a more accurate diagnostic process and

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[126] Here Higginson refers to Dr. Minor—a famous Civil War physician who, after the war, was placed in lunatic asylums, cut off his own genitalia, and became one of the first major contributors to the Oxford English Dictionary. See Elizabeth M. Knowles, “Dr. Minor and the Oxford English Dictionary.”

believes that physical involvement—the matching of “agitation with agitation”[127]—results in better medical treatment. Dr. Rogers, whom Higginson prefers to the other available doctors, practiced hydrotherapy as the proprietor and resident doctor of the Worcester Hydropathic Institution. Rogers was therefore not well regarded by the American Medical Association, which disregarded the skills of hydrotherapists, who were depicted as quacks. By saying that every patient likes to *think* that somebody else “knows what’s what,” Higginson also acknowledges the possible limits on even Dr. Rogers’ knowledge. Nevertheless, Higginson believed that a doctor was superior at performing a diagnosis if he did not merely ask a patient to describe symptoms in language; a physician actively “pulsed & thumped & ausculated” patients—biological acts that confirm a physician’s knowledge and authority.

Despite his interest in homeopathic medicine, Higginson took a medical view towards literary editing that feels much more like allopathic, patriarchal medicine in that it reads deformity as akin to helplessness. This mindset is especially clear in Higginson’s 1862 article “Letter to a Young Contributor,” noteworthy because Dickinson first contacted Higginson and asked him to become her mentor after she read it. The article demonstrates that Higginson *constantly* thought about health and fitness, even when he was writing about seemingly unrelated topics (such as poetry, editing, and publication). As the war raged on, Higginson used the figurative language of deformity while he advised young authors on how best to publish their writings. Of poor articles, he writes that an editor “stands up stoutly for the surpassing merits of the misshapen thing, as a mother for her deformed child; and as the mother is nevertheless inwardly imploring that there may never be such another born to her, so be sure that it is not by reminding the editor of this calamity that you can allure him into risking a repetition of it”

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[127] *Liberator*, 2 Feb. 1854, quoted in Kytle (343).

(*Atlantic Essays* 79). He also advises authors against producing "deformed" works: "Do not habitually prop your sentences on crutches, such as Italics and exclamation points, but make them stand without aid.... These devices are commonly but a confession of helplessness" (81). Higginson suggests that literary conventions must be met for a work to avoid deformity, drawing upon metaphors about the "helplessness" of disabled people who need prosthetic aids in order to make his point. He draws together the form of disabled bodies and the form of literary works, bringing a medical perspective to both in this essay.

After reading "Letter to a Young Contributor," Dickinson evidently realized that Higginson was interested in medicine and that his approach to literary editing was fundamentally corrective. When she reached out to him, she adopted his use of medical metaphors, seemingly deciding that using these metaphors would help them find common ground. In her introductory letter, she suggested that poems are like living bodies and asked him to examine her own poems' vitality. She famously asked,

> Are you too deeply occupied to say if my Verse is alive? The Mind is so near itself – it cannot see, distinctly – and I have none to ask – Should you think it breathed – and had you the leisure to tell me, I should feel quick gratitude (L260).

Dickinson invites Higginson to try to "see, distinctly," a request that could evoke an objective, scientific form of observation. As discussed in the introduction, diagnosis originates from a stem meaning "discern, distinguish," literally "to know thoroughly" (oed.com). "Diagnostics" was soon defined as a practice with the goal to "discerne…the sick and infirme from the whole."[128]

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[128] Quoted from Thomas Willis, *The Remaining Medical Works of Dr. Thomas Willis*, transl. Samuel Pordage (1681) and James Hart, *The Anatomie of Urines: Containing the Conviction and the Condemnnation of Them* (1625).

When she asks him to judge whether he thinks her verse is "alive," she accepts Higginson's earlier suggestion that a verse can be compared to a living body.[129] Here she suggests that a mind can be examined (from afar, as if being too "near itself" it loses perspective) and that one might listen for the breath of Verse (as in auscultation). Medical methods of examination blend into Dickinson's request that Higginson read her poetry.

Dickinson continued to draw on the language of medicine in her exchange with Higginson. When Higginson first read Dickinson's introductory letter, health—including the health of young women—was on his mind. According to Wineapple, in the moment that Higginson read this letter, he was simultaneously contemplating his life as a fitness enthusiast and abolitionist. Wineapple relates, "Higginson opened [Dickinson's] cream-colored envelope as he walked home from the post office, where he had stopped on the mild spring morning of April 17 after watching young women lift dumbbells at the local gymnasium. The year was 1862, the war was raging" (3). Higginson then read Dickinson's poetry and sent back a reply. We do not know what Higginson said to Dickinson, since his letters are lost. However, we know that he replied with some criticism; it seems that Higginson believed that the young poet wanted her poetry to be "pulsed & thumped & ausculated a little." In her reply, Dickinson then teased Higginson by referring to his critiques as "surgery." In using the term surgery, Dickinson invokes a topic of interest in both her own life and American culture at this time. The discovery of anesthesia (which was first named in 1846) revolutionized medical science—for white

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[129] Her request that Higginson check on the breath of her poetry may also remind us of one of her later poems: "I am alive – I guess" (Fr605A) reads, "if I hold a Glass/ Across my mouth – it blurs it – / Physician's – proof of Breath –." Her reference to the method physicians used to see if a patient was alive or dead—by holding glass to a patient's mouth to see if condensation appeared—demonstrates her curiosity about the ways life and death can be medically determined.

patients and physicians.[130] In 1846 and 1847, physicians demonstrated that they could numb patients' pain via ether and chloroform, respectively. Anesthesia became well-known during the Civil War, as Americans debated the safety and morality of amputations and the use of ether and chloroform. The wide use of anesthesia led to what Sari Altschuler has termed a "crisis of knowing," one that "unsettled longstanding ideas of pain and suffering" (161). This crisis sparked debates among medical professionals and the general public, compelling them to consider whether pain is ever valuable or necessary (173). Americans began to debate numerous difficult questions: "What is pain? What is its role in life and health? And when is anesthesia (literally the state 'without feeling') useful—and when is it dangerous?" (Altschuler 161).

Dickinson frequently addressed surgeons specifically in her writings and was especially curious about surgeons' attempts to numb pain via the use of recently-discovered anesthesia. Though Dickinson's own Dr. Williams likely did not operate on her, he did employ anesthetics in his surgeries.[131] Dickinson considered ethical questions in her poetry, asking whether surgeons act rationally or with enough caution when they attempt to numb pain. Dickinson's "There is a Languor of the Life," for example, produces knowledge about diagnostic approaches to bodymind pain:

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[130] Dentist William Thomas Green Morton publicly demonstrated the use of ether at Massachusetts General Hospital's Bulfinch Amphitheater in 1846. Scottish physician Sir James Young Simpson successfully used chloroform as an anesthetic a year later. The discoveries of ether and chloroform revolutionized surgery because previous usage of alcohol and other medications merely sedated patients, whereas anesthesia seemed to completely eliminate pain during surgery. See Richard Hollingham's *Blood and Guts: A History of Surgery*.

[131] Dr. Williams writes in *Recent Advances* that "The use of chloroform or ether, till complete insensibility is induced, greatly increases the chances of success" in operations for cataracts, iritis, and other eye disorders (36). Bauman observes that "In cataract surgery, [Dr. Williams] favored ether anesthesia and a single limbal suture without an iridectomy" and adds that "it is again important to remember that no record survives of any diagnosis of her condition during her lifetime," nor do we know whether she had surgery (1593-1594).

There is a Languor of the Life
More imminent than Pain –
‘Tis Pain’s Successor – When the Soul
Has suffered all it can –

A Drowsiness – diffuses –
A Dimness like a Fog
Envelops Consciousness –
As Mists – obliterate a Crag. (F522A)

Although the poem can be read as a metaphorical portrayal of spiritual suffering, it also demonstrates Dickinson’s familiarity with medical innovations as well as her skillful use of simile to depict complex states of being. The poem describes a “languor” that envelops consciousness after periods of great pain, a condition that is not clearly diagnosed but remains ambiguous. This languor bears a “Drowsiness” that “diffuses – / a Dimness like a Fog,” evoking the embodied sensations one might feel while under the influence of anesthesia. The poem goes on to examine the consequences that may result if pain gives way to this “fog”:

The Surgeon – does not
blanch – at pain –
His Habit – is severe –
But tell him that it
ceased to feel –
The Creature lying there –

And he will tell you –
Skill is late –
A Mightier than He –
Has ministered before Him –
There's no Vitality

The surgeon of this poem has a simple view of pain: he can potentially operate on a person who feels, but a "Creature," whom he determines as lacking in vitality, cannot be treated by any skill he possesses. He seems knowledgeable about some aspects of the body, yet he also seems authoritarian, dehumanizing, and "severe" in the guise of his profession. In the space of this short poem, Dickinson takes an approach to pain that extends beyond the surgeon's diagnostic and corrective one. We also see the failure of the physician's corrective abilities: "A Mightier than He" has stepped in and, presumably, caused the patient's death. The surgeon claims to be able to fix all, but when the patient dies, he appeals to the fact that it was God's work that he could not have countered. Dickinson thus imagines the extreme experience of pain, the sensation of languor that follows it, and the consequences of losing pain completely—and with it, life. All of this demonstrates her knowledge about medical approaches to bodyminds, and about Dickenson's willingness to represent visceral experiences in poetic form—without identifying those experiences in clear-cut diagnostic terms. Dickinson cannot or will not name this "languor" in terms of a specific disease (after all, it is a symptom that could arise during or after any experience of pain). She will, however, compare languor it to concepts to further flesh it out: dimness like a fog, as mists envelop a crag. In other words, Dickinson offers similes as an antidote to diagnostic language, using literature to revise and refine medical approaches to embodied experiences.

In “Ah, Necromancy Sweet!” (1860), the speaker, seeking vengeance, reminds readers of the possibility that pain might be incurable:

> Teach me the skill,
> That I instill the pain
> Surgeons assuage in vain,
> Nor Herb of all the plain
> Can heal! (Fr167)

The speaker asserts that surgeons’ efforts to ease this powerful pain—with anesthesia, or by successfully operating on a patient—are “in vain.” The speaker implies that because surgeons and medicines cannot fully assuage pain, a person may as well learn the power to *instill* pain instead. The word “instill” suggests both conveying an idea to a person—passing on wisdom of pain, for example—and introducing something tangible, such as medicine, to their bodies. This alignment of pain with a possible allusion to the provision of medicine recalls the fact that Dickinson found Williams’s eye drop treatment painful. Most urgently, the poem speaks to the idea that there is power in instilling incurable, unassuageable pain. In another poem from 1860, Dickinson warns that surgeons must not objectify their benumbed patients, a warning that recalls Foucault’s idea of the medical gaze:

> Surgeons must be very careful
> When they take the knife!
> Underneath their fine incisions
> Stirs the Culprit – Life! (Fr155B)

The poem proposes that the “Culprit” under the surgeon’s knife is not the patient’s defective form, the failure of a body to be whole; rather, the culprit is life itself, for illness and pain are natural parts of that life. The poem predicts a moment of great danger when this patient “Stirs.” Surgeons must be very careful if they let Life—an offensive “Culprit”—awaken, for Life might not hesitate to defend itself, and they should be very careful about doing more harm than good. No matter how carefully surgeons make their cuts, they will perpetually chase after the innumerable impairments, illnesses, and other harbingers of pain that necessarily accompany human life. Dickinson thus investigates the morality of surgeons’ actions, asserting that while surgeons may think they are helping patients, they may kill or cause irreparable harm if their immobile patient awakens and stirs under their hands.

Dickinson’s meditations on surgery further reveal her concerns about both diagnostic attempts to label disorder and the interventions used to correct deformity that may follow diagnoses. These concerns form the backdrop for Dickinson’s use of the term “surgery” in her letter to Higginson. Her second letter to her editor reads:

> Mr. Higginson, Your kindness claimed earlier gratitude – but I was ill – and write today, from my pillow.
>
> Thank you for the surgery – it was not so painful as I supposed. I bring you others – as you ask – though they might not differ –
>
> While my thought is undressed – I can make the distinction, but when I put them in the Gown – They look alike, and numb (L261).

Here Dickinson references the illnesses she was experiencing at the time, and she thanks Higginson (perhaps sardonically) for his “surgery.” She then attests that she can see her poems’ individualities only when they are alluringly “undressed.” This undressed quality might refer to when they are unwritten. Placing them in a "Gown" seemingly readies them for male eyes.[132] "Undressed" could have additional meaning: her thoughts may seem unique only before they are "dressed" in *bandages*. Dickinson claims that Higginson's surgery was "not so painful" as she thought it would be, perhaps because dressing them rendered them "alike and numb"; in this case, she is collapsing herself with the bodies of her poems. This word "numb" could point to the anesthesia that inspired people to wonder about the value of pain and the danger of surgical interventions. Her statement that the surgery was "not so painful" may further tease Higginson, hinting that he either used too much ether while trying to numb the pain or that his surgery was unimpressive.

Thus, Dickinson uses an extended surgical metaphor to describe Higginson's criticisms. This metaphor gives her a vehicle to convey her fear about exposing her poems; as she wrote in "Publication – is the Auction/ Of the Mind of Man –" (F788), publication is aligned with the crude public spectacle of an auction.[133] We might also wonder how this metaphor answers her own question of whether her verse is "alive." As she claims in "Surgeons must be very careful," a surgeon would never operate on something that was dead. Her letter deftly insists that beneath her editor's "fine incisions," her poetry "stirs" with life. In such letters, Dickinson often teases Higginson while thanking him for his help, indicating that she understood that his editorial efforts would necessitate potentially painful surgical operations. In her fourth letter, Dickinson

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[132] This poem was written before the invention of the hospital gown, so the reference to a "Gown" likely means that she alluringly prepares her poems for a reader's eyes.

[133] "Publication—is the Auction" could also be studied in an exploration of enslavement and slave auctions in Dickinson's works. The lines "Possibly – but We – would rather/ From Our Garret go White – unto the White Creator –/ Than invest – Our Snow –" (5-8) refer to death's whiteness but also to whiteness more generally. The last lines, "But reduce no Human Spirit /To Disgrace of Price –" (15-16) should hardly be read without their historical context, since this poem was published in 1863 as the war was raging.

welcomes Higginson's editorial methods: "Men do not call the surgeon, to commend– the Bone, but to set it, Sir, and fracture within, is more critical" (L268). Although Dickinson's tone generally indicates she is teasing Higginson, she also assures him that she is grateful for his help. Dickinson seems to take pleasure in repeating her use of this metaphor. She understood that surgeons destroyed in order to improve, and she invites the pain of Higginson's editorial practice, since in her poetic imagination, pain signifies vitality and is necessary for life.

For his part, Higginson assumed the role of surgeon Dickinson gave him. He reminisced after Dickinson's death: "I remember to have ventured on some criticism which she afterwards called 'surgery,' and on some questions, part of which she evaded, as will be seen, with a naive skill such as the most experienced and worldly coquette might envy" (Buckingham 184). Higginson questioned her and sensualized her evasive responses. He openly tried to correct what he thought were deformities in her poetic form; letters reveal he wanted her to be less "spasmodic" and "uncontrolled" (L265). He wrote after her death: "It would seem that at first I tried a little—a very little—to lead her in the direction of rules and traditions. I fear it was only perfunctory, and that she interested me more in her—so to speak—*unregenerate condition*" (Buckingham 188, my italics). Higginson's commendation of Dickinson's nonconformity should be read with a grain of salt, since, as one of Dickinson's first editors after her death, Higginson was trying to sell and promote her as a poet *despite* her (medically, or religiously phrased) "condition." For her part, Dickinson's use of a medical metaphor to describe Higginson was apt, for his approach to editing poetry often seems to have mimicked the diagnostic and surgical steps medical professionals take to "fix" disorderly bodies.

The poems Dickinson sent Higginson for critique seem to tease him for taking a surgical approach and to demonstrate the poet's ongoing fascination with medical efforts to eliminate pain.[134] Written just as Dickinson was undergoing eye treatments, the poem "Before I got my eye put out –" appears in Dickinson's fourth letter (the one that includes the reference to surgeons' bone-breaking techniques), accompanied by the cheeky question, "Are these more orderly?" (L271).[135] Far from being "orderly" in form or style, the poem refers to surgery as it challenges the necessity of medical interventions:[136]

> Before I got my eye put out –
> I liked as well to see
> As other creatures, that have eyes –
> And know no other way – (Fr336).

At first it seems that the speaker laments a loss of sight, caused when someone "put out" her eye. However, the speaker soon claims that looking is dangerous. She claims that if she were told she could have

> As much of noon, as I could take –
> Between my finite eyes –....
> For mine – to look at when I liked,

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[134] Alexandra Socarides agrees that we might read the poem "Before I got my eye put out –" "As another version of what it feels like to receive [Higginson's] criticism" (58).

[135] "Orderly" of course means "proper," but an "orderly" is also "an attendant in a hospital (originally a military hospital) responsible for the non-medical care of patients and the maintenance of order and cleanliness" (oed.com). Given that Higginson was familiar with looking after the health of his soldiers during the Civil War (and, according to *Army Life in a Black Regiment,* had an "orderly" who performed odd tasks for him) the word "orderly" here may have served as a medical pun.

[136] Davidson refers to "Before I got my eye put out –" while arguing that many of Dickinson's poems "are about non-sighted experience." He goes on to assert convincingly that "although metaphors of blindness are common in all poetry, Dickinson had an especially acute awareness of what we might call the 'agential' [i.e., relating to having agency] understanding of sensory experience" (para. 2).

The news would strike me dead –

A straightforward gaze (such as the one that caused the subject of "It knew no Medicine" to see "Paradise") can be deadly. The speaker begins to accept and even to *promote* the blindness she is experiencing, since an examination, whether it is diagnostic and physical or poetic and critical, may be dangerous, for her eye is put out either naturally or by a physician. Dickinson contends that loss might not require medical intervention but may be beneficial. The poem supports Michael Davidson's argument that while she recognized the difficulties resulting from losing vision, she also "thought hard about what is gained from losing sight, not from the tragedy that it implies" (para. 2).

The poem defends blindness as something that protects one from absorbing an excessive amount of information, akin to how Dickinson controlled access to her person; however, it further suggests that nothing, not even blindness, can prevent a poet from seeking knowledge. The conclusion reads,

So safer – guess – with just my soul
Opon [sic] the window pane
Where other creatures put their eyes –
Incautious – of the Sun –

The speaker now puts her "soul," rather than her eyes, in the way of the sun, a light which would render disordered eyes sensitive. She still seeks dangerous knowledge and blindness does not stop her from sensing something past the "finite." Dickinson seems to imply that even if her eye is put out, she can still use her soul to explore. By sending "Before I got my eye put out –" to Higginson, Dickinson responded to Higginson's attempt to bring order to her poetry by asserting that her poetry possesses a vital force that neither blindness nor surgery can impair. In this way, "Before I got my eye put out —" engages a central theme of Dickinson's work in relation to Higginson: that Higginson is interested is taming what he sees as unruly physical bodies and textual bodies, and Dickinson's poetry, while playing with his surgery metaphor and repeatedly seeking surgery, questions the value or even possibility of "successful" corrective surgery.

Dickinson's Poetics of Pain

Because the experience of pain challenges the limits of language, many have asked whether the lived reality of pain is narratable.[137] Dickinson's poems attempt to narrate pain often—so often, in fact, that literary scholar Ann Jurecic called her "America's poet laureate of pain" (44)—and test different methods to explore realities of illness. Dickinson's poetry experiments with ways of thinking about undiagnosed or undiagnosable bodies. She did not always advocate for the diagnostic and surgical approaches to disorderly forms taken by her father, doctor, and editor, and her poetry provides opportunities for considering pain and disability without returning to models of pathologization or pity. Dickinson acknowledges that pain may be difficult to narrate, but she nevertheless makes an effort at communicating the experience of pain in poetry—just as she attempts to inhabit the experience of impaired vision. Dickinson's writings do not provide a solution to pain, yet they may validate the feelings of readers who also grapple with ways to express their embodied realities. In other words, Dickinson's poetry explores the elements of disability that a diagnosis cannot capture, demonstrating all that literature can teach us about the complex realities of bodily and mental experiences. Dickinson's poetry addresses the problem of pain's lack of narratability by

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[137] Literary scholars such as Elaine Scarry have observed that the lived reality of pain cannot be narrated without confusion or mistranslation. Meanwhile, disability studies scholars including Susannah B. Mintz and Martha Stoddard Holmes urge critics to look at a wider range of relationships between pain and language.

welcoming pain's contradictions, enfolding them into her poetic forms. With her poetry, she bridges the gap between bodymind pain and language without relying on diagnostic terms.

Dickinson's embrace of paradox and contradiction stands in sharp relief against assumptions about diagnosing disorders made by the professional medical field of her day. We can situate her poetry against a possibly surprising non-literary source: the American Medical Association's 1847 Code of Ethics. This Code—which set a clear standard for professional medicine previously undetermined in American health culture—makes clear that the process of diagnosing a disease and understanding the theory of disease should be a harmonious process. It reads, "There should be minds of a high order and thorough cultivation, to unravel [medicine's] mysteries and to deduce scientific order from apparently empirical confusion" (90). Dickinson's poetic experiments with bodymind states, with all its ambiguities and paradoxes, would not be thought useful in this way and may even be considered dangerous to the advancement of knowledge.[138] Her poems do the opposite of "unravel[ing] [medicine's] mysteries," instead dwelling in mystery as a source of humanistic exploration. The Code informs physicians:

> Hasty generalization, *paradox and fanciful conjectures*, repudiated at all times by *sound logic*, are open to the severest reprehension…. Among medical men…there ought to exist…a general harmony in doctrine and practice; so that neither students nor patients shall be perplexed, nor the medical community mortified by *contradictory views* of the theory of disease, if not of the means of curing it (89, my italics).

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[138] Robin Peel defends Dickinson's scientific knowledge. See *Emily Dickinson and the Hill of Scienc*e.

The assumption is that “general harmony” among “medical men” leads to a better understanding of the disorders of the human body. As a poet, Dickinson is rather less interested in “sound logic,” and demonstrates her willingness to explore what the AMA imaginatively terms “paradox and fanciful conjectures” as she scrutinizes disorderly bodily experiences. Dickinson demonstrates that pain may be difficult to narrate because it is inherently contradictory. For example, one poem suggests that “Pain – expands the Time –” and then contradicts itself by claiming, “Pain contracts – the Time –” (Fr833A). Rather than resolving this contradiction, Dickinson simply lets it inform her articulation of pain’s temporality.

While the AMA searches for the “means of curing” disease, Dickinson’s poetry does not approach symptoms with a curative end goal. It simply acknowledges symptoms such as pain without attempting to diminish, simplify, or fix. This approach opens new possibilities for thinking about pain as an important part of disabled life and causes her poems to resonate with readers in pain. For example, Cynthia Hogue relates that both she and Adrienne Rich, another Dickinson scholar and a popular poet in her own right, were diagnosed with rheumatoid arthritis. Hogue thought about Dickinson’s poetics of pain while living with pain herself, writing, “Dickinson’s words helped me to share the unsharable, to speak the unspeakable in my poems.... Words cannot comfort at a time like this, but the fact of their presence, their accompanying me through this time, was a line cast to the drowning” (MacKenzie 109-110). Hogue reminds us that while words cannot be expected to assuage real bodymind pain, Dickinson’s poems help simply by being present and providing company. As Susannah B. Mintz argues, Dickinson voices narratives of pain without evoking fear or self-pity. Poems of consolation would presumably offer a “promise of resolution or cure,” but in many poems, “Dickinson *perpetuates* pain more often than she soothes it” (Mintz 36-37, original italics). Dickinson’s poetry does not merely comfort readers experiencing pain, nor does it overvalue cure. In Dickinson's letter to her brother Austin, cited above, she shows that she is willing to *try* to translate physical pain into language through vivid similes: "May I change places, Austin? *I* don't care how sharp the pain is, not if it dart like arrows, or pierce bone and bone like the envenomed barb, I should be twice, *thrice* happy to bear it in your place," representing his pain as something that darts "like arrows" and pierces like "the envenomed barb" (L66). She asserts that she would be extremely happy to feel pain herself, in her brother's place. What she offers her brother is not pity; rather, her words provide solidarity by acknowledging that pain can be felt as something deep, sharp, and piercing.

Dickinson's writings do not provide a solution for disease, yet they may validate the feelings of readers who also grapple with ways to express pain and what we might gain from it. In "My first well Day – since many ill –" (Fr288A) Dickinson questions the nature of sickness, marveling at the ways it can change one's perspective on death and life.[139] The speaker recounts that spring was

A'blossom just – when I went in,
To take my Chance with pain –
Uncertain if myself, or He,
Should prove the strongest One.

The speaker takes her "Chance with pain," going "in"—either indoors, or inside herself—to try to discern whether her strength measures up to that of the anthropomorphized pain. After

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[139] Much of the criticism about the representation of loss in Dickinson's poetry points to her conviction that gain is derived from willed or rationalized deprivation. Richard Wilbur, for example, saw this poem as part of a dominant motif running through Emily Dickinson's poetry and through her life: that of "sumptuous destitution." To further the goal of Michael Davidson's essay about the politics of "disability gain," I add that this poem offers opportunities to contemplate illness "gain" through a contemporary disability studies lens.

communing with pain in this way, the speaker goes outside to appreciate the freshly arrived autumn, wondering:

My loss, by sickness –
Was it Loss?
Or that Ethereal Gain
One earns by measuring the Grave –
Then – measuring the Sun –

This poem does not try to take a diagnostic approach or puzzle out the nature of sickness. The term “measuring” puts the emphasis not on illness acting on the passive patient, but on what the patient actively chooses to make of the experience. Further, the poem suggests that pain and sickness are valuable. The speaker voluntarily took her “chance” with pain, asserting her agency in living with pain and suggesting that pain offers a chance for growth. Furthermore, sickness earned the speaker something positive, “Ethereal Gain,” (possibly a pun on “ether”) and gave her valuable insights about the world and what lies beyond it. Dickinson thus contemplates what one might gain from the embodied parts of disabled life.

Dickinson’s poetry explores other ways in which pain can be uttered, using figurative language to explore pain’s unnameability. The AMA’s Code of Ethics states that “medical writers and teachers” should avoid “the *utterance* of crude hypotheses, *the use of figurative language*, a straining after novelty for novelty’s sake, and the involution of old truths, for temporary effect and popularity” (89, my italics). Dickinson, meanwhile, uses figurative language to utter pain and name it:

There is a pain – so utter –
It swallows substance up –

Then covers the Abyss with Trance –
So Memory can step
Around – across – opon it –
As One within a Swoon –
Goes safely – where an open eye –
Would drop Him – Bone by Bone – (Fr515A)

Although “utter” means “absolute,” it also evokes the ways pain is “uttered”—expressed through sound as well as poetry (Mintz 37). Because “There is a pain – so utter –” is largely about the emptiness that follows pain, the poem may capture the frustration that comes with trying to “utter” pain, to attempt to speak the unspeakable. The AMA warned against “the utterance of crude hypotheses, the use of figurative language”—qualities that Dickinson’s poem embraces wholeheartedly. “Utterance” in Dickinson’s language gives shape to the image of pain as a devouring monster and unending abyss. As Mintz suggests, the pain depicted is paradoxical, for it simultaneously possesses the power to destroy and to create; pain does not merely suppress memory and destroy substance, because it also enables safe passage (36). Memory is able to “step” “Around – across – opon” a “Trance” that covers the “Abyss” that pain has left.[140] As Mintz claims, the “Swoon” seems antagonistic, as it drops someone “Bone by Bone,” and yet it also seems surprisingly renewing, as it allows one to go “safely” (36). While initially we may find the pain to be horrifying, we may also admire pain’s appetite, its powerful ability to swallow everything in its path. As Mintz suggests, this poem of pain “allows Dickinson to indulge

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[140] Helen Vendler points out that Dickinson runs the quatrains of “There is a pain – so utter –” together without a break, and “does something even more rare: she enjambs her quatrains, bridging what would normally be the white space separating two stanzas. She literally steps ‘across’ her Abyss” (231).

fantasies of an expansive self that...displays a power to ruin and renew at once" (36).[141] The poem does not eliminate the pain it describes. Ending with the image of one being dropped "Bone by Bone," it illustrates an ongoing, chronic pain. This demonstrates Dickinson's willingness to imagine and embody this unnamed, powerful, and contradictory experience.

Dickinson's poetry allows pain to remain inarticulate and undiagnosable, for it does not try to label different kinds of pain but rather acknowledges that those dealing with pain will constantly be perplexed. For example, "Pain – has an Element of Blank –" makes pain the subject of the poem to embrace the fact that pain cannot truly be known:

> Pain – has an Element of Blank –
> It cannot recollect
> When it begun – or if there were
> A time when it was not –
>
> It has no Future – but itself –
> Its Infinite contain

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[141] Marianne Noble even suggests that Dickinson's fascination with pain was as an example of masochistic desire that explores "the nature of power, eroticism, and identity" (24). She writes that "evident in Emily Dickinson's writing is a strain of masochistic expression, as the first lines of many poems ('Bind me, I still can sing'; 'Joy to have merited the pain'; 'He put the belt around my life / I heard the Buckle snap') and countless other phrases…suggest" (22). Disability scholars such as Dawn Reynolds contend that because BDSM "plays with the unstable boundary between pain and pleasure, an issue that affects many people with disabilities, particularly those living with chronic pain," acknowledging BDSM in scholarship offers an "important potential mode of personal empowerment for people with disabilities" (40). While Noble's claims may reduce Dickinson's interest in pain to predominantly erotic desire, they helpfully recognize the ways pain can be understood in positive terms and may draw attention to the ways Dickinson's poetry does not pathologize or stigmatize those who experience pain.

Its Past – enlightened to perceive
New Periods – of Pain. (Fr650)

Both beginning and ending with “Pain,” this poem represents pain as an impenetrable cycle, an infinite loop so immense that it cannot even know itself. Pain’s “Element of Blank,” renders it unknowable, and though it is “enlightened to perceive,” all it perceives are “New Periods – of Pain.” This last line—“New Periods – of Pain.”—is the only one to end with a period, a reminder of the finality we attribute to pain, even if “It has no Future – but itself –.”

The poem represents pain as fearsomely vast, yet it also indicates admiration for pain’s powerful, “Infinite” qualities. Martha Nell Smith explains her own personal connection to this poem, writing, “That she took the practically unfathomable, ameliorable, unrelievable realm of physical hurt as a poetic subject has been tender comfort in many a dark sweat of nights agonistes” (MacKenzie 115). Because Dickinson represents pain as unfathomable and does not offer easy poetic solutions for resolving or fixing it, her poetry reaches readers who understand that pain is not always relievable. While medical men such as Dr. Williams attempted to pin down the causes, natures, and names of disorders, Dickinson took time to ponder pain as a chronic and sometimes unnamable force. This gave her poetry the power to reach readers in pain and offer them care beyond the pharmaceutical, an approach that embraces rather than runs from pain’s many unknowns.

As this chapter has demonstrated, Dickinson used poetry to describe embodied experience and explore medicine’s possibilities and limitations. Dickinson’s interpretation of diagnosis as a way of knowing operates in opposition to that of her father, physician, and poetry editor—three men who experimented with diagnosis to resolve disorderly minds, eyes, and poems respectfully. Dickinson’s interest in contemporary medical practices, her curiosity about the usefulness of surgical approaches to poetry editing, and her eagerness to craft poetry that explores and sometimes perpetuates pain show us that Dickinson was deeply invested in medical ethical debates of her time and was fascinated by diagnosis and other rapidly changing medical processes.

Dickinson's poetry provides opportunities for us to consider disability without returning to models of pathologization or pity. The poems above do not promote strictly medical approaches to pain and do not promise that diagnoses or treatments will lead to resolution. Instead, her poems invite readers to see impairments and symptoms as valuable human experiences that cannot be understood through diagnostic means alone. If a symptom like pain cannot even know itself, it certainly cannot be resolved by its inclusion in a straightforward diagnosis of illness or impairment. Dickinson's use of ambiguous language to describe pain demonstrates the complex nature of symptoms that medical discourses disavow when they aim for simplicity. Although Dickinson wrote a century before the fields of disability studies and the medical humanities emerged, her writings produce knowledge about pain that moves beyond the diagnostic and sheds light on the value of humanistic approaches to bodily and mental experiences. Her poems recognize impairments and disability to be complex, embodied realities, causing the poet herself to become a powerful utterer of disabled experience.

While "medical men" attempted to pin down names of disorders, Dickinson took time to ponder pain as a chronic and sometimes unnamable force. The next chapter will consider one famous medical man—Dr. Silas Weir Mitchell—and this time show that his patient Charlotte Perkins Gilman used literature and the knowledge of a female physician, Dr. Mary Putnam Jacobi, to surpass Mitchell's confined view of women's health and possible treatments. The paradoxical desirability and danger of diagnosis is transformed into twisted representations of narrative confinement in Gilman’s literary experiments, as I will next reveal.

CHAPTER TWO

Charlotte Perkins Gilman, Undiagnosable Contradictions, and Destructive (Rest)oration

Introduction

Dr. Silas Weir Mitchell observed in an 1888 lecture on the treatment of nervous diseases
that hysteria was the most vexing of all, precisely because it manifested itself in
"infinite numbers of forms and [an] infinite variety of masquerade."
(Cynthia J. Davis, *Bodily and Narrative Forms,* 123).

It is impossible to name all the ways in which diagnosis is useful.
It propels eradication and affirms what we know about our own body-minds…
It disregards what we know about our own body-minds and leads to cure.
Diagnosis is useful, but for whom and to what ends?
(Eli Clare, *Brilliant Imperfection: Grappling with Cure,* 48, original italics).

The hashtag "No End in Sight Void," or "#NEISVoid" recently trended on Twitter. It was created by Brianne Benness, who welcomes chronically ill and disabled people to her Twitter page with the words "No DX required / All DX welcome."[142] No End in Sight generates a paradoxical "void space" for people to grapple with individual experiences as well as socio-cultural problems in medicine. People discuss frustrating and undiagnosed symptoms, debating whether to try to obtain a diagnosis. This is a difficult question for anyone who has experienced

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[142] "DX" is shorthand for diagnosis, a 20th-century abbreviation. See Benness, B. [@bennessb]. (2021, March 22). Twitter. Retrieved May 1, 2021 from https://twitter.com/bennessb?lang=en.

medical trauma and who is exhausted from trying to convince physicians of the authenticity of their symptoms.[143] People in the "void" wonder what an "end" to the story of symptoms they continuously tell would even look like. As the poem by Bettina Judd shared in the introduction states: "a diagnosis is an ending / to the idea we are not human" (82); yet without a diagnosis, people experiencing complex symptoms might feel dehumanized and invalidated. Many NEISVoid community members ask questions that also resonate with that of disability scholar Eli Clare, above: "*Diagnosis is useful, but for whom and to what ends?*"

Such questions were imperative in the late nineteenth century when feminist author Charlotte Perkins Gilman reached out to renowned neurologist Dr. Silas Weir Mitchell, himself a literary author, for his diagnosis and treatment. Gilman told Mitchell that, after giving birth to her daughter, she was experiencing "brain troubles," a phrase that strategically emphasized her biological brain, not her mind or emotion (Knight 270). Mitchell did not diagnose Gilman—as many critics say—with hysteria. In fact, he refused to diagnose Gilman at all. Gilman writes in a note: "[Mitchell] kept me a month. Found nothing the matter apparently. Sent me home with this prescription: 'Live as domestic a life as possible…Never touch pen, brush, or pencil again as long as you live'" (271). Mitchell left his patient in the dark—in the void, we might say—and yet he prescribed his renowned, dangerous "rest cure" treatment (calling for isolation, physical inaction, massage, electrical stimulation, and fattening). So, in a way he *did* diagnose Gilman, interpreting her as hysterical, even while he dismissed her concerns. There was still "no end in sight" for her confusion, but there was a sentencing.

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[143] Medical trauma is "a trauma that occurs from direct contact with the medical setting, and develops through a complex interaction between the patient, medical staff, medical environment, and the diagnostic and/or procedural experience that can have powerful psychological impacts due to the patient's unique interpretation of the event" (Hall and Hall, 19).

As discussed in the last chapter, Emily Dickinson was, like Gilman, kept from her pens when Dr. Henry Willard Williams treated her for an (possibly undiagnosed) eye condition; later on, Dr. Orvis Bigelow diagnosed Dickinson with “Nervous Prostration,” and sent her to bed “bereft of Book and Thought” (L1042). While Dickinson might not be said to have medical expertise, she crafted poems that speak to disabled knowledge that go beyond the epistemological capabilities of physicians’ “Names of Sickness.” After surviving the rest cure, Gilman famously mailed Mitchell her short story “The Yellow Wallpaper” to try to put an end to his methods. Like Dickinson, she *wrote*, physically resisting the prescription to “never touch pen, brush, or pencil” again. Her story, often studied a prime example of Gothic horror, is now famous thanks to the work of feminist scholars who, beginning in the 1970s, read Gilman’s treatment at the hands of Mitchell as paradigmatic of the patriarchal silencing of women.

