

“A Strange Fever of the Nerves and Blood”
Nervous Illness in the Literature of the Nineteenth Century

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A thesis
Submitted to Victoria University of Wellington
In fulfilment of the requirements for the degree of
Master of Arts in English Literature

Victoria University of Wellington
March 2014

Abstract

In the nineteenth century, the discussion of personal health and wellbeing became almost a national pastime. With publications such as the *British Medical Journal* and *Lancet* freely accessible to the everyday reader, common medical terms and diagnoses were readily absorbed by the public. In particular, the nineteenth century saw the rapid rise of the ‘nervous illness’ – sicknesses which had no apparent physical cause, but had the capacity to cripple their victims with (among other things) delirium, tremors and convulsions. As part of the rich social life of this popular class of disorder, writers of fiction within the nineteenth century also participated in the public dialogue on the subject. Authors such as Charlotte Brontë, Wilkie Collins, Charles Dickens and Sir Arthur Conan Doyle all constructed narratives involving nervous sufferers, particularly hypochondriacs and victims of brain fever. Despite writing in a wide variety of genres ranging from Gothic to realist, the roles played by the illnesses within the texts of these authors remain a vital feature of the plot, either as a hindrance to the protagonists (by removing key players from the plot at a critical moment) or a method of revealing deeper aspects of their character. Nervous illnesses carried with them social stigmas: men could be rendered feminine; women could be branded recklessly passionate or even considered visionaries as ideas about the nerves, the supposed seat of emotion and passion, brought into sharp relief the boundaries between physical and mental suffering, and physical and spiritual experiences.

The central aim of this thesis is to examine the cultural understanding of nervous illness and how nineteenth-century texts interacted with and challenged this knowledge. It focuses on how nineteenth-century authors of different genres – particularly the Gothic, sensation and realist genres – use the common convention of nervous illness – particularly hypochondria and brain fever – to develop their protagonists and influence the plot. Through comparisons between literary symptoms and those recorded by contemporary sufferers and their physicians, this thesis analyses the way that the cultural concept of nervous illness is used by four principal Victorian authors across a range of their works, looking at how hypochondria and brain fever function within their plots and interact with gender and genre conventions to uphold and subvert the common tropes of each. Whether it aids or hinders the protagonist, or merely gives the reader an insight into their personality, nervous illness in the Victorian novel was a widely used convention which speaks not only of the mindset of the author, but also of the public which so willingly received it.

Acknowledgements

Thanks to the postgraduate students and staff of the School of English, Film, Theatre and Media Studies at Victoria University of Wellington. In particular, I would like to thank Jane Stafford for her supervision of this thesis.

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Introduction

In Charlotte Brontë's final book, *Villette* (1853), the nervous heroine Lucy Snowe finds herself left alone in a boarding school during the term vacation, and suspects herself of succumbing to illness. She lies "in a strange fever of the nerves and blood" (231), fraught with nightmares and hallucinations. She fantasises about those who live happier lives than herself, and ponders the question that was perhaps central to the minds of many at that time: "how shall I keep well?" (231). In many ways, the nineteenth century was a time in which illnesses took on a life of their own, as they were reimagined, talked of, invented and denied by physicians and laymen alike. To talk of illness was "an Arabian Nights entertainment" (Vrettos 1), containing the thrilling elements of horror story, fantasy and biography. Along with scientific publications such as *The Lancet* and *The British Medical Journal* (established in 1823 and 1840 respectively), accounts of illnesses spread by word of mouth from nurses, invalids and their relatives, giving every disease its own social and cultural significance as symptoms were discussed, analysed, and entered into the public consciousness. Publications such as *The Cyclopaedia of Practical Medicine* (1859) and other handbooks of medical self-help were commonplace, and a medical encyclopaedia was an expected addition to the bookshelf of every middle-class home (Peterson 449). Publications such as these, and other more specific tomes such as Thomas Trotter's *A View of the Nervous Temperament* (1808) were written for the public as much as medical professionals in order to, as Trotter states in his introduction, "sound the alarm and announce the danger" (iv) of illnesses to the general public.