This silencing was fraught in the nineteenth century, which witnessed cultural conflicts and conversations about the “epidemic” of hysteria. The label “hysterical” (often a synonym for “nervousness,” “nervous prostration” and “neurasthenia”) was, and is, paradoxical.[144] A diagnosis of hysteria was a “real” diagnosis, understood in biological terms; sometimes it was associated with problems in a woman’s uterus, but more often was attributed to any person’s nervous system.[145] However, “you are hysterical” was also a non-diagnosis—a dismissal and minimization of pain as fakery or purely emotional symptoms that are problematically feminine.

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[144] The Diagnostic and Statistical Manual no longer lists “hysteria” as a mental illness, and the diagnosis is likely to be phased out in the tenth edition of the International Classification of Diseases. However, each of these guides retains disease labels whose diagnostic criteria resemble those for “hysteria.” After Sigmund Freud publications revolutionized treatment—disorders of the “nerves” began to be thought of as disorders of the “psyche.” (Schuster 18).

[145] The term “hysteria” was coined by Hippocrates in the 5th century BC. This diagnostic label is so named because Hippocrates believed that the cause of hysteria lay in the movement of the uterus (Sigerist 2-4). By the nineteenth century, hysteria was associated more with the brain and the nervous system than the uterus.

This blanket label replaced language that might better communicate the anger that might prompt a woman (or man read as feminine, or any "invalid") to behave in ways that went against cultural and behavioral norms. Testifying to the multiformity of hysteria's forms, as in the quote above, Dr. Silas Weir Mitchell tentatively identified a class of hysterics whose symptoms register between the "charlatans" who "fake illness as a mask for selfish behavior" and "those who genuinely suffer from 'womb troubles'" (Davis 123). A third type, by Mitchell's own admission, was more difficult to categorize or dismiss: a woman might experience what he once evocatively called "'dreamed pains'—which, Mitchell sympathetically urges, 'are, to her, real enough'" (123). While Mitchell recognizes the reality of these "dreamed pains," he and many other physicians nevertheless regarded hysterics with frustration. Physicians struggled to distinguish between neurasthenia[146] and hysteria[147], and anorexia[148] and insanity. Many people seeking diagnosis emphasized the corporeal, physical, and biological—rather than mental—components

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[146] Now a discredited diagnosis and removed from the *Diagnostic and Statistical Manual of Mental Disorders* in 1980, neurasthenia was one of the most widely used diagnoses in the United States from the early 1880s through 1920. Neurasthenia is defined as "a disorder characterized by feelings of fatigue and lassitude, with vague physical symptoms such as headache, muscle pain, and subjective sensory disturbances, originally attributed to weakness or exhaustion of the nerves and later considered a form of neurotic disorder" (oed.com). These conditions (neurasthenia, hysteria, anorexia) were intertwined while the medical community struggled to define [neurasthenia's] diagnostic boundaries" (Schuster 5).

[147] In the nineteenth century, hysteria complicated the process of diagnosis because of its "clinical fluidity… [and its] unsurpassed ability to assume the physical form of other diseases" (Micale 22). Also removed from the DSM, hysteria has been replaced somewhat by "conversion disorder functional neurologic disorder," defined as when a person experiences neurological symptoms not attributable to any medical condition. Women are also two to three times more likely to receive a diagnosis of conversion disorder than men (Stone et al.).

[148] William Gull argued for a connection between self-starvation and underlying psychological problems. Gull, who created the diagnosis of anorexia nervosa in 1873, believed that the refusal to eat was "a central rather than a peripheral condition" in this category of patients, and he insisted that this want of appetite was "due to a morbid mental state" (516).

of their experience.[149] Patients had good reason to do this; by the 1890s, asylums were crowded with patients who were imprisoned without much evidence of insanity, and the insane were discriminated against by alienists—what we might today refer to as "saneist" discrimination.[150] Hysteria patients were often women with chronic conditions, who presented with paralysis or blindness for which there were no apparent physical causes. Today, their symptoms might point to any number of illnesses including depression, post-partum depression, anorexia, schizophrenia, anxiety, and nerve damage (Poirier 16). It almost strains credulity today to think of people suffering together in an insane asylum for these ailments.

In nineteenth-century literature, the "voids" of knowledge created by these "vexing" disorders (to use Mitchell's phrase, quoted above) and by "No DX" were filled by questions, contradictions, phantoms, mysteries, stories of symptoms that come and go—narratives of *unreliability* and *undiagnosability,* as I will argue. I will also explore the concept of the messiness of undiagnosed conditions, reading Tobin Siebers' understanding of "Complex Embodiment"— the enmeshment of the social and the embodied within disabled experience. By thinking about how complex embodiment is not just complex but is also messy, we can even

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[149] Anorexia's relation to insanity further baffled physicians; there was a split among physicians, such as William Stout Chipley, chief medical officer of the Eastern Lunatic Asylum of Kentucky, who viewed it as attributable to a craving for attention, and others who saw it as a contributing factor to what was undeniably a clear-cut case of insanity (van Deth and Vandereycken, 398, 391; Kelly).

[150] Saneism is visible in even contemporary criticism of Gilman's story, which worries about the ways Gilman depicts and even spreads insanity. PhebeAnn Wolframe outlines several examples of saneism, and defines the circular logic behind the term, "psychiatrized": a phenomenon that begins when those who have been diagnosed with a mental illness or who have merely received psychological treatment speak out against psychiatric oppression. This act is itself taken by the sane, or non-psychiatrized, as evidence of the patient's illness, because the patient obviously lacks the sanity or insight to recognize the symptoms of her own disease. This privilege, afforded the sane but denied to the psychiatrized, operates in Gilman's "The Yellow Wallpaper." See "The Madwoman in the Academy" (2012).

more explicitly ponder the impossibility of understanding symptoms, resisting patriarchal medicine, and destroying treatment. These are some of many aspects of disabled and chronically ill life that fundamentally defy simplicity and organization, yet fuel collective resistance, and which Gilman explores with openness.

The chapter brings a disability studies lens to short stories: first, Dr. Silas Weir Mitchell's "Autobiography of a Quack" (1867) and "The Case of George Dedlow: Told by Himself" (1866), and then, much more substantially, Gilman's "The Yellow Wallpaper" (1892). I begin with Mitchell's Civil War-era works and writings—not to prioritize Mitchell over his female patient, but to work chronologically from the 1860s-1890s. Mitchell began studying nervousness during the Civil War when men began showing numerous symptoms of neuralgia after amputation and mental illness caused by trauma. Mitchell's short stories help us to better understand his role in using literature and medical case studies to craft diagnostic categories; they also expose his hatred of fakery and unreliable patient narratives, even as he created narrators that might be called unreliable. I then offer a full history of Gilman's correspondence with Mitchell that goes beyond past readings depicting Gilman as a passive patient, as little more than a victim of Mitchell's ministrations. Significantly, I bring in Dr. Mary Putnam Jacobi, the female doctor Gilman connected with after she essentially fired Mitchell. Few scholars discuss Dr. Jacobi in any tangible way, possibly because her existence frustrates the narrative that Gilman "beat" medicine and turned decidedly away from treatments like electrical stimulation. Finally, I devote full attention to Gilman's "The Yellow Wallpaper," and analyze the readers' diagnostic urge, and also the narrative *rebuttal* to diagnosis that can be read in its pages.

While most scholarship treats Mitchell (pretty fairly) as a villain in feminist history, I show that in many ways, Mitchell and Gilman's *texts* have much in common. They both shed light on disabled life and also condemn disability (including madness) as unknowable and unreliable states of being, problematically representing them as fates worse than death. Their texts reveal fascination with malingering (when people faked symptoms to dodge the Civil War draft), seemingly unbelievable symptoms (such as pain in an amputated limb), and the possibility that *hysteria* (often understood as pure emotion and fakery) could produce real embodied symptoms. I focus on key theories from disability scholarship and the health humanities: first, *unreliability*; specifically, the bodymind violence that occurs when physicians who do not or will not believe (women's) self-reported symptoms.[151] I then assert that *undiagnosability*, a strategic, frustrating, and sometimes tragic state of being, is best understood through close readings of winding, confusing narratives that refuse to resolve that confusion. The chapter also deals with *cure* extensively, expanding on the notion that *diagnosis is an ending* and *cure the final sentence*.

The chapter, like the whole dissertation, draws heavily upon disability studies and crip theory. Crip theory expands disability studies by "including within disability communities those who lack a 'proper' (read: medically acceptable, doctor-provided, and insurer approved) diagnosis for their symptoms" (Kafer 18). While other approaches might more uncritically accept common ableist beliefs, these fields challenge ableism outright and often contradict the assumption that medicine is fundamentally beneficial. I point to literary disability scholar Anna Mollow, who, in "Criphystemologies: What Disability Theory Needs to Know about Hysteria," a study of Sigmund Freud's writings about his patient Dora, argues that the cultural construction of "hysteria" is a crucial factor in the oppression of people with impairments that are neither visible

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[151] Health humanists (with and without clear stakes in disability studies) study notions of patient unreliability to demonstrate physician bias. See Jarmila Mildorf, "Unreliability in Patient Narratives: From Clinical Assessment to Narrative Practice" and Johanna Shapiro, "Illness Narratives: Reliability, Authenticity and the Empathic Witness."

nor definitively measurable by modern Western medical technologies. She introduces the term "criphystemologies" to reference epistemologies that validate the lived experiences of disabled people without diagnoses.[152] Mollow's reading is significant, for while feminist theorists have sharply criticized Freud's misogyny, the ableism that "undergirds the Freudian concept of hysteria is seldom contested, and indeed is often reinforced, by these feminist scholars" (191).[153] Here I expand Mollow's study, which finally, necessarily moves hysteria into the realm of disability scholars, who are skilled at critiquing ableism.

This dissertation reads select nineteenth-century texts through the lens of disability theory, which teaches us about disability as a lived experience and as a product of social and cultural norms. Neither Mitchell nor Gilman are, biographically speaking, *easy* to present as disability theorists. Mitchell created the rest cure, and the damage it has done to women is irrefutable.[154] Such "cures" brought to hysteria and neurasthenia in the nineteenth century were actually experimental treatments that often harmed the people they were supposed to help. Disability scholarship troubles linear diagnosis-to-cure narratives (through the concept of "crip time" for example).[155] Diagnosis (not just misdiagnosis) and consequential efforts at cure are

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[152] In "Criphystemologies: What Disability Theory Needs to Know about Hysteria," Anna Mollow theorizes what she calls "undocumented disabilities," which result from impairments that are "invisible" (i.e., unapparent to the casual observer) and not definitively measurable by mainstream Western medical technologies. Her heuristic distinction between "undocumented" and "documented" disability marks an unstable process, not a static binary (185).

[153] For example, Elaine Showalter has likened what she calls "hysterical illnesses," such as chronic fatigue immune dysfunction syndrome and Gulf War Syndrome, to fantasies of alien abduction (124, 128–29) (Mollow 191).

[154] See Lindsey Grubbs for more on Mitchell's rest cure and its fatalities. The rest cure is described Mitchell's book in *Fat and Blood: The Treatment of Certain Forms of Neurasthenia and Hysteria,* first published in 1877. This chapter cites an edition of *Fat and Blood* published in 1899.

[155] Crip Time is a concept arising from disabled experience that addresses the ways that disabled/chronically ill and neurodivergent people experience time (and space) differently than

lifesaving necessities,[156] and yet they *always* exist in relationship to destruction and violence. Cure is generally depicted positively, as a "restoration of health" and a return to a "better" state of being; however, cure is "laced with violence, which [prompts] resistance, which in turn [is] met with more violence, all of it sustained by diagnosis" (Clare 42; 47). Cure seems triumphant, yet the term often signifies an unrealized, impossible, even violent fantasy of able-bodiedness.[157] Eli Clare argues that "cure requires damage, locating the harm entirely within individual human body-minds…it grounds itself in an original state of being, relying on a belief that what existed *before* is superior to what exists *currently*" (15, original italics). Though Mitchell sent women like Gilman indoors to bed when they displayed symptoms of nervousness, he sent several men he treated—including Walt Whitman and Theodore Roosevelt—outdoors, urging them to travel and hunt. Mitchell's "rest" and "go West" treatments, as they are sometimes called, reinforced "proper" gendered behavior, serving to masculinize men and discourage women from entering professions.[158] Mitchell's cures signify that he believed that what existed *before*—a world of women who remained in the home and did not perform intellectual labor—was superior to a world of working women.

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able-bodyminded folk. In her essay on Crip Time, Ellen Samuels quotes her friend Alison Kafer, who defines crip time: "rather than bend disabled bodies and minds to meet the clock, crip time bends the clock to meet disabled bodies and minds" (*Feminist, Queer, Crip* 27).

[156] See Tobin Siebers' *Disability Theory*, which analyzes the tension between the "social model" of disability and the material details of impairment, and Alison Kafer's *Feminist, Queer, Crip*.

[157] This may bring to mind the concept of the "normate"—Rosemarie Garland-Thomson's term for the fantasy image of perfect bodily health, beauty, and functioning. See *Extraordinary Bodies.* The concept of compulsory heterosexuality will also come up in this chapter. In Robert McRuer's terms, compulsory heterosexuality "is intertwined with compulsory able-bodiedness; both systems work to (re)produce the able body and heterosexuality…able-bodied heterosexuality's hegemony is always in danger of being disrupted" (97).

[158] The "Rest Cure" for women is notorious; but the "West Cure" for men, though little known today, is a fundamental part of American mythology. See Matthew Wills, "Go West, You Nervous Men."

As I will demonstrate in readings of Mitchell's Civil War-era stories, Mitchell shows thoughtfulness and sensitivity towards people with nervous conditions—but Mitchell typically thinks of only *white men* as whole persons, whose wholeness has been challenged by disability after they fought in the war. Mitchell empathized with these men in nonfiction and fiction alike. After empathizing with disabled men, though, he often takes a patronizing view and begins to express the belief that death is better than incurable disability. "George Dedlow" is an especially important work for those interested in the literary medical humanities, for Mitchell makes a serious attempt to articulate the pain of the first-person narrator, George Dedlow. Significantly, Mitchell uses the structure of a medical case study to define, and educate readers about, a diagnostic category he invented: phantom limb syndrome. "George Dedlow" builds medical knowledge, rendering Dedlow's authority as trustworthy. However, At the end of the story, Dedlow participates in a séance and is temporarily reunited with his "lower half." After staggering on his phantom limbs, Dedlow collapses, and reveals that he eagerly awaits death. In this way, the story paints Dedlow's narrative as unreliable by implying that a physician-turned-patient narrative will involve, at its end, a desperate, ridiculous search for repair. The final, absurd séance scene practically mocks its readers for taking the rest of the "case study" seriously, and hints that disabled people in pain will do *anything* to end their stories, so to speak. I thus read Mitchell's short stories from the 1860s to consider the ways he explored physician authority, challenged quacks and non-American Medical Association-certified medical practices, and attempted to empathize with patients in pain.

Gilman's writings can also be difficult to read as contributions to disability theory; she was a feminist, one with many white supremacist views,[159] who also internalized ableist beliefs. She characterized disabled people as useless "invalids," and advocated for eugenics and euthanasia (Knight 168). In a lecture, Gilman claimed that for an individual who construes writing as "the relieving of himself," it is "as much his business to stop producing—to cease to express himself—as for the consumptive to forbear marrying."[160] This suggests that neither ill people nor people who write for themselves ("relieving" themselves, too incontinent to hold back their urine) should not reproduce. This is a bold, even shocking statement, coming from a woman who routinely wrote for herself in her journal.

Gilman fully embraced her eugenic beliefs; when she was diagnosed with incurable breast cancer in 1932, she completed suicide. Her suicide note explained her actions: "Believing this open choice to be of social service in promoting wiser views on this question, I have preferred chloroform to cancer" (*Living* 333-34).[161] She fully embraced the euthanasia she had long asserted should be made readily available to ill and disabled people. One possible reading of the ending of "The Yellow Wallpaper" is that the narrator dies at the end: she "suddenly commit[s] suicide" (648) by hanging herself (with a "well-hidden rope" mentioned in passing (656), and then she haunts the house. This possible interpretation especially calls for a greater understanding of suicide and eugenics from a disability-studies standpoint than has previously been brought to the text. In light of all this, Gilman should not be rendered a simple symbol for

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[159] See Knight, Denise D. "Charlotte Perkins Gilman and the Shadow of Racism." *American Literary Realism*, vol. 32, no. 2, 2000, pp. 159–69.

[160] "Art for Art's Sake," 16, 34, Folder 171, Gilman Papers.

[161] For more on Gilman's cancer and death, see Denise D. Knight, "The Dying of Charlotte Perkins Gilman."

feminist resistance of patriarchal medicine (as many undergraduates learn when studying her story). Her views on disability and race, and her own lived experiences, are complicated, unruly, and do not fit neat argumentative boxes—in keeping with the messiness that characterizes the complicated and diverse field of disability studies today.[162]

Many feminist scholars treat Mitchell as villain and Gilman as hero, one who triumphed over personal limitations (sickness) and larger social problems (the patriarchy's construction of hysteria).[163] My close readings of "The Yellow Wallpaper" revise past scholarship that relies on an "overcoming" disability narrative,[164] one that attempts to resolve the story's mysteries by revising the story into language fit for sane readers.[165] The story is a fictional account of an ill, young, unnamed wife and mother whose physician-husband John takes her to the country to recuperate. The narrator is put on the rest cure, and Mitchell is referenced explicitly. The story is cast as a series of the female protagonist's diary entries—which she writes disobediently, since John has forbidden her from holding a pen. She asks her diary in desperation, "If a physician of high standing, and one's own husband, assures friends and relatives that there is really nothing

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[162] Descriptions of disability studies and access as "messy" abound; see, for example, Akemi Nishida's *Just Care*: *Messy Entanglements of Disability, Dependency, and Desire.*

[163] For scholars who present Gilman's text as a feminist triumph, see: Wai Chi Dimock, "Feminism, New Historicism, and the Reader," and Mary Jacobus, "An Unnecessary Maze of Sign Reading." Sandra Gilbert and Susan Gubar, *The Madwoman in the Attic* (89-92); Annette Kolodny, "A Map for Rereading" (451-67); and Jean E. Kennard, "Convention Coverage or How to Read Your Own Life" (168).

[164] The overcoming narrative of disability is the idea that someone must *overcome* the disability that "holds them back" in order to achieve "success" as a normative body. See more definitions in Brenda Jo Brueggemann's "Articulating Betweenity: Literacy, Language, Identity, and Technology in the Deaf/Hard-of-Hearing Collection."

[165] Some exceptions include PhebeAnn Marjory Wolframe's "The Madwoman in the Academy, or, Revealing the Invisible Straightjacket" and Kellie Herson's "Transgression, Embodiment, and Gendered Madness." Some scholars have begun to point out Gilman's eugenicist beliefs; for example, see Sharon Lamp's "It Is for The Mother."

the matter with one but temporary nervous depression—a slight hysterical tendency—what is one to do?" (Gilman 648). Insistent that she is ill (but with something more than a "slight hysterical tendency," a diagnosis which she finds unsatisfactory) the narrator hints at a question that dominates the text. "What is one to do" about diagnosis, its corporeal consequences, its lived reality inscribed on flesh and paper? Gilman's narrator grows preoccupied with the wallpaper in her sickroom, hinting that confinement within the house itself is the root cause of her sickness. Of the wallpaper, the narrator writes: "It is dull enough to confuse the eye in following, pronounced enough to constantly irritate, and provoke study, and when you follow the lame, uncertain curves for a little distance they suddenly commit suicide—plunge off at outrageous angles, destroy themselves in unheard-of contradictions" (648). She practices diagnostic methods of looking, searching, interpreting, and reading paper, as she uses her diary's paper to protest her husband's diagnosis and prescription. Both narrator and the narrative become increasingly unhinged, and the narrative ends with the woman crawling over the body of her swooning husband.

The labels "hysterical" and "nervous" came with real body and mind-altering treatments and, for some privileged patients, with life changes we might consider early "accommodations"; for Gilman's narrator, her "accommodations" (in every sense of the word) are clearly *unreasonable,* both because the narrator is made to rest beyond her needs and because she slowly loses her reason.[166] John's prescription of the rest cure makes clear the violence that can accompany restoration. In Eli Clare's framing, cure is a form of restoration that requires elimination and enforced regression (27). Gilman's narrator is prescribed rest—a seemingly

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[166] Under Title I of the Americans with Disabilities Act (ADA)," a reasonable accommodation" is an adjustment made in a system to accommodate or make fair the same system for an individual based on a proven need.

nonviolent, “restorative” prescription (or accommodation). The story emphasizes matters of maternal heritage and health, criticizing the inept physician-husband who made that prescription. Rest destroys the narrator’s control, and leads her to fantasize about a different kind of restoration— one that that would allow her to completely wreck the home that accommodates her.

Restoration—the destruction of an actual home—is then performed literally, for the narrator fights her physician-husband in “ancestral halls,” in a home described as “haunted” in the story’s first paragraph: “A colonial mansion, a hereditary estate, I would say a haunted house, and reach the height of romantic felicity—but that would be asking too much of fate! Still I will proudly declare that there is something queer about it” (Gilman 648). The narrator later thinks “seriously of burning the house” and rips at the wallpaper (654). As Clare argued, diagnosis and cure always involve targeting an object that might be, ideally, destroyed. I find that Gilman’s story suggests that sometimes destruction is necessary to tear down (in this case, literally institutional) systems. In the end, we are left with a torn-up “hereditary estate”—a phrase that signals the hereditary nature of the narrator’s madness, hinting that though the room is wrecked, and even if she is dead, her condition will be passed on, *not* eradicated (648).

With these possible interpretations, I continue to explore methods of reading. “The Yellow Wallpaper” has often been read as an example of a feminist take on patriarchal medicine. As Thrailkill argues, some scholars try to resolve ambiguities in Gilman’s text by practicing diagnostic-esque methods of interpretation. Like Thrailkill, I critique those who perpetuate a diagnostic gaze. My reading of Gilman’s text might nevertheless be considered “diagnostic,” since I engage with specific details in the texts that might shed more understanding on these author’s views of diagnosis, treatment, and cure. Diagnosis is a helpful form of knowledge production, after all. However, I try to differentiate between literal medical diagnosis and vaguely diagnostic-like interpretations, performed without critical disability studies in mind, that are steeped in discriminatory beliefs about disability and illness. This latter reading method neglects to attend to the ways Gilman's story is steeped in the contemporaneous belief that disability is a fate worse than death and can only be fixed in death.

I also continue the argument of Martha J. Cutter, who makes clear the value of Gilman's story for the subject of diagnosis. According to Cutter, Gilman

> formulates a model of medical discourse that goes beyond many of the practices of her time period. In this model, medical information *circulates* between doctor and patient and between reader and writer, and medical authority is dispersed. Most radically, in Gilman's paradigm, diagnosis is to some degree coauthored, created by an interaction between readers/patients and authors/doctors. Doctors "read" patients—they interpret their symptoms and produce diagnoses—but patients also learn, in collaborations with their doctors and medical texts, to "read" and interpret themselves. Moreover, the processes of collaborative reading and diagnosis are meant to work within the story (intratextually) as well as outside the story (extratextually). Of course, in the world outside the story the doctor still holds a very real position of authority over diagnosis, for he or she is most empowered to treat and/or write about disease. But Gilman's fictions do illustrate a process whereby the "fictional" practices she describes can be translated to the "real" world. It is language, *logos* itself, that allows this transformation, for once patients become active intratextual and extratextual readers—readers who learn about medical and social conditions from a variety of cultural texts—they may be able to intervene in the production and formulation of diagnoses that have disempowered them. Gilman's

> writings therefore foreshadow contemporary medical research about the crucial role gender plays in medical diagnosis, the need for effective doctor-patient collaboration and coauthorship in the creation of a diagnosis and a treatment, and, above all, the importance of the patient's ability to articulate, and thereby take control of, his or her illness. (152)

Cutter explains clearly the relationships between diagnosis and reading. She expresses a common approach to Gilman's story; that it targets a problem in medicine and asserts a solution (that of effective doctor-patient collaboration). I agree with much of Cutter's argument, though I will also argue that Gilman's story makes clear that it is, to some degree, impossible for a (female) patient under heteropatriarchy to "take control of" any illness.

I further trouble the notion that the act of writing the story cured Gilman, for the author experienced depressive illnesses chronically. I suggest that Gilman's story spreads, rather than corrects, illness, and propose that contemporary readers who see the text as curative may be influenced by concepts tied to the medical model of disability. Reading against several other Gilman critics, I emphasize that there is no proof that writing eradicated Gilman's ailments and that it is crucial to remember that some impairments are undiagnosable and chronic. I also point out issues with Gilman's (probably false) claim that Mitchell stopped prescribing the rest cure after he read her story. Above, I reveal that Gilman thought people must be productive to avoid being useless invalids. This belief might explain why she characterized "The Yellow Wallpaper" as serving a utilitarian purpose. Feminist scholars have believed Gilman's claim that the story stopped Mitchell from using the rest cure, declaring that her story "diagnosed" the rest cure as a sexist problem, part of patriarchal efforts to control women and to confine them to motherhood, and then "cured" the problem by convincing Mitchell to stop using the rest cure.[167] I generally do believe the women writers I study; however, believing erroneously that Gilman somehow "cured" a patriarchal problem (when we have records that Mitchell continued to prescribe the rest cure) is wishful thinking that ignores realities of ongoing oppressions. Moreover, treating illness and disability as pure metaphors for sexism is also problematic, and fails to understand ableism as a main, valid issue that is also closely entwined with racism. Given that many scholars have read "The Yellow Wallpaper" as a story that identified, targeted, and even fixed sexism in the world of medicine, I ask how the text *works*—i.e., what does it *do* for studies of medicine, feminism, disability theory—and I ask whether its mimicry of the diagnostic act to identify systems of oppression is helpful, given the oppressive politics of diagnosis itself. How does the story rely on ableist views—like the notion that disabled people are better off dead than alive—to depict the extreme violence of social oppression?

To respond to these questions: I find that the story produces disabled knowledges and tackles ableism, even if it does not "cure it," and can be read as a narrative bent on educating readers that grapples with the full experience of illness.[168] "The Yellow Wallpaper" speaks to diagnosis's desirability, mimicking diagnostic methods to define *diagnosis* as a flawed, dangerous method of knowing. It further represents the violence of cure and perpetuates the ableist notion that only death can truly cure an "invalid." It can be read through a mad studies

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[167] For one of many feminist scholars who celebrated Gilman's triumph over Mitchell's rest cure, see Herndl, 74. Cutter also says, "Gilman later abandoned Mitchell's rest cure, published 'The Yellow Wall-Paper,' and became a successful writer and lecturer. Gilman was healed, at least partially, by becoming an active participant in the reading and writing of her own 'disease'" (151).

[168] Ann Jurecic defends studying the illness memoir in academia, asking how personal, painful accounts of confusing and frightening experiences fit into literary studies as a genre for critical examination (*Illness as Narrative*).

lens because it embodies madness—in a sense, literal anger at the failure of medical knowledge—at the level of form.

Further, the story teaches us about the urge and appetite for diagnosis and reminds us of the dangers of that appetite. Literary disability scholar Margaret Price analyzes autobiographical narratives written by persons with psychosocial disabilities, arguing "that such narratives can refigure conventional assumptions of autobiography through a strategy designated *counter-diagnosis*" (11). She combines disability studies with critical discourse analysis, close reading narratives' uses of pronouns to highlight what she calls "counter-diagnostic strategies" (21). When analyzing Lauren Slater's book *Lying*, which depicts the author's imitation of epilepsy symptoms while she struggled to be diagnosed for an unknown disorder, Price writes:

> I am tempted to read this case study as a kind of kernel of truth…however, this impulse in itself is the diagnostic urge, the desire to figure out what is really wrong with Lauren. And that is precisely the counter-diagnostic strategy of *Lying*: it dangles an illusory promise of truth before its reader, and calls our attention once again to the appetite for diagnosis (27).

Price is grappling with the same problem that I have: that when doing work in disability studies, the urge to diagnose is very real. This verification of a label would justify the use of a disability studies lens. However, this also draws attention to the fact that disability studies can and must be inclusive of disability defined very broadly, and without the restrictive confines of medically-enforced "Names of Sickness."

Price concludes that "we must pay attention to the problems that have characterized much disability autobiography, recognition of these narratives' creatively disruptive strategies can lead us toward a context in which all of us—psychosocially disabled or not—can better tell our stories on our own terms” (18). Similarly, in my reading, “The Yellow Wallpaper” performs counter-diagnosis and tries to escape the whirlpool of diagnosis in which the narrative is trapped. The story creates a sort of analytical or over-analytical paralysis, a self-defeating constancy of mirrored reflection caused by, we might say, over-diagnosis. The ambiguity and possible death at the end of the story—the narrative’s “creatively disruptive strategies” to use Price’s phrase—signal Gilman’s internalized ableism and saneism as well as her very legitimate understanding of the ways disability is rendered delegitimate.

Just as today people seek diagnoses to find answers to their confusing, agonizing, and stress-inducing symptoms, people in the nineteenth century turned to medical authorities to better understand the complex nervous systems that seemed to be at the root of so many debilitating disorders. Yet physicians used their knowledge about disorders to prescribe expensive treatments and bring about social control. These issues are all tangled in Mitchell’s and Gilman’s texts, the plot of which twist and turn in unheard-of contradictions. Literary analysis offers opportunity for us to grapple with those ambiguous parts of disabled experience that surpass the limited scope and oppressive power of medical frameworks.

Phantom Limbs: Imagining Disabled Life with Silas Weir Mitchell

> "Good gracious!" said I, "they are my legs! my legs!" What followed, I ask no one to believe except those who, like myself, have communed with the beings of another sphere. Suddenly I felt a strange return of my self-consciousness. I was re-individualized, so to speak…Presently, however, I felt myself sinking slowly…All that was left of me fainted and rolled over senseless.
>
> ~ "The Case of George Dedlow" (Silas Weir Mitchell, 1866, 108)
>
> As the current affected the brachial plexus of nerves, [the patient] suddenly cried aloud, "Oh, the hand, the hand!" and attempted to seize the missing member. The phantom I had conjured up swiftly disappeared, but no spirit could have more amazed the man, so real did it seem. Very many have a constant sense of the existence of the limb, a consciousness even more intense than exists for the remaining member.
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> ~*Injuries of the Nerves* (Silas Weir Mitchell, 1872, 349)

I open here with the writings of Dr. Silas Weir Mitchell, whose experiments with literature and nonfiction medical writings informed and shaped each other. As a 37-year-old neurologist, his "The Case of George Dedlow, Told by Himself," quoted above, was published anonymously, and its depiction of "phantom limbs" as literal phantoms was supposedly interpreted as true by some readers. Afterwards, Mitchell published a popular article in Lippincott's magazine entitled "Phantom Limbs" (1871). In it, he called back to his own fictional story to explain a real medical phenomenon. The following year, he published *Injuries of Nerves and Their Consequences* to share his findings with the medical community. Mitchell's nonfiction medical texts are full of literary references, dialogue, and poetry quotes, embracing literature in a way that helps them explore medical phenomena and to reach a broader audience. For example, in the quote above from "George Dedlow," Dedlow suddenly feels reunited with the ghosts of his amputated legs; likewise, in *Injuries*, a man suddenly feels the presence of his lost hand. In both quotes, Mitchell writes, "My legs my legs!" and, "the hand, the hand!" representing lost body parts as phantoms. Narrator George Dedlow assumes no one will believe a medium's reconnection of his torso with his lost legs, "except those who, like myself, have communed with the beings of another sphere" (108). In the second quote, from *Injuries,* Mitchell does ask the readers to believe the medical phenomenon: "The phantom I had conjured up swiftly disappeared, but no spirit could have more amazed the man, so real did it seem" (349). He inserts himself as the medium who "conjured" the phantom and establishes his own authority and authenticity, even as he plays with fantastical modes of embodied representation.

Mitchell, often considered the "father" of neurology, was indeed a patriarch: he wrote extensively about nervous disorders, defining "neuralgia" and "phantom limb pain," often to help male veterans.[169] Mitchell experimented with medicine in Philadelphia beginning in 1851. He published essays and gave numerous presentations to the Academy of Natural Science, and in 1860 he published his 145-page monograph, "Researches Upon the Venom of the Rattlesnake." In 1862, according to health humanist Nancy Cervetti, "This animal experimentation was radically transformed, however, when Mitchell became a contract surgeon in the U.S. Army and began to focus on wounded soldiers. In a nightmarish substitution, human beings replaced the animals of his earlier experiments—many of them very young men with torn flesh and shattered bones, burning pain, and phantom limbs" (69). Mitchell treated nervous cases from the twenty-five thousand army hospital beds in the Philadelphia area. He wrote in exhausted fascination:

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[169] For more of this history, see David G. Kline's "Silas Weir Mitchell and 'The Strange Case of George Dedlow.'"

"Here at one time were eighty epileptics, every kind of nerve-wound, palsies, singular choreas, and stump disorders. I sometimes wonder how we stood it…In fact, it was exciting in its constancy of novel interest… That hospital was, as one poor fellow said, a hell of pain ("Medical Department" 1449). The excitement, interest, and fascination soon flickered out in this hell. Mitchell became exhausted and resigned in 1864. He remained productive as a writer: a year after publishing "The Case of George Dedlow," he published *Injuries to Nerves and Their Treatment* in 1872. According to Cervetti, in 1864, Mitchell co-authored important works on malingering including "On Malingering, Especially in Regard to Simulation of Diseases of the Nervous System." He also wrote *Gunshot Wounds and Other Injuries of Nerves*, a work that "soon became the authority on nerve injuries, containing the first distinct descriptions of phantom limbs, ascending neuritis, and burning pain or causalgia and discussing various methods of treatment" (Cervetti 69). An expert on pain, Mitchell displayed fascination with the ways pain is imagined and even faked.

After treating numerous men who experienced symptoms of neuralgia during the American Civil War, Dr. Silas Weir Mitchell published short stories that help us to better understand the role literature plays in crafting diagnostic categories. My argument brings a disability studies and medical humanities lens to two stories: first, Mitchell's "Autobiography of a Quack" (1867) then "The Case of George Dedlow: Told by Himself" (1866). Mitchell's stories expose his underlying hatred of medical quacks and unreliable patient narratives, even as Mitchell himself created narrators that might be called unreliable. The question remains: how does literature—especially that written by a physician like Mitchell—represent discourses surrounding medicine, health, and disability? In this chapter, I explore nineteenth-century literary texts by this physician-author that are filled by questions, contradictions, phantoms, and mysteries to demonstrate that physicians used literature to explore unknown and even unknowable states of embodied existence.

Mitchell's Civil War-era stories demonstrate his thoughtfulness towards specifically white male veterans with disabling nervous conditions, as he empathizes with these men in nonfiction and fiction alike. After initially empathizing with disabled men, though, he often takes a patronizing view and begins to express the belief that death is better than incurable disability. I first briefly explore Mitchell's "Autobiography of a Quack," which parodies "quack" physicians while also representing blackness and disability as punishments for medical fakery. I turn to Mitchell's "George Dedlow," a fictional, first-person short story that masquerades as factual, in which Dedlow struggles to come to terms with life as an amputee after serving as a physician in the Civil War. While I explore these stories, I draw mainly upon medical humanists like Sari Altschuler, who explores what she calls the "disparate" experiences of pain offered in "The Case of George Dedlow" in her book *The Medical Imagination* (188) and Nancy Cervetti, who also suggests the uniquely radical nature of pain's articulation in "George Dedlow." I also turn to feminist disability scholars such as Susan Wendell, who asserts that "our understanding of pain can be greatly enriched by experiences of chronic pain," a pain that "promises to go on indefinitely" and "unpredictably" (1996, 171). Developing these scholars' projects, I read Mitchell's texts through a directly assertive disabilities studies lens, which challenges normative assumptions about the impossibility or tragedy of living with pain.