With illness and diagnosis taking up such a large part of the public consciousness, it is not unexpected that writers of fiction would also participate in the discussion. Authors such as Charlotte Brontë, Wilkie Collins, Charles Dickens and Sir Arthur Conan Doyle all conceived popular novels within the period that contain multiple references to sickness, and through the bodies of their suffering protagonists entered into dialogues that helped to challenge and confirm contemporary medical theories, as well as illustrate social understandings of what it meant to be ill. While illness is a common convention in Victorian fiction, it is rarely one which is used without purpose. Taking this into account, the central aim of this thesis is to examine the relationship between medical and fictional writings within the nineteenth century, focussing on how the cultural, public knowledge of illness is used by authors throughout a variety of different genres, both in terms of aiding the plot and developing their protagonists.

However, illness as it appears in the fiction of the nineteenth century is a very broad and

complicated field – it is almost impossible to find a novel from the period which does not contain a reference to some form of sickness or injury. Because of this, the focus of this thesis is narrowed down to what was commonly known in the nineteenth century as nervous illness; in particular, hypochondria and ‘brain fever’. It is important to realise that in the nineteenth century, both of these afflictions were considered to be very real, and often fatal disorders. Modern readers of nineteenth-century novels may consider a character suddenly becoming insensible due to a sudden shock unrealistic, but in the nineteenth century such nervous reactions were expected, both by the public and the physicians of the day. While many characters in Victorian-era literature (and supposedly many sufferers at the time) are fatally afflicted by such conditions, it is my intention to focus solely on cases where the illnesses are survived, in order to ascertain the way in which the authors use the convention to advance the plots of their novels and the fates of the sufferers.

Defined by the eighteenth century physician Dr. Cheyne as “the English malady”, nervous illnesses by the nineteenth century accounted for at least two thirds of “the diseases of mankind” (Trotter xiii). Originally thought to be the sole province of the upper classes, by the nineteenth century nervous complaints were being detected among the poorer populations, striking both men and women irrespective of age, occupation or gender (Trotter xiv). Its widespread social contamination also appears to be reflected by its use in different genres. In particular, Gothic, sensation and mystery fiction, and social realist works all contain references to nervous illness which form a vital part of the plot. By focussing on the traditional Gothic conventions in Charlotte Brontë’s *Jane Eyre* and *Villette*, the sensation and mystery plots of Wilkie Collins’ *The Woman in White* and Sir Arthur Conan Doyle’s detective fiction, and lastly the social realist works *The Old Curiosity Shop* and *Great Expectations* by Charles Dickens, the following chapters will analyse how hypochondria and brain fever interact within these staple nineteenth-century genres, either by perpetuating the classic traditions or subtly changing them.

In general, there are two important ways in which nervous illness is used in the writings of nineteenth-century authors: either as a way to develop or illustrate an important point of a character’s personality, or to conveniently remove them from the story for a period of time in order to change the direction of the plot. As a form of disease which links ideas of physical suffering with emotional pain, both hypochondria and brain fever are perfect illustrations of how a person could become completely overwhelmed by their passions, often to the point of insensibility. In this way, characters in a sensation or mystery novel can easily be overcome by witnessing a crime, and become unable to give vital evidence until a recovery at the end of the story allows them to validate

the theories of the detective. Alternatively, protagonists can fall prey to such afflictions and be unable to stop the machinations of their adversaries, or even, in the case of the Gothic, cause them to fall prey to nervous ‘visions’ of future events. However it is used, neither brain fever nor hypochondria is an illness which can befall an emotionless victim. Passionate natures were considered to be the natural cause of such nervous conditions (Peterson 464), whether or not said passion was directed selfishly or hysterically inward, such as in the case of hypochondria, or outward towards other people as often befits the courageous hero of a detective or realist work. In afflicting a character with such an illness, then, an author does not only add an embellishment to their plot, but also to the sufferer.