I look next to Mitchell's short stories from the 1860s to consider the ways he explored physician authority, challenged quacks and non-American Medical Association-certified medical practices, and attempted to empathize with patients. That Mitchell himself experienced depression is a meaningful observation. So, too, is the fact that he wrote while contemplating the boundaries of the human, a category he imagined as non-animal, white, male, able-bodied and able-minded, and free.[170]

Gilman and Her Contemporaries

Quacks and Malingerers and Phantoms of Pain: Whiteness and Disability in Mitchell's Literary Imagination

Mitchell's writings reveal an interest in distancing whiteness from blackness, and in fakery, malingering, and the thin line he saw between nerve injury and hysteria. His story "The Autobiography of a Quack," first published anonymously in the *Atlantic Monthly* in October and November 1867, was a cleverly constructed satire that incorporated a realistic account of the methods used by a dishonest physician. According to Arthur Hobson Quinn, the story is useful for scholars of the history of medicine because of the specific remedies charlatans foisted upon a gullible public (Quinn 306). The story begins with a claim to autobiographical authenticity: narrator Ezra Sanderaft begins to write his autobiography while he is ill in a hospital. He explains that he was medical quack who harmed patients with cleverly-invented homeopathic and spiritual remedies. Eventually, Sanderaft complains that he was "now in the midst of a most absurd war with the South" (Mitchell 1905, 68)—an inconvenience to his get-rich-quick schemes. Sanderaft tried to dodge the Union draft by faking disability of the nerves (epilepsy); however, he was caught, imprisoned for his crimes, freed, and then became disabled. He is punished for his sins not just with a deadly illness, but also with a "dark mulatto tint" caused by his Addison's disease (3). Finally Sanderaft dies, and some ghostly spirit apparently finishes writing his story down. Unlike "George Dedlow," Mitchell never claimed that "Autobiography"

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[170] I write about Mitchell's study of rattlesnakes, venom, and antidotes—which he performed to make Western settlement (in other words, the seizing of Native lands) easier—in my article "Rattlesnake Kinship: Disability, Indigeneity, Animality" in *Disability Studies Quarterly* (2021).

was ever interpreted as factual by readers. Yet like "George Dedlow," the tale could, in theory, be read as true, up until its very end when the story takes a supernatural turn. In this way, the story practices a sort of masquerade, much like the malingering it critiques.

From the first moment of the story, Sanderaft represents anxiety over blackness and an urge to medically distance himself from both blackness and disorder alike.

> At this present moment of time I am what the doctors call an interesting case, and am to be found in bed No. 10, Ward 11, Massachusetts General Hospital. I am told that I have what is called Addison's disease, and that it is this pleasing malady which causes me to be covered with large blotches of a dark mulatto tint. (3)

Mitchell sets up the story with clear details, both temporal ("at this present moment of time") and specifically geographical (in bed "No. 10, Ward 11, Massachusetts General Hospital"). These establish the story as potentially written by one of many real, injured veterans. The narrator represents his doctor—and his methods of examination—with great skepticism; as we later learn, he distrusts doctors, having been a quack himself. He emphasizes his skepticism by pointing to the doctors' use of language: "I am what the doctors call an interesting case"; "I am told that I have what is called Addison's disease." Privileging the "I," these phrases cast doubt on the doctors' phrases; "I am told," for example, hints at Sanderaft's suspicion.

Sanderaft then notes that his condition "is a rather grim subject to joke about, because, if I believed the doctor who…thumps me, and listens to my chest with as much pleasure as if I were music all through—I say, if I really believed him, I should suppose I was going to die" (3). He suggests he might not believe the doctor who thumps and listens to the "music" of Sanderaft's prone body. This phrase, in which Sanderaft creatively imagines himself to be an object, a drum that the doctor thumps, is reminiscent of the auscultation and Civil War medical examinations discussed in Chapter 1. This innovative auscultation practice seems to be off-putting for the narrator of Mitchell's tale, who feels that the doctor is enjoying the work. Repeating the words "believe" and "I" often, the narrator asserts his own knowledge over the doctors: "I say, if I really believed him, I should suppose I was going to die. The fact is, I don't believe him at all." Yet Sanderaft's fearful uncertainty is palpable in these repetitions. Much of Sanderaft's fear might stem from the nature of his illness. Of Sanderaft's symptoms, we learn: "It is rather dull for a stirring, active person like me to have to lie still and watch myself getting big brown and yellow spots all over me, like a map that has taken to growing" (3). This "map" of brown and yellow evokes a Civil War battle map, and suggests Sanderaft's (and maybe Mitchell's) concern about miscegenation, blackness, and war.

The story engages a sustained, funny critique of Sanderaft's past; while I will not detail this past too thoroughly, here, it is worth noting Mitchell's scathing depiction of Sanderaft's quack remedies, his thefts, and his interest in the shady patent business that crafted fake treatments, mostly for neurasthenics. Towards the end of the story, Sanderaft grows desperate for funds as the Civil War begins, and so Mitchell puts his immoral nature on greater display. He decides to help a rebel sea-captain purchase "quinine, chloroform, and other medical requirements for the Confederates"; however, he is thwarted by the captain, who steals the goods (70). Sanderaft reflects, defensively: "It was a promising investment, and I am free to reflect that in this, as in some other things, I have been free from vulgar prejudices" (70). Hardly "free" of prejudices, given his uncritical gaze towards the Confederate agenda, Sanderaft took actions which undoubtedly resulted in an economic benefit for a Confederate captain. Mitchell characterizes Sanderaft as a "quack" physician, but is quick to also associate this medical school dropout as immoral due to his refusal to condemn slavery or the Confederate army.

The story then engages a sustained, funny critique of Sanderaft's past: his quack remedies, his thefts, his interest in the shady patent business that crafted fake treatments, mostly for neurasthenics. Sanderaft uses his shaky medical knowledge to keep evade service in the war he thus influenced. He entered the army three times and deserted with the bounty. He was at last forwarded to the front and so he began to feign epilepsy: "I found it necessary to perform fits about twice a week, and as there were several real epileptics in the ward, I had a capital chance of studying their symptoms, which, finally, I learned to imitate with the utmost cleverness" (73).[171] Sanderaft's skill at *studying* symptoms thus translates into skill at *performing* symptoms. Yet then there was a problem: a new surgeon who had "a way of looking at you without saying much" caught malingerers in the act. This surgeon's diagnostic skill obliterated Sanderaft's charade. While faking an epileptic fit, Sanderaft "felt a finger on my eyelid, and as it was raised, saw the surgeon standing beside me. To escape his scrutiny I became more violent in my motions" (76). After performing this invasive scrutiny, the surgeon tricked him into revealing his fakery, and Sanderaft was sent to jail, rather than the battlefield. When the war was over, he was released and thus did escape the dangers of soldiering.

Yet then, Sanderaft's true punishment—disability and blackness—is revealed, and he is imprisoned in a hospital until his death. He describes how he "first began to feel a strange sense of lassitude, which soon increased so as quite to disable me from work of any kind…After nearly a year had elapsed, I perceived on my face a large brown patch of color" (77). Here the word "disable" appears in its nineteenth-century context (when disability decided whether a person

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[171] For more on malingering, see: WW Keen, Mitchell SW, and Morehouse GR, "On malingering, especially in regard to simulation of diseases of the nervous system." Also see Lindsey Grubbs "'A Wasted Sympathy': Undiagnosing Winifred Howells" for more on Mitchell's exploration of nerves and hysteria.

could work or fight in war or not). Sanderaft's illness manifests in a brown patch, which could be read as racist punishment (keeping him from whiteness) or as a fit punishment for refusing to support the Union. Sanderaft quickly learns what it is like to be on the receiving end of a physician's examination, prescription, diagnosis, and prognosis. He "went in some alarm to consult a well-known physician. He asked me a multitude of tiresome questions, and at last wrote off a prescription…of arsenic" (77). Here Sanderaft experiences some of the sensations that surround a new embodied experience:[172] "alarm," the physician's "multitude of tiresome questions" that accompany the narrative of finding a diagnosis; and finally, being given a prescription. Sanderaft urges the doctor to diagnose him, asking, "What do you think…is the matter with me, doctor?" (77). The doctor's diagnosis follows: "I am afraid…that you have a very serious trouble—what we call Addison's disease…an affection of the suprarenal capsules" (77). This condition, which Dr. Thomas Addison diagnosed in patients by noticing their fatigue, an appearance like a "bad wax figure," darkening skin, and other signs, required acute observation of symptoms.[173]

Sanderaft, exhausted by his own doctor, looks down on the doctor's knowledge, as he has been mimicking and mocking doctors for years. Unhappy with his prognosis, and suspicious of his doctor, Sanderaft demands to know, "what's the truth about it?" The doctor replied "gravely," a term that hints at Sanderaft's imminent demise, "I'm sorry to tell you it is a very

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[172] For more on feelings that accompany disability and diagnosis, see Ellen Samuels, *Fantasies of Identification,* and Rosemarie Garland-Thomson, *Extraordinary Bodies.*

[173] Addison's disease is one "Name of Sickness" that demonstrates how invaluable dead patients are for famous physicians. Addison's disease was named after British doctor Thomas Addison, who described the condition in 1855 (Bishop 35). He located the cause of disease by autopsying people who died from the condition, and originally gave the condition the name "melasma suprarenale," indicating the supra-renale capsules, now called the adrenal glands. But as often happens in medicine, the disease was later named after him.

dangerous malady" (78). Sanderaft asserted: "Nonsense!" said I; "I don't believe it"; for I thought it was only a doctor's trick, and one I had tried often enough myself. "Thank you," said he; "you are a very ill man, and a fool besides. Good morning" (78). Sanderaft, suspicious of doctors because he was able to imitate them so well, meets his fate with this doctor, who reads through him, calling him a "fool" while treating him with basic, if cold, decorum. Soon Sanderaft sees himself an "inmate": "My clothes were ragged, and, like my body, nearly worn out, and now I am an inmate of a hospital" (78). Thus, Mitchell crafted a text that understands a hospital to be a fitting punishment (and an ironic satirical way) for a white quack whose body is now turning brown.

The ending of the "Autobiography" takes a supernatural turn. Sanderaft has a disturbing dream about his family, whom he had previously robbed. Then Sanderaft reflects in his draft:

> I am better to-day. Writing all this stuff has amused me and, I think, done me good…I suppose I must tear up all this biography.
>
> "Hello, nurse! The little boy—boy—"
>
> "GOOD HEAVENS!" said the nurse, "he is dead! Dr. Alston said it would happen this way. The screen, quick—the screen—and let the doctor know." (79)

It is unclear who is speaking in the "Hello, nurse!" lines, and it is also unclear as to who the "little boy" refers to. What we can assume from these last lines is that Sanderaft has died, and somehow the words are transported to us from beyond the grave. I will come back to this key feature of Sanderaft's final moments—that he died, and yet continued writing his autobiography afterwards—later on, for this exact confusing impossibility of fiction also appears in Gilman's "The Yellow Wallpaper." An example of Gothic horror in Gilman's story, here it signals to readers—if they have not caught on yet—that the story is a fiction. It also serves Sanderaft justice. The screen, presumably wrapped around the dead body, also wraps around the ending of the story and Sanderaft's shenanigans.

With "Autobiography of a Quack," Mitchell tells a humorous story that criticizes quacks and experiments with what literature can do in educating the public about medicine. It warns of real, exploitative practices from the mid-nineteenth century, and further tests ways of establishing, then wrecking, any claim to autobiographical authenticity. The story proves that Mitchell was concerned with ethical medical practice. It also evokes what Ellen Samuels has called the "Fantasy of Identification"—the urge to distinguish between embodied social identities, in this case, between race and disability in the nineteenth century (Samuels 1-24). Diagnosis serves to sentence Sanderaft to his fate at the end, and the particularities of his skin-darkening condition reinforce the story's context as a piece nestled in a raging battle to try to keep whiteness, blackness, ablebodiedness, and disability separate from each other.

The short story form gave Mitchell the chance to experiment with additional ways to represent the phenomenon of pain. That Mitchell wrote "The Case of George Dedlow," to define "phantom limb" syndrome invites our appreciation of what Sari Altschuler terms "imaginative experimentation" for the production of medical knowledge.[174] In early America, doctors understood the imagination to be directly connected to health, intimately involved in healing, and central to medical discovery. According to Altschuler in her book *The Medical Imagination*,

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[174] The story has been cited by many medical and health humanists (or neurologists with an interest in literature) who excitedly reflect on Mitchell's use of fiction to explore medical knowledge. For example, see Satz, ""The conviction of its existence": Silas Weir Mitchell, phantom limbs and phantom bodies in neurology and spiritualism."; Louis, Elan D., Stacy Horn, and Lisa Anne Roth, "The neurologic content of S. Weir Mitchell's fiction."; William K. Beatty, "S. Weir Mitchell and the ghosts"; and Dee James Canale. "S. Weir Mitchell's prose and poetry on the American Civil War."

during the nineteenth century, literature provided physicians with important forms for crafting, testing, and implementing theories of health. Mitchell's medical imagination gave him a unique, even pseudo-Godlike perspective, as he sometimes flits into the consciousness of fictional patients in his literature. Mitchell came in close contact with carnage during the Civil War; he was not dismissive, as some doctors were, of the pain reported by his patients, and the story acknowledges how fully pain can affect a person's life. However, the story becomes pitying, as Mitchell asserts that the loss of a body part tragically ruins an individual and that the return of a phantom limb is the only way an amputee can be made whole again. Moreover, study of this and other stories serves as a reminder of the ways Mitchell imagined masculinity and whiteness to be normal states of being, and that medicine should endeavor to promote these states.[175]

Mitchell, in his introduction to a new edition of "The Autobiography of a Quack" and "The Case of George Dedlow: Told by Himself,'" made several bold claims:

> "The Case of George Dedlow" was not written with any intention that it should appear in print. I lent the manuscript to the Rev. Dr. Furness and forgot it.…The story was inserted as a leading article [in *Atlantic Monthly*] without my name. It was at once accepted by many as the description of a real case. Money was collected in several places to assist the unfortunate man, and benevolent persons went to the "Stump Hospital," in Philadelphia, to see the sufferer and to offer him aid. The spiritual incident at the end of the story was received with joy by the spiritualists as a valuable proof of the truth of their beliefs. (ix)

In this preface Mitchell makes a few assertions that spark concern about reliability, unreliability, and intention. Mitchell claims that he never authorized the publication of the story, and that a

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[175] For a health humanist's excellent reading of pain in "George Dedlow" see Nancy Cervetti, "S. Weir Mitchell Representing 'a hell of pain': From Civil War to Rest Cure."

friend sent it to *The Atlantic Monthly* on his behalf. Regardless of whether Mitchell intended it or not, the story was published anonymously in July 1866. His nonfiction work treats pain as a ghostly reminder of an essential part of a human's identity. Mitchell claims he wrote "George Dedlow" after having a conversation with a friend who asked, "How much of a man would have to be lost in order that he should lose any portion of his sense of individuality?" (Burr 16). Without limbs, in Mitchell's framing, a human is fractured and subjected to nervous disorders (which he links to both whiteness and femininity). Mitchell's project exemplifies the notion that literature is a valuable site for testing theories of health; that literature serves a utilitarian purpose for promoting the necessity of medicine for maintaining a "natural order"; and can be helpful when one wants to construct, perform, and carefully protect physician authority, which, as the above passage suggests, is as delicately performed as literary authority.

Mitchell saw his own pain as valuable and used the act of writing to reflect on the ways the experience of pain teaches a physician to *think*. Mitchell wrote in his nonfiction book *Doctor and Patient* that "to a physician, it is simply invaluable to have known in his own person pain, and to have been at close quarters with his constant enemy, and come off only wounded from the context" (59). This constructs a war metaphor, drawing on the image of Mitchell as a Civil War physician. It also grants Mitchell an image of authority and knowledge by signaling all that the experience of pain grants an individual. Further on, Mitchell writes about a time when he himself was ill. He does not offer a diagnosis of his own illness, but claims it was caused when a "little girl coughed in [his] face a hideous breath of membraneous decay" (68). This locates the cause of sickness in a little girl in a humorous and vivid statement. Mitchell reflects on what illness does to thought and writing: "the mental state of one on the way to health is not favorable to connected thought. It is more grateful to lie in the sun…and now and then, day after day, to jot down the thoughts that hop about one's brain like the friendly birds on the mail-clad twigs" (60). Realizing, perhaps, that his prose writing about "mail-clad twigs" seems more poetic than scientific, he continues, "I make no apology for the disconnectedness of my reflections, but turn gladly to my records of the joyous and less grave observations which the passing hours [in disease] brought me" (64). As a patient himself, Mitchell realizes that his "mental state" becomes disconnected, but not in a negative way. His hopping thoughts become expressive observations. In short story form, Mitchell then proves that thinking about pain and injury produce fantastical—even absurd—experiments with fiction.

This brings us to "The Case of George Dedlow." In the story, George Dedlow is injured while serving as assistant-surgeon for the Union. Mitchell created a character who is both a doctor who can understand medical issues, and a patient experiencing great pain. Dedlow is injured in the Civil War and wonders in his first-person "case" whether his training as a doctor will turn him into a knowledgeable patient.[176] When he was first injured, he reflected, "My wounds were properly cleansed and dressed by a Dr. Oliver Wilson, who treated me throughout with great kindness. I told him I had been a doctor; which, perhaps, may have been in part the cause of the unusual tenderness with which I was managed" (88). Dedlow thinks his medical training improves his relationship with his own doctor, making treatment easier.

However, when Dedlow comes into closer quarters with injury, he discovers that even for a doctor, articulating and healing pain does not come easily. Pain is highlighted throughout Dedlow's experiences in the war. He describes how he "screamed, cried, and yelled in my torture" after being first wounded (87). Dedlow's arm felt as if it was being "perpetually rasped

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[176] For more on the presence of phantom limbs in the story, see Debra Journet, "'Phantom Limbs and Body-Ego': S. Weir Mitchell's "George Dedlow."

with hot files." Even without anesthetic, amputation was a blessing: the "strange lightning of pain" was followed by "instant, unspeakable relief" (89). After his arm is amputated, his first thought upon looking at the limb on the floor is, "There is the pain, and here am I" (89). Subsequent wounding and gangrene infection eventually led to the amputation of his other three limbs. He became, in his words, nothing more than "a useless torso, more like some strange larval creature than anything of human shape" (94). This phrase, "strange larval creature," connects back to my own interest in Mitchell's conceptualization of human (as white, able-bodied, male) and his work killing rattlesnakes (non-human animals he interpreted as vermin, and as dangerous threats to white settlers' bodies).

I briefly discuss Mitchell's study of rattlesnakes, venom, and antidotes, which he performed to make "Western settlement"—in other words, the possession of Native lands—"a little less dangerous" (Schuster 26), in my article "Rattlesnake Kinship: Disability, Indigeneity, Animality" (2021). The article shows that white people fearfully killed the rattlesnakes indigenous to the Americas, representing the animals in terms of disability and as objects of fascination, disgust, and terror. I showed that early Euro-American settlers performed community snake-killings, killing hundreds of rattlesnakes at a time; these eliminations migrated into a laboratory when white physician Mitchell killed 150 rattlesnakes to develop a venom antidote.[177] I revealed that many "nineteenth-century white physicians incorrectly believed that rattlesnakes did not experience pain as other beings do and studied the animals as fascinating

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[177] Mitchell's experiments led to the first major scandal surrounding large-scale animal experimentation in the U.S., largely because he also killed dogs and cats. His critics often admitted that rattlesnake killings could be justified or ignored but saw dogs and cats as having subjective lives (Schuster 26). For more about early rattlesnake killings, see Whitney Barlow Robles, "The Rattlesnake and the Hibernaculum: Animals, Ignorance, and Extinction in the Early American Underworld." *The William and Mary Quarterly*, vol. 78, no. 1, (2021), pp. 3-44.

unfeeling objects"[178] (Delchamps 2021). When Mitchell wrote about George Dedlow, he seemingly assumed that Dedlow would represent the extremity of his disabled experience through connections to the animal, and as "useless"—a word that explicitly links disability to its meanings relating to productivity. This representation of Mitchell's feels linked to Mitchell's assumptions about the supremacy of a whole, human body.

Mitchell experiments with ways to describe pain and its relation to the self; he imagines the thoughts of his own patients, asserting that disability causes amputees like Dedlow to feel dehumanized and incapable of speech. Dedlow writes, "Of my anguish and horror of myself I dare not speak" (94). Dedlow's dual role as doctor and patient gives him language to communicate with his doctor, but he "dare not" speak of the impact his disability has on his perception of his body. So profound was Dedlow's horror at his now-dehumanized body, which he decreed "useless," that he dared not voice his feelings. Through Dedlow, Mitchell experimented with ways to describe pain and its relation to the self; he also imagined the thoughts of his own patients, asserting that amputees like Dedlow feel unhuman and useless. Dedlow represents the extremity of his disabled experience through connections to the animal, and as "useless"—a word that explicitly links disability to its meanings relating to productivity.

Through Dedlow, Mitchell speculates freely about what causes absent limbs to itch and feel pain, using his literary text as a form of medical speculation. Dedlow soon began experiencing what Mitchell coined "phantom limb pain." The story explains why Mitchell chose

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[178] Nineteenth-century physicians including Oliver Wendell Holmes, Richard Harlan, and Silas Weir Mitchell grappled with questions about pain and its usefulness after the discovery of anesthesia. They turned to rattlesnakes as objects of study, influenced by Robley Dunglison's *Human Physiology,* which claimed that rattlesnakes lived "'largely without feeling'" (Altschuler 178). Claims that the animals feel little to no pain might relate to (but are not equivalent to) early American assertions that black people do not feel pain as white people do—a reminder of the animalizing approach white physicians have taken to black people in America (Samuels 14).

this rather imaginative phrase and helped popularize it. Mitchell, through Dedlow, educated his reading public about the causes of nerve pain. Dedlow then uses his own medical training to explain his neuralgia diagnosis to his reader. He constructs and accepts his own theories about neuralgia, self-diagnosing himself: “This change [of the nerves], as I have seen in my practice of medicine…occasions a more or less constant irritation of the nerve-fibres, producing neuralgia” (96). Dedlow calls upon his medical practice to authenticate his explanation:

> In other words, the nerve is like a bell-wire. You may pull it at any part of its course, and thus ring the bell as well as if you pulled at the end of the wire…But in some cases, such as mine proved at last to my sorrow, the ends of the nerves undergo a curious alteration, and get to be enlarged and altered. This change, as I have seen in my practice of medicine, passes up the nerves towards the centres, and occasions a more or less constant irritation of the nerve-fibres, producing neuralgia, which is usually referred to that part of the lost limb to which the affected nerve belongs. This pain keeps the brain ever mindful of the missing part, and, imperfectly at least, preserves to the man a consciousness of possessing that which he has not. (96)

This is one indication of how for Mitchell, literary and medical blend together; it almost seems that with his short story, Mitchell hoped he could inform amputees about what causes this kind of nerve pain, in hopes that they could self-diagnose. The image here of a bell-wire usefully captures the workings of the nerves, as Mitchell understood them; moreover, it conveys Dedlow’s “sorrow,” even as he also interestedly reflects upon the “curious” alteration of his own nerves.

As Mitchell educates his readers in this way, he also asks questions about what it means to be an individual person, ultimately arguing that a man without limbs loses his identity. Dedlow remarks,

> I found to my horror that at times I was less conscious of myself, of my own existence, than used to be the case…I felt like asking some one constantly if I were really George Dedlow or not…At times the conviction of my want of being myself was overwhelming, and most painful. It was, as well as I can describe it, a deficiency in the egoistic sentiment of individuality…This set me to thinking how much a man might lose and yet live. (100)

After reflecting in this way on his "want of being" himself, he then "reached the conclusion that a man is not his brain, or any one part of it, but all of his economy, and that to lose any part must lessen this sense of his own existence" (100). While Dedlow's introspection does interestingly question the notion of the mind/body split, suggesting that a person is indeed more than their mind, he reaches a conclusion disturbingly familiar to those working in disability studies. The notion that physical difference or debility reduces a person, so they are no longer whole or useful, is damaging—and *vital* to ideologies of ability that still resonate today. After Dedlow reaches this conclusion about his unwholeness, he reveals, "The strange want I have spoken of now haunted and perplexed me so constantly, that I became moody and wretched" (107). The word "haunted" here becomes significant, for the story suddenly takes a supernatural turn.

After the pain continues to overwhelm Dedlow, he decides to visit a medium and attempt a spiritualist séance. In the bizarre climax, his phantom legs are physically conjured up by a medium named Sister Euphemia. Dedlow's legs had been in storage at the US Army Medical Museum in Washington, where army surgeons during the Civil War routinely sent amputated limbs for study. Dedlow is then reunited with the ghosts of his amputated legs, and briefly given the ability to walk again:

> Suddenly I felt a strange return of my self-consciousness. I was re-individualized, so to speak. A strange wonder filled me, and, to the amazement of every one, I arose, and, staggering a little, walked across the room on limbs invisible to them or me. It was no wonder I staggered, for, as I briefly reflected, my legs had been nine months in the strongest alcohol. At this instant all my new friends crowded around me in astonishment. Presently, however, I felt myself sinking slowly. My legs were going, and in a moment I was resting feebly on my two stumps upon the floor. It was too much. All that was left of me fainted and rolled over senseless. (108)

No longer a scientific observer of his own pain, Dedlow walks with nonscientific phantoms. The disruption of Dedlow's medical authority corresponds with a disruption of generic constancy, for the story exhibits a sudden shift from serious medical case study to humorous, absurdist fantasy.

Mitchell eventually asserted that the story's "absurd conclusions" should have signaled to readers that it was a "humorous sketch."[179] In other words, he essentially mocks his own readers for believing his untruth. He implies that the supernatural nature of Dedlow's encounter with the spirits of his amputated legs did not deter readers from believing the story to be true, as the

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[179] Silas Weir Mitchell, "Phantom Limbs." *Lippincott's Magazine of Popular Literature and Science* (Dec. 1871): 563. Mitchell's assertion that the story was a hoax connects him to other authors, such as Edgar Allan Poe and Sir William Ostler, who concocted medical hoaxes and medical horror stories during this era.

longing for cure will drive a longing for any mode of salvation. The humor is best exemplified in Dedlow's assumption that he "staggered" because his "legs had been nine months in the strongest alcohol" an observation that invites us to wonder what Mitchell, or Dedlow, has been drinking. I think we can take Mitchell's claim that people read the story as true with a grain of salt. The notion that his story was so well-written that it convinced people it was real would be useful for Mitchell, for that might increase his readership. He claims the story does not masquerade as fact, but this claim that people did read it as fact might itself be a masquerade—one that draws more and more attention to physician authority and the methods used to secure it. Mitchell, in other words, both criticizes and mimics quacks while he stretches his medical imagination. Furthermore, remembering that this story is contextualized by the fractured state of America during and after the Civil War, it seems that Dedlow's brief reunion with his legs may serve as a metaphor for the necessity of reunion. This is something of a stretch, though, as the scene is far from serious; we can nevertheless appreciate that Mitchell is doing something unique by blending genuine medical expertise, an imagined experience of disability, a true fear about racialization, and the shattering of America into one absurdist-yet-scientific story.

The next paragraph reveals that Mitchell does not believe amputees like Dedlow could have happy endings. The limbless Dedlow simply awaits death:

> I am now at home in the West, surrounded by every form of kindness, and every possible comfort; but, alas! I have so little surety of being myself, that I doubt my own honesty in drawing my pension, and feel absolved from gratitude to those who are kind to a being who is uncertain of being enough himself to be conscientiously responsible. It is needless to add, that I am not a happy fraction of a man; and that I am eager for the day when I

> shall rejoin the lost members of my corporeal family in another and a happier world. (109)

This quote establishes that because Dedlow can never find a permanent way to be reunited with amputated parts of his body, he would be better off dead. Again, Mitchell wrote the story after having a conversation with a friend who asked, "How much of a man would have to be lost in order that he should lose any portion of his sense of individuality?" (Burr 16). Dedlow does not even trust his own honesty because disability has so fractured his awareness of a conscious self; with this, Mitchell reinforces the stereotype that disabled people are dishonest when they draw their pensions.

Literature offered Mitchell the chance to explore disability after the war, and to experiment with his own theories about medicine and phantom limb pain. It also allowed Mitchell to imagine life from a patient's perspective, and he experimented with entering the consciousness of someone he would otherwise treat. Looking at the world from a patient's point of view in this way compelled Mitchell to represent the patient's experiences with pain sympathetically; however, he also made negative generalizations about the tragedy of disabled men. Mitchell suggested that amputation led to a lack of wholeness that destroyed an individual's identity and made them simply wait for death, while remaining dependent on others. Mitchell depicts the people around Dedlow at the hospital as largely caring and useful; he little asks whether Dedlow's feelings about his situation are the result of social encounters, but instead insists that Dedlow is doomed to a terrible fate because of his amputations.

As suggested above, Mitchell's later book directed to the medical profession, *Injuries of the Nerves,* expands on Mitchell's "George Dedlow." The book captures Mitchell's interest in the poetics of pain. He writes:

> Nearly every man who loses a limb carries about with him a constant or inconstant phantom of the missing member, a sensory ghost of that much of himself, and sometimes a most inconvenient presence, faintly felt at times, but ready to be called up to his perception by a blow, a touch, or a change of wind. (352)

This writing engages with the same issues as “George Dedlow,” and in similarly literary ways. Mitchell then expresses his confidence that disability is effeminizing. He writes,

> Perhaps few persons who are not physicians can realize the influence which long-continued and unendurable pain may have upon both body and mind. The older books are full of cases in which…the senses grew to be only avenues for fresh and increasing tortures, until every vibration, every change of light…brought on new agony. Under such torments the temper changes, the most amiable grow irritable, the soldier becomes a coward, and the strongest man is scarcely less nervous than the most hysterical girl. (200)

This passage does several things: it reduces men who experience pain to women, who are portrayed as weak and cowardly. As it enforces the same opinions expressed in “The Case of George Dedlow,” the passage also embraces a poetic form of writing (with descriptive phrases such as “every vibration, every change of light”), and acknowledges the pains upon both “both body and mind” that the wounded experienced. Even in his medical books, written to educate the public about issues of health and medicine, Mitchell continues to build upon his literary texts, blending together his dual interests in medicine and literature while influencing the ways people understood the nervous system and thought about gender.

Troubling though Mitchell’s claims about hysteria are, it is significant that Mitchell was willing to realize, imagine, and portray unendurable pain: first by imagining the perspective of a patient in “The Case of George Dedlow,” and later by recounting the experiences of his patients in books such as *Injuries of the Nerves*. Modern disability theorists comment on the still-present issue of phantom limb pain and argue that even modern doctors have been known to ignore this pain in patients. Feminist disability scholar Susan Wendell writes:

> Even when your experience is recognized by medicine, it is often re-described in ways that are inaccurate from your standpoint. The objectively observable condition of your body may be used to determine the severity of your pain, for instance, regardless of your own reports of it. For example, until recently, relatively few doctors were willing to acknowledge that severe phantom limb pain can persist for months or even years after an amputation. The accumulated experience of doctors who were themselves amputees has begun to legitimize the other patients' reports. (1989, 120-121)

This passage is interesting for a few reasons. First, doctors still may fail to believe patients have phantom limb pain, even though Mitchell coined the phrase and wrote about it back in the nineteenth century. Wendell points out that medicine can describe pain in inaccurate ways. With "The Case of George Dedlow," Mitchell at least tried to envision and embody pains experienced by one of his fictional patients, though his depiction of life as an amputee is probably somewhat inaccurate. Mitchell believed his patients when they complained of pain in their amputated limbs; however, he also suggested that amputees no longer have anything to live for.

Mitchell spread the damaging ideology that unruly bodies must be either cured or eradicated through his literary and medical writings, which blur generic boundaries between fiction and nonfiction in a way that afforded them additional popularity and enabled them to reach greater audiences. That said, Mitchell also demonstrates a willingness to imagine and sympathize with the pain of his patients through his stories. The literary utterances of doctors in the nineteenth century demonstrate that fiction writing gave doctors a chance to at least try to comprehend the cultural issues, as well as the physical pains, that make life difficult (but not, as Mitchell might think, unlivable) for severely disabled people.

Disability Studies Approaches to Late Nineteenth Century Hysteria and Neurasthenia

Two decades after he published "George Dedlow," Silas Weir Mitchell observed that nervousness was a major concern throughout the nineteenth century: "I am nervous. I did not used to be. What can I do to overcome it?" was, Mitchell reported, a question on the lips of a vast number of Americans ("Nervousness" 116).[180] Even though, or perhaps because, they were confusing, hysteria and neurasthenia became common, even "fashionable" diseases,[181] in the late nineteenth century. Self-diagnosis of neurasthenia especially became widespread. Numerous (mainly upper-class, white, female) patients began bypassing professional diagnosis and treating themselves in order to try to improve their conditions.[182] The embrace of neurasthenia and products by commercial interests in the 1880s, its popularity as a topic for journalists and writers in the 1890s, and the resulting propensity of individuals to self-diagnose wrested control of the diagnosis away from medical professionals (Schuster 48).

Relevant here is Austin Flint's 1881 assertion that "[i]n medical consultations it is here [with diagnosis] that the want of aid and counsel is oftenest felt by the physician. The diagnosis involves more embarrassment than the management of diseases. This fact is not appreciated by

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[180] For an examination of how the late nineteenth-century discourse of nerves is linked to cultural and industrial modernization, see Tom Lutz's *American Nervousness, 1903.* As Roy Porter argues, "the chronological epicenter [of nervous disease] is bound to be the nineteenth century" (226); similarly, Caroll Smith-Rosenberg observes, "Hysteria did not emerge as an endemic disease among bourgeois American women until the mid-nineteenth century" (198).

[181] On hysteria and nervousness as "fashionable," see Ann Douglas Wood's "The Fashionable Diseases."

[182] In his study, Schuster does not bluntly say that neurasthenia was an "unreal" diagnosis, but his work raises many questions about the "realness" of illness, disability, and diagnosis (18).

the people at large, many of whom undertake to decide respecting the nature and seat of the disease whenever their friends are ill" (106). Physicians were potentially "embarrassed," to use Flint's term, by their own lack of understanding of the disorder, and thought themselves undermined by the many men and women who casually diagnosed friends or themselves with the disorders. Doctors often questioned the reliability of what these patients reported to them. Edward Shorter suggests that some of them may even have fabricated illness by choosing from a "symptom pool," leaving it up to the physician to "disentangle the somatogenic from the psychogenic" (5, 106). Physicians who treated hysteria did so not just to aid ill individuals, but also to flaunt their authority, reduce their own "embarrassment," make a profit off of their patients (for diagnoses and self-diagnoses generated profit for doctors and pharmacies) and return women to a domestic sphere (Schuster 62).

Disability studies' focus on the politics and social context that surround medical approaches to disorder, helping to demonstrate that the diagnoses of neurasthenia and hysteria were socially constructed and forged divides between already-marginalized groups of people. Questions about how certain nervous disorders were diagnosed are tied to larger social and cultural issues pertaining to a person's race, class, gender, and outwards performance of ability. Mitchell's treatment was based on class, as Mitchell and Beard believed that a person's social status provided a crucial predisposition to nervous disease. Mitchell maintained that elite class status in the U.S. was correlated with an excessively sensitive nervous system, indicating overinvolvement in the draining postwar economy. Despite this disagreement over who became nervous, one class-related issue was incontrovertible: only well-to-do patients could afford Mitchell's rest cure, which required the intensive medical attention of both doctor and nurse, as well as months (and sometimes years) of diminished activity. Doctors and pharmaceutical companies took advantage of those who self-diagnosed, prescribing and labeling medicines (which we know now were often made of addictive substances such as alcohol and cocaine) as treatments for "nervousness" (Schuster 62). As many modern disability scholars have demonstrated, significant problems arise when diagnosis-to-cure is conceptualized as a restorative process; this is especially evident when we look at the politics and damage done by the divisive ways neurasthenia and hysteria were diagnosed.[183]

White women like Gilman were diagnosed with hysteria, a mark of their class status and participation in the world of work; however, insanity or "feeble-mindedness" were still more likely diagnoses for black patients than were hysteria or neurasthenia. In 1837, physician James Cowles Pritchard argued that mental illness did not exist in Africa because of the primitiveness of the cultures housed there. As I demonstrate in my third chapter, black patients were diagnosed with "freedom" (a supposed cause of madness, insanity, and feeble-mindedness) after the Civil War. Some doctors like Samuel Cartwright argued that mental illness occurred in black people who were not enslaved, or that black people and other racialized groups, including indigenous people and Jewish people, were susceptible because race made a person predisposed for mental and physical illnesses (Willoughby 598).

Hysteria and other nervous disorders were largely presented as curable, treatable disorders—*if* patients were obedient and submitted to their physicians' authority. The AMA warned in its *Code of Ethics* that although "reasonable indulgence should be granted to the mental imbecility and caprices of the sick," nonetheless:

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[183] Eli Clare argues this point in *Brilliant Imperfection.* For another foundational disability studies work that asserts disability studies' place at the center of such literary and cultural inquiries, see Ellen Samuels' *Fantasies of Identification.*

> the obedience of a patient to the prescriptions of his physician should be prompt and implicit…The patient, furthermore, should never permit his own crude opinions as to their fitness, to influence his attention to them…This remark is equally applicable to diet, drink, and exercise. [Patients] are very apt to suppose that the rules prescribed for them may be disregarded, and the consequence but too often, is a relapse. (93, 96)

It was believed that such potentially unruly patients *needed* to be cured, because otherwise both individuals and the American nation as a whole would be weak and unproductive. The only illnesses depicted as incurable in the AMA's code of ethics are fatal ones, and hysteria was not believed to be fatal.[184] Physicians and patients aimed to eliminate the disorder completely, rather than simply mitigate symptoms. Physicians like Mitchell did not pause in their prescription of treatments when they encountered the "curable" issue of hysteria, and women like Gilman struggled to articulate their beliefs that their illnesses were chronic.[185] While chronic illness and "chronic invalids" were understood to exist in this moment in history, people with chronic conditions struggled then (as they do now) to assert that there is no cure and they might never be "fixed."[186] As I show in my later readings, Gilman tried on occasion to express that her disorder was not readily fixed by any means.

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[184] For fatal disorders, the AMA counseled physicians to soothe "mental anguish": "A physician ought not to abandon a patient because the case is deemed incurable; for his attendance may continue to be highly useful to the patient, and comforting to the relatives around him, even in the last period of a fatal malady, by alleviating pain and other symptoms, and by soothing mental anguish" (94).

[185] For more on chronic illness and crip time, see Alison Kafer's *Feminist, Queer, Crip*; Ellen Samuels' "Six Ways of Looking at Crip Time"; and Emma Sheppard's "Performing Normal but Becoming Crip."

[186] Physician Andrew Combe wrote about chronic invalids in *The Physiology of Digestion (*1836*)*. Being a chronic invalid was certainly marginalizing then as being chronically ill is today.

Mitchell took an individualized approach to correcting women's bodyminds. The title of Mitchell's book, *Fat and Blood,* indicates his belief that flesh (the amount of fat on a woman's body) and blood (genetic inheritance, but also, more subtly in the book, menstrual blood) were significant parts of a nervous patient's experience. The "rest cure" was based on his belief that the patient had reached a state of "cerebral exhaustion…. a condition in which the mental organs become more or less completely incapacitated for labor" (*Wear and Tear* 48). His remedy was therefore enforced bed rest, and the patient was barred from physical exertion and deprived of intellectual stimulation.[187] In his 1871 study *Wear and Tear,* Mitchell insisted that education is

> at least in part the source of very many of the nervous maladies with which our women are troubled…To-day, the American woman is, to speak plainly, too often physically unfit for her duties as woman*,* and is perhaps of all civilized females the least qualified to undertake those weightier tasks which tax so heavily the nervous system of man. She is not fairly up to what nature asks from her as wife and mother. How will she sustain herself under the pressure of those yet more exacting duties which nowadays she is eager to share with the man? (40).

Mitchell understands femininity as crucially linked to invalidism. Jessica Horvath Williams explores this representation of womanhood and disability in her dissertation, *A Monster of Virtues: Female Ideality, (Dis)Ability, And Nineteenth-Century Womanhood* (2020). In the above passage, the terms "to-day" and "nowadays" emphasize Mitchell's belief that women's ailments were a contemporary issue that might be resolved by returning to a life without "exacting duties" involving education and work.

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[187] Mitchell discusses "race" in this book, but only the "English" and "American" races—and only wealthy white people became his patients.

Mitchell followed the AMA's assumptions about the authority of the physician even as he prescribed harmful and regressive treatments aimed at returning women to their roles as mothers. Mitchell's "success stories" were not of women who learned to manage chronic disorders, but of women who had visible and verifiable evidence of "improvement" such as weight gain. He cites many changes that came from his use of diet, massage, rest, and electric therapy. He gave women milk—in fact, *only* let them imbibe milk—until they gained weight, began menstruating, and developed color in their flesh. (In 1873, Austin Flint wrote, a tad redundantly, "In order to carry out effectually the 'milk cure'…milk…should be taken largely," bestowing the label "milk cure" upon this practice (304)). Many of Mitchell's patients are now thought to have been anorexic, and Mitchell's treatments aimed to correct their reproductive cycles. As Abbey Perreault writes:

> women were now capable of discharging their roles as wives and mothers, since an additional benefit of the Rest Cure was that severely underweight patients resumed normal menstrual cycles. However, although the Rest Cure undeniably alleviated some physical symptoms, it did not address underlying issues of what had caused so many of these patients to take to their beds in the first place, often for years at a time. ("The Father")

Mitchell claimed that as a woman improved, milk might be swapped out for various "children's foods," such as malted milk or "Nestle's food" (*Fat and Blood* 129). He admitted that this infantilizing treatment gave rise to extreme sleepiness as well as "a white and thick fur on the tongue, and often for a time an unpleasant sweetish taste in the early morning … neither of which *need be regarded*" (97, my italics). Mitchell's good intentions are overwhelmed by his blatant disregard for his patients' discomfort during his treatment.

Mitchell's book details the physician's concern that his patients might not submit to his authority. After women gained some weight, he began stuffing them full of food, an act that was not "easy" but that brought about "growing surprise" in the physician:

> For my own part, I can only say that I have watched again and again with growing surprise some listless, feeble, white-blooded creature learning by degrees to consume these large rations, and gathering under their use flesh, color, and wholesomeness of mind and body. It is needless to say that it is not in all cases easy to carry out this treatment. (138)

The words "listless, feeble, white-blooded creature," indicating that whiteness can literally be debilitating, will be relevant later when I discuss the importance of color to Harper's depiction of nervousness as an affirmation of life in her mixed-race characters in *Iola Leroy*. For now, I note that Mitchell decided that the benefits of this treatment outweighed (literally) the difficulty in carrying it out. He observed with satisfaction that one patient, Mrs. C, showed "gain in flesh about the face" and resumed menstruation after years of missing periods. He found this to be evidence enough for the neurologist that fat, blood, and vitality had been restored.[188] Mitchell describes the experiences of a "Miss L" in the following way:

> A physician advised rest, to which she took only too kindly, and in a year from the time of her accident she was rarely out of bed…her nurses crept about in a darkened room…By slow degrees a whole household passed under the selfish despotism of an

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[188] Soon, other physicians adopted the practice, which seemingly encouraged Mitchell, or at least allowed him to absolve himself of full accountability: "I am fortunate now in having been able to show that in other hands than my own, this treatment has so thoroughly justified itself as to need no further defence [sic] or apology from its author" (*Fat and Blood* 289). He adds, however, "I am now more fearful that it will be misused, or used where it is not needed, than that it will not be used," and concludes, "and, with this word of caution, I leave it again to the judgment of time and my profession" (*Fat and Blood* 290).

> hysterical girl…She was…very sallow, with pale lips…I made the most careful search for signs of organic mischief, and, finding none, I began my treatment as usual with milk, and added massage and electricity without waiting…It is perhaps needless to state that I isolated her with a nurse she had never seen before, and that for seven weeks she saw no one else save myself and the attendants. (*Fat and Blood* 194)

This passage shows Mitchell's view of a patient who was prescribed (his own) rest cure, and became, in Mitchell's eyes, a "selfish" hysterical girl. It also shows his casual cruelty. Repeating the phrase "needless to say," Mitchell indicates his view that his choice to isolate this woman with a strange nurse was an obvious one. He then celebrates her recovery: "In two months she was afoot and weighed one hundred and twenty-one pounds. Her change in tint, flesh, and expression was so remarkable that the process of repair might well have been called a renewal of life" (*Fat and Blood* 195). Mitchell's description of "the process of repair" serves as a reminder of the closeness of restoration and destruction; while Mitchell allowed for "reasonable indulgence" of his hysteria and neurasthenia patients, he starved and electrocuted them, and, like other physicians of the day, he expected patients to adhere to his plans for their restoration. Patients did not always listen, however; women like Charlotte Perkins Gilman found alternative diagnoses and treatments when their proximity to Mitchell's more experimental treatments began to pose threats not only to their bodies and minds, but also to their writing and participation in the political sphere.

"Nothing the Matter Apparently": Gilman and Mitchell

I turn now to Charlotte Perkins Gilman, who survived Mitchell's treatment. Feminist scholars[189] have told a straightforward, but incomplete, story of the events that inspired Gilman's "The Yellow Wallpaper." According to past tellings, misogynistic physician Silas Weir Mitchell diagnosed Gilman with hysteria, put her on bed rest, and ordered her to stop writing. Isolation brought Gilman close to insanity, so she wrote a story in which a female narrator also refutes her physician-husband's prescription that she cease from writing. The narrator writes in her diary, a defiant act of curative knowledge production, then physically triumphs over her husband. Critics often suggest that the act of writing cured both Gilman and her narrator. They also repeat a claim made by Gilman herself: that after reading "The Yellow Wallpaper," Mitchell was persuaded to stop administering the rest cure. So, according to this neat tale, a feminist literary author recovered her health by writing. Her writing then convinced a powerful, sexist physician to alter the way he treated women's bodies and minds. This narrative touches on the truth, but the full account of Gilman's composition is more complex and more interesting. Below, I reflect on erroneous assumptions that critics have made about Gilman's history and offer a disability studies-informed approach to the tale of Gilman's authorship and to the story itself.

First, Gilman was not a passive victim of Mitchell's ministrations. She *invited* Mitchell's diagnosis and treatment because she hoped that he would help her understand her symptoms, legitimize her experience, and give her the tools to write and have energy again. In 1887, Gilman began to experience symptoms of "terrible fits of remorse and depression," so she wrote a letter to "the greatest nerve specialist in the country…Dr. S. W. Mitchell of Philadelphia," requesting

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[189] See Sandra Gilbert and Susan Gubar, *The Madwoman in the Attic* (89-92); Annette Kolodny, "A Map for Rereading" (451-67); and Jean E. Kennard, "Convention Coverage or How to Read Your Own Life" (168). These are all mostly older texts, published before 2000; "The Yellow Wallpaper" seems to have gone out of style of late.

his help (Knight 276). The letter Gilman sent Mitchell was only discovered and published by Denise D. Knight in 2005; it therefore does not appear in much of the earlier scholarship on Gilman, and it offers important insight into Gilman's self-diagnoses and experience of illness.[190] In Gilman's letter, she explains that she began to experience complicated symptoms while she was pregnant. When confined to rest during her pregnancy, she "began to show 'nervousness' in the months [sic] confinement. Had wild and dreadful ideas which I was powerless to check, times of excitement and times of tears" (Knight 276). After giving birth, Gilman treated herself for this self-described "nervousness" by traveling to Pasadena and taking Dr. Buckland's Essence of Oats.[191] This self-administered "treatment" helped her symptoms abate, in part because in Pasadena she stayed with friends and did political work, writing feminist essays. Symptoms returned, however, after Gilman returned to her husband.

Gilman reached out to Mitchell, requesting his diagnosis and treatment, and shared with him some of her ableist beliefs about productivity and illness. I include a large passage from the letter below, especially because the letter is so under-utilized by scholars of feminist disability studies and Gilman's writings:

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[190] In "'All the Facts of the Case': Gilman's Lost Letter to Dr. S. Weir Mitchell," Knight describes the long scholarly search for this letter. She reveals that the Schlesinger Library received a copy of the letter to Mitchell in 1997. She says that "Cynthia J. Davis is the first Gilman scholar to not only corroborate the existence of the letter, but also to use it in the research of her biography, forthcoming from Stanford Univ. Press in 2007. I first learned that the letter had survived while reading a draft of Davis's biography" (275). Also see Knight, *Charlotte Perkins Gilman and Her Contemporaries: Literary and Intellectual Contexts*, co-edited with Cynthia J. Davis.

[191] Dr. Buckland's Scotch Essence of Oats was purported to treat, among other things, "insomnia, paralysis, opium habits, drunkenness, neuralgia, sick headaches, sciatica, nervous dyspepsia, locomotor ataxia, ovarian neuralgia, nervous exhaustion, epilepsy, and St. Vitus's dance" (Knight 265).

> There is more physical prostration than ever before. And there are mental symptoms which alarm me seriously. These I can tell you better. But I beg of you not to laugh at me as every one [sic] else does, not to say it is “almost as bad as a disease” as one of my friends does, not to turn me off. I am an artist of sufficient merit to earn an easy living when well. I am a writer, a poet, a philosopher, in little. I am a teacher by instinct and profession. I am a reader and thinker. I can do some good work for the world if I live. I cannot bear to die or go insane or linger on [in] this wretched invalid existence, and be a weight on this poor world which has so many now. I want to work, to help people, to do good. I did for years, and can again if I get well. Surely it is worth while [sic] to save a good worker, one who asks little and longs to give much! I have long wished I could see you, without hope of it; and now some kind friend has given me means to go away and stay awhile, to rest and try to get well. I understand you are the first authority on nervous diseases. Are you on brain troubles too? There is something the matter with my head. No one here knows or believes or cares. Of course they can’t care for what they don’t believe. But you will know. (Knight 274)

As Knight points out, “A close rhetorical analysis of the paragraph reveals a woman who is attempting to reclaim her identity, to advance an agenda, and to illustrate her self-worth. The personal pronoun ‘I’ appears at the beginning of nine out of the ten sentences, a striking pattern that appears nowhere else in the letter” (263).

The fact that Gilman requested diagnosis in this way subverts the popular narrative that Mitchell acted upon a passive, victimized Gilman and discounts Gilman’s tendency to demean people with bodily and mental states that she found inferior. This is not to say that Gilman “deserved” the treatment that resulted from her request, nor that she is at fault for trying to voice her experience with illness to a renowned doctor whom she trusted. Rather, it shows that many people in this time requested, performed, refuted, challenged, and pleaded for diagnoses and self-diagnoses, demonstrating that diagnosis provoked, to use Clare's phrase, a "furious storm" (Clare 47). Without diagnosis and treatment, Gilman would be lost and continue to struggle to write, would continue to feel the bodily, mental, and emotional consequences of her experience. Gilman made an effort to self-diagnose, calling her disorder "brain troubles." In requesting diagnosis and treatment (and in making an attempt to perform both acts herself), Gilman participated the processes of the ideology of cure that is so optimistic and so damaging. She suggests that she believes being an invalid is burdensome. She believes she cannot "do good" if she does not "get well." Her initial response to her symptoms was to paint invalidism as pathological weakness. Scholars have begun to show that Gilman held eugenic beliefs about disabled people,[192] and this letter reflects some of those beliefs. She used her own productivity as proof that she deserved to recover from an impairment she saw as potentially fatal ("If I live").[193] As Tom Lutz has pointed out, Gilman's exhaustion, in *addition* to her husband's proscription that she needed to rest from writing, kept her from putting pen to paper during the early years of her marriage (Thrailkill 524). Gilman's journal is riddled with entries describing her lassitude and her husband's diligent house cleaning, baby tending, and wife nursing during her malaise. She recounted later in her autobiography, "I was so weak that the knife and fork sank from my

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[192] See Sharon Lamp, "It Is for The Mother"; Douglas C. Baynton, "Disability and the Justification of Inequality in American History"; Mary Ziegler, "Eugenic Feminism"; and Ewa Barbara Luczak, "Eugenic Strands in the Gynaecocentric Criticism of Charlotte Perkins Gilman."

[193] Some of her remarks bring to mind statements by Douglas C. Baynton: "Disability has functioned historically to justify inequality for disabled people themselves, but it has also done so for women and minority groups. That is, not only has it been considered justifiable to treat disabled people unequally, but the concept of disability has been used to justify discrimination against other groups by attributing disability to them" (57).

hands—too tired to eat. I could not read nor write nor paint nor sew nor talk nor listen to talking, nor anything…To the spirit it was as if one were an armless, legless, eyeless, voiceless cripple" (*Living* 97). Gilman's experience of disability, probably depression, is linked closely to her womanhood, but she also distances herself from another group—that of "invalid[s]"—to evidence her self-worth (Knight 274). Gilman also highlights Mitchell's authority. Immediately after self-identifying as a writer/poet/teacher, Gilman cites Mitchell's reputation as "the first authority on nervous diseases" and expresses confidence that as a prominent member of the medical community, he will be able to make a proper diagnosis (Knight 267). She complains that "no one here knows or believes or cares" that "there is something the matter with my head," and she ends the paragraph with a simple declarative sentence that sets Mitchell apart from those who dismiss her complaints: "But you will know," she resolutely states, highlighting her faith in his expertise and in his ability to identify and treat her condition (Knight 274).

At the end of her letter, Gilman also included the most thorough medical history of her family that she could piece together, thinking this would help Mitchell diagnose her. Evident is the influence of the AMA's Code of Ethics, which enumerated the tenants of the patient/physician relationship that eventually became commonplace. The Code emphasizes that patients should communicate symptoms and history, so that a physician may make a diagnosis:

> Patients should, faithfully and unreservedly communicate to their physician the supposed cause of their disease. This is the more important, as many diseases of a *mental origin* simulate those depending on external causes, and yet are only to be cured by ministering to the *mind diseased*. A patient should never be afraid of thus making his physician his friend and adviser; he should always bear in mind that a medical man is under the strongest obligations of secrecy. Even the female sex should never allow feelings of

> shame or delicacy to prevent their disclosing the seat, symptoms and causes of complaints peculiar to them. (96, my italics)

The Code of Ethics encouraged patients (especially female ones!) to thoroughly share their symptoms. Gilman does detail her struggle to return to health after childbirth. As Knight points out, "By providing a brief biography…Gilman proposes to aid S. Weir Mitchell in making a diagnosis. Her characterization of her progenitors revolves around three discrete themes: nervous symptoms (e.g., allusions to 'nerves' or 'nervousness' appear eight times in the letter); other weaknesses, including the 'exaggerated . . . feminine qualities' inherent in her mother; and strengths, ranging from 'benevolence' to 'intellect' and 'distinction'" (261). Gilman uses this abbreviated exercise in ancestral mapping not only to search for hereditary causes of her present nervous condition, but also to justify her past action of leaving her husband and child during a bout of severe depression until she "'felt better'" (Knight 270). Gilman associates her nervousness with her mother, indicating her awareness of many physicians' views of the matrilineage of hysteria.

Mitchell read Gilman's letter to diagnose her; however, because he scorned women who had medical knowledge, he dismissed most of it. Rather than take her work seriously, he used her efforts at self-diagnosis and her comprehensive family history as proof that she had a problem. As one of Gilman's biographers writes, Mitchell "found utterly useless the long letter she had written to him detailing her symptoms; he told her that the fact that she imagined her observations would be of any interest to him was but an indication of her 'self-conceit'" (Lane

113).[194] We might connect Mitchell's reaction to the next piece of advice in the AMA's Code of Ethics:

> A patient should never weary his physician with a tedious detail of events or matters not appertaining to his disease. Even as relates to his actual symptoms, he will convey much more real information by giving clear answers to interrogatories, than by the most minute account of his own framing. Neither should he obtrude the details of his business nor the history of his family concerns. (96)

This statement emphasizes that patients should be wary of making their physician "weary." Though Mitchell should have appreciated Gilman's thorough history, he might have felt she gave a "most minute account" that included too many "family concerns." Gilman took the time to lay out her relationship to her mother and her mother's family in order to provide her physician with details about her case, but Mitchell, who thought that women "would do far better if the brain were very lightly tasked," probably saw her efforts as additional symptoms, not as medical knowledge (*Wear and Tear* 47). This can be connected to disability scholar Mollow's argument that "any subject who insists that she or he is 'not hysterical' articulates a claim that the very definition of hysteria renders absurd; to be hysterical, after all, means not to know one is so. To be defined as 'hysterical,' therefore, means to be subjected to a process of epistemological disablement by which one is presumed deficient in self-awareness" (191). In a way, the patient's knowledge becomes nothing but a symptom. This also is reminiscent of Eli Clare's words about diagnosis at the start of this chapter: "[Diagnosis] propels eradication and affirms what we know about our own body-minds…It disregards what we know about our own body-minds and leads to

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[194] Lane's source for this anecdote is Gilman herself, who wrote of the encounter in her autobiography, published 43 years after "The Yellow Wallpaper."

cure" (48), in Gilman's case, the rest cure. Though Gilman performed self-awareness through her letter's detailed research, Mitchell probably decided she was hysterical before he even opened the letter.

However, Mitchell did not then diagnose Gilman with hysteria. He refused to diagnose Gilman at all. A note Gilman added to the bottom of her copy of the letter reads: "He kept me a month. Found nothing the matter apparently. Sent me home with this prescription: 'Live as domestic a life as possible. Have your child with you all the time. Lie down an hour after each meal. Have but two hours intellectual life a day. Never touch pen, brush, or pencil again as long as you live'" (Knight 271).[195] Mitchell did not help Gilman understand her condition. So, whether Mitchell believed Gilman had hysteria, neurasthenia, anorexia, insanity, or just "self-conceit" is impossible to say with certainty. For my purposes, it does not really matter which diagnosis is the "real" one. Gilman says he "found nothing the matter," and yet he clearly *did* decide that something was wrong with her, because he issued controlling orders. Mitchell both denied that Gilman was really ill and at the same time treated her as if she had a nervous disorder that forbade her to behave as a woman "should." This incident exemplifies one of the key points in my dissertation: at times, physicians skipped over the diagnostic step completely. Its absence then loomed large as physicians moved directly to body and mind-altering treatments and became a vast void of knowledge filled by literary experimentation.

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[195] The following note, describing Mitchell's recommendation for Gilman's post-treatment regimen, was later appended in Gilman's hand at the bottom of the letter and forms the basis of her autobiographical account of her experience: "I did it, that summer, and came to the edge of insanity. To save others I wrote The Yellow Wallpaper. Sent Dr. Mitchell a copy. No answer. But years later I heard that he said he had changed his treatment of neurasthenia after reading T. Y. W." (Knight 271). As I discuss later, Gilman's assertion that Mitchell had read "The Yellow Wallpaper" and had subsequently changed his treatment of neurasthenia has never been corroborated.

Gilman eventually rejected Mitchell's efforts, after she lived through the harm done by his rest cure. He did not send her back to her life of intellectual freedom in California, even though he often sent his male patients (including Theodore Roosevelt and Walt Whitman) out West or out into nature and encouraged them to write.[196] Gilman later claimed that when Mitchell forbade her to write, she was brought "so near the borderline of utter mental ruin that [she] could see over" ("Why I Wrote" 271). Mitchell's efforts at *restoration* counterproductively brought about "ruin." After three months of bed rest, Gilman finally rejected Mitchell's advice and began to follow his *other* advice—the treatment plan he generally concocted for his male patients: she wrote, travelled west back to Pasadena, and became politically active.

After publishing "The Yellow Wallpaper" in California, Gilman tried to distance herself from insanity and to persuade her contemporary readers that the story existed not to spread insanity, but to put an end to it. She relates that she "sent a copy" of the story "to the physician who so nearly drove me mad." She then claims that the story is neither a reflection on insanity, nor a story that aims to drive its readers mad. Rather, she claims that she wrote the story to convince Mitchell "of the error of his ways." She boasts:

> The best result is this. Many years later I was told that the great specialist had admitted to friends of his that he had altered his treatment of neurasthenia since reading *The Yellow Wallpaper*.
>
> It was not intended to drive people crazy, but to save people from being driven crazy, and it worked. (Gilman, "Why I Wrote" 271)[197]

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[196] Mitchell even endorsed western health spas and sent patients to them as part of an economic agreement (Schuster 132).

[197] As described earlier, Gilman later appended the letter which forms the basis of her autobiographical account of her experience: "To save others I wrote The Yellow Wallpaper. Sent

Just as when Gilman distanced herself from insanity (which she associated with laziness and invalidism) in her initial letter to Mitchell, now she dissociates her own story with craziness and claims that the story aims to cure and prevent insanity. However, Gilman's assertion that Mitchell read "The Yellow Wallpaper" and subsequently changed his treatment of neurasthenia—her insistence that her story "worked," and performed the labor she asked of it—has never been corroborated. Scholars have not discovered any comment by Mitchell referring either to his treatment of Gilman or to her work of fiction, and he continued to administer the rest cure until Freud's work transformed the field of psychotherapy and led to the popularity of the "talking cure" instead.[198] While Gilman's avid writing does seem to have helped her, these actions did not alone "fix" her disorder, nor did the story "fix" the patriarchal rest cure.

Many critics wishfully think that writing "The Yellow Wallpaper" cured Gilman, but I do not present writing as a "cure" for any diagnosable ailment. This is tricky, because Gilman herself claimed that writing helped her recover from her nervous disorder—that the act of writing "The Yellow Wallpaper" poetically "fixed" the problem that motivated the story in the first place. Contemporary literary critic Diane Herndl reads this so:

> Gilman managed to cure herself…. Gilman's writing proved to be *restorative*. She claims to have recovered from her nervous breakdown by writing, directly disobeying the directions of her doctor. She was probably right. In writing out an alternative narrative, in writing a breakdown, rather than having one, Gilman not only made her position as subject visible, but she found

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Dr. Mitchell a copy. No answer. But years later I heard that he said he had changed his treatment of neurasthenia after reading T. Y. W.?" (Knight 271).

[198] The unsubstantiated story that Mitchell changed his diagnosis and treatment of hysteria and neurasthenia after reading a copy of "The Yellow Wallpaper" is questioned by Suzanne Poirier in "The Weir Mitchell Rest Cure."

> that the writing could take her place. In creating a narrative of her hysterical condition, she no longer had to embody illness directly but could represent it in her text…. She too, became a doctor-saviour, social worker, feminist crusader, and writer—a visible subject in the outer world, with new metonymic possibilities open to her. ("The Writing Cure" 74, my italics)

Herndl analyzes hysteria as "a sort of rudimentary feminism" (54), in which women's bodies speak a truth that cannot be expressed by "women existing in a patriarchal signifying system" (55). Herndl concludes that it is Gilman, not the narrator, who triumphs by "writing a breakdown, rather than having one" (74). Her explicit phrase, "Gilman's writing proved to be restorative," directly confirms the definition of cure as a "restoration of health" and also evokes the way in which a room like that of "The Yellow Wallpaper" might require restoration. By suggesting that Gilman "no longer had to embody illness directly but could represent it in her text," Herndl proposes that illness can be transported from bodymind to paper (74). While I explore the ways illness and symptoms can be *articulated* in literature, the notion that literature *fixes* the experience of illness in some way is erroneous and dismissive of the long-term lived experience of symptoms. In "Disease versus Disability" Herndl makes claims about disciplinary divides between the medical humanities and disability studies, arguing that "most people in the disability community do not want to be considered ill, and most people who are ill don't want to be considered disabled" (593). As Tanja Reiffenrath points out, the binaries Herndl employs "do not take chronic or long-term diseases into account that do not require constant medical attention when patients are in a state of remission…many of these binaries are effectively resolved when disabled and chronically ill individuals…do not see their conditions in need of cure" (63-64).

Our understanding of Gilman's experience of illness, writing, diagnosis, and cure may shift when we take chronic illness into greater account.

Numerous other critics also assume that writing fixed Gilman. Catherine Golden agrees with Herndl, arguing that the "cogent madness" that the narrator achieves "circumvents" and "banishes" the malevolent force of both her husband and masculine language (200). Similarly, Gilbert and Gubar in *The Madwoman in the Attic* assert that "it was quite clear to Gilman herself that the narrator's escape from the patriarchal text—and by extension Gilman's own—was a flight from dis-ease into health" (91). Paula Treichler agrees that Gilman's story is about freeing "women's discourse" from a silencing "patriarchal language" (195). Knight, too, suggests that writing fixed Gilman: "Once she separated from Stetson and moved to Pasadena, her recovery was swift. In 1890, the year that she wrote 'The Yellow Wall-Paper,' Gilman began one of the most productive periods of her career" (267). Knight assumes that "recovery" is synonymous with a "productive period." However, as is now understood by many disability studies scholars, productivity is not a sign of "overcoming" disability. The critics discussed above support the idea that Gilman prescribed a "writing cure" that healed herself, constructing a tidy if inaccurate story supporting the notion that, "if patriarchy made her sick, feminism and writing healed her" (Thrailkill 562).

While many critics have taken at face value Gilman's claim that her own text cured the world of the rest cure, the full history reveals that cure is not so easily eradicated. Though Gilman claimed her story prevented "craziness," she also wrote in a letter, "I read the thing to three women here…and I never saw such squirms!" (quoted in Allen 186). As Thrailkill argues, Gilman's story was not just written "to instruct" readers like Mitchell but was instead crafted to shock readers into feeling the effects of long-lasting hysteria and nervousness for themselves. By the author's own admission, the story seemed only to induce symptoms in some of the women who heard it. The story continues the violence of diagnosis by implicitly diagnosing the women who are affected by it and points us to rich and fascinating diagnostic mysteries while also emphasizing hysteria's destructive power. Though the rest cure and writing are offered by Mitchell and Gilman respectively as possible treatments that may correct disorder, neither erases disorder from existence.

In fact, as I argue, "The Yellow Wallpaper" communicates the experience of madness so forcefully that it turns the diagnostic gaze back upon its readers, and neat understandings of Gilman's short story are frustrated by the story's own winding contradictions. Feminist readings seem to take hysteria as merely a figure for oppression under patriarchy, rather than considering what the text says about mental disability. I also find that readings insisting that both Gilman and her narrator triumphed over disability often perpetuate notions of cure bound to ableist ideologies.

When Gilman's story was published, it was not thought to "diagnose" or "cure" any patriarchal attitudes or medical treatments. According to Thrailkill, many critics suggest that Gilman's contemporary readers understood the story as Gilman's indictment of Western male approaches to medicine. The evidence shows that readers in Gilman's time largely found that the story confirmed their beliefs that women are susceptible to nervous breakdowns. Readers thought the story confirmed the then-current belief that inharmonious decor (like highly patterned wallpaper) might contribute to nervous illness (Thrailkill 526). "After reading [the story]," one reviewer concluded, "the model husband will be inclined seriously to consider the subject of repapering his wife's bed chamber according to the ethics of William Morris." [199] From this perspective, the husband's failure did not lie in his misogyny, but rather in his ignorance about the physiological effects of interior design for women susceptible to nervousness.

Gilman's contemporary readers found the text to be not curative but *disabling* in its effects. After "The Yellow Wallpaper" attracted significant attention, critics began to worry that it might inflame (female) imaginations and therefore spread more madness. One wrote that the tale is "uncommonly effective…. Here the progress from nervous sensitiveness to illusion, and on to delusion, is put before the readers so insidiously that he feels something of that same chill alarm for his own mental soundness that accompanies actual contact with lunatics" (Anon, "Book Notes" 25). Some critics also saw the story merely as a chilling Gothic tale along the lines of Edgar Allan Poe.[200] So many contemporary readers were afraid that Gilman's story perpetuated instability for its women readers that Gilman felt a need to comfort them, and to persuade them otherwise. In 1913, Gilman wrote a note to deny readers' fears that her story might cause mental instability. She begins her essay "Why I Wrote the Yellow Wallpaper" by observing:

> When the story first came out…a Boston physician made protest in *The Transcript*. Such a story ought not to be written, he said; it was enough to drive anyone mad to read it.

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[199] Anon., "A Question of Nerves," Times [Baltimore], 10 June 1899, in Folder 301, Gilman Papers (Quoted in Thrailkill 554).

[200] Thrailkill writes that "Physiologically…while nineteenth-century reviewers differed on the story's ultimate meaning (from a cautionary tale about the dangers of tasteless home decorating to a Poe-esque study of psychosis), almost all commented explicitly on the story's powerful effects on the reader" (526). Some today still see the tale predominantly as an example of the American Gothic. See Carol Margaret Davison's "Haunted House/Haunted Heroine."

> Another physician, in Kansas I think, wrote to say that it was the best description of incipient insanity he had ever seen, and—begging my pardon—had I been there? (271).

Gilman then acknowledges that she *nearly* became insane during her time in Mitchell's care. Her contemporary readers felt that the story "ought not to be written" because it would "drive anyone mad to read it." This interpretation, that Gilman's story is a text that spreads rather than corrects illness, is plausible, and contemporary readers who see the text as curative may be influenced by the medical model of disability—the approach to disability that assumes those with disabilities must be cured or will be better off dead.

Contrary to these critics, I emphasize that there is no proof that writing eradicated Gilman's ailments and that it is extremely important to remember that some impairments are undiagnosable and chronic. While Gilman asserted that the act of writing helped her get better, she also confirmed that she experienced illness long after she wrote "The Yellow Wallpaper." At the end of her life, she wrote: "[T]he effects of nerve bankruptcy remain to this day" (*Living* 91). Gilman provided no evidence to indicate that escaping Mitchell's treatment plan provided her with lasting good health.[201] Moreover, productivity is *not* proof that someone has been cured of impairments. Because of Gilman's voluminous publications and speeches, her own friends (to Gilman's chagrin) received her complaints of chronic nervous weakness "with amiable laughter and flat disbelief" (*Living* 104). To assume that writing became an easy fix is to re-prescribe writing, rather than rest, as a cure-all remedy. Reading Gilman as cured of mental illness—or

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[201] Some current critics construe the narrator's journal-keeping in "The Yellow Wallpaper" as potentially therapeutic. However, Gilman herself asserted in an 1894 lecture that production of writing not intended for communication is a sign of individual and social ills. For an individual who construes writing as "the relieving of himself," she maintained, it is "as much his business to stop producing—to cease to express himself—as for the consumptive to forbear marrying" ("Art for Art's Sake," 16, 34, Folder 171, Gilman Papers, quoted in Thrailkill 563).

Dickinson as cured of her eye impairments, as explored in the last chapter—is to impose a wishful medical model onto the lives of women who plausibly possessed revolutionary, lifelong knowledge of disability, if only because they were continuously disabled by their social surroundings.

The "Most Patient Physician": Gilman and Dr. Mary Putnam Jacobi

There is a final piece of Gilman's story that has gone strangely ignored: after denouncing Mitchell with her statement on "The Yellow Wallpaper," Gilman sought treatment from a renowned female physician, Mary Putnam Jacobi, whose expertise and very existence caused Mitchell himself a great deal of anxiety and consternation. Jacobi offered to treat Gilman after reading "The Yellow Wallpaper." So, while other critics have asserted that writing the story served as a kind of writing-cure for Gilman, I assert that the text had a different influence: it brought her to Jacobi's care, which involved extreme treatments and yet gave Gilman a sense of control over her situation.

Jacobi resisted the belief that women were solely compassionate and thus better able to serve the emotional and spiritual needs of their patients; she saw herself as a physician and scientist first, and she used scientific method and rational arguments to protest prejudice against female physicians. In 1876, Dr. Mary Jacobi's essay, "The Question of Rest for Women during Menstruation," refuted the supposed physical limitations of women, in response to Dr. Edward H. Clarke's publication *Sex in Education; or, A Fair Chance for the Girls* (1873), which questioned the expanded role of women in society and the professions. Dr. Jacobi provided tables, statistics, and sphygmographic tracings of pulse rate, force, and variations to illustrate the stability of a woman's health, strength, and agility throughout her monthly cycle. Dr. Jacobi's admission to the Academy of Medicine made her the society's first female member. Before her death at age 63, Jacobi wrote a detailed account of her own illness in “Description of the Early Symptoms of the Meningeal Tumor Compressing the Cerebellum. From Which the Writer Died. Written by Herself.”[202]

Physicians of the 1860s-1880s especially were concerned that menstruation taxed a woman’s body and mind too much for her to pursue an education and career. In Chapter 1, I mentioned that Dickinson’s ophthalmologist, Dr. Williams, found that women could not be doctors because of their menstruation cycles. Similarly, Mitchell believed that during the ages of fourteen to eighteen, a girl’s nervous system is excessively “sensitive” and “irritable” (40). He begs the reader to closely analyze to understand his meaning: “To show more precisely how the growing girl is injured by the causes just mentioned would carry me upon subjects unfit for full discussion in these pages, but no thoughtful reader can be much at a loss as to my meaning” (40). He adds: “these, then, are a few of the reasons why it were better not to educate girls at all between the ages of fourteen and eighteen, unless it can be done with careful reference to their bodily health” (*Wear and Tear,* 40).

Jacobi and Mitchell were scientifically at odds; for example, Jacobi wrote to Mitchell criticizing his attitudes toward “medical women.”[203] Regina Morantz-Sanchez then argued that “Jacobi’s willingness to engage Gilman as an equal partner in effecting her cure stood in direct contrast to S. Weir Mitchell’s authoritarian approach” (214). Jacobi’s scientific rebuttal of the popular idea that menstruation made women unsuited to education was influential in the fight for

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[202] Jacobi was not the only physician to have this idea of writing an autobiography describing her own death: much more recently, American neurosurgeon Paul Kalanithi wrote *When Breath Becomes Air*, a non-fiction autobiographical book about his life and experience with stage IV metastatic lung cancer. The book was posthumously published in 2016.