Due to these links with emotion, nervous illnesses often had distinctly gendered connotations. According to critics Sally Shuttleworth and Jane Wood, ideals of masculinity within the nineteenth century were largely tied up with concepts of emotional control and social responsibility – neither of which is compatible with the nervous invalid. However, female sufferers were just as often exalted as condemned, with their nervous natures allowing them to receive visions of future events, or granting them further insight into the emotional lives of those around them. By looking not only at how hypochondria and brain fever act within different genres, but also how they affect different genders, this thesis aims to shed light on how the social knowledge of nervous illness as an effeminate or empowering force was viewed in the public gaze, and how authors were able to use this to their advantage.

Hypochondria

Although the recently approved *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5 2013) no longer recognises hypochondriasis as a mental disorder, patients displaying chronic fears in regards to imagined pain are still considered to be suffering from some form of anxiety disorder today.¹ In the nineteenth century however, the illness encompassed a range of physical and psychological symptoms, including impaired digestion and, in some cases, visions of the future (Chambers 6; Vrettos 54). Although hypochondria is now considered to be a purely psychological illness, and unlikely to grant powers of clairvoyance, in the nineteenth century the spiritual and emotional components of the affliction turned it into a strangely gendered disorder. As an emotional and psychological affliction, the presence of hypochondria in men hinted at unmanliness, whereas female sufferers could become empowered by receiving clearer emotional and spiritual insight

¹ In a radical departure from the DSM-4, the DSM-5, instead of recognising hypochondriasis as a disorder in its own right instead breaks the affliction into two separate afflictions: somatic illness disorder, and illness anxiety disorder.

(Vrettos 56). Thomas King Chambers, honorary physician to the Prince of Wales, lectured on the ailment at St. Mary's Hospital in 1873, wherein he argued against the popular theory of hypochondria being the masculine homologue of hysteria in females, and instead argued for sufferers to be treated with sympathy, as men struck down by an incurable 'misery' (Chambers 6). Despite this plea, the very fact that Chambers felt it necessary to make such an appeal hints that in reality, hypochondriac males were more than likely to be considered as the effeminate, nervous and impotent characters seen so often in the fiction of the period. Dating back to the turn of the eighteenth century, with characters such as Jane Austen's Mr. Woodhouse in *Emma*, the hypochondriac male has traditionally been seen as a clownish character, whose role in the plot is usually restricted, and often made more noticeable by their absence than their presence. Both Wilkie Collins and Sir Arthur Conan Doyle certainly follow this course, with Mr Frederick Fairlie of *The Woman in White* and Thaddeus Sholto of *The Sign of Four* filling the roles of absent father figures. Although physically present, their nervous, perpetually ill yet unblemished bodies force them into genteel retirement away from the squalid physical world and all of its inherent responsibilities. Whether or not they are miserable and depressed, as Chambers would claim, or merely effeminate and inactive, their role in the plot is certainly dictated by their nervous disorder.

In the works of Charlotte Brontë, however, hypochondria has quite a different meaning. In looking at the female protagonists of Brontë's *Jane Eyre* and *Villette*, the illness has the ability to obscure the thoughts of the main character while simultaneously revealing the feelings and emotions of those with whom they interact. Instead of focussing on hypochondria as a form of bodily dysfunction, wherein the sufferer is assailed by fictional, physical pain, Brontë uses another, equally valid nineteenth-century form of the disease: what we would nowadays refer to as depression (Dillon 51). In her extensive analysis, *Charlotte Brontë and Victorian Psychology*, Sally Shuttleworth argues that hypochondria in Charlotte Brontë's work is largely due to sexual repression and anxiety, an idea which certainly rings true with characters such as William Crimsworth in *The Professor* and Lucy Snowe of *Villette*. This repression, however, also allows characters, as Athena Vrettos suggests, to read the same marks of suffering that they feel on the faces of others, providing an invaluable tool for the heroine to almost read another's soul (Vrettos 66). While physicians of the nineteenth century were actively investigating the ways in which the mind, body and soul were connected, Brontë's works actively illustrate the theory, connecting physical suffering, emotional repression, and spiritual enlightenment together. In this way, characters are not always removed from the plot, but rather have a more significant place within it. While hypochondria in Brontë's work blurs the lines between truth and fiction, particularly in the

confused narrative of Lucy Snowe, it also has the potential to enhance a character's narrative power.