[203] This letter has been republished as “Mary Putnam Jacobi’s Letter of Protest to S. Weir Mitchell (Circa 1891),” introduced and transcribed by Nancy Cervetti, *Transactions & Studies of the College of Physicians of Philadelphia*.

women's educational opportunities (Swaby 3). In "The Question of Rest for Women during Menstruation," Jacobi wrote plainly and clearly:

> we can find no reason to suppose that menstrual rest is desirable or necessary…It remains true, however, that in our existing social conditions, 46 per cent. of women suffer more or less at menstruation, and for a large number of these…under the command of an employer, humanity dictates that rest from work during the period of pain be afforded whenever practicable (307-308).

Jacobi navigates the question of women's rest with nuance, pointing to "our existing social conditions" and employers as the determiners of women's well-being at work. Jacobi does not refute the benefit of rest—indeed, she lists many "modifications which may be demanded in female labor" (308) that resemble modern-day work accommodations. However, Jacobi also overtly dismisses the beliefs of Clarke and Mitchell, who used menstruation as a reason to discriminate against women in schools and the professions.

Both Jacobi and Gilman shared deep concerns about the mental health of American women and operated from feminist standpoints. Jacobi prescribed to Gilman mental and physical training, used electric therapy, and gave Gilman a mixture of phosphoglycerates in wine. She also set Gilman to mental exercises, giving her books to read and recommending that Gilman write *Human Work* (which Gilman published in 1904). Though Jacobi directed Gilman's therapy, the relationship was a collaboration between peers. As quoted by Martha J. Cutter, Gilman complemented the doctor's treatments, writing that Jacobi was the "most patient physician I had ever known," who "seemed to enter into the mind of the sufferer and know what was going on there" (Cutter 170). As Gilman explains, Jacobi's treatment involved setting the "inert brain to work . . . on small, irrelevant tasks; this to reestablish the capacity for action" (*The*

Living, 291). Gilman seemingly thought that women should be allowed to participate in medical discourse (Cutter 170). While Mitchell scoffed at Gilman's written case history, Jacobi found Gilman's elaborately prepared "fever-chart" of her illness "helpful" (291). Gilman also states that Jacobi seemed to be an example of a "free and original mind, thinking for itself and working out its own methods."[204]

Jacobi and Gilman both considered the doctor-patient dynamic as potentially collaborative. According to Cutter, though, an examination of Jacobi's writings "reveals a much less positive picture of doctor-patient relations" (270). Cutter says that Jacobi:

> firmly encouraged doctors to establish their authority over patients, especially women patients. In a 1900 inaugural address at the opening of a women's medical college, for example, Jacobi states that "while treating his patient as though he were a personal friend…the physician must never forget that this same patient is, from the nature of things, a possible enemy." (Cutter 270)

Jacobi thus supported the AMA's assertion that "the obedience of a patient to the prescriptions of his physician should be prompt and implicit" (93), possibly thinking of the dangers that a patient might pose a physician in a moment of medical crisis.

I bring up Jacobi's later treatments of Gilman not because it dramatically alters the way we might interpret "The Yellow Wallpaper," which I will examine closely next, but because this female doctor's role in Gilman's life is difficult to find in some other histories. It is also noteworthy that Jacobi reached out to Gilman after reading "The Yellow Wallpaper," since—although Gilman's story in many ways failed to reach Mitchell—it *did* impact a different doctor.

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[204] Both of these statements are reminiscences Gilman wrote about her treatment by Jacobi and can be found in the *Alumnae Transactions* of the Woman's Medical College of Pennsylvania, 1907, 66 (Quoted in Cutter 270).

While Jacobi sometimes strove to grant physicians authority over patients, she and Gilman shared some interest in thinking about how physicians and patients could co-author diagnoses together.

“The Yellow Wallpaper,” Diagnosing Diagnosis, and Destructive (Rest)oration

The narrative form of “The Yellow Wallpaper” unravels as the narrator both requests and rejects diagnosis. The narrator is trapped in the winding, inescapable contradictions that surround the question of how to diagnose and whether an accurate diagnosis for medical symptoms is even possible. In doing so, Gilman’s text provides an interpretive framework for understanding issues of gender relevant to modern discourses in disability studies. The story challenges masculinized performances of medical treatment by resisting the ideology of certain kinds of cure; however, it also embraces diagnosis and cure, representing them as simultaneously desirable and destructive approaches to disorderly bodies and minds. The story is not merely an instructive, feminist text designed to teach a male physician a lesson about the dangers of infantilizing women. As Jane F. Thrailkill suggests, it shocks readers into experiencing an extreme mental and physical state of being for themselves and embraces diagnostic and curative approaches to illness. This reading captures the argument of this dissertation that diagnosis is both desirable and dangerous, a form of knowledge production that brings violent destruction even as it gestures towards healing.

For many critics, reading “The Yellow Wallpaper” has involved wondering at the text’s “symptoms.” As thoughtful as Gilman is about nervousness and hysteria, her text also brings in descriptions of suicidality and signs of potential insanity. Some critics[205] have, in Thrailkill’s wording, tried to “doctor” Gilman’s text, suggesting ways of reading the story that clarify,

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[205] See Wai Chi Dimock, “Feminism, New Historicism, and the Reader,” and Mary Jacobus, “An Unnecessary Maze of Sign Reading.”

organize, or heal the hysteria that resonates throughout its pages (557).[206] Thrailkill's main thesis, which influences my own thought, reads:

> What has led critics astray in reading Gilman's story, I would argue, is that in presenting a creepy story that in fact becomes a story of creeping, it emulates the form of such a patient, which in turn elicits in its post-Freudian readers an almost irresistible will to interpret: to in fact doctor the text….And, despite many indicators to the contrary, in almost every case the doctoring leads inexorably to an account of someone "getting better": whether it's the narrator (who, last seen on all fours, purportedly triumphs over her husband and patriarchy), or Gilman (whose biography, which involved a lifelong struggle with nervous illness, is dramatically reshaped to model an archetypal feminist success story), or even the text itself (which has, in recent decades, quite literally been canonized)….Contemporary scholars have continued to do its work, and in so doing have conflated the activities of literary critic and psychotherapist….such critics are left with the satisfied sense that someone's life story has been successfully reconfigured—if only their own. I am arguing, by contrast, that contemporary readers of Gilman's story were not duped by the patriarchal script when they avoided the hermeneutic entanglements of the text and instead reacted to "The Yellow Wallpaper" in physiological terms. (549-550)

Like Thrailkill, I am suspicious of reading methods that conflate "the activities of literary critic and psychotherapist" (as in my chapter on Dickinson and diagnostic reading). I am reading the "entanglements" of Gilman's text differently, considering how symptoms in stories might not be

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[206] Critics who famously read "The Yellow Wallpaper" in order to explain the narrator's symptoms or diagnose the author herself include Sandra Gilbert and Susan Gubar, *The Madwoman in the Attic* (89-92); Annette Kolodny, "A Map for Rereading" (451-67); and Jean E. Kennard, "Convention Coverage or How to Read Your Own Life" (168).

diagnosed but could instead lead readers to embrace tangles and messiness as crucial to knowledge of disabled embodiment. I lean into the concept of messiness in particular, turning Tobin Siebers' understanding of "Complex Embodiment"—the enmeshment of social and embodied for disabled experience—into *messy* complex embodiment, a phrase that even more explicitly invites the impossibility of understanding symptoms, resisting patriarchal medicine, and destroying treatment. These are some of many aspects of disabled and chronically ill life that fundamentally defy simplicity and organization yet fuel collective resistance, and which Gilman's story explores with openness.

As the narrator embraces destruction and the promise of the destruction of her own illness, her writing itself becomes fragmented and ambiguous. Over the course of the text, hysteria, the rest cure, the house itself, and the wallpaper are all submitted as possible causes for the narrator's symptoms. Each of these uncertain diagnoses is met with confusion, rejection, and demolition while the narrator is trapped in systems of medical authority. As Clare argues, "Cure [is] laced with violence, which [prompts] resistance, which in turn [is] met with more violence, all of it sustained by diagnosis" (47). By thinking about Gilman's history through this lens, we can see that Gilman requested a diagnosis, discovered the deceptively and violent quality of Mitchell's gendered treatment, and was prompted to resist. However, Gilman's story does not cure hysteria or offer new modes for its treatment. The urge to diagnose is itself under question throughout the tale, and there is no neat resolution to either Gilman's or the narrator's ailments.

Today, the realization that nervous disorders may not be fixed is not necessarily a depressing or pessimistic discovery. Rather, this knowledge may empower new ways of appreciating disorders that are chronic, undiagnosable, and incurable and help us to recognize the times when care outweighs cure. I next reveal that "The Yellow Wallpaper" puts into literary language the desire for diagnosis and cure. These desires are politically fraught, violent, and idealistic rather than achievable—especially for people with chronic illnesses that are not magically named by diagnosis nor easily eradicated by cures.

In the story, a woman is driven mad by her physician-husband, John, who contains her in her room as a part of medical treatment. Motherhood, and the narrator's struggle to live as a mother, are also positioned as causes of the narrator's illness. In in the story, the narrator mentions how she is incapable of taking care of the child: "It is fortunate that Mary is so good with the baby. Such a dear baby. And yet I cannot be with him, it makes me so nervous" (Gilman, "Yellow Wallpaper" 12). Mitchell proposed that the rest cure for women consisted of staying at home and fulfilling their responsibilities as "good mother[s]." The "cure" was based upon the dominant gender roles of the time, which assumed that a woman's highest calling was to be a caregiver, which then led to "myths" about women's physiology and psychology. It seems that doctors such as Mitchell believed that locking women in a room with their family (including children) was a good idea, as returning women to their "natural state" would "cure" them of their mental illness. In fact, what happened is the complete opposite, as Gilman mentioned in her letter that her agony only came after the childbirth.

Though the narrator is a patient, she also acts as a diagnostician. Finding John's explanation that there is "nothing the matter with [her] but temporary nervous depression—a slight hysterical tendency" unsatisfactory, the narrator diagnoses her surroundings, writing, "there is something strange about the house—I can feel it" (Gilman 10). The narrator then spends large portions of the text studying her room's ugly yellow wallpaper, gazing out of the window, and contemplating "burning the house" (Gilman 15). Generally assumed to signify the protagonist's growing insanity or the destruction of a symbol of domesticity, the focus upon the house in fact indicates the narrator's longing for cure, suggesting that the narrator intuits that cure necessitates some form of destruction. Hoping to find the answer to her problems, the narrator understands the desirability of diagnosis and realizes that a "restoration of health" would require violent, architectural "restoration." She writes:

> John is practical in the extreme. He has no patience with faith, an intense horror of superstition, and he scoffs openly at any talk of things not to be felt and seen and put down in figures. John is a physician, and perhaps— (I would not say it to a living soul, of course, but this is dead paper and a great relief to my mind—) perhaps that is one reason I do not get well faster. You see he does not believe I am sick! And what can one do? (Gilman 10)

The story finds John to be a poor physician, perhaps reflecting Gilman's loss of faith in physicians like Mitchell. The narrator assumes diagnostic authority, suggesting that she herself has a better understanding of her own condition than the male doctors do. The narrator is willing to diagnose her problems, seeing John as one reason she does "not get well faster." She is also willing to consider various cures in hopes of mitigating her symptoms. The story continues:

> I take phosphates or phosphites whichever it is, and tonics, and journeys, and air, and exercise, and am absolutely forbidden to "work" until I am well again. Personally, I disagree with their ideas. Personally, I believe that congenial work, with excitement and change, would do me good. But what is one to do? I did write for a while spite of them; but it does exhaust me a good deal-having to be so sly about it, or else meet with heavy opposition. I sometimes fancy that in my condition if I had less opposition and more society and stimulus—but John says the very worst thing I can do is to think about my condition, and I confess it always makes me feel bad. (10)

The narrator disagrees with the ideas presented by male authorities in her life, but, as she repeats several times, “What is she to do?” She does not complain about any physiological symptoms here, but instead complains about the “opposition” she is facing. She desires good health, shown by the fact that she has thought about what kind of actions—such as exercise—would help “do her good” (10).

The narrator claims that she does not write very much because John has forbidden it; however, she *is*, of course, still writing, because we are reading her first-hand account, secretly written in her journal. The existence of the story itself, penned by a narrator forbidden from pen and paper, signifies resistance and defies John and his views. The narrator attempts to cure herself—not just of hysteria, but of the oppressive attitudes that surround her. Later on, the story addresses Mitchell directly: “John says if I don’t pick up faster he shall send me to Weir Mitchell in the fall. But I don’t want to go there at all. I had a friend who was in his hands once, and she says he is just like John and my brother, only more so!” (11). The narrator’s desire for diagnosis and cure is driven, in part, by the fear that further illness will result in additional, damaging treatments. She needs to “pick up” because the threat of additional diagnosis and treatment loom over her future. While John treats the narrator with “tonics and things, to say nothing of ale and wine and rare meat” (11) the narrator tries to alleviate her symptoms by writing. She feels conflicted over this choice, writing, “I don’t know why I should write this. I don’t want to. I don’t feel able. And I know John would think it absurd. But I must say what I feel and think in some way—it is such a relief! But the effort is getting to be greater than the relief” (11).

When the narrator becomes obsessed with the ugly wallpaper in the room John confines her in, she performs what Price might call a “counter-diagnosis,” by insisting that the wallpaper worsens her sickness. She fervently writes in her journal: “The color [of the wallpaper] is repellant, almost revolting; a smouldering unclean yellow, strangely faded by the slow-turning sunlight. It is a dull yet lurid orange in some places, a sickly sulphur tint in others…I should hate [the wallpaper]…if I had to live in this room long" (13). The narrator's description of the paper mimics a body's experience of sickness, echoing the changing pallor that transformed the face of Mitchell's patient in "Autobiography of a Quack." Critics often argue that the wallpaper symbolizes the narrator's sickness (hysteria);[207] however, the wallpaper magnifies not the effects of the illness, but of the cure. The winding leaf pattern in the wallpaper resembles a cage, symbolic of her imprisonment in the room. Moreover, the narrator's claim, "I should hate [the wallpaper] myself if I had to live in this room long" indicates that she realizes that if the rest cure is inflicted upon her for a long time, her hatred of the wallpaper will only grow. The narrator grows suspicious not of her hysteria symptoms, but of the paper, and indulges in diagnostic patterns of thought that lead her to see the paper as the cause of her problems. Believing that the paper is infectious, and that its mind-altering consequences impact John's abilities to diagnose, the narrator satirically diagnoses John, demonstrating her simultaneous desire for diagnosis and hatred of what the rest cure is taking from her. After noticing that John is watching her and observing her symptoms, the narrator mockingly imitates John's diagnostic thought, explaining why he "seems very queer sometimes" by saying that "It strikes me occasionally, just as a scientific hypothesis,—that perhaps it is the paper!" (26-27). This appropriation of John's scientific approach demonstrates that the narrator continues to simultaneously experiment with, and mock, diagnostic performances as overconfident attempts to understand reality.

The narrator begins to imagine destroying the wallpaper so earnestly that she visualizes death within its pattern. She secretly writes in her journal:

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[207] Gilbert and Gubar famously offer this analysis in *The Madwoman in the Attic* (89-92).

> I never saw a worse paper in my life. One of those sprawling flamboyant patterns committing every artistic sin. It is dull enough to confuse the eye in following, pronounced enough to constantly irritate and provoke study, and when you follow the lame uncertain curves for a little distance they suddenly commit suicide—plunge off at outrageous angles, destroy themselves in unheard of contradictions. (13)

The narrator's insistence that the wallpaper has the power to "provoke study" indicates that she wants to bring a diagnostic eye to the scene. She seems almost frustrated at the pattern's lack of interest in keeping itself alive—a frustration echoing Mitchell's annoyance at the lethargy and suicidality of some of his nervous patients. The narrator is not merely a patient when she studies the wallpaper; she is also imitating a doctor, performing the diagnostic inquiries that readers of the story so often dismiss as patriarchal acts that signify the failures of Western male medical science. In other words, the narrator does not simply hate diagnosis and its resulting treatments; she displays her observative mind, her ability to mimic the acts of physicians and psychotherapists.

The narrator notes here that the curves and lines of the wallpaper seem to "destroy themselves" (13). While this phrase is generally interpreted as symbolic of the possibility that hysteria may lead to the urge to complete suicide, the narrator's interpretation of the wallpaper's pattern could indicate that she recognizes that treating hysteria necessitates a death of the self. John's insistence on her imprisonment becomes a violent destruction of the narrator's creative desires. As the narrator continues to fixate upon the wallpaper as the source and embodied material reality of her physical *and* social condition, the short story itself copies the paper's disorderliness. The narrator had described the paper as "one of those sprawling flamboyant patterns committing every artistic sin" (13). For paper—the material on which Gilman's very story is printed—to be described in such an extreme way demonstrates that “The Yellow Wallpaper” is becoming as unruly and destructive as the wallpaper itself. The narrator’s own written journal and Gilman’s written story arguably commit “every artistic sin.” They are written despite the commands of the narrator’s and Gilman’s doctors, and they fixate on wallpaper—an object traditionally thought to belong to a domestic, not literary or scholarly, realm.

As time passes, the narrator begins to suspect that she is having, in Gilman’s words, “brain troubles.” However, her fears are rapidly dismissed by her husband, who refuses to even think about the possibility that there is something wrong. He insists:

> “Really, dear, you are better!”
>
> “Better in body perhaps”—I began, and stopped short, for he sat up straight and looked at me with such a stern, reproachful look that I could not say another word.
>
> “My darling,” said he, “I beg of you, for my sake and for our child’s sake, as well as for your own, that you will never for one instant let that idea enter your mind! There is nothing so dangerous, so fascinating, to a temperament like yours. It is a false and foolish fancy. Can you not trust me as a physician when I tell you so?”
>
> So of course I said no more on that score. (Gilman 13)

Here, John consistently silences his wife, rejecting even the implication that there is something the matter with her mind. John is insistent that the narrator should “trust” him as a physician. The narrator follows this conversation with more rumination about the paper:

> I lay there for hours trying to decide whether that front pattern and the back pattern really did move together or separately.
>
> On a pattern like this, by daylight, there is a lack of sequence, a defiance of law, that is a constant irritant to a normal mind. (13)

Like John, the narrator struggles to accept the possibility that her mind is playing tricks on her. The narrator suggests that she still thinks of herself as having a "normal mind." This echoes Gilman's refusals elsewhere to consider the possibility that she ever experienced madness. In Gilman's world, madness was the worst possible answer to health issues, and nervous disorders were a more satisfactory diagnostic explanation. As frustrating as the rest cure was, at least conditions of the nerves were treated with rest while madness might result in confinement in the asylum.[208]

The narrator soon begs John to get rid of the wallpaper, hoping that she can banish the material embodiment of her imprisonment as well as her perceived cause of illness. However, John laughs at her, evoking Gilman's own plea of Mitchell: "I beg of you not to laugh at me as every one else does" (12). The narrator writes:

> I suppose John never was nervous in his life. He laughs at me so about this Wallpaper! At first he meant to repaper the room, but afterwards he said that I was letting it get the better of me, and that nothing was worse for a nervous patient than to give way to such fancies. "You know the place is doing you good," he said, "and really, dear, I don't care to renovate the house just for a three months' rental." "Then do let us go downstairs," I said, "there are such pretty rooms there." (14)

John never does permit his wife to leave the room, insisting, "You know the place is doing you good." He finds the house and room to be curative, whereas the narrator picks out the room and house as *causes* of her illness. The narrator's desire to be rid of the wallpaper can be read as an attempt to cure herself *of* the rest cure. Just as Eli Clare argues that cure involves restoration, a type of destruction with the end goal of returning something to a previous, presumably healthy

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[208] For more on literature, the asylum, and madness, see Benjamin Reiss's *Theaters of Madness*.

state, the narrator desires to see the room renovated, and herself freed from the house and the wallpaper's winding, lurid pattern that invites diagnostic interpretation.

Renovation and repair are hidden in plain sight in the story's pages. The fact that John and the narrator's former home is being restored while John tries to restore the narrator to good health also indicates the narrator's longing for the violence of restoration. The narrator tries to convince John that she would like to leave these "ancestral halls":

> I thought it was a good time to talk, so I told him that I really was not gaining here, and that I wished he would take me away.
>
> "Why darling!" said he, "our lease will be up in three weeks, and I can't see how to leave before. The repairs are not done at home, and I cannot possibly leave town just now. Of course if you were in any danger I could and would, but you really are better, dear, whether you can see it or not. I am a doctor, dear, and I know." (14)

Just as Mitchell asserted that "the process of repair might well have been called a renewal of life," which he associates with women who gain weight, here Gilman shows her understanding that the narrator's health connects to "gaining" (Mitchell, *Fat and Blood* 195). John insists that the narrator is "better" but that their home is not yet complete. Gilman cleverly presents us with a woman who is still not repaired, as well as a distant home that is also not yet repaired. John is able to perceive that "[t]he repairs are not done at home"; however, he fails to see that the narrator is still struggling. He cites his own knowledge and authority, reassuring her, "I am a doctor, dear, and I know" (14.) The abruptness of this line evokes Gilman's own assurance that she believed in Mitchell's authority: "But you will know" (Knight 274). John continues:

> "You are gaining flesh and color, your appetite is better. I feel really much easier about you."

> "I don't weigh a bit more," said I, "nor as much; and my appetite may be better in the evening, when you are here, but it is worse in the morning when you are away."
>
> "Bless her little heart!" said he with a big hug; "she shall be as sick as she pleases!"
>
> (Gilman 12)

The focus on "flesh and color" indicates the story's attention to Mitchell's *Fat and Blood.* The narrator again reveals her attention to her own symptoms, asserting that she still lacks appetite. John again dismisses her self-diagnostic claims about her symptoms by saying that "she shall be as sick as she pleases!" This statement echoes the lack of faith that physicians had in their female patients, especially, as well as their refusal to trust a woman's description of her own experiences.

The complexities and contradictions of "The Yellow Wallpaper" deepen when the narrator next begins to see a woman, trapped and creeping, within the wallpaper. She becomes fascinated by this human form. The narrator writes:

> At night in any kind of light, in twilight, candlelight, lamplight, and worst of all by moonlight, it becomes bars! The outside pattern I mean, and the woman behind it is as plain as can be. I didn't realize for a long time what the thing was that showed behind, that dim sub-pattern, but now I am quite sure it is a woman. By daylight she is subdued, quiet. I fancy it is the pattern that keeps her so still. It is so puzzling. It keeps me quiet by the hour. (23)

The bars on the window are shadowed by moonlight onto the walls and the narrator's shadow seems trapped within them. The sudden insertion of this trapped woman into the narrative creates a doubling effect that shapes the story into a tale about two women, the narrator and her echo in the wall. This may inspire (especially female) readers to become self-conscious about the fact that they themselves are gazing upon Gilman's on-paper story—especially since, evidently, paper has the power to push a woman's imagination in astonishing and dangerous directions. Readers themselves are studying, with rapt and productive fascination, a paper which has a pattern that becomes more complex "by the hour" (23). The hysteria of the wallpaper is passed onto the narrator's text, which is then absorbed by Gilman's audience.

While the woman in the wallpaper can be read as the narrator's desire for community with other, similarly confined women, a disability studies framework challenges this feminist reading by revealing the woman in the wallpaper as part of the story's power to spread disability via textual engagement with unruly forms. Through reading a complex piece of paper, readers do not just gain experience with diagnostic puzzles (as Cutter suggests). Readers might, in fact, experience the symptoms of the narrator, who makes her condition contagious through the act of journalistic writing.

As she follows the movements of the woman behind the paper, the narrator confesses her watchfulness to her ever more attentive reader and indicates that she no longer sees the wallpaper solely as a symbol of imprisonment. Studying the wallpaper gives her mind something to do, demonstrating the intriguing power of diagnostic thought:

> Life is very much more exciting now than it used to be. You see I have something more to expect, to look forward to, to watch…[John] laughed a little the other day, and said I seemed to be flourishing in spite of my Wallpaper. I turned it off with a laugh. I had no intention of telling him it was because of the Wallpaper—he would make fun of me. He might even want to take me away. (Gilman 27)

The narrator no longer thinks about her "return" to health and doesn't want the wallpaper to be taken away; she rather thinks about what she has "to look forward to" (27). She identifies with the woman she sees within it, and the symbol of her imprisonment is twisted into a symbol of liberation. By now, the narrator is determined to find out the wallpaper's meaning. During the day, by "normal" standards, it remains "tiresome and perplexing" (28). But at night she sees a woman, or many women, shaking the pattern and trying to climb through it. Women "get through," she perceives, "and then the pattern strangles them off and turns them upside down, and makes their eyes white!" (30). The wallpaper never becomes attractive, nor do the women inside it find liberation through healing. It remains indeterminate, complex, unresolved, disturbing; it continues to embody, like the form of the story we are reading, "unheard of contradictions" (13).

The story ends in confusion. The simultaneous urge to diagnose and the hatred of diagnosis and its consequences meet in a moment of total unruliness. The narrator invites John into her room. John cries, "'What is the matter?'...'For God's sake, what are you doing!' I kept on creeping just the same, but I looked at him over my shoulder. 'I've got out at last,' said I, 'in spite of you and Jane! And I've pulled off most of the paper, so you can't put me back!' Now why should that man have fainted? But he did, and right across my path by the wall, so that I had to creep over him every time!" (36). These lines refuse to clarify what has happened. "Jane" has never before been mentioned—the narrator's true name seems to have been dictated only in this moment of destruction. The woman in the wallpaper and the narrator—now seemingly the same woman—have pulled off the wallpaper, so that the hysteria is liberated and the symbol of the rest cure is demolished. The narrator claims that John fainted; she implies that he has been infected with "weakness," or the hysteria he himself assigned to the narrator.

While at the beginning of the story the narrator indicated that she was writing down this entire first-person account in her journal, that narration is now thrown into disbelief (for how could she write this account if she is “creeping?”) Hysteria is never cured in the story; rather, hysteria—its wildness, its randomness, and its slippery diagnostic categorization—makes Gilman’s most famous literary work possible. The story’s narrator rejects a restoration or return to health; instead, she has produced something very new, an outcome completely at odds with her physician-husband’s expectations. She has, in alignment with the story’s many contradictions, cured herself of the rest cure. By making explicit the impossibility that the narrator could write this story down in the midst of the story’s final moments, Gilman abandons a traditional form of narration, which causes the story itself to embody forms of both disorder and cure.

This chapter has taken past readings that assume diagnosis and cure are the natural consequences to finding disorder within a bodymind or paradox within a literary text. As I have argued, sometimes literature can utter symptoms while passing on disorder, maintaining a sense of the chronic nature of some conditions, and while identifying diagnosis itself as a possible negative condition that might physically harm the human beings who are made objects of medical scrutiny. Continuing my analysis of the “names” that are given to sickness, the next chapter will even more dramatically consider the metaphorical use of terms like “cancer” to resist and fight debilitating institutions—the “cancer of slavery,” for example. While the metaphorical leveraging of disability (as tragedy) can be damaging for people living with disabilities, I show that real and metaphorical are not concrete, especially for black writers of the nineteenth century who use figurative language of disability to target systemic sources of oppression and then explore the ways writing contributes to the foundation of community for disabled people of color.

Chapter Three

Frances E. W. Harper, Diagnosing Injustice, and Communities of Care

Introduction

> "Slavery," said Iola, "was a fearful cancer eating into the nation's heart, sapping its vitality, and undermining its life."
>
> "And war," said Dr. Gresham, "was the dreadful surgery by which the disease was eradicated…Time alone will tell whether or not the virus of slavery and injustice has too fully permeated our Southern civilization for a complete recovery."
>
> (Frances E. W. Harper, *Iola Leroy Or, Shadows Uplifted,* 1892, 189)

In letters, Black American lecturer and writer Frances E. W. Harper represented her own general illness and fatigue. "I am still in the lecturing field," she wrote, "though not very strong physically" (Still 761). Harper adds, "I am almost constantly either traveling or speaking…I am giving all my lectures free…how tired I am some of the time…yet today, with my limited and fragmentary knowledge, I may help the race forward a little" (772). She depicts her symptoms in general terms and refers to the necessity of her labor—which she is compelled to do without pay. Harper also represents her knowledge as "limited and fragmentary," connecting her work to the limitations she may perceive in her bodymind. Ending with "I may help the race forward a little," Harper modestly acknowledges that she possesses the skills to imagine and build free futures. Harper then created her 1892 novel *Iola Leroy,* a novel that features abrupt leaps through history and genre, moving rapidly from Civil War nursing stories to political speeches to dialogue about education. With this pedagogical focus, *Iola Leroy* leads us through a complex epistemological history of disability and race from 1861-1872, entangled with fact and fiction.

I open with Harper's self-expression of her fatigue to argue that her novel produces knowledge about disability by teaching us how to reckon anew with bodymind pain. Early critics declared *Iola Leroy* a failure both aesthetically and politically, dismissing it "on the grounds of a lack of artistic merit" (Carby 63). Sterling Brown, Arthur P. Davis, and Ulysses Lee have said that the novel emphasizes "dull" piety rather than focused politics. Iola is outwardly white, which has also been controversial, as some critics condemn her appearance as evidence of her creator's subservience to white norms. Other characters (including Iola's mother Marie and her husband Dr. Latimer) also look white. Key to the overall story is Iola's insistence on her Blackness and the attention she shows her Black heritage.[209] Its form drew much negative attention, a sign that fragmentation (of body, knowledge, and text) was and is too often read as a shortcoming. More recently, scholars including Michelle Ann Stuckey, Cynthia J. Davis, Kyla Schuller, and others celebrate the novel despite—or perhaps because of—the ways it bridges different genres such as realism and sentimentalism.

Harper's *Iola Leroy* features abrupt leaps through history and genre, moving rapidly from Civil War nursing stories to political speeches to dialogue about education. Fatigue is a common theme in the story, but furthermore, aesthetic and formal elements of the text are altered slightly by Harper's choice to include her lecture notes verbatim in the story. This was done for many reasons—the lectures Harper gave could reach a larger audience when included in a novel, and it makes sense for characters like Iola to give similar speeches. One other reason was necessity and ease; by including previously-written material, Harper might have spared herself the effort of

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[209] I will not bother with the question of whether the novel was an aesthetic failure as that question has already been decried as racist and sexist by scholars such as Michele Birnbaum.

reinventing the wheel and writing new material, effort that could have been a struggle while she was "tired some of the time" (Still 761).

This chapter will analyze *Iola Leroy* alongside other works that use analogy and figuration to compare race to disability and render slavery as virus or cancer. Literary texts, I suggest, offer something unique to this way of figuring diagnosis as a tool for social justice, because within them is a particular place or set of forms that renders a relationship between structure and health visible. Literature often explores the figurative, and it can take diagnostic tools beyond the clinic and use them to productively address social problems beyond the imagined boundaries of the human bodymind.[210] I also investigate figurative uses of diagnosis. While our understanding of diagnosis is often individuated, it is also often used figuratively to address larger social ills. This is not a uniquely Black feminist perspective—many "epidemics," such as epidemics of loneliness and obesity in the past few decades, were simply figurative uses of the term. I ask, how do nineteenth-century Black American authors revise diagnosis's individuality—its focus upon sole specimens—and use diagnosis-analogous methods (of examination, labeling, and then prescription) to address larger social "ills"?

The previous chapter analyzed Charlotte Perkins Gilman's "The Yellow Wallpaper," published in 1892 after Mitchell treated Gilman with the damaging rest cure. Like "The Yellow Wallpaper," *Iola Leroy* was also published in 1892, and also explores nervous disorders and alternatives to the rest cure. While Gilman engages the horror genre to explore extremes of insanity and hysteria, Harper mines the sentimental genre, which often relies on depictions of

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[210] Thank you again to Sari Altschuler for her help on this section when she gave comments on my paper "'The Virus of Slavery and Injustice': Analogy and Disabled Life in Black American Writings, 1856-1892" at the Dina G. Malgeri Modern American Society & Culture Seminar for the Massachusetts Historical Society. (Oct. 28, 2021).

disability to facilitate social reform.[211] The novel complicates our notions about the boundaries between genres, and also complicates our understandings of "bodyminds"—the entwining of the mental and physical—in the context of race, gender, and disability. *Iola Leroy* exposes Mitchell's rest cure as an ineffective way of treating nervousness, and goes beyond the critique of "The Yellow Wallpaper" by making clear that while white women were diagnosed with nervousness and prescribed rest, Black women were often not allowed to rest from work, even if their bodyminds demanded it. When Harper depicts physiological reactions to emotional distress, she represents darkening and flushing of the face as a marker of passion and vitality, while paleness is represented as a sign of illness. In a sense, Harper shares this view with white physician Dr. Silas Weir Mitchell, per the last chapter. In his seminal work *Fat and Blood: An Essay on The Treatment of Certain Forms of Neurasthenia and Hysteria* (1872), Mitchell describes feeding milk to women he diagnosed with neurasthenia or hysteria. He claims the milk "cured" them when, after his treatment, they began to breastfeed and menstruate again. Mitchell remarks, "I can only say that I have watched again and again with growing surprise some listless, feeble, white-blooded creature learning by degrees to consume these large rations [of milk], and gathering under their use flesh, color, and wholesomeness of mind and body. It is needless to say that it is not in all cases easy to carry out this treatment" (138). These "white-blooded" patients, exposed to what Mitchell called the "rest cure," would have indeed been white: in 1881, Dr. George M. Beard claimed that because neurasthenia was caused by modernity and evolution, "Catholics, southerners, Indians, and Blacks" were not susceptible to the disorder (Schuster 18).

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[211] *Iola Leroy* explores the sentimental genre, but as Michele Birnbaum argues, "the medicalization of the mulatta and of her sentimental plot…puts the lie to any easy generic distinctions among realism, romance, and racial uplift fiction" (9). For more on Black feminist biopolitics in Harper's sentimental novel, see Kyla Schuller's "Body as Text, Race as Palimpsest: Frances E. W. Harper and Black Feminist Biopolitics" (2018).

White physicians often diagnosed Black patients with "Negro Diseases" instead, as discussed above. When Mitchell looks for "color," he sees white women's flushing skin as evidence that he successfully cured disorder; meanwhile, when Harper refers to Iola Leroy's flushing face, she depicts a mixed-race woman with neurasthenia who possesses the vitality needed to undertake care work and the labor of working for racial uplift. Moreover, while Black characters (such as Harry Leroy, as I will show) sometimes rest when they are ill, but generally, rest is inaccessible for Black mothers, nurses, and physicians in the novel. Issues of gender are clearly relevant here, as women do much of the labor of caring for others who experience the traumas of enslavement and racial prejudice.

Iola Leroy acknowledges care work labor, presenting it as necessary if America is to rebuild; yet the novel also recognizes that this work results from gendered and racialized oppression, and the work itself has disabling consequences. As *Iola Leroy* represents the damage done by the institution of slavery, it suggests that embodied experiences teach us that such damage might be remedied and cared for. *Iola Leroy* challenges the general idea of cure; unlike Mitchell, Harper understands nervousness to be chronic and connected to enslavement, racial prejudice, and labor. Though cure may be desirable, it is a radical destruction of an unwanted condition and, like rest, it is inaccessible for Black characters. Iola is never cured of her nervousness, which she experiences all her life. Nevertheless, the novel ends on a hopeful note when Iola marries a physician-husband, Dr. Latimer, who proposes by asking that she "commit [herself]. . . to my care" (268). Significantly, I suggest, Harper denounces the disablement of slavery without advocating for the erasure of disability in the process. By offering care for Black characters, Harper counters the notion that all illnesses result in either cure or death; furthermore, she manages to decry the disabling effects of slavery without necessarily decrying disability itself.

In the nineteenth century, slavery and racial prejudice were often likened to illness, as in the quote above. Modern debates about analogy and cure-care, as I will demonstrate, shed light on pressing issues in nineteenth-century Black American texts and offer new ways of pursuing coalitional work across disability studies and critical race studies relevant to ongoing political-medical crises. Since May 2020, numerous articles that figure *racism* as a *virus* have appeared in popular publications. Several of these articles suggest that "racism is a virus" or "racism is the real pandemic," drawing upon the tragedy of the coronavirus pandemic to expose racism as deadly.[212] Occasionally, but not often, these pieces address the ways racism, ableism, and the pandemic are disabling, and disproportionately impact disabled people of color; sometimes, they troublingly imply that racists are mentally ill. Some activists criticize the analogies in these articles, pointing out that unlike a pandemic, racism is intentional and structural.[213] These articles and activists ask imperative questions: How do ideologies spread like viruses? How do people in power use a pandemic to bring about intentional harm? What do we gain when we compare racism to illness, and race to disability?