Brain Fever

In a recently published article in the *British Medical Journal*, retired doctor Theodore Dalrymple commented that “it sometimes seems that no Victorian novel is quite complete without a bout of brain fever” (1001). While an exaggeration, the statement is far from baseless, with an incredibly large number of fictional characters from the period falling prey to a ‘brain fever’ of some description. It is an illness which does not discriminate between genders, and, according to critic Audrey C. Peterson, is unique among the illnesses inflicted in fiction in the way that it applies “emotional causes to a disease which then follows a prescribed physiological course like that of other recognised diseases” (464). It is perhaps because of this that brain fever gained such popularity during the Victorian period. Peterson’s article, “Brain Fever in Nineteenth Century Literature: Fact and Fiction” cites eighteen separate texts in which the illness plays a role, and even this is considered to be a limited selection. In all of them, the ‘brain fever’ is characterised by a sudden onset of weakness and feverish delirium, usually after the victim has received a sudden emotional shock. The fever tends to last for a number of weeks, leaving the patient incapable of acting for themselves and utterly reliant on the nursing of others. While violent, however, the fictional illness is usually survivable, and often ends with the patient returning to consciousness in some way changed by their experience, as if passing through a symbolic death to be reborn as a wiser, gentler person. Taking these symptoms into account, a modern physician presented with such a case would diagnose the complaint as either meningitis or encephalitis (Dalrymple 1001; Peterson 445), both illnesses which affect the brain and cause similar symptoms. Indeed, post-mortem examinations of nineteenth-century brain fever victims show symptoms consistent with certain forms of what we now call encephalitis (Peterson 447). However, as Dalrymple notes, the 2008 recorded statistics for encephalitis in Great Britain showed only four cases per 100,000 people – while statistical records of illnesses in the Victorian period are scant in regards to brain fever deaths, the amount of times it occurs in the pages of nineteenth-century fiction would indicate a far higher rate of illness than this (1001). Because of this fact, it is common for a modern reader to assume that brain fever was a largely fictional ailment, a plot convenience rather than a serious medical condition. On the contrary, ‘brain fever’ in the mind of the nineteenth-century reader was a real, serious and often fatal medical condition. As Peterson states in her article, “[w]hen the nineteenth-century physician arrived at the bedside of the patient, shook his head gravely, and said that he feared a brain fever was setting in, he was speaking of a disease which was ... just as real to him – and to his lay contemporaries – as measles, smallpox, or consumption” (464).

Authors of the same period were as eager to diagnose their own characters with the complaint as their contemporary physicians were to diagnose their patients. Charles Dickens, Wilkie Collins and Sir Arthur Conan Doyle all use the illness to varying effect within their works, both as plot device and a tool for character development and expression. Doyle and Collins in particular use the illness to remove key witnesses from a plot after the sudden shock of a crime committed leaves them ‘understandably’ insensible, and as a socially acceptable way of displaying intense feeling, as becoming physically ill is seen as more than an emotional problem. Dickens, perhaps most famously, uses the illness in a different way. Although Peterson claims that the disease was often fatal in reality, the fictional sufferers usually survive, altered by the experience after only a brief period of inactivity (Peterson 449). More than any other illness, brain fever has the ability to serve as a symbolic death for a character, placing them in a vulnerable position where they pass through hallucination and delirium to reach new realisations about themselves and their behaviour, particularly in the case of *Great Expectations*’ Pip and Richard Swiveller of *The Old Curiosity Shop*. As an illness founded on emotional upheaval and sudden insensibility, brain fever was considered to be an invaluable tool for any writer, admittedly with varying degrees of feasibility and effectiveness.

This thesis has been divided into four chapters; the first two focussing on hypochondria in the works of Brontë, Collins and Doyle, and the last two examining brain fever as it is used by Collins, Doyle, and Dickens. While the area of medical humanities is gaining rapid attention, there are still large gaps in the field. Little work has been done exclusively on Dickens and brain fever for instance, and the works of Shuttleworth, Wood, Vrettos and Peterson remain the most comprehensive examinations of nervous illness in fiction to date. By drawing on the groundwork laid out by these authors, the following chapters aim to create a coherent picture of the way that two particular forms of nervous illness operate in the fiction in the nineteenth century, as a force which highlight and demonstrate what Peterson refers to as “the relationship between the physical, social and mental aspects of men’s and women’s lives” (1).

A Note on Referencing

The British Medical Journal and its subsidiaries, *The Provincial Medical and Surgical Journal* and *The London Journal of Medicine* are all primary sources of information used in this thesis. Unfortunately, the authors of many of the articles published in these journals are unknown, due to

the common practice in this period of publishing anonymously. In these cases, I have referenced the articles used with the publisher, BMJ Publishing Group (BMJ) as the principle author for both in-text referencing and in the bibliographic information, and simply listed the year and page number alongside this for the in-text citations. Similarly, the various contemporary newspaper articles used did not provide page numbers, so I have instead cited the articles using the issue number rather than the pagination for further identification.

“A Bundle of Nerves Dressed Up to Look Like a Man”
Hypochondria in *The Woman in White* and *The Sign of Four*

In his collection of biographies entitled *Tormented Hope: Nine Hypochondriac Lives*, Brian Dillon describes the modern hypochondriac as

a malingering drain on one’s capacity for patience and empathy ... that person who suspects that an organic disease is present in his or her body ... when there is no medical evidence to support that opinion... the hypochondriac will have established a pattern of such suspicions, almost a career. He or she has in common with the clown (for the hypochondriac is also a figure of fun) the tendency to repeat the same behaviour, to make the same mistakes, in the face of all indications that they ought to desist. (Dillon 5)

In short, a modern reader would view a hypochondriac as unsympathetic and clownish, and would usually infer that the sufferer was mentally ill, perhaps suffering from some form of depression or anxiety disorder. This viewpoint, however, is relatively recent. Until the nineteenth century, hypochondria was regarded as a solely physical and perfectly valid illness, possessing a unique set of symptoms and various supposed remedies. The medical term ‘hypochondria’ was formerly applied to any illness which affected the *hypochondrium*, an organ directly beneath the ribcage, and thus became associated with digestive disorders circa 300 BC (Dillon 10). It was not until the seventeenth century that hypochondria began to denote connotations of not only a physical illness, but a mental one as well. Robert Burton’s 1621 work *Anatomy of Melancholy* describes (among various other personified versions of illness) “Melancholy Hypochondriacus” – the depressed hypochondriac. Burton explains the condition as possessing a distinct set of symptoms, including

wind and rumbling in the guts, vehement gripings, pain in the belly and stomach ... vertigo and giddiness come by fits, turbulent dreams, dryness, leanness ... grief in the mouth of the stomach, which maketh the patient think his heart itself acheth. (Dillon 11-12)

Added to this, Burton asserts that hypochondriacs may experience delusions of their bodies being invaded by unlikely parasites, such as serpents or frogs, or even of having been physically transformed into such a creature (Dillon 12).

Despite this vast leap in interpretation of hypochondria as a mental as well as a physical illness,

Burton still believed that the psychological factors were not an indication of hypochondria, but merely a side-effect caused by the illness. It was not until 1628, with the publication of Thomas Willis' *The London Practice of Physick* that hypochondria was finally seen as having what we would now call psychological symptoms. Willis combines both the physical and psychological indicators of the disease, asserting that sufferers of hypochondria

are wont to complain of a trembling and palpitation of the heart, with a mighty oppression of the same, also frequent failings of the spirits, a danger of swooning come upon them, that the diseased always think death at hand ... an imaginary being affected with diseases for which they are free and many other distractions of the spirit ... (cited in Dillon 12)

By the nineteenth century, physicians continued to work with Willis' model, focussing on the victims' fears of illness and death, only with far greater emphasis placed upon the psychological aspects of the disease: the melancholy and paranoia finally replacing the physical symptoms of bodily unrest. Hypochondria became a psychological disorder, an illness of the mind that was somehow exempt from the usual prejudices associated with madness. It is largely defined in this period as a metaphysical, occasionally even spiritual disorder born of the thoughts of an orderly, rather than disorderly mind.