These questions gesture towards a larger issue in disability studies and critical race studies: that of analogy and figuration. I draw upon crip theory, which expands disability studies by "including within disability communities those who lack a 'proper' (read: medically

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[212] There are many examples of this; see Aimee Fanter, "Hate Is a Virus—Racism during COVID-19," and Monica Cannon-Grant & David J. Harris," Structural Racism is the Real Pandemic."

[213] Disability activist Mia Ives-Rublee asserts: "Racism is not a virus. It's structural. It's intentional. Let's not be ableist while describing racism. Ableism is enmeshed in racism and we don't need to feed into that system" (Ives-Rublee).

acceptable, doctor-provided, and insurer approved) diagnosis for their symptoms" (Kafer 18). I also agree with Kafer's point that diagnosis has contributed to assumptions about who can identify as disabled and participate in the disability studies community underlines diagnosis's power in these fields of study. Disability studies and crip theory usefully focus on the social aspects of disability and illness rather than uncritically accepting stigmatizing representations of pain in texts.[214] Literature can illustrate overlapping dynamics between disability, race, and gender, inviting us to explore the ways race is "like" disability, slavery is disabling, and disability shapes new communities of care.

In thinking about how systems disable individuals, I draw on the work of two scholars here in particular: Jasbir K. Puar and Lauren Berlant. As Puar writes in *The Right to Maim: Debility, Capacity, Disability*, debility

> Foregrounds the slow wearing down of populations instead of the event of becoming disabled. While the latter concept creates and hinges on a narrative of before and after for individuals who will eventually be identified as disabled, the former comprehends those bodies that are sustained in a perpetual state of debilitation precisely through foreclosing the social, cultural, and political translation to disability (xiv).

Puar finds disability is something largely denied historically marginalized communities, and that for people who are marginalized and historically marginalized, not working is not an option. My analysis of care work in Harper's novel will benefit from attention to Puar's argument. For

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[214] See Tobin Siebers' *Disability Theory*, which analyzes the tension between the "social model" of disability and the material details of impairment. Also see Sari Altschuler's recent definition of historical cripistemology, a method that quote "centers the embodied experiences and epistemologies of disability in particular times and places to help us understand literary and cultural landscapes anew" ("Touching the Scarlet Letter: What Disability History Can Teach Us about Literature," 92).

example, her project evolves around the question, “What are the vectors for a politics of disability if debility marks the convergence of capitalism and slow death via its enfolding into neoliberalism?” (1). With this question, Puar usefully builds on the work of Lauren Berlant, who, though a scholar of gender studies and not explicitly a disability scholar, does situate their theories about chronic conditions in America within a nineteenth-century framework. Of “slow death” Berlant writes:

> This so-called epidemic, seen as a shaming sickness of sovereignty, a predicament of privilege and of poverty, a crisis of choosing and antiwill, and an endemic disease of development and underdevelopment, engenders strong data, florid prose, and sensational spectacles that I have no intention of reducing to their proper analytical and affective scale. I recast these within a zone of temporality we can gesture toward as that of ongoingness, getting by, and living on, where the structural inequalities are dispersed, the pacing of their experience intermittent, often in phenomena not prone to capture by a consciousness organized by archives of memorable impact. I want to prompt a thought about a kind of interruptive agency that aspires to detach from a condition or to diminish being meaningful. In short, every day more and more advice circulates about how better to get the fat (the substance and the people) under control. It would be easy and not false to talk about this as an orchestrated surreality made to sell rugs, services, and newspapers and to justify particular new governmental and medical oversight on the populations whose appetites are out of control (a conventional view of the masses, subalterns, the sexually identified, and so on). We learned most recently from AIDS, after all, that the epidemic concept is not a neutral description; it’s inevitably part of an argument about

> classification, causality, responsibility, degeneracy, and the imaginable and pragmatic logics of cure.

These terms, debility and slow death, are both valuable for this chapter, yet I will primarily draw upon Berlant's notion of slow death to explore Iola's encounters with hysteria and nervous prostration. In doing so, I also take up Berlant's call to expand the nineteenth century archives and contribute to scholarship that centers Black women who, exhausted by the labor of fighting for Black rights, wrote with and through bodymind fatigue, producing new knowledges about the value of communal care.

I also continue to draw upon theories from critical disability studies, which usefully focuses on the social aspects of disability (and connected experiences of illness and pain), rather than uncritically accepting symptoms and diagnoses represented in texts.[215] I am particularly delighted about Dennis Tyler Jr.'s new book, *Disabilities of the Color Line: Redressing AntiBlackness from Slavery to the Present*, which reveals how disability and disablement have shaped Black social life in America. Tyler argues that Black authors and activists have consistently avowed what he calls the *disabilities of the color line*: the "historical and ongoing anti-Black systems of division that maim, immobilize, stigmatize, and traumatize Black people in a manner that advances or sustains white supremacy and white privilege" (xiii). Tyler argues that "Black people from the antebellum period to the present have been cast as disabled—as unfit for freedom, incapable of self-governance, or contagious within the national body politic" (xiii).

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[215] See Tobin Siebers' *Disability Theory*, which analyzes the tension between the "social model" of disability and the material details of impairment, and Alison Kafer's *Feminist, Queer, Crip*. For another foundational disability studies work that asserts disability studies' place at the center of such literary and cultural inquiries, see Ellen Samuels' *Fantasies of Identification.*

Tyler and I agree that the Black literary tradition exposes the disablement of racism without disclaiming disability (back cover). The book shows how

> Black writers and activists live through, recount, and avow such discursive and material disablement without unequivocally disclaiming disability or the lived experiences of disabled people. In doing so, they conceive or create dynamic new worlds that account for people of all abilities through a variety of ways: their acts of writing…radical traditions and performances, activism and defiance against ableism and racism (1).

Tyler claims that "while some writers have affirmed disability to capture how their bodies, minds, and health have been made vulnerable to harm and impairment by the state and its citizens, others' assertion of disability symbolizes a sense of community as well as a willingness to imagine and create a world distinct from the dominant social order" (back cover). This is a crucial intervention, one that revises past disability scholarship that has historically been narrowly focused on white people with disabilities.[216]

Tyler critiques, among other ableist literary interpretive traditions, the "triumphalist narrative of overcoming where both disability and disablement alike are shunned" (back cover). Sari Altschuler also observes and questions the "triumphalist narrative of medicine" (2020 para. 1).[217] As demonstrated in the previous chapters on Dickenson and Gillman, rethinking triumphalist narratives of medicine is crucial for my project as well. Michel Foucault's *The Birth of the Clinic* (1963) remains influential for studies of the codification of institutionalized medical authority in the modern Western world. Foucault emphasizes how socio-political objectives

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[216] See Chris Bell, "Is Disability Studies Actually White Disability Studies."

[217] In an article about the coronavirus pandemic, "Learning from Crisis: Narrative and the History of Medicine," Altschuler writes, "Triumphal narratives about medicine are failing us" (para. 1).

shaped the motives and desires of medical practitioners and patients, arguing that the triumphalist narrative of modern medical progress in the Western world should be regarded not as a history of scientific advancement, but as a discourse of power. As Tiffany DeRewal writes, the field of medical history has long been dominated by an "established, establishment" narrative, "thought to be written exclusively by physicians for other physicians, consecrated to heroic celebration of great doctors and their achievements, Whiggish and triumphalist, unapologetically internalistic and naively positivist" (Huisman and Warner 2, quoted in DeRewal 23). In the nineteenth century, some texts also represented "the triumph of enlightened Christian science over the problem of slavery" (DeRewal 198). The twentieth century especially saw a complex methodological shift too complicated to detail here, but essentially, by the 1980s,

> An increasing number of scholars and institutions began to offer critiques of linear, progressivist histories of Western medical progress…. The "problem with this triumphalist tradition, as Ludmilla Jordanova emphasizes, 'was that the teleology did not allow for discursive negotiations or for considerations outside of the medical establishment's progressivist ideals…the search for truth was told in terms of blind alleys and right answers," (DeRewal 23)

I revise triumphalist narratives of medicine and the overcoming of disability as I turn to literary texts that, I suggest, supplement diagnostic terminology and offer more specific ways for us to understand disability as a lived experience. In this dissertation I focus on the keyword "diagnosis," yet physicians in the nineteenth century often relied on catchall categories such as neurasthenia and hysteria, and sometimes sidestepped diagnosis and moved right to curative methods. Although today we may recognize that a diagnosis is necessary to provide a person with healthcare and access to legal protections, this was not exactly the case in the nineteenth century. Patients *wanted* diagnoses to validate their experiences of pain and other symptoms, but physicians did not *have* to diagnose patients until the early twentieth century, when insurance companies began to require diagnoses (and still today, diagnosis and treatment overlap as physicians try to discern the causes of sickness). As I study diagnosis, I therefore also study treatments and cures as well as refusals or failures to diagnose. Disability scholar Eli Clare defines the "ideology of cure" as "a network of five overlapping and interlocking medical processes: diagnosis, treatment, management, rehabilitation, and prevention" (70). This ideology and diagnoses themselves are socially constructed, racialized and gendered; they also have embodied consequences, as Mitchell's milk treatment makes only too clear. In literary scholarship, diagnosis and treatment in texts are thought to fix dangerous conditions; in other words, some literary scholarship follows the triumphalist narrative of medicine over disability, a narrative I hope to challenge.

The ways in which disability shows up in Harper's work matter, for there is an oscillation, familiar to disability scholars, between "metaphorical" disability (the cancer of slavery) and literal disability (amputees and neurasthenics). Early works in disability studies trouble metaphors that turn disability into a stand-in for other oppressions. Though not a disability scholar, Susan Sontag famously wrote in *Illness as Metaphor*: "It is toward an elucidation of those metaphors, and a liberation from them, that I dedicate this inquiry" (4). David T. Mitchell and Sharon L. Snyder argued that "through the corporeal metaphor, the disabled or otherwise different body may easily become a stand-in for more abstract notions of the human condition, as universal or nationally specific; thus, the textual (disembodied) project depends upon—and takes advantage of—the materiality of the body" (50). They critique specific kinds of "corporeal" metaphors, though elsewhere (their section on Oedipus, for example) they explore the value of metaphors for writing new ways of thinking of disability in literature. In a later passage, they write: "One might think of disability as the master trope of human disqualification" (51). Mitchell and Snyder usefully acknowledge that marginalization on the basis of ability is at the heart of other forms of marginalization—on the basis of race, gender, and sexuality, for example. While these scholars usefully work to subsume race, class, gender, and sexuality into disability, a useful way of moving Mitchell and Snyder's work further might come from an intersectional approach, one that both highlights ableism as a main issue for other forms of discrimination, and simultaneously acknowledges that racism, for example, comes with discrimination that differs in major ways from ableism. So, while we can consider disability as "the master trope of human disqualification" we can also move towards intersectional methods that generously open up new ways of thinking about the overlaps between ableism, racism, and sexism, and so forth.[218]

Harper also does not "overcome" her fatigue—her letters reflect a sustained experience that we might call chronic. Moreover, Harper's novel does not insist that Iola must be cured of her nervous condition. Other scholars read *Iola Leroy* as a curative text that erases disability in a hopeful, sentimental way by the novel's end; I intervene in these readings and put pressure on why we might be tempted to read stories as *narratively curative.* Ann DuCille suggests that Harper "cures" Iola by marrying her to Dr. Latimer, and that other turn-of-the-century Black American authors likewise employ what she calls "the coupling convention" to subvert dominant constructs of Black womanhood (122). Michele Birnbaum also argues, "The sentimental angst of

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[218] Thank you to Sari Altschuler for her help on this section when she gave comments on my paper "'The Virus of Slavery and Injustice': Analogy and Disabled Life in Black American Writings, 1856-1892" at the Dina G. Malgeri Modern American Society & Culture Seminar for the Massachusetts Historical Society. (Oct. 28, 2021).

[Iola's] 'condition' is scrutinized, diagnosed, and finally cured by marrying the doctor treating her. Thus, monitored simultaneously by medical and marital institutions, race loyalties and desires represented as warring within, the mulatta proves the means to control the race wars without" (10). Michelle Ann Stuckey also proposes that, for Harper,

> *Reconstructing* dispersed Black families and communities after emancipation serves as a means to "cure" the racial ambiguity of the biracial heroines…In Harper's novel… the curing of the hysterical mulatta by a Black physician is the impetus for the heroine's fulfillment of her Black identity…Black doctors in these novels *restore* Black women's bodies to health by *reconstructing* them as Black…Harper engage[s] in a deliberate project of Black American self-making that reaffirms Black subjectivities and Black bodies as healthy in direct opposition to a dominant discourse that links Blackness with disease and degeneracy. (120-121, my italics)

These scholars productively claim that Black subjectivities are reaffirmed in Black American narratives such as Harper's, and accurately observe that *Iola Leroy* ends on a hopeful note, as characters celebrate the eradication of the "disease" of slavery (217). Birnbaum, duCille, and Stuckey all place great emphasis on the value of cure. Quotation marks around "cure" above remind us that Stuckey's is a non-literal usage; however, the question of whether or not we find disability in Black American stories is, quite literally, at stake.

Moreover, these critics seemingly ignore the fact that in *Iola Leroy*, Iola is never cured of nervousness. Iola accepts that her nursing and educational work will come with a cost to her bodymind and pursues it anyway—for her own good and that of her community. Thus, *Iola Leroy* serves as evidence for the claim that narrative plots do not and need not take a linear diagnosis-to-cure path. It accepts the desirability of cure and simultaneously hints that access to communal care will remain vital for Black Americans. The novel manages to decry the disabling effects of enslavement without decrying disability itself, encompassing the concept of care-cure so valuable for understanding disability in Black writings.

A few recent disability scholars have demonstrated that some critical race scholars use metaphors of disability without addressing ableism. For example, Stuart Hall has described the life experiences of a racialized subject as “crippling” and “deforming” (Erevelles 146). These scholars fail to recognize that, “rather than rejecting oppressive biological criteria, they unwittingly reaffirm an imagined biological wholeness (normativity) that was instrumental in the propagation of the same oppressive ideologies they were seeking to dismantle in the first place” (Erevelles 147). There are too many examples of this use of disability as a synonym for tragedy in the works of feminist and critical race scholars to count; rather than focus on the harm that these scholars may intentionally or unintentionally bring to cultural conceptualizations of disability, we might simply observe that these uses of terms like “crippling,” are slowly understood to be both outdated and harmful to the disabled community.

More recent scholarship explores analogy and figuration to move the fields of literary disability studies and critical race studies forward together. Todd Carmody has recently invited scholars to consider how “race might have been ‘like’ disability in the late nineteenth century” (438). He writes that it has “[b]ecome a commonplace, in disability studies as in literary and cultural analysis more broadly, to prioritize intersection over analogy,” then suggests that analogy might help us to engage “‘what has been unassimilable, what has been confounding, what has been messy, what has been disabling, in disability’ and its discursive relations to race” (432). Analogy as method, Carmody asserts, attunes us to the discursive noisiness of race and disability and to the formal exchanges that echo across discrete cultural registers and social histories. Michael D. Snediker praises Carmody's work then suggests that *figuration* should also receive more attention in disability studies. In defining figuration, Snediker uses an example from Foucault's *Herculine Barbin*, which describes a world of pleasure as "a world in which grins hung about without the cat" (2). Snediker asserts that such figuration "brings us closer to the bafflements of phenomenal intensity than otherwise possible," adding, "figuration isn't external to the variable experience of lived embodiment: it *is* lived embodiment" (13; 32). The figurative exists only in a material world; when it is dismissed as mis-representation of reality, we lose valuable ways of understanding the material particularity of disability.

As I explore questions about diagnostic-analogous figuration in select Black American texts alongside theories from disability studies, I also consider two widely mobilized concepts in medical and health humanities today: "social determinants of health" and the concept of "structural competency." The first refers to the social conditions that structure health: the social conditions for Black women that can be, themselves, the cause of disability. Stories, in an earlier America and today, shed light on these social determinants of health and on the ways race relates to a person's experiences of health, disability, and care. Literary structures also train us in a kind of "structural competency"—that is, in Jonathan Metzl and Helena Hansen's framing, the ability to read for the structures that determine the health beyond what the individual clinical encounter might reveal. Metzl and Hansen revise "cultural competency," arguing that "the clinical presentations of persons at both ends of the economic spectrum are shaped by 'cultural' variables, and also by the economic and political conditions that produce and racialize inequalities in health in the first place" (127). Their paper

> describes a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients,

> toward attention to forces that influence health outcomes at levels above individual interactions (126).

In other words, Metzl and Hansen demonstrate how medical education must stop looking solely at individual experiences and begin examining structural issues and forces.

This move—shifting from specific to general and back again—is of course also at the center of literary analysis, which uses close reading to move from detail to broad structural argument. Stories give substance (and "embodiment" even) to the (social and literary) critic's work, which would otherwise be completely formless, and even impossible. My chapter will attempt to navigate between individual experiences of disability (like Iola's experience) and think more broadly about the system of enslavement without negating disabled experiences.

While navigating through these ideas, I suggest that Harper's *Iola Leroy* balances the weight of disability with the cruelty of disablement. This speaks to what Tobin Siebers wrote when he defined disability beyond either medical or social models to offer a more complex view: the "theory of complex embodiment." Siebers wrote: "We seem caught as persons living finite lives between two sets of contradictory ideas about our status as human beings. The first contradiction targets our understanding of the body itself' (2010, 316).[219] Just as disability scholars Sami Schalk and Jina B. Kim revisited Audre Lorde's work on Black feminist theory and self-care from a disability studies perspective, I turn to disability studies to revisit Black American literatures that convey so impressively the complexity inherent to complex embodiment.

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[219] Siebers, Tobin. "Disability and the theory of complex embodiment—for identity politics in a new register." *The disability studies reader* (2010): 316-35.

The texts I analyze here "diagnose" various conditions, including enslavement and racial prejudice, and recommend "treatments" for Black Americans who live with the consequences of these conditions. In the *Official Report of the Niger Valley Exploring Party* (1861), physician Martin Robison Delany offers a rich description of symptoms that a Black person might experience when setting foot in Liberia, Africa, rendering oppression as illness and prescribing emigration as a treatment. I look to Delany to consider what a Black physician might make of the conditions of slavery and racial prejudice and his poetic articulations of the embodied realities of returning to Africa as a Black man. I turn also to Charlotte L. Forten**,** an educator and nurse during the Civil War, who used her *Journals* (1854-1864) to articulate experiences of depression in overt ways: "Am tired and depressed" (1988, 278). Forten, whose full name is actually Charlotte L. Forten Grimké, was an ardent abolitionist, and taught freed slaves on St. Helena Island, South Carolina, for two years at the end of the Civil War. Forten had health concerns throughout her life; as a child she had a condition described as "lung fever" and also experienced periods of depression (Beltway, para. 2).[220] In her writings, Forten identifies the oppression of Black and mixed-race people such as herself to be the root cause of her own embodied depression. Nonfiction works like Forten's resonate with Frances E. W. Harper's fiction novel *Iola Leroy,* which references Delany blatantly by including a female character "Miss Delany,"

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[220] Though her full, married name was Charlotte Forten Grimké, I usually use "Forten" in keeping with the writing of other scholars. During her lifetime Forten published articles in white magazines: "Life on the Sea Islands" (in the *Atlantic Monthly*), and "Personal Recollections of Whittier" (in *New England Magazine*). Between 1855 and the late 1890s, she published many poems and essays in Black American periodicals; she also kept a diary which was published posthumously in 1953 (*Beltway*, para. 3). For more information about Forten, see *Beltway Poetry Quarterly*, "Nine Poems by Charlotte Forten Grimké."

and imagines what it would be like to Civil War nurse like Forten (though no specific nurse is referenced).[221]

Though I will not have time to explore the works of other Black novelists writing at the turn of the century, Charles Waddell Chesnutt and Pauline Hopkins certainly offer further future possibilities for analysis.[222] In Chesnutt's *The Marrow of Tradition* (1901), Doctor William Miller cuts a white child's throat not to hurt him, but to perform a healing tracheotomy. Dr. Miller's wife, it is revealed, is mixed-race and shamed by the white side of her family. Medical science operates in tandem with efforts to identify racial identity in the text. In *Of One Blood: Or, The Hidden Self* (1902-03) Hopkins's mixed-race heroine, Dianthe Lusk, is paired with two doctors, Reuel Briggs and Aubrey Livingston. Both men are mulattoes and brothers, but as Lusk tragically learns, they are also *her* brothers. Another tragedy takes place when Dianthe almost dies; Dr. Briggs diagnoses her with "suspended animation" and saves her with the supernatural, unscientific practice of magnetism. The question presented by the novel, "who is clear enough in vision to decide who hath Black blood and who hath it not?" (608) works in tandem with the bizarre medical experiments in the plot. Furthermore, the book—which could be called melodramatic, realist, or gothic—resists generic categorization. Its exposure of the failure of medicine to classify races is paralleled in this resistance.

These "race novels" complicate simplistic biological equations of identity. Blending realism and sentimentalism, they each include mixed-race couples and characters; each also includes at least one Black doctor. Efforts to diagnose occur alongside the novels' attempts to

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[221] For more on Delany's presence in *Iola Leroy,* see John Ernest's "From Mysteries to Histories: Cultural Pedagogy in Frances EW Harper's *Iola Leroy*."

[222] Charles Waddell Chesnutt was a Black author, essayist, political activist and lawyer. Like many of Harper's characters, Chesnutt could possibly have passed as white but self-identified as Black throughout his life.

upset generic boundaries and criticize struggles to solidify boundaries between races. Through analysis of such novels, this chapter asks, how do patients wield medical authority to question bodily classifications in the novels? How do the novels encounter the troubling ways in which Black bodies were simultaneously denied the status of, and yet heavily associated with, disability? While this chapter does not have space to explore all of the aforementioned novels, new scholarship such as Tyler's *Disabilities of Color,* and studies by Stephen Knadler, respond productively to such questions.[223]

The texts explored in this chapter offer new ways of thinking about these questions as they navigate "real" biopolitical debates by experimenting with the materiality of the figurative. *Iola Leroy,* in particular, conveys knowledge of realities of disabled life, while it wields diagnostic-like narrative methods to target *systemic* sources of debilitation. Harper's novel points to slavery and racial prejudice—*not* race or disability—as "problems" to be solved, just as modern disability scholars position ableism, not disability, as the problem to be solved. Harper seizes upon the figurative potential of literary writing to address the most substantial threats to future wellness—without advocating for the erasure or cure of disability in the process, as I next suggest.

Harper and Her Contemporaries

Care-Cure, Charlotte L. Forten, and Black Feminist Disability Politics

Iola Leroy leads us through a complex history of disability and race entangled with fact and fiction. The novel tracks the history of its main character Iola from 1861-1872, and was

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[223] Tyler claims that Charles Waddell Chesnutt "inquired about the construction of" the disability of color "within US culture" (122). In "Neurodiverse Afro-Fabulations: Pauline Hopkins's Counterintelligence" Stephen Knadler demonstrates that Black studies and critical disability studies approaches disavow conceptualizations about biologic certainty.

published in 1892, shaped by Harper's own embodied realities at that moment. Harper worked as a feminist speaker for much of her late life, and her own speeches are mixed into her sentimental story. It includes terminology to describe nervous disorders that would have been commonplace in the 1890s but little-known in the 1860s. What were Harper's—and Iola's—experiences *like*, fighting for racial justice while struggling? To respond to this question, I also analyze Charlotte Forten's *Journals,* which offer an autobiographical account of depression that is explicitly linked to racial prejudice. As I weave between sentimentality and realism, between the targeting of systemic issues and offerings of communal care, I hope to contribute to scholarship that centers Black women who, exhausted by the labor of fighting for Black rights, wrote with and through their fatigue.

So here is *Iola Leroy*'s plot: Iola's mother Marie, a mixed-race woman, is diagnosed with nervous prostration after she realizes her children will be enslaved after the death of their white slaveholding father. Iola and her siblings inherit not only the "condition of the mother"—the historical euphemism for slavery—but also their mother's illness (Spillers 269). After Iola is freed, she works as a Civil War nurse. Iola is wooed by two different doctors, white Dr. Gresham and mixed-race Dr. Latimer (their titles are always kept prominently in view), who worry about how hard she works. Ironically, Iola then performs substantial emotional labor to convince both doctors to accept that she will not stop working for racial uplift. Dr. Latimer helps Iola's mother Marie with her nervous condition, then proposes to Iola by asking that she "commit [herself]. . . to [his] care" (268). Iola accepts his proposal. In marrying Iola and Dr. Latimer, Harper participates in larger literary trends, yet she also expands on these trends by emphasizing Iola's agency. [224] Once Iola is married, she begins new work as an educator.

The novel produces knowledge about disability by suggesting that Black disabled people from the Civil War and Reconstruction eras did much of the work of racial uplift.[225] Diane Price Herndl writes that Harper "probably comes closest to the standard model of white sentimental fiction," a model that is characterized by the "privileging of pale, invalid women" ("Invisible" 559, 562). Yet *Iola Leroy* has only somewhat been considered from a disability studies perspective. Literary scholar Geoffrey Sanborn complains that there is a tendency in criticism of *Iola Leroy* "to refer to Iola as a 'neurasthenic mulatta,'" and to minimize the novel's "emphasis on the strength of Black people in general and Black women in particular" (697). Though I understand Sanborn's desire to move away from pathologizing approaches, I attest that we can discuss the "strength of Black people" *and* the illnesses of characters by drawing upon a critical disability studies framework, which challenges outdated conflations of strength with greatness.

I'm curious about potential overlap between *restoration* and *Reconstruction* for critical analysis of disability and race together. Though *Iola Leroy* was written and published during the aftermath of the failure of Reconstruction, when social contact between white and Black people was limited by Jim Crow segregation, it nevertheless explores Reconstruction as a powerful future restorative. Recent scholarship on restoration and cure is useful here. Cure is generally understood positively, thought to be a "restoration of health" and a return to a "better" state of being (Clare 14). But as disability scholar Eli Clare argues, "cure requires damage, locating the

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[224] As Cynthia Davis points out, at least four novels written between 1890 and 1903 "employ the convention of a mulatta coupled with an ambitious mulatto male doctor" (Davis 164).

[225] For more on disability and racial uplift, see Stephen Knadler, "Dis-abled Citizenship: Narrating the Extraordinary Body in Racial Uplift."

harm entirely within individual human body-minds…it grounds itself in an original state of being, relying on a belief that what existed *before* is superior to what exists *currently*" (15, original italics). Diagnosis (not just misdiagnosis) and consequential efforts at cure are lifesaving necessities that *always* exist in relationship to destruction, and often represent a fantasy of future ability.[226]

The violence of cure becomes especially attractive when the "condition" to be destroyed is a violent institution. Delany, Forten, and Harper present views of slavery that are necessarily destructive. Delany asserts: "And how would all good men rejoice to see the blow which shall effectually prostrate the giant Slavery, struck by the Black Man's arm!" (1998; 53). Forten believed that "nothing but an open and manly denunciation of slavery…would ever be of the slightest avail" (116). In Harper's novel, Dr. Gresham refers to war as "the dreadful surgery by which the disease was eradicated" (217). These statements do not necessarily draw on medical language—Delany's is a clear Biblical reference. But this physician, this nurse, and this educator all recommend denunciation and eradication, which share something in common with medical *diagnosis* and *cure*. The problem, of course, with imagining that injustice can or will be "cured," is that we might then be tempted to ignore ongoing and future inequalities.

Forten and Harper especially focus upon the value of *care* for anyone who experiences the tangible harm done by slavery and racial prejudice. This resonates with additional new scholarship. Furthermore, *Iola Leroy* produces knowledge about disability by depicting Black neurasthenic characters who benefit from *care* and *work* (concepts that conveniently contrast the "rest cure"). Any attempt to understand or take up *care* "in its lived, philosophical and political

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[226] This may bring to mind the concept of the "normate"—Rosemarie Garland-Thomson's term for the fantasy image of perfect health, beauty, and functioning. See *Extraordinary Bodies.*

aspects is a slippery affair…It encompasses the intimate, fleshy and mundane exchanges between bodies engaged in everyday affects and acts—of giving and receiving, of living and growing, of teaching and learning—that are fraught with ethical complexity" (Douglas et al. 1). Recently, queer disabled writer Leah Lakshmi Piepzna-Samarasinha has explored "care work" as "a place where disability justice and queer femme emotional labor intersect" (35), asking, "What does it mean to shift our ideas of access and care…from an individual chore, an unfortunate cost of having an unfortunate body, to a collective responsibility that's maybe even deeply joyful?" (41). Still today, much of the burden of care work falls upon women (especially mothers and women of color) and disabled people who provide care interdependently.[227] Throughout *Iola Leroy*, we see racial prejudice and enslavement as the problems that need to be "cured." Harper ends on a note of hope, acknowledging the "cost" that work takes on these characters' bodies while she represents the care work done by these women as "deeply joyful." The medical cure/care dichotomy labels "cure" as the goal of the male physician and "care work" as the job of the female nurse, creating a hierarchy wherein men do the "real" work and women merely a domestic chore. Piepzna-Samarasinha's framing treats care as collective, moving away from individual models.

Forten, a mixed-race woman like Iola, articulates lived experiences of nursing while depressed. According to Brenda Stevenson's reading, "Times of personal loss apparently robbed [Forten] of support, comfort, and hope, making her commitment to the larger struggle of her race seem that much more futile. It was during these periods of despair that she dwelt on the near

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[227] The fetishizing of productivity is also criticized in David T. Mitchell and Sharon Snyder's *The Biopolitics of Disability: Neoliberalism, Ablenationalism, and Peripheral Embodiment*, who point out that many disabled people cannot be productive in traditional ways that adhere to capitalist models.

impossibility of trying to survive and achieve something worthwhile in a fundamentally oppressive society" (21). In an 1856 entry, Forten wrote, "Often I think there is nothing worth living for. Nothing! Those whom we love best die and leave us. We are a poor, oppressed people, with very many trials, and very few friends. The Past, the Present, the Future are alike dark and dreary for us…Oh! For strength," she concluded. "Strength to bear the suffering, to do the work bravely, unfalteringly!" (21). This was an earnest plea, for Forten wanted to continue educating children and nursing, even when she developed "lung sickness." She wrote in anguish: "*Au desespoir* [sic] to-day…I think I *must* go home. I am weary! I am weary! And oh, so unsettled and troubled! I know not what to do…I am *heart sick,* and my physical strength is giving way fast: I feel it…. I will go home *now.* And *write,* if I can" (100, original italics). Unfortunately, Forten did not have the funds to go home, and her recovery was a slow one. Her plea for strength to do "the work" resonates with Harper's novel, which likewise grapples with a contradictory desire for strength to work and freedom to rest.

One Monday in November 1870, Forten wrote in her journal: "A gloomy, chilly, and, to me, most depressing day…. I am *sick,* today, sick, sick at heart!" (Forten, 344-345, original italics). While this speaks mostly to emotional and mental exhaustion (which she discusses numerous other times in the journal) this also speaks to her chronic lung condition. That Friday, she was full of new energy: "Went to hear Mr. [George William] Curtis… [The lecture] is as much Anti-Slavery as Woman's Rights…. the fearlessness with which he avowed his noble and radical sentiments before that…doubtlessly mostly pro-slavery audience… awakened all my enthusiasm. I *will not* despair when such noble souls…devote the glory of their genius…to the holy cause of Truth and Freedom" (345). Curtis's speech,[228] which notably engages what we now call intersectional thinking by merging anti-slavery and woman's rights activism, awakens "[her] enthusiasm" in a moment of her embodied, emotional fatigue.

This section will briefly introduce Forten's journals and poetry from the 1850s and 60s. I'll quickly suggest that Forten's fascinating writings invite us to think not just about wellness not as the absence of illness or the cure and restoration of bodymind; they *also* invite us to consider how unwellness might be framed as natural, and to consider how energy is gleaned from self-care and radical care. Forten's journal entries and poems come alive when situated alongside Black lesbian poet and writer Audre Lorde's assertion that "Survival isn't some theory operating in a vacuum. It's a matter of my everyday living and making decisions" (*A Burst of Light* 53). Lorde also wrote, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (130). Like Jina B. Kim and Sami Schalk, I understand Lorde's articulation of radical self-care [as] deeply grounded in experiences of disability" (325). Forten sews and rests to care for herself some days, and on other days seeks out enthusiastic lectures that focuses on addressing systemic issues. This opens up ways for us to approach restoration by thinking about *rest* and *oration*, the tools that Forten uses to make possible her own survival.

Some of the earliest scholarship on Forten's writing invoked disability as a way of reckoning with the pain clearly expressed in Forten's writing. For example, in Ray Allen Billington's 1981 edition of her journal, Billington titles Chapter III, "Teacher and Invalid." Billington introduces Forten, a biracial woman, in terms of wellness:

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[228] This refers to George William Curtis's "Fair play for women: an address delivered before the American Woman Suffrage Association."

> Forten was a delicate young woman of sixteen when in 1854 she left her native Philadelphia…. [She] took mild pleasure in the ailments that were the stock in trade of all well-bred females during the Victorian era…. She was then…a handsome girl, delicate, slender, and with a finely chiseled countenance which revealed in the lightness of the skin a trace of white blood among her ancestors. All who knew her commented on the alert intelligence of her face and on the frailty of her graceful body. Indeed, as the pages of her Journal disclose, she was destined to long periods when "lung fever" forced her to forsake her studies and teaching.

Participating in a much larger trend of associating whiteness and Victorian femininity with illness, Billington claims Forten took pleasure in wearing illness as a fashion. Other scholars, such as Lisa M. Koch in 1998, take seriously Forten's journal entry where she reflected on "playing the invalid" (151). While Forten did write that phrase, this certainly does not mean that we readers should invalidate her illnesses. These introductions focus on associating ailments with Forten's whiteness and femininity rather than attending mainly to her Blackness and race work.

As I have previously demonstrated in this dissertation, the field of disability studies productively challenges some of these problematic modes of representing illness as fakery or disability as a defect within the individual that must be cured. As Ellen Samuels writes, "there is less of a 'before and after' to the modern, institutionalized definition of disability than an ongoing tension between efforts to codify disability's meaning and the resistance posed by the messiness of impairment, as lived and represented through bodies, minds, and texts" (170). Cautiously leaning on anachronism's possibilities, I read Forten while pondering more modern understandings of how disability is articulated in writing. For example, I find that Forten's

Journals convey her bodymind experiences in language that captures a fraught relationship with both space and time—what we might call "crip time." In 1858, she wrote: "I wonder why it is that I have this strange feeling of not *living out myself.* My existence seems not *full* not expansive enough. I…What means this constant restlessness, this longing for—something, --I know not what?" (Billington 99). Ending with a question mark, this passage reflects Forten's continuous exploration of an embodied sense of confinement and restlessness, and carries out Forten's questioning of self and personal identity.

While I connect Forten's writing to disability scholarship, I explore Reconstruction and wellness by thinking about a related concept, *restoration.* As explained elsewhere in this project, Clare questions the idea of restoration as part of what he calls the "ideology of cure." While cure is generally understood positively, as a "*restoration* of health," "cure *always* operates in relationship to violence" (15). Clare makes clear that not all instances of cure are dangerous, yet when disability is represented as an individual abnormality, focus often shifts towards fixing the individual and away from an acknowledgement of larger social issues. It is important to note that the violence of cure, or restoration, becomes suddenly more attractive when the "condition" to be destroyed is, itself, a violent institution. Forten presents views of slavery that are necessarily destructive. In 1855, for example, she wrote that "nothing but an open and manly denunciation of slavery…would ever be of the slightest avail" (116). That same year, Forten wrote while describing white people in the school where she was teaching: "There is one young girl and only one… who I believe thoroughly and heartily appreciates anti-slavery—*radical* anti-slavery, and has no prejudice against color." Forten's focus on radical and open denunciation of slavery and injustice grows even more ardent through her Reconstruction-era writings.

As I consider here how the violence of restoration can be leveled away from individual bodyminds and towards systemic issues, I also continue considering the restorative possibilities of care. Anthropologist Christina Giordano seeks a much less binary approach to care and cure, a "care-cure": "A relation not punctuated by diagnoses and the eradication of disease, but by a holding, and the acknowledgment that others have their own words that need to be spoken and heard, and their own timing to be cared for" (32). As I demonstrate, Harper creates characters who perform interdependent care work to help each other grapple with the damage done by disabling institutions. Neurasthenic characters have their "own words that need to be spoken and heard," as Harper explores their experiences of illness without ending the novel in the erasure of cure. The other texts studied here also gesture to a longing for care-cure; they seek to cure America of destructive political systems, and they also treat care work as a collective responsibility for anyone disabled by those systems. Forten, too, developed an approach to care-cure—balancing caring for herself while advocating for the violent erasure of slavery and injustice.

Again, this resonates with the work of Audre Lorde. While Lorde lived through the late stages of her liver cancer, she wrote in her essay "A Burst of Light":

> I am learning to reduce stress in my practical everyday living. It's nonsense, however, to believe that any Black woman who is living an informed life in America can possibly abolish stress totally from her life without becoming psychically deaf, mute, and blind. *(News Item: Unidentified Black man found hanging from a tree in Central Park with hands and feet bound. New York City police call it a suicide.)* I am learning to balance stress with periods of rest and restoration. (123)

While Lorde's words refer generically to Deafness, muteness, and blindness without further reflection, they also grapple with the impossibility—and necessity—of self-care. Lorde wrote, pondering the role self-hypnosis plays as she tries to complete difficult articles: "I respect the time I spend each day treating my body, and I consider it part of my political work. It is possible to have some conscious input into our physical processes—not expecting the impossible, but allowing of the unexpected—a kind of training in self-love and physical resistance" (128).

Though written a hundred years previously, Forten's journal entries likewise struggle with the impossibility of sleep at night while she and so many others live with violence and indifference. During the Reconstruction era, Forten's journals grapple with the relationship between lived experiences of injustice and the wellbeing of the mind. Forten wrote in 1867: "Oh, how inexpressibly bitter and agonizing it is to feel oneself an outcast from the rest of mankind, as we are in this country!...Were I to indulge in the thought I fear I should become insane. But I do not despair. I *will* not despair; though *very* often I can hardly help doing so…. Oh, that I could do much toward bettering our condition. I will do *all,* all the *very little* that lies in my power, while life and strength last!" (187, original italics). Forten expresses her fear that she could become insane if she dwells too long on the overwhelming alienation of racial prejudice in America and calls upon her power and strength to help her endure. Elsewhere, as I discuss, Harper too expressed a sense of urgency in her letters. Despite fatigue and anguish, Forten and Harper both continued working both as a means of caring for themselves and others and in order to survive. Later, in 1867, Forten wrote: "Night. Feel *terribly* depressed. Think of our wrongs, and Oh! the *indifference* of many of us to them…I dare not trust my mind to dwell upon it" (Billington 207, original italics). Forten uses characteristic italics and exclamation points to express her frustration. She also describes her mind's experience as overwhelming and contradictory—she possesses a longing to think about “indifference” and a simultaneous desire not to think (not “to dwell”) upon that indifference.

Both rest and activist work constitute Forten’s reach towards care-cure. Forten’s 1868 entry reads, “Sewed busily;—Am tired and depressed” (*Journals* 278). While Forten cared for herself here and in other moments through sewing, she also continued her political work while living with this embodied condition. As literary scholar Carla L. Peterson writes in “Reconstructing the Nation,” Forten grew more than willing to express anger and demand racial justice. For example, Forten’s letter, “Mr. Savage’s Sermon, ‘The Problem of the Hour,” published in the 1876 issue of the *Commonwealth,”* elucidates even more forcefully Forten’s wrath over continuing racial injustice. For example, when challenging Savage’s horrible description of Black people as “disagreeable, barbarous and ape-like” (7), Forten calls the words a “very gratuitous insult, and a decidedly unchristian expression of contempt for a much-abused people…. In being thus contemptuous he has made himself contemptible, as those always do who sneer at the weaker side” (7). This resonates with modern conversations about mockery and cruel statements made at the expense of marginalized people. Forten concludes her letter: “I have felt it my duty…to say what I have said because it seems to me that such words, uttered by a minister of his wide influence, may do infinite harm….If the views expressed by Mr. Savage are those entertained by most Republicans…I can only say, in his own concluding words, “from these, above all things, may the good Lord in heaven deliver us!” (14). With her fierce rhetoric, Forten becomes, for scholars of nineteenth-century literature, a writer who profoundly represents living with pain and fatigue while exploring different methods of caring for herself and addressing head-on the many “problems of her hour.”

One of Forten's poems: "The Angel's Visit," further articulates a spiritual response to the experiences of embodied exhaustion and pain. In the poem, the speaker gazes upon the "gentle moon," then is visited by her angelic mother who soothes her pain and offers her a prayer:

> And lovingly she smiled on me,
> And softly soothed the pain—
> The aching, heavy pain that lay
> Upon my heart and brain. (5-8)

While its simplicity offers perfect rhymes like "June/moon" and "pain/brain," the poem complexly evokes an image of pain resting "upon" both heart and brain with weight, an "aching, heavy" material that moonlight might alleviate.

The poem continues by expressing that the speaker is "sad, and sick at heart," then: "I longed to lay me down and rest, / From all the world apart" (18-20). This echoes with Forten's journal entry which reads: "I am *sick,* today, sick, sick at heart…I am weary of life, and would gladly lay me down and rest in the quiet grave. There, alone, is peace, peace!" (344-345, original italics). In the poem, Forten likewise calls for her mother and longs for her company on the grave, saying, "Methinks I feel thy cooling touch / Upon my burning brow" (31-32). The speaker is relieved to continue: "from my heart the weary pain / Forevermore had flown" (61-64). The pain that once invaded brain, heart, breast, that made her brow burn, and made her faint is now alleviated, thanks to the mother's breath.

This lost mother's speech on the speaker's behalf before God is, in so many ways, a restoration in Forten's imagining. The poem can be read as a daughter's plea to help her remain moral in a world full of evil and temptation; it can also be read as a way of thinking about lived experience of bodymind pain. The poetic mother says:

> I know the cruel wrongs that crush
> The young and ardent heart;
> But falter not; keep bravely on,
> And nobly bear thy part. (53-56)

What the mother has spoken against are the forces that demand that the speaker "keep bravely on"—the source of sickness is not contagion; the source is the forces that demand courage. Forten, exhausted by illness and by the labor of fighting for black rights, wrote with and through that fatigue, and her writing speaks to issues of caring and restoration that resonate in our contemporary moment. As Forten articulates the lived experience of depression, she also writes that her political speeches and the everyday act of sewing sustain her. Though these forms of care afford Forten the energy to continue working and writing, she does not "overcome"[229] depression, to use a cliched term, and continues to experience it throughout.

"Diagnosis: FREEDOM": Martin Robeson Delany

Forten, Delany, and Harper each grappled with a question that fueled many debates during their time: can Black Americans survive—whether disabled or not—in America, or would emigration back to Africa be the best "care-cure"?

In the nineteenth century, many white physicians held up *freedom* as a cause of illness in Black people, pointing to an increase in insanity and tuberculosis among freed men and women as "proof" that civilization was an unnatural state for them. Diagnostic categories that targeted Black people included: drapetomania ("the disease causing Negroes to run away");

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[229] Disability studies puts pressure on what it terms "*overcoming* rhetoric," which—in the words of activist and scholar Simi Linton—emphasizes 'personal triumph over a personal condition' and fails to attend to the social circumstances that perpetuate ableism or the privileging of bodily and mental capacity" (50).

hypochondriasis ("attributed to grief over enslavement"), and various "negro Physiological Peculiarities" including "deficiency of red blood in the pulmonary and arterial systems," and "shade of pervading darkness through the skin and bone," "Black to the bone" (Byrd and Clayton 101). Black people were also more likely to be diagnosed with "feeble-mindedness" and insanity rather than neurasthenia. As Katherine Ott argues, "whites urged Black-Americans to adopt white ways, and, by implication, white diseases, as proof that they could handle freedom. The result was that whites located Black illness in Blackness, and Blackness remained a deviancy from white norms" (103). In other words, Blackness and Black freedom were rendered as illness.

One alienist, Dr. Peter Bryce, superintendent of the Alabama Insane Hospital, diagnosed "freedom" as source of illness overtly:

> In [1868], a hyper vigilant forty-five-year-old ex-slave named John Patterson had been brought for treatment…[Bryce] believed that…the psychological pressure of carafe for himself when Patterson possessed neither the intelligence nor the judgement to do had proved too great, and Patterson had sunk into madness. Hence Patterson's mania could have only one cause.
>
> "Diagnosis: Freedom," wrote Bryce. (Washington 143)

Bryce had meticulously documented the progression of Patterson's mental illness over the previous dozen years, and Patterson had been free for only five. Bryce's diagnosis, clearly illogical, became an act of white supremacist biopolitical warfare.

Because white doctors like Bryce made such cases for why enslavement was healthy and freedom dangerous, physician Martin Robison Delany presented emigration to Libera as a lifesaving act that would remove Black Americans from medical cruelty. Eventually, though, Delany returned to the States to fight for the Union. This choice is presented in *Iola Leroy.*

Harper illustrated a debate between Dr. Latimer and Miss Delany—named after the real Delany. Dr. Latimer expressed his concern: "I do not believe self-exilement is the true remedy for the wrongs of the negro. Where should he go if he left this country?" (Harper 246). Miss Delany, in a statement fitting the real Delany's eventual decision, indicated her belief that America "is the best field for human development" (247). Here, Harper gave a female character the chance to critique Delany's "remedy." Though Delany eventually came around to the fictional Miss Delany's way of thinking, he initially figured emigration as the sole remedy for oppression.

In an 1861 report, Delany used medical rhetoric to support the Back-to-Africa movement, suggesting that he believed health was unattainable for Black people in America.[230] In 1850, Delany was one of the first three Black men admitted to Harvard Medical School, yet all of these men were dismissed after a few weeks because white students protested their inclusion. Nevertheless, Delany trained as a physician's assistant and treated patients in Pittsburgh during the cholera epidemics of 1833 and 1854. In Liberia, he needed his medical rhetoric, as well as religious rhetoric, because the small number of people who did settle in Africa faced brutal conditions. The mortality rate of these settlers was the highest in accurately-recorded human history—of the 4,571 emigrants who arrived in Liberia between 1820 and 1843, only 1,819 survived.[231] Nevertheless, Delany treated freedom in Liberia as remedy for a global disease:

> "Princes shall come out of Egypt; Ethiopia shall soon stretch out her hands unto God." …With the fullest reliance upon this blessed promise, I humbly go forward

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[230] Delany worked alongside Frederick Douglass and others, published his novel *Blake,* and in 1865 became the first Black American field grade officer in the army. For more scholarship on the influence of Delany's novel *Blake*, see Katy Chiles, "Within and without Raced Nations: Intratextuality, Martin Delany, and Blake; or the Huts of America," and Rebecca Skidmore Biggio, "The Specter of Conspiracy in Martin Delany's *Blake*."

[231] See Tom W. Shick, *Behold the Promised Land: A History of Afro-American Settler Society in Nineteenth-Century Liberia*.

> in—I may repeat—the grandest prospect for the regeneration of a people that ever was presented in the history of the world. The disease has long since been known; we have found and shall apply the remedy. (360).

Delany dreamed of an effective, conclusive end to oppression that would lead to "regeneration." He wrote: "The time has fully come when we, as an oppressed people, should do something *effectively*, and use those means adequate to the attainment of the *great and long desired end*—do something to meet the actual demands of the present and prospective necessities of the rising generation of our people in this country" (229, original italics). Delany, who viewed Liberia as a home of "The dignity of manhood, the rights of citizenship, and all the advantages of civilization and freedom" (240), saw freedom as a source for a conclusive end to social "ills."

In Delany's writing on health in Liberia, figurative illness becomes real—and then figurative again. When touching upon the fevers in Liberia that led to emigrants' deaths, Delany subtly indicates that death in Liberia was preferable to oppression in America. He wrote, "The question is not whether our condition can be bettered by emigration, but whether it can be made worse. If not, then, there is no part of the wide spread universe, where our social and political condition are not better than here in our native country" (230). Delany's represents slavery as a fever, he suggests that skillful physicians can treat it, and he offers settlement as a primarily corrective:

> The native fever which is common to all parts of Africa, in Liberia while to my judgment not necessarily fatal (and in by far the greater percentage of cases in the hands of an intelligent, skillful physician, quite manageable)…The natural remedy for the permanent decrease of the native fever, is the clearing up and cultivation of the land, which will be for some time yet to come, tardy; as emigration to Liberia is very slow…The clearing

> away of the mangrove swamps…will add greatly to the sanitary condition of Liberia; but this also will take time, as it must be…brought about by…civilizing progress. (282)

Delany clearly hoped to undermine fear about the fevers in Liberia in the hope that Black Americans would return to Africa despite the threat of illness.

In a section entitled "DISEASES—CAUSE—REMEDY," Delany names the symptoms that emerge when a Black person moves from America to Liberia, and it might be tempting to suggest that Delany is writing figuratively about "symptoms" (or emotional responses). Evidencing Snediker's claim that the figurative is also material, Delany's writing circumnavigates embodied medical issues that surrounded his political project. Delany links what he calls the "first symptoms" of entering Africa with enjoyable feelings grounded in both body and mind: "The first sight and impressions of the coast of Africa are always inspiring, producing the most pleasant emotions" (279). He warns the reader that "these pleasing sensations…gradually merge into feelings of almost intense excitement, not only mentally, but the entire physical system share largely in it, so that it might be termed a hilarity of feeling almost akin to approaching intoxication…like the sensation produced by the beverage of champagne wine" (279). He notes a physical "hilarity of feeling" like "intoxication," but is sure to assure the reader that he does not drink: "Never having enjoyed the taste for it, I cannot say from experience" (279). This renders Liberia a healthy, even delightful space, one where freedom might feel intoxicating, but is predominantly inspiring. He then adds: "The first symptoms are succeeded by a relaxity of feelings, in which there is a disposition to stretch, gape, and yawn, with fatigue" (279). This calls upon the readers' possible past experiences with drinking champagne to elicit a sense of satisfaction and relief upon entering Africa.

But next, Delany acknowledges the troubling physiological signs that might motivate one to leave Liberia and return to America and explores these with greater seriousness. The distinction between real illness and figurative ones grows hard to parse:

> The second [stage of symptoms] may or may not be succeeded by actual febrile attacks, with nausea, chills, or violent headache; but whether or not such symptoms ensue, there is one most remarkable, as almost (and I think quite) a necessary affection, attendant upon the acclimation at this incipient stage: a feeling of regret that you left your native country for a strange one; an almost frantic desire to see friends and nativity; a despondency and loss of the hope of ever seeing those you love at home again. (280)

Now warning of “actual febrile attacks,” Delany conflates symptoms of disease— “native fever,” which he himself caught—with symptoms of less-deadly conditions such as “regret.” He insists: “These feelings, of course, must be resisted, and regarded as a mere morbid affection of the mind at the time, arising from an approaching disease, which is not necessarily serious, and may soon pass off; which is really the case” (280). If we interpret “disease” as the fever, then sadly the disease was serious, and fatal for many of the emigrants. If we instead read this as speaking of a regret so profound that people elected to return to America (which Delany clearly views as a deadly choice), then the passage can also be seen as linked to imaginative figuration. We read a slippage between unpleasant symptoms and Delany’s own longing to comfort Black Americans who might experience regret about emigrating. He then begins a section called “Recovery”: “When an entire recovery takes place, the love of the country is most ardent and abiding. I have given the symptoms first, to make a proper impression first” (280). Delany acknowledges his rhetorical strategy: he conveyed negative symptoms to express hardship, then undermined these symptoms to advocate for the Back-to-Africa movement that, for him, equaled a “remedy.” In

Delany's imagining, one can only recover fully from the great disease of injustice when they live in a nation whose name means "Freedom."

Delany's little-studied writings on Liberia serve as a fascinating example of how rendering oppression as an illness offers ways of imagining potential treatments. Harper wove Delany's name into her story, which also represents the deadly effects of slavery and potential remedies for enslavement in medically-coded terms. As this suggests, fiction novels like Harper's actively participate in historically vital debates about medicine and politics that construct Black American well-being.

Blood, Nerve, and Skin: Chronic Pain and Care in *Iola Leroy*

As *Iola Leroy* engages in historical debates, the text also subverts literary conventions popular during its time. For example, the novel frames embodied illness within a "mulatta" character, Iola, as a natural, rather than tragic, consequence of racial prejudice. This is significant because many Black Americans who were freed from enslavement were targeted by specific diagnoses and were kept away from other diagnostic categories reserved for white patients.

For example, in the 1880s, the conditions neurasthenia and hysteria became essential to the construction of dominant ideologies of white womanhood.[232] By the nineteenth century, hysteria was associated more with the brain and the nervous system than with the uterus. Physicians struggled to distinguish between neurasthenia and hysteria, demonstrating that "[t]he two conditions were intertwined while the medical community struggled to define [neurasthenia's] diagnostic boundaries" (Schuster 5). These conditions were famously treated in

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[232] The term "hysteria" was coined by Hippocrates in the 5th Century BC. Hysteria was removed from the *Diagnostic and Statistical Manual of Mental Disorders* in 1980. It has been replaced somewhat by "conversion disorder functional neurologic disorder," when a person experiences neurological symptoms not attributable to any medical condition. Women are also two to three times more likely to receive a diagnosis of conversion disorder than men (Stone et al.).

debilitating ways. Hysteria treatments exacerbated the "symptoms" of femininity, as white women became increasingly confined to the home (Stuckey 146). Carol Smith-Rosenberg argues that hysteria was a sort of exit strategy for [white] women from gender-role conflict, in that "it purchased her escape from the emotional and—frequently—sexual demands of her life only at the cost of pain, disability, and an intensification of women's traditional passivity and dependence" (207). Smith-Rosenberg seems to hint that hysteria almost became a way for women to obtain what we today call "accommodations."

As discussed in the last chapter, debates about hysteria at the close of the nineteenth century were rooted as much in stereotypes about race as they were in the claims of its origin in the wandering womb, and Black women had to struggle against the conventions that made it impossible for them to receive similar accommodations, such as rest, that white women could access.[233] I point out again that in 1881, George M. Beard claimed that neurasthenics stood as proof that the American nation had evolved beyond the rest of the world, and asserted that "Catholics, southerners, Indians, and Blacks" were not susceptible to the disorder (quoted in Schuster 18). According to feminist scholar Laura Briggs, "the characterization of the nervous woman was figured over and against a figure understood as her opposite: the 'savage' woman" (250). Because of this figuration, there emerged a racial system of "two discontinuous bodies and constitutions: one white, nervous, and plagued by weakness; the other racialized, colonized, and hardy" (Briggs 250).

Although Black women were constructed as distinct from white women, they were more often subject to experimentation, in part because this figuration rendered them insensate to pain. Gynecologist J. Marion Sims purchased enslaved women and operated on them without

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[233] See Sander L. Gilman, "The Image of the Hysteric," pp. 345-347.

anesthesia, citing his belief that Black women did not feel pain like white women. Between 1845 and 1849, Sims conducted experimental surgery on twelve enslaved women with fistulas in his backyard hospital. Sims performed twenty-nine unsuccessful operations without anesthesia on one enslaved woman, Anarcha, before perfecting his surgery—discovering that silver sutures would heal the fistula. Sims ignored the AMA's Code of Ethics by performing these operations, but he was not punished (Harris 214). Sims then pioneered gynecology in 1852 with a publication. Laura Briggs writes of Sims' belief that Black women felt no pain: "The corollary to the hyper-impressionable nervous systems of white women was the belief that Black women could feel little, even being somewhat exempt from pain…Sims's belief in the ability of Black women to stand pain was unshakable; he reported in his autobiography that the slave women on whom he operated begged him to repeat his attempts. 'They were clamorous,' he wrote'" (263). One of the staples of nineteenth-century American racial discourse was that Black people existed on the plane of the physical and were devoid of intellect and calm emotion.

Diagnoses were both attributed to, and withheld from, Black people depending on the racist discourse at hand, and as Sander L. Gilman argues, debates about hysteria at the close of the nineteenth century were rooted as much in stereotypes about race and mental illness as they were in the claims of its origin in the wandering womb. Stuckey shows that representations of hysteria then developed as a rich literary convention important in post-Reconstruction Era fiction by Black American writers.[234] The mulatto[235] became a common literary trope to explore

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[234] This includes Harper's *Iola Leroy* as well as Pauline Hopkins' *Of One Blood* and Charles Chesnutt's *The Marrow of Tradition.* As Stuckey argues, part of the project of crafting a national semiology of the Black middle-class after the failure of Reconstruction involved invoking illnesses, such as hysteria, previously associated with whiteness (146).

[235] The category "mulatto" first appeared in the census in 1850 (Hodes). In 1860, 13 to 20 percent of the Black American population had white ancestry, and the free Black population was predominantly biracial (Berzon 11).

interracial relationships, and in particular the legacy of miscegenation resulting from the rape of Black women by their white masters.[236] By representing Black women—or more specifically, biracial women—as susceptible to the diseases of overcivilization, Black American writers challenged the dominant construction of Black womanhood as sexually promiscuous, and tended to underscore their roles as wives and mothers. "Tragic mulattas" typically appear white, and often do not know they are of mixed race. The narrative tension in these storylines—what Susan Gillman calls "the race melodrama"—most typically revolves around the characters' discovery of their secret parentage and the usually fatal consequences.[237]

Harper's novel subverts this expectation. As Stuckey argues, "Harper's *Iola Leroy* employs the trope of the 'hysterical mulatta'…to challenge the tragic end that has traditionally been the fate of biracial characters" (118). Harper contests dominant constructions of racial amalgamation as a medical disorder and suggests that it is rather the lack of knowledge or acknowledgement of their family histories that causes physical and mental illness. When Iola's mother Marie tells Iola she will be enslaved, Iola responds with diagnostic scrutiny, and "eyed her mother curiously…Had grief dethroned her reason? Yet her eye was clear, her manner perfectly rational" (105). Iola slowly ceases to think her mother irrational: "Deathly pale" Iola becomes "almost wild with agony" (105) then burst "into a paroxysm of tears succeeded by peals of hysterical laughter" (106). This "paroxysm," the most acute moment of illness, presents us with the disabling harm of oppression. Harper's novel insists that not only were biracial women

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[236] Hazel Carby argues, "The mulatta figure was a recognition of the difference between and separateness of the two races at the same time as it was a product of a sexual relationship between white and Black" (90).

[237] Gillman argues that the American race melodrama emerged in conjunction with the institutionalization of anti-Black repression. See "The Mulatto: Tragic or Triumphant? The Nineteenth-Century American Race Melodrama." For a more detailed analysis of the "tragic mulatto/a," see Berzon, *Neither White nor Black: The Mulatto Character in American Fiction.*

capable of experiencing hysteria, but also that they were more *likely* to do so because of the harm done by the system of enslavement. After this scene, Iola is enslaved; her brother and sister fall ill, and her sister Grace actually dies of hysteria.

While it might be tempting to read Iola as one who "overcomes" the hysteria that kills her sister, Harper maintains that Iola and her mother are both ill throughout. After Iola is freed, she works as a Civil War nurse. Iola is wooed by two different doctors, white Dr. Gresham and mixed-race Dr. Latimer, who worry about how hard she works and about her pain. Ironically, Iola then performs substantial emotional labor to convince both doctors to accept she will not stop working, insisting that that work is her choice. While she works, "Iola, after a continuous strain upon her nervous system for months, began to suffer from general debility and nervous depression" (112). Dr. Gresham recognizes the symptoms, telling Iola, "You are sinking beneath burdens too heavy for you to bear," to which Iola replies, "Doctor, you are right" (112). Iola accepts that she is exhausted. Yet still, she does not quit working. Hysteria and nervous depression are often negatively associated with rest largely in white women's stories, (famously, in Gilman's "The Yellow Wallpaper"). Harper's framing of Iola's embodied "general debility" and mental "burdens" draw attention to the inaccessibility of rest for women like Iola who are busy fighting for racial uplift.

Many scholars have read the ending of *Iola Leroy* as "narratively curative," arguing that Harper "cures" Iola's problems in the novel by marrying ill Iola to a mixed-race doctor. The doctor in question, Dr. Latimer, proposes to Iola by asking that she "commit [herself]. . . to [his] care" (268). Iola accepts his proposal. But Harper's novel does not, in its finale, insist that Iola must be cured of her nervous condition. I make this point clear because it reveals that the ending of *Iola Leroy* offers us new ways of thinking about bodymind pain and *cure versus care*. Cure is generally understood positively, thought to be a "restoration of health" and a return to a "better" state of being (Clare 14). But as disability scholar Eli Clare argues, "cure requires damage, locating the harm entirely within individual human body-minds…it grounds itself in an original state of being, relying on a belief that what existed *before* is superior to what exists *currently*" (15, original italics). Diagnosis (not just misdiagnosis) and consequential efforts at cure are lifesaving necessities that *always* exist in relationship to destruction, and often represent a fantasy of future ability.

Iola Leroy refutes the notion that Black people are unable to become nervous and simultaneously challenges notions of Black weakness and frames disability as a social, rather than individual, problem.[238] Iola's mother Marie, a mixed-race woman, is diagnosed with nervous prostration when she realizes her children will be enslaved. Iola and her brother Harry develop nervous prostration, inheriting not only the "condition of the mother"—the historical euphemism for slavery—but also their mother's illness (Spillers 269). While Harper depicts neurasthenic Black characters, she simultaneously renders bodies nearly invisible, giving us "something that borders on the realm of science fiction: a body that becomes visible only when it flushes or goes pale" (Sanborn 698). Harper's characters do not *blush*, they *flush.* Iola is outwardly white; this has been controversial, as some critics view this as evidence of Harper's subservience to white norms. However, key to the overall story is Iola's insistence on her

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[238] As Jean Franzino argues about Harriet Wilson, it was important for Wilson to refer to her character as an "invalid mulatta," given assumptions about Black women's bodies as more labor-ready, and thus indestructible, than white women's bodies. Meina Yates-Richard argues in "What Is Your Mother's Name" that Harper makes Black pain legible to her readers by tapping into preconceived understandings about the power and trauma of nervous disorders. In a study of Harper's poetry, Carolyn Sorisio argues that Harper negotiates the dilemma posed by representing pain, resisting the sentimental assumption that corporeal pain is a universally understandable and translatable experience ("The Spectacle of the Body").

Blackness and the attention she shows her Black heritage. Iola grows pale when ill, then "a deep flush overspread[s] her face" (115) when she relates her dedication to working for racial uplift. We meet another enslaved character, Ben Tunnel: "[a] spasm of agony and anger darkened his face and distorted his features, as if the blood of some strong race were stirring with sudden vigor through his veins" (Harper 29-30). In the nineteenth century, blushing was understood to be a distinctly feminine and white manifestation of sensibility. Meanwhile, flushing, in *Iola Leroy*, signals a renewed battle for racial uplift (Sanborn 699). In the nineteenth century, blushing was understood to be a distinctly feminine and white manifestation of sensibility. Sanborn claims,

> Flushing, by contrast, was understood to be the result of an increased flow of blood from the heart to the extremities, prompted not by one's thoughts about what others might be thinking, but by a sudden and overwhelming passion, like anger or joy or sexual arousal…In none of the three major works written by Black women before *Iola Leroy*—Hannah Crafts's *The Bondwoman's Narrative* (c. 1855), Harriet Wilson's *Our Nig* (1859), and Harriet Jacobs's *Incidents in the Life of a Slave Girl* (1861)—is there a scene in which a character flushes. At the moments in those works when the body is salient, the body in question is almost always in pain or suffering from illness. (131)

As I discuss later on, Harper is also fascinated with hands (especially ones at work).

As Sanborn argues above, Iola grows pale when ill, then "a deep flush overspread[s] her face" (115) when she angrily relates her experiences with enslavement and her dedication to working for racial uplift. This may connect to Toni Morrison's claim that the in American literature, "Images of Blackness can be evil *and* protective, rebellious *and* forgiving, fearful *and* desirable—all of the self-contradictory features of the self. Whiteness, alone, is mute, meaningless, unfathomable, pointless, frozen, veiled, curtained, dreaded, senseless, implacable. Or so our writers seem to say" (Morrison 59). By hiding the bodies of her characters, Harper makes it harder, in some ways, for readers to pathologize their pain—connecting to a longer tradition of representation of illness in Black American literature and scholarship.[239] For example, critics have noted that Audre Lorde's more recent writings about feminism and cancer feature a paradox of flesh and insides. Lorde's writing "lives close to the vulnerable and uncertain flesh, and yet enjoys rhetorical authority, sureness, and even righteousness" (Perreault 14), and Lorde reclaims power in "showing us her insides, that sanctified, veiled territory that looks so different because she is showing it herself" (Alexander 700). Also, Ellen Samuels points out that many texts emphasize "wholeness, uprightness, good health, and independence" in order to get away from pathologizing histories of racist "Negro" diagnoses (18). Harper develops a unique semiotics of the biracial body: outwardly white people whose Blackness appears in moments of fury and empowered race work.

Iola Leroy centers disability and yet remains unusually disembodied, hinting that we need to know about characters' political views first and their external appearances second. For example, we learn about white suitor Dr. Gresham's patronizing views about Iola's illness and race five hundred and seventy-four pages before Dr. Gresham casually tells another character that he is an amputee and has nervous prostration. As Sanborn points out:

> If this were an ordinary sentimental novel—or an ordinary novel, period—we would have learned of the armlessness of the heroine's suitor at an earlier moment, and the information would not have been presented in passing by the suitor himself…. And if, for

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[239] Hortense Spillers defines "body" as a discrete entity, whereas "flesh" is related to desire and sexualization, connoting an undistinguished mass of Black people, particularly Black women. See "Mama's baby, papa's maybe: An American grammar book" (67).

> some strange reason, his armlessness was at first unmentioned and then at last referred to in the course of a conversation, that reference would have led *someone*—the heroine, the brother, the narrator—to *look* at the armless sleeve. Not here. (691, original italics)

Harper also initially conceals Blackness. When we are introduced to Dr. Latimer, we immediately learn he is dedicated to racial uplift. Several chapters later, we (and other characters) discover that although Dr. Latimer looks white, he *is* Black. By hiding her characters' bodies, Harper makes it harder, in some ways, for readers to pathologize them—connecting to a longer tradition of representation of disability in Black American literature and scholarship.[240] Disability scholar Ellen Samuels points out that many texts emphasize "wholeness, uprightness, good health, and independence" in order to get away from pathologizing histories of racist "Negro" diagnoses (18). That said, many authors provide indications of disability and race upfront so that readers might grasp something about that character's identity. Harper suggests that outward biological signs are not concrete markers of disability and race, and furthermore focuses upon whether characters perpetuate racial prejudice or work towards uplift. Through her concealing and revealing, Harper commands control over how we identify bodies as we read.

Maternal Care and the "Condition" of the Mother

Harper expands upon contemporary understandings of nervousness by exploring the disabling effects of enslavement while remaining attentive of the fact that children followed the conditions of their mothers. Harper begins by focusing on mothers—first, Iola's mother, Marie, whose experience of nervous prostration and enslavement inform Iola's. The plot of *Iola Leroy* revolves around the fact that Iola's father Eugene, a white slaveholder, fails to protect his mixed-

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[240] Hortense Spillers defines "body" as a discrete entity, whereas "flesh" is related to desire and sexualization, connoting an undistinguished mass of Black people, particularly Black women. See "Mama's baby, papa's maybe: An American grammar book" (67).

race wife Marie and his children from slavery. Eugene's love for his enslaved nurse Marie emerged after Marie restored him—body, mind, and soul—after he became deathly ill.[241] Eugene relates:

> I was sick nigh unto death, and had it not been for Marie's care I am certain that I should have died…. When I was nervous and restless I would have her sing some of those weird and plaintive melodies which she had learned from the plantation negroes…I was surprised at the native vigor of her intellect. (Harper 68)

Eugene was attracted to Marie because his "nervous and restless" self was soothed by her "care" and "weird and plaintive melodies," a statement that bridges her feminized labor and her labor as an enslaved woman on his plantation. Eugene proposes to Marie, touching her hand while saying, "This is the hand that plucked me from the grave, and I am going to retain it as mine; mine to guard with my care" (74). Eugene declares possession over his nurse's hand, claiming he will do the caring now—as husband rather than slaveholder. At the prospect of being freed and married, but still under another's possession, Marie "started, trembled with emotion, grew pale, and blushed painfully" (74). This reaction to his romantic confession is complex, and one of the few instances of blushing in *Iola Leroy*. Marie's reaction may foreshadow her later embodied forebodings when the freedom of her children comes into question. Her lack of enthusiasm—the

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[241] Eugene's description of the moral failings that led to his illness echo those of other male authors describing queer desire and sexuality: "My lavish expenditures and liberal benefactions attracted to me a number of parasites, and men older than myself led me into the paths of vice, and taught me how to gather the flowers of sin which blossom around the borders of hell. In a word, I left my home unwarned and unarmed against the seductions of vice. I returned an initiated devotee to debasing pleasures" (Harper 68-69). The way that Marie "restores" Eugene's health and heterosexuality both might be said to connect to Robert McRuer's concept of compulsory able-bodiedness.

silence after she blushes is described as “awkward” (74)—also suggests her powerlessness to refuse Eugene’s proposal.

It is worth noting that Harper includes a white man under the diagnostic label of “nervous” before she ascribes nervousness/hysteria to any woman. Furthermore, when she depicts white characters as ill, she makes clear that their racial prejudice is a weakness much more worrying than illness. Because Eugene wants to free Marie, he is called insane by his closest relative, another slaveholder named Alfred Lorraine:

> “Madness and folly inconceivable!” exclaimed Lorraine.
>
> “What to you is madness and folly is perfect sanity with me. After all, Alf, is there not an amount of unreason in our prejudices? . . . Will you accompany me North?”
>
> “No; except to put you in an insane asylum. You are the greatest crank out…” replied Lorraine. (72)

Eugene draws attention to construction of madness (“What to you is madness and folly is perfect sanity with me”), while Lorraine makes the (probably insincere) threat to throw Eugene into an insane asylum. Though Eugene denounces the “unreason in our prejudices,” we later learn that he is hardly an abolitionist. He “was in favor of gradual emancipation, which would prepare both master and slave for a moral adaptation to the new conditions of freedom” (86). He does not fight slavery overtly, despite his love for his freed wife and children, because “so strong was the force of habit, combined with the feebleness of his moral resistance and the nature of his environment, that…he had learned to drift where he should have steered, to float with the current instead of nobly breasting the tide. He conducted his plantation with as much lenity as it was possible to infuse into a system darkened with the shadow of a million crimes” (86). This passage significantly criticizes Eugene but also addresses “the nature of his environment” and the cruelty of the system of slavery. The white slaveholder, rather than an often-pathologized Black person, possesses “feebleness”; the institution of slavery, rather than the enslaved person, is “dark.” This connects to my point that in *Iola Leroy,* neither race nor disability is the problem to be fixed; racism is the problem. Harper indicates that refusing to oppose slavery “nobly” is true weakness. She paints Eugene as a moral failure not because of nervousness or insanity, but because white people who perpetuate enslavement and racism do direct harm to Black people.

Meanwhile, when Marie expresses valid concerns that are inconvenient for Eugene’s perceptions of the world, Eugene wields diagnosis and says Marie is growing nervous in order to delegitimize her concerns. Marie warns Eugene that their children might not be safe:

> If it annoys you…I will stop talking…[But] think how dear these children are to me; and then for the thought to be forever haunting me, that if you were dead they could be turned out of doors and divided among your relatives. I sometimes lie awake at night thinking of how there might be a screw loose somewhere, and, after all, the children and I might be reduced to slavery.” (78)

Marie is compelled to offer silence if her words annoy her husband; however, she goes on to express the fears that are “haunting” her. Her worry that “there might be a screw loose somewhere” seems to refer to “mental disturbance in a person; something wrong in one’s way of thinking…a significant weakness in an arrangement” (oed.com). This refers both to the flaws in the system, a mistake in the construction of freedom, and to the possibility of madness (either in herself or someone else). Eugene interprets Marie’s fears as a sign that something is wrong with his wife. He asks, “Marie, what in the world is the matter with you? Have you had a presentiment of my death, or, as Uncle Jack says, ‘hab you seed it in a vision?” (Harper 80). That he uses the dialect of an enslaved person to question Marie’s behavior possibly reinforces her fears. Marie replies seriously, telling him of an apt premonition: "I have had such sad forebodings that they almost set me wild. One night I dreamt that you were dead; that the lawyers entered the house, seized our property, and remanded us to slavery" (80). Eugene replies to Marie's phrase "almost set me wild," with a diagnosis: "'Marie, dear, you are growing nervous. Your imagination is too active. You are left too much alone on this plantation…I have manumitted you, and the children will follow your condition'" (80). This response may feel reminiscent of "The Yellow Wallpaper," when physician-husband John warns his wife that she permits her imagination to run too freely. Marie resists this claim and tries to warn of Lorraine's cruelty, telling Eugene: "There is something about your cousin that fills me with nameless dread. I always feel when he enters the room as if some one were walking over my grave" (89). Eugene repeats his diagnosis: "But, Marie, you are growing nervous. How cold your hands are. Don't you feel well?" (89). Eugene assumes that her concern is reflective of a nervous disorder that might be diagnosed; however, she herself defied diagnosis by calling her dread "nameless." Marie replies by confirming her embodied reaction as well as her horror at Lorraine's presence: "Oh, yes; I am only a little faint. I wish [Lorraine] would never come" (90). Eugene's failure to take Marie's prediction to heart results in the tragedy of the rest of the novel: after Eugene dies of yellow fever, Lorraine finds the marriage certificate between Eugene and Marie to be null and remands Marie and her children into slavery.

Upon Eugene's death and Lorraine's betrayal, Marie's conditions—her "condition" of freedom, and her bodymind conditions—worsen simultaneously, demonstrating Harper's understanding of disability as bound to enslavement:

> [Marie] tried to speak, reached out her hand as if she were groping in the dark, turned pale as death as if all the blood in her veins had receded to her heart, and, with one heart-

> rending cry of bitter agony, she fell senseless to the floor…For awhile [sic] she was stricken with brain fever, and her life seemed trembling on its frailest cord. (96)

Lorraine's friend later says that Marie was diagnosed with "brain fever and nervous prostration" (102). Harper's description of Marie's ailment brings together different symptoms of nervous afflictions. It emphasizes blood ("as if all the blood in her veins had receded to her heart"), suggesting that paleness motivates her loss of vitality. Though she was "groping in the *dark*," her body cannot resist the whiteness that overwhelms her. While descriptions of fainting are common in sentimental literature, Harper articulates the physiological reactions to trauma, legitimizing an embodied reaction to traumatic news and demonstrating that reactions have external causes, such as enslavement. Harper makes clear that a white man is enacting violence against a Black family, giving new meaning to Mitchell's association of whiteness to unhealthiness. We later read that "[i]n a darkened room lay the stricken mother, almost distracted by her late bereavement" (105). Marie is "stricken" (by illness and violence) and is "almost distracted." Distracted can mean pulled apart or deranged/driven mad. This exact phrase is repeated later in the book when Iola tells her brother Harry, "Mamma is almost distracted" (122). This phrasing emphasizes the role of binaries in this story; just as light and dark, illness and health, and dark and pale contrast, so too does Marie battle a state of division as a result of her agony.

When Eugene died, Iola Leroy was in a boarding school, where, under the impression that she was white and free, she defended slavery; upon learning she is to be enslaved, she undergoes a bodymind transformation as well as a moral lesson. Lorraine sends Iola a fake telegram, supposedly from Marie, tricking her into returning to the plantation. Lorraine took advantage of Marie's illness, as Marie explains: "It was Lorraine who sent the telegram. I wrote to you as soon as I could after your father's death, but fainted just as I finished directing the letter" (106). Harper explains a potential plot hole—that Marie should have warned Iola of her fate—by writing that Marie fainted from illness, exhaustion, and emotional strain. This suggests that enslavement's embodied harm haunts a mother's efforts to rescue her children from it. When Marie tells Iola of her cruel fate, Iola responds with diagnostic scrutiny. She "eyed her mother curiously. What did [her mother] mean? Had grief dethroned her reason? Yet her eye was clear, her manner perfectly rational" (105). Marie "saw the astounded look on Iola's face," then, "nerving herself to the task, said: 'Iola, I must tell you what your father always enjoined me to be silent about. I did not think it was the wisest thing, but I yielded to his desires. I have negro blood in my veins'" (105). Again, we see the harmful consequences of Eugene's silencing of his wife. Iola ceases to think her mother irrational: "An expression of horror and anguish swept over Iola's face, and, turning deathly pale, she exclaimed, 'Oh, mother, it can't be so! you must be dreaming!'" (105). Iola turns "deathly pale," again indicating whiteness as a source of cruelty and illness. Iola then becomes "almost wild with agony" (105), repeating her mother's earlier "wild" forebodings. Iola "paced the floor, as the fearful truth broke in crushing anguish upon her mind. Then bursting into a paroxysm of tears succeeded by peals of hysterical laughter, said:—'I used to say that slavery is right. I didn't know what I was talking about'" (105-106).[242] This "paroxysm," the most acute moment of illness, is not merely figurative. Iola has a reaction to the news that highlights the disabling nature of oppression. Though possibly figurative, the reference to a literal illness, Iola's "peals of hysterical laughter," demonstrates Harper's insistence that not

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[242] The word "anguish" is repeated in the phrase "crushing anguish upon her mind," her suffering mimicking the "oppression, physical and moral suffering (*e.g.,* of Christ)" (oed.com).

only were Black women capable of experiencing hysteria, but also that they were more likely to do so because of the harm done by the system of enslavement.

The novel emphasizes both the embodied and social realities of illness, as all of Marie's children become ill after learning of their mother's dual conditions. When Iola's sister Gracie becomes fatally sick Marie accepts Gracie's death, saying, "The fever has exhausted all her rallying power, and yet, dear as she is to me, I would rather consign her to the deepest grave than see her forced to be a slave" (107). As Gracie died, she "[r]eached out her thin, bloodless hand, clasped Iola's palm in hers" (108), a phrase that again associates the exhaustion caused by enslavement and trauma with bloodlessness. When Iola writes her brother Harry to tell him of the news, he enters the family experience of illness, demonstrating again that Harper's male characters experienced symptoms of grief, nervousness, and hysteria, just as the women did. Paleness and flushing also characterize Harry's reaction: "As he read, he turned very pale; then a deep flush overspread his face and an angry light flashed from his eyes. As he read on, his face became still paler; he gasped for breath and fell into a swoon" (120). The principal of the school was "appalled at the sudden change which had swept over [Harry] like a deadly sirocco," and called for a doctor (120). This comparison to a "deadly sirocco" holds symbolic potential, since a sirocco is a hot wind that blows from North Africa to southern Europe (oed.com). This wind symbolically binds Harry to his Black roots despite his European appearance. The deadly potential of whiteness and paleness characterize Harper's writing as illness haunts every one of Marie's children.

Harry's white doctor exemplifies Harper's view of good medicine that focuses on care rather than cure. The doctor has a diagnostic mystery on his hands; he "was greatly puzzled" because "less than an hour before, he had seen [Harry] with a crowd of merry, laughter-loving boys, apparently as light-hearted and joyous as any of them" (121). Now, Harry lay with an abundance of difficult-to-diagnose symptoms: "features drawn and pinched, his face deadly pale, as if some terrible suffering had sent all the blood in his veins to stagnate around his heart…. A terrible shock had sent a tremor through every nerve, and the doctor watched with painful apprehension its effect upon his reason" (121). The doctor makes a quick prescription: "[g]iving him an opiate and enjoining that he should be kept perfectly quiet" (121). He seeks the principal and asks him for diagnostic information: "Can you throw any light on the subject? . . . I am not asking you as a matter of idle curiosity, but as a physician. I must have all the light I can get in making my diagnosis of the case" (121). This repetition of the "light" the doctor needs ties into the novel's light/dark theme, more specifically suggesting that social context is needed. Upon reading Iola's letter, the doctor remarks, "The boy is too ill to be removed. It is doubtful if the nerves which have trembled with such fearful excitement will ever recover their normal condition. It is simply a work of mercy to watch over him with the tenderest care" (122-123). The empathetic doctor realizes Harry's nerves may never recover. Harper's doctor does not try to force Harry into different kinds of cure, though he does suggest rest; rather, he offers a "work of mercy" and "tenderest care"— care work—in this moment of tragedy. Harry battles illness for months, finally requesting his doctor's diagnosis, asking, "Doctor, tell me how it is?" (123). The doctor replies to Harry's question: "Taking his emaciated hand in his, the doctor said, in a kind, fatherly tone: 'My dear boy, you have been very ill, and everything depends on your keeping quiet, very quiet'" (123). The doctor does not offer Harry a concrete diagnosis, and the only prescription he gives is to tell him to be silent that he might better hide from the social forces that sickened him in the first place. Harper creates a sympathetic doctor who understands Harry's condition, a result of the systematic debasement that leaves a permanent mark.

After Iola and Harry each experience these bouts of illness, they both dedicate their lives to fighting against injustice and finding their mother—acts that relate to disability. Harry joins the Union army in the ranks of Black soldiers. A friend asked him later, “Were you aware of the virulence of caste prejudice and the disabilities which surround the colored people when you cast your lot with them?” Harry immediately replies, “Love for my mother overcame all repugnance on my part” (202- 203). He then becomes injured in the war, which leads him to reunite with his mother: “Nursed by his mother’s tender, loving care, he rapidly recovered, but, being too disabled to re-enter the army, he was honorably discharged” (192).[243] Though Harry experiences illness, prejudice, and multiple types of disability (both nervousness as a result of learning of his enslavement and injury incurred in the Civil War, which we might see as connected), his willingness to fight for justice leads to disability, which enables a reunion with his (nursing) mother. As demonstrated in the previous chapter, Gilman’s “The Yellow Wallpaper” criticizes the way women were forced to *return to motherhood* by physicians. By contrast, Harper’s *Iola Leroy* embraces characters’ *returns to their mothers*, as this offers recovery from the damage done by enslavement. Harry stops fighting because he is “too disabled,” and yet we immediately learn: “Having fully recovered his health, and seeing the great need of education for the colored people, Harry turned his attention toward them, and joined the new army of Northern teachers” (192). Harry is disabled, and yet “fully recovered”—contradictorily able to pursue his preferred form of race work after receiving his mother’s care. The novel thus succeeds in denouncing the disabling effects of slavery without necessarily condemning disability itself. It further offers a solution to the violence of some curative efforts. A doctor’s “tenderest care” and a mother’s

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[243] On physical impairments as a result of military service in *Iola Leroy,* see Jennifer C. James’ *A Freedom Bought with Blood.*

"tender, loving care" enable Harry to pursue the race work that he finds restorative without wholly eliminating his relationship to disability.

Immediately after Harper explains that Harry is too disabled to fight in the war further—and right before she explains Harry's decision to work as an educator—she casually kills off Lorraine as retribution for his cruelty, prejudice, and slaveholding, a disgraceful ending that aids Marie and her family by destroying the greatest source of their agony and indicates the usefulness of such violence when it is warranted. Lorraine "had taken Marie to Vicksburg, and…at first attempted to refugee with her in Texas," suggesting that he attempted to stay near Marie for sexual exploitation. Lorraine was "foiled in the attempt, and "compelled to enlist in the Confederate Army, and met his fate by being killed just before the surrender of Vicksburg" (192). This tiny scene is wedged in between the paragraphs that explain that Harry is disabled yet happy, reunited with the caring Marie and ready to work. The location of the scene suggests that a slaveholder gets what he deserves: a far worse fate than that of a disabled Black man.

As I will next discuss, Iola spends the war nursing ill soldiers, is diagnosed with nervousness, and ultimately finds happiness: factors that shed light on Harper's vision of a caring, hopeful future for Black Americans who constantly face sources of debilitation.

Iola's Romantic Doctors: Rest Cure and Care Work

To recapitulate Iola's romantic involvements, she is wooed by two different doctors, Dr. Gresham and Dr. Latimer, who both diagnose her with hysteria and nervousness upon seeing how hard she is working (as a nurse, then as a political speaker and educator). Both of these courtships entangle disability, gender, and race, as Iola's suitors talk to her about her illness, her desperation to find and help her ill mother, and her race work. Iola performs substantial emotional labor to motivate her suitors to understand race work as a positive way of handling nervousness and anxiety, and ultimately convinces both doctors to think more progressively about racial uplift.

She chooses Dr. Latimer, the mixed-race doctor who helps Iola's mother Marie with her nervous condition by "prescribing" time with family (notably, a social approach to illness rather than a physiological one as well as the antithesis of the condition of slavery). As Cynthia Davis points out, at least four novels written between 1890 and 1903 "employ the convention of a mulatta coupled with an ambitious mulatto male doctor" (Davis 164). Davis argues that we "could read the recurring appearance of this fictional doctor character as gesturing toward a larger anxiety about medico-scientific epistemes," one that brings forth "prospects for reconciliation" of that anxiety, "with the relative happiness of the union attesting to the power of this counternarrative to subvert dominant medical-aesthetical hierarchical scales" (Davis 164). As Harper explores the embodied and social realities of neurasthenia and the diagnostic/curative methods brought to it, she also suggests that Iola's knowledge as a skilled nurse enables her to propose care work and race work as alternatives to the rest initially prescribed by her medically-trained male suitors. I suggest that while Iola accepts that all this work will come at a cost to her bodymind, she pursues it anyway—for her own good and for that of her country.

Iola commits herself to fighting for racial justice when she follows the "condition" of her mother again—this time to become a nurse in the Civil War, when she gains knowledge of medicine as she cares for disabled soldiers. She becomes a nurse with the help of the enslaved Tom Anderson, who helps her break free from a cruel slaveholder, Master Thomas Anderson (Tom is made to carry the slaveholder's name). Master Thomas tries to touch Iola, and as Tom relates of this attempted assault: "[Iola's] eyes fairly spit fire. Her face got red ez blood, an' den she turned so pale I thought she war gwine to faint, but she didn't, an' I yered her say, 'I'll die fust'" (41). Here we encounter the enslaved Tom's dialect—a marked contrast to the speech patterns of other Black characters in the novel. Again, blood and paleness are used to indicate both Iola's emotion and her determination to resist. When Tom sends Iola to work as a nurse, he is "doubly gratified at the success of his endeavors, which had resulted in the rescue of the beautiful young girl and the discomfiture of his young master who, in the words of Tom, "'was mad enough to bite his head off' (a rather difficult physical feat)" (39). While "mad" refers to anger here, this superfluous parenthetical—the literalization of a metaphor of madness—also pushes insanity onto the master rather than the enslaved person, in a reversal of stereotypes about race. Further, this statement is made by a disabled Black man. Tom Anderson "[w]as a man of herculean strength and remarkable courage. But, on account of physical defects, instead of enlisting as a soldier, he was forced to remain a servant, although he felt as if every nerve in his right arm was tingling to strike a blow for freedom" (87). These "physical defects" are not expanded upon; what matters is Tom's desire to fight for freedom, which is represented alongside his "herculean strength." This showcases Harper's skill at representing weakness and strength simultaneously, when depicting disabled Black characters. Iola's nursing is made possible by an enslaved Black man with "nerve" in his body—as well as disability.

Iola becomes a skilled nurse, and she is drawn to Dr. Gresham because they are both skilled at caring for Black and white soldiers; both also experience disability in some way, giving them first-hand knowledge of how to care for patients. When Tom is injured while volunteering in the war, a captain immediately states, "Give him into Miss Leroy's care. If good nursing can win him back to life, he shall not want for any care or pains that she can bestow. Send immediately for Dr. Gresham" (53). Iola and Dr. Gresham are thus paired together as the best medical advisors who could potentially help Tom recover, and "as nurse and physician, Iola and

Dr. Gresham were constantly thrown together" (59). The emphasis on Iola's abilities in these passages indicates Harper's interest in representing Black women as understanding health and care beyond maternal nursing stereotypes.

During the Civil War, Iola is freed from enslavement and becomes a nurse; her nursing can be seen as a form of self-care, even though it is also exhausting and debilitating. We know that Iola remains ill during the Civil War because Dr. Gresham, a white doctor, consistently observes that overwork is causing her pain. Dr. Gresham develops feelings for her, and they are drawn together by the horrors of their setting. He makes clear his concern: "This hospital life is telling on you. Your strength is failing…. you are running down, and if you do not quit and take some rest you will be our patient instead of our nurse" (60). Iola rejects his suggestion that she "take some rest," as she is unwilling to cease her work. "Doctor, if that is your only remedy," replied Iola, "I am afraid that I am destined to die at my post" (60). This suggests Harper's belief that care work—especially work that is performed by, and benefits, Black people—is inescapable, even when one is ill or tired. In a sense, *Iola Leroy* thus offers a glaring alternative to Mitchell's "rest cure." Later, the novel tells us that "Iola, after a continuous strain upon her nervous system for months, began to suffer from general debility and nervous depression" (112). Dr. Gresham recognizes the symptoms, telling Iola, "You are sinking beneath burdens too heavy for you to bear," to which Iola replies, "Doctor, you are right" (112). While earlier Iola dismissed his claim that she needed rest, now she accepts that she is exhausted. Yet still, she does not quit working.

Iola further expresses her concern that Dr. Gresham's family will discriminate against her and warns him that her children would be exposed to racial prejudice. "'Doctor,' [Iola] said, and a faint flush rose to her cheek, 'suppose we should marry, and little children in after years should nestle in our arms, and one of them show unmistakable signs of color, would you be satisfied?'" (117). Iola refers to Gresham solely as "Doctor," emphasizing his medical perspective while distancing herself from him emotionally by referring to him professionally by title rather than personally by name. Now Iola is the one performing an examination, searching for truth. Iola "looked steadfastly into his eyes, which fell beneath her truth-seeking gaze. His face flushed as if the question had suddenly perplexed him" (117). Gresham reacts to Iola's question by dropping his eyes, and his face flushes, just as Iola's did, as Sanborn notes (698). But while Iola's flushing is typically a sign of her passion for Black rights, Gresham's is a marker of shame at refusing to agree to have Black children. Gresham asks, "What is to hinder you from sharing my Northern home, from having my mother to be your mother?" (116). This strikes an uncomfortable chord; she has resolved, she tells Gresham, "never to marry until I have found my mother" (Harper 118). Iola agrees with Dr. Gresham's comment that she is struggling with the burden of care work as a nurse; however, she rejects his proposal, realizing that his perspectives would all cause her pain.

Further, Dr. Gresham will not accept that race is *like* disability, a framing that Iola seems to find productive. Iola asserts that the world will treat Dr. Gresham differently if he marries her. She claims, "It is easier to outgrow the dishonor of crime than the disabilities of color…Is not the most arrant Rebel to-day more acceptable to you than the most faithful colored man?" With this phrase, "the disabilities of color," Iola draws a clear analogy between disability and race, framing both as dependent on social context. She also pushes Dr. Gresham to recognize that he has taken a critical approach to an ill biracial woman like herself. As we think about disability's rich complexity in the novel, we must also consider the use of the word "disability" in the past. Although this use is more foreign to us now, when Iola says "It is easier to outgrow the dishonor of crime than the disabilities of color," she seems to actually not refer to physical impairment or drawing an analogy between race and disability, but instead using the older understanding of disability as an impediment, often a legal one. "Disability" was historically a legal term describing impediments to rights that were most often not physical or cognitive.[244] That seems very resonant with what Iola is saying here. To think about disability in this historical context means to acknowledge that disability has everything to do, not just with a person's medical identity or medical treatment, but with a person's legal status in the country. Iola is expressing a material, tangible concern with her own and future family's citizenship and rights.

Dr Gresham worries that Iola worries about the state of racial relations in America too much, and consequently comes across as somewhat dismissive of the fight Iola believes the most important fight of her time. He says, "Iola, dear, surely you paint the picture too darkly," a line that connects to the novel's association of light and darkness with piety and passion, respectively. She replies: "Doctor, I have painted it with my heart's blood," significantly confirming the darkness of her "heart's blood." She concludes, "I must serve the race which needs me most" and Dr. Gresham "rose to go" (218). We learn that Dr. Gresham

> Felt it was useless to attempt to divert her from her purpose. He knew that for the true reconstruction of the country something more was needed than bayonets and bullets…the South needed the surrender of the best brain and heart of the country to build, above the wastes of war, more stately temples of thought and action. (218).

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[244] Thank you again to Sari Altschuler for her help on this section when she gave comments on my paper "'The Virus of Slavery and Injustice': Analogy and Disabled Life in Black American Writings, 1856-1892" at the Dina G. Malgeri Modern American Society & Culture Seminar for the Massachusetts Historical Society (Oct. 28, 2021).

Here Harper represents Dr. Gresham's acceptance of Iola's "purpose," as she also shares a vision of "true reconstruction of the country," one that involves a literal building of temples. Dr. Gresham's vision requires the "best brain and heart," a phrase that demonstrates Harper's attentiveness to the internal workings of the body and the body's relationship to the morality of one's soul. Dr. Gresham, who we eventually learn is also disabled, finds that Iola, despite his initial concerns about her health, possesses the brain and heart that the country needs in order to recover from war and violence.

We do not find out that Dr. Gresham is disabled until months and pages after Iola rejects his hand in marriage—not only is he an amputee, but he must also treat his own exhaustion with rest, a factor that makes his rest prescription for Iola seem less patronizing.[245] When Dr. Gresham is asked about his health, he replies, "I was running down through exhaustion and overwork, and I was compelled to go home for a few weeks' rest…It seemed as if I had lived through ages during these last few years. In the early part of the war I lost my arm by a stray shot, and my armless sleeve is one of the mementos of battle I shall carry with me through life" (144). We learn that he has been an amputee all along. We also realize that in the hospital, a disabled woman with two functional hands worked together with a disabled man with one hand—an image of interdependent care. He also reports, "I have been sick, and am just now recovering from malaria and nervous prostration" (213). We discover that Dr. Gresham, not Iola, needs to seek rest for exhaustion. It seems his prescription that Iola should rest was not merely paternalism, but a prescription he was willing to take for himself. This breaks down a dichotomy

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[245] Jean Franzino argues that much print and visual culture immediately following the war assured white men that they could still be men with amputations (whereas the messages were much more mixed for Black men.) See "Harmonies of Form and Color."

of rest and work as bad and good; both are potential approaches to illness that vary in usefulness depending, in part, on factors such as gender, race, and war.

Although Dr. Gresham's amputation was not previously mentioned, his "hand" was mentioned several times in repeated references that serve, conventionally, as analogies for marriage and strength. When Dr. Gresham proposed to Iola, "As he held her hand in his a tell-tale flush rose to her cheek…She withdrew her hand from his" (109); then "for a moment [Dr. Gresham] held her hand as it lay limp in his own" (118). Right after we learn he is an amputee, he says in conversation, "Power…naturally gravitates into the strongest hands. The class who have the best brain and most wealth can strike with the heaviest hand. I have too much faith in the inherent power of the white race to dread the competition of any other people under heaven" (223). This harmful statement about the inherent power of the white race repeats "strongest hands" and "heaviest hand," suggesting that while Dr. Gresham gave one hand during the war, he still associates hands with power.

The way the novel reveals and hides disability affords the work unique freedoms of representation. Gresham's disability is not used as what Mitchell and Snyder call a "narrative prosthesis," wherein disability works as a totalizing feature of characterization (by suggesting something like an incomplete moral sense) (9). His disability is one component of his life, and the fact that he then develops more open-minded views about race is featured much more prominently. Harper offers disability for her characters in a way that points, usefully, to social context rather than individual failing.

Dr. Gresham is then given a chance to unlearn ableist and racist beliefs, for in the following chapter, he expresses more progressive views towards race (largely because Iola has worked so hard to change his perspectives):

> "Slavery," said Iola, "was a fearful cancer eating into the nation's heart, sapping its vitality, and undermining its life."
>
> "And war," said Dr. Gresham, "was the dreadful surgery by which the disease was eradicated. The cancer has been removed, but for years to come I fear that we will have to deal with the effects of the disease. But I believe that we have vitality enough to outgrow those effects."
>
> "I think, Doctor," said Iola, "that there is but one remedy by which our nation can recover from the evil entailed upon her by slavery…A fuller comprehension of the claims of the Gospel of Jesus Christ, and their application to our national life."
>
> …Continued Dr. Gresham… "Time alone will tell whether or not the virus of slavery and injustice has too fully permeated our Southern civilization for a complete recovery."
>
> (217)

The dialogue here clearly uses medical language to address the problems of slavery, war, racial prejudice, and lynching. While earlier he said that Black people must help themselves, Dr. Gresham now asserts that "*our* work" is "to build over the desolations of the past a better and brighter future," and that "*we* will have to deal with the effects of the disease" (217, my italics). Later, when Dr. Gresham defends Black voting rights, we see him "flushing, and rising to his feet" (219). As noted above, flushing, in *Iola Leroy,* signifies the desire to combat the "disease" of racial prejudice. While Iola and Dr. Gresham use medical metaphors to consider various "remedies," they both inhabit disabled and ill bodies, flushed with darkening skin, that Harper presents thoughtfully and without pity. In other words, Harper balances a search for a remedy for "the virus of slavery and injustice" with characters empowered to remain disabled and ill.

Although Dr. Gresham's views about race have become more progressive, Iola had to do much of the emotional labor of convincing Dr. Gresham to revise his opinions; moreover, his new views about race might also have to do with his disabled identity. Soon after we see Dr. Gresham *acknowledge* his disabilities, both his amputated arm and his nervous prostration, we also learn that he no longer believes that "[O]ut of the race must come its own defenders" (116). His acceptance of disabled identity might be said to accompany his greater understanding of slavery and racism's ongoing effects and shape his newfound desire to fight for racial uplift. In Harper's novel, disability is not merely a metaphor for immorality, nor is it something that must be overcome; rather, disability is simply a fact of the Civil War. White doctors do not merely eradicate disability in *Iola Leroy;* rather, they feel it for themselves, and learn to participate in the debilitatingly difficult but invigorating work of combating racial prejudice.

"Commit Yourself…To My Care": Iola Leroy and Dr. Frank Latimer

Iola Leroy has an uplifting ending—one which other scholars, as I will show, have read as narratively curative. Iola's romantic life takes a turn when she meets Dr. Frank Latimer. Like Iola, Dr. Latimer is outwardly white; his identity as a Black person is figured, significantly, through his relationship to his mother. She "belongs to that race," he says eventually to Iola. "Where else should I be?" (263). Iola and Dr. Latimer are both committed to their Black mothers, as Harper subverts the "tragic mulatto" genre that typically presents Black mothers through a pitying lens. The ending continues to serve a pedagogical purpose. Iola's brother Harry proposes to the lovely Miss Delany, who accepts only after he assures her that his mother Marie and Iola will not express "complexional prejudices," which she reminds him "are not confined to white people" (282). The marriage of a dark-skinned Black woman, inspired in many ways by the physician Martin Robison Delany, to light-skinned Harry makes the issue of colorism more tangible in the story. As I will demonstrate, Iola and Dr. Latimer's romance plays only one small role in giving *Iola Leroy* an uplifting ending; Iola's reunion with maternal figures is arguably more foundational for the story's focus on spiritual, continuous uplift and care.

Iola meets Dr. Latimer when he treats Iola's mother Marie for a nervous condition, and Iola responds positively to his open-minded medical approach that resonates with what today we might call a "social model" approach to illness. "Without appearing to make a professional visit," Dr. Latimer "engaged Marie in conversation, watched her carefully, and came to the conclusion that her failing health proceeded more from mental than physical causes" (242). Marie confesses, "I am so uneasy about [her son] Harry," to which Dr. Latimer replied, "His presence will do you more good than all the medicine in my chest" (242). While Dr. Latimer diagnoses Marie's bodymind, he also recognizes that family will serve Marie better than medicine in this case. Iola and Dr. Latimer begin to flirt, with Iola "faintly blushing" (243). This unusual blush in a story full of flushing signals the beginning of Iola and Dr. Latimer's romance. Later on, Dr. Latimer proposes that Iola "commit [herself]…to [his] care" (268), a proposal that combines medical and romantic language.

Iola then finds herself in a familiar position: her physician-suitor diagnoses her with nervousness, and she must convince him that she does not wish to stop working. As Dr. Latimer woos Iola, he warns her that he believes she broods "too much over the condition of our people," adding, "I am afraid…that you will grow morbid and nervous. Most of our people take life easily—why shouldn't you?" (269). Dr. Latimer re-assumes medical authority:

> "I am not counseling you to be selfish; but, Miss Iola, had you not better look out for yourself?"
>
> "Thank you, Doctor, I am feeling quite well."

> "I know it, but your devotion to study and work is too intense," he replied. (270)

Like Dr. Gresham, Dr. Latimer finds that Iola is working too hard in her efforts to help her fellow Black Americans. However, when Iola was with Dr. Gresham, she admitted that he was correct when he asserted that she was tired. This time, she says she is "feeling quite well," and does not concede her fatigue as she did with Dr. Gresham. She seems to be taking care, even as she works and studies intensely.

Iola and Dr. Latimer fall in love, partially, it seems, because Iola accepts Dr. Latimer's offer to care for her. When Dr. Latimer says he will be moving to start a medical practice in North Carolina, Iola says she wishes

> "That you…could take care of that high-spirited brother of mine."
>
> "I suppose if he were to hear you he would laugh, and say that he could take care of himself. But I know a better plan than that."
>
> "What is it?" asked Iola, innocently.
>
> "That you will commit yourself, instead of your brother, to my care." (268)

This marriage proposal begins as a lighthearted conversation about whether Iola should be "commit[ed]" to Dr. Latimer's "care," combining medical and romantic language. Unsurprisingly, Iola's first reaction to Dr. Latimer's proposal is to ask about her mother's reaction, since her mother plays a significant role in determining Iola's views on health, race, and her future. She replies, "Oh, dear . . . What would mamma say?" Dr. Latimer replies, "That she would willingly resign you, I hope" (268). Dr. Latimer cheerfully suggests that her family would "all consent" (268). That Iola's first instinct is to think of her mother's reaction ties into the novel's ongoing concern with mothers, race, and illness. The references to "commitment" (to medical care and to marriage), motherhood, and the need for consent in medicine and marriage continue to bring together the novel's focus upon the relationship between medicine and matrimony, one that is seemingly necessary for the future of Black health and happiness—so different from the gendered dynamics between Gilman's characters in *The Yellow Wallpaper* (Davis 165).

Dr. Latimer (aptly) connects race work to exhaustion, but Iola rejects the idea that she should rest. Dr. Latimer replies with a social "prescription" that is really a proposal:

> "As a teacher you will need strong health and calm nerves. You had better let me prescribe for you. You need," he added, with a merry twinkle in his eyes, "change of air, change of scene, and change of name."
>
> "Well, Doctor," said Iola, laughing, "that is the newest nostrum out. Had you not better apply for a patent?"
>
> "Oh," replied Dr. Latimer, with affected gravity, "you know you must have unlimited faith in your physician."
>
> "So you wish me to try the faith cure?" asked Iola, laughing.
>
> "Yes, faith in me," responded Dr. Latimer, seriously. (270)

Iola decides to accept Latimer's "nostrum" of "change of name." Literary scholar Ann DuCille calls this marriage of biracial physician to biracial woman "the coupling convention," asserting that the marriage is a narrative form of cure that allows Harper to figuratively fix Iola's racial identity and illness.

However, Iola refuses to stop doing race work, and fully accepts the illness that may be the consequence of that work. After they agree to marry, Dr. Latimer says to Iola, "Your heart should be as light as a school-girl's" (272). But Iola wants Dr. Latimer to understand why she believes they should both perform exhausting race work, even though it weighs her and her heart down. Dr. Latimer reacts to Iola's account of her history as an enslaved woman:

> "You are like a tender lamb snatched from the jaws of a hungry wolf, but who still needs protecting, loving care. But it must have been terrible," he added, in a painful tone.
>
> "It was indeed! For awhile I was like one dazed…. I was wild with agony, and had I not been placed under conditions which roused all the resistance of my soul, I would have lost my reason." (272)

Iola thus finds the "conditions" which roused her "resistance" also empower her to care for herself. She tells him, "I must be prematurely old. I have scarcely known what it is to be light-hearted since my father's death…. Yet, in looking over the mournful past, I would not change the Iola of then for the Iola of now" (271). Iola does not, this passage suggests, associate feeling old and exhausted with self-pity. Dr. Latimer ultimately grows to understand Iola's feelings—her passion for her work and her view of her painful past. He remarks, "There are souls that never awaken; but if they miss the deepest pain they also lose the highest joy" (274). Dr. Latimer's words capture Harper's forward-thinking understanding of the fatigue and the joy that simultaneously spawn from political engagement.

Though Iola works hard, she *also* has the care of one trained in medical science, as Dr. Latimer becomes a "true patriot" who cares for Iola as she works (274). Iola becomes an educator, and "her life is full of blessedness" (279). In the conclusion, Iola and Dr. Latimer also reunite with Iola's Aunt Linda, and "Dr. Latimer was much gratified by the tender care Aunt Linda bestowed on Iola" (281).

In a happy conclusion, Iola and Dr. Latimer marry, and Iola begins new work as a teacher in the South. As mentioned above, other scholars seemingly assume that marriage to a Black physician will eliminate Iola’s symptoms. For example, literary scholar Michele Birnbaum argues, “The sentimental angst of [Iola’s] ‘condition’ is scrutinized, diagnosed, and finally cured by marrying the doctor treating her” (10). Birnbaum puts “condition” in quotation marks here, representing Iola’s illness as mere “sentimental angst.” Stuckey also proposes that, in Harper’s novel, “The curing of the hysterical mulatta by a Black physician is the impetus for the heroine’s fulfillment of her Black identity” (120).

Again, this gives us a chance to ponder how reading literature through a disability studies lens can shift our approach to a text. Disability scholars have criticized the medical model approach to disability, which involves viewing disability as an aberration that must be cured or eliminated. Pondering this, Eli Clare challenges the “ideology of cure.” He writes that while not every “individual instance of cure is violent….as a widespread ideology centered on eradication, cure always operates in relationship to violence” (14). Thus, there is a difference between seeking “healing” and “cure.” Disability scholars acknowledge that most everyone wants to envision a world where fatal illnesses such as cancer have been cured—but not everyone wants to envision a world where disabled identity has been cured.

Unlike the scholars mentioned above, I find that Harper’s novel does not insist that Iola was or needs to be cured in order to fully connect to her Black identity. After the engagement, Dr. Latimer and Iola discuss Iola’s experiences as an enslaved woman. Iola says, “I must be prematurely old. I have scarcely known what it is to be light-hearted since my father’s death…. Yet, in looking over the mournful past, I would not change the Iola of then for the Iola of now” (271). Iola still feels old and exhausted, and takes this moment of conversation to reflect on that status, as well as on her growth and personal identity.

The novel does not leave us, in its final pages, with the finality of cure; rather, it demonstrates the importance of Black mothers and communities of care. Iola begins work as a teacher and community leader. She reunites with her Aunt Linda, who offers "tender care" (281). Iola also reunites with her mother, Marie, as well as her "Grandmother Johnson." Though Marie is "frail in health, she is always ready to lend a helping hand wherever and whenever she can," and Grandmother Johnson, "[a]lthough feeble," "is in full sympathy with her children for the uplifting of the race" (281). All these women are, in some way, "frail," in Harper's term. Yet, with the reunion of these women, there is hope that the virus of injustice will be steadily confronted. The women do not imagine injustice to be cured, but see it as something they must continue striving against. Harper does not "cure" the novel's problems of racial identity and disability; in some ways, the story *perpetuates* embodied fatigue by recommending work—along with collective care—to its readers.

Thus, *Iola Leroy* serves as evidence for the claim that narrative plots do not and need not take a linear diagnosis-to-cure path. It accepts the desirability of cure, and simultaneously hints that access to communal care will remain vital for Black Americans. Even though Iola has married a doctor, there is no evidence that pain is completely, unnaturally eliminated. To me, this is testament to Harper's narrative power—rather than unrealistically eradicating bodymind experiences, she melds realism and sentimentality by depicting the co-existence of pain and joy. *Iola Leroy* thus manages to decry the disabling effects of slavery *without* advocating for the eradication of disability in the process.

The reunion of these women, *not* just the marriage of Iola to a doctor, gives the novel its hopeful ending based on an image of collective care. The fatigue that each of these women experiences seems inescapable because none of them can or will stop striving towards racial uplift. Because the novel recommends each reader also continue to work against injustice, it anticipates that readers are possibly going to experience exhaustion and possibly discrimination, as well. To manage this, the novel advocates for creating communities of support. In doing so, the novel offers a remarkable example of disability writing that imagines futures in which disability is witnessed, cared for, and not erased.

CODA

Why do we fill silences with guesses about symptoms?

How does literature challenge dominant discourses about the necessity of ability for human knowledge?

When should we ask questions (about another person's bodymind especially) and when should we stay quiet?

Throughout this project I thought about the transformative power of writing, and the ways authors challenge ableist violence. I thought about people yearning for diagnosis and those longing to hide, undiagnosable—people diagnosed and undiagnosed; people yearning for diagnosis and those longing to hide, undiagnosable.

The women in this project cannot "identify" as disabled, a term that has much more recent connotations. Yet through writing, these women combat *ableism*, a term they also would not recognize. I want to advocate for those who identify as disabled, those who could not, and those who never will—and who nevertheless will experience ableism in all its manifestations. Diagnosed and undiagnosed, these women writers dwell in knowledge of sickness and in the lack of knowledge about sickness. From within that space of knowing and not knowing, their voices echo across the centuries, offering ways for us to imagine accessible worlds full of care.

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