On the 25th of June 1873, Dr Thomas King Chambers, Honorary Physician to the Prince of Wales, delivered a seminar to the staff of St Mary's Hospital on an illness he called *hypochondriasis*. In his lecture, Chambers defined the key element of the illness as a single emotion: misery (Chambers 6). While physical symptoms were reported by the patient, Chambers claimed that these were side-effects of an overwhelming feeling of melancholy or fear, often caused by no recognisable external agent, that the patient attempts to justify to themselves by manifesting it as a physical symptom: a weak heart, a suspicious pain, or a lack of appetite (7). With psychological and not physical reasons being put forward as the catalyst, hypochondria in the nineteenth century began to be classed as a nervous condition, alongside another common ailment of the period: hysteria.

As an illness which affected the nerves, hysteria in the nineteenth century was a highly discussed malady. Although the terms "nerves" and "nervousness" had been in use in the public consciousness since at least the eighteenth century (as can be attested by a number of Jane Austen's characters), by the nineteenth century the links between nervous tissues and emotional responses were being given serious consideration. Emotional outpourings were considered to be the effect of "imperfect

innervation”, or damage to the nerves by their becoming overstretched, either as a result of stress and emotion, or alternatively, as a cause for the loss of emotional control (Vrettos 51). Either way, such a malady was considered acceptable and perhaps even expected in a woman, but not so for a man. Noted physician Thomas Weatherley wrote in 1872 that while “no woman can control her nervous system... Hysteria is second nature to them” (75, quoted in Vrettos 92), men were expected to be biologically more stable. Weatherley describes men in general as having “coarser brains... [and a] less impressionable nervous system” (75, quoted in Vrettos 92), allowing them to bear emotional outbursts with an alacrity that the female body would be incapable of replicating (Vrettos 92). As both illnesses shared the symptoms of uncontrollable trembling, imagined pain and seemingly causeless distress, it was commonly received that hypochondria was simply the masculine form of the well-documented, essentially feminine ‘hysteria’. While females could suffer from hypochondria, it was rare for a man to be a victim of hysteria, especially in Britain. Cases of hysteria found in males of other countries, particularly France, were largely considered to be due to the more excitable temperaments of the foreigners themselves rather than a validation of “masculine hysteria” (BMJ 1891:135-136). With the advent of hypochondria as a psychological illness, then, came the concurrent discovery that it must somehow be a feminine one – physical pain can be tolerated, but emotional pain should be concealed and controlled in the age of reason propagated by Victorian ideologies.

In his lecture, Chambers argues for hypochondriacs to be treated sympathetically, as people who are not inventing an illness, but are genuinely suffering from complaints which they fully believe to exist, rather than hysterics who supposedly lie for the purpose of gaining attention (8). In his contemporary reality, however, the theory of hypochondria as a form of masculine hysteria appears to be far more prevalent, and treated with far less understanding than Chambers would perhaps have counselled. While some fictional hypochondriacs are viewed with sympathy in this period, such as Lucy Snowe in Charlotte Brontë’s *Villette* and the titular character of her early work *The Professor*, others in literature have fared far worse at the hands of their Victorian authors. While hypochondria may have been occasionally portrayed as an almost spiritual illness in fiction, as will be discussed in later chapters, the physical aspect of it, particularly in males, is consistently seen as an hysterical, feminine weakness, a loss of control and sense in the face of adversity and an act of relinquishing all-important social responsibility for no acceptable reason. In both Wilkie Collins’ *The Woman in White* (1860) and Sir Arthur Conan Doyle’s *The Sign of Four* (1890), both Mr Fairlie and Thaddeus Sholto are confirmed hypochondriacs who share many of the same symptoms and preoccupations. Despite both being central, pseudo-father figures in mystery plots involving the fortunes of young

women, both Fairlie and Sholto are incapable or acting, or unwilling to act, either on behalf of their charges or as a part of wider society as a whole. They are bachelors who have withdrawn from the outside world, and contribute nothing to its progress and social advancement. Both portrayals follow the more popular convention of hypochondria as a masculine form of hysteria, and present the sufferers not as tormented, but as weak, effeminate and powerless in the face of crisis.

In Victorian terms, Mr Frederick Fairlie could easily be described as the model hypochondriac. As master of Limmeridge House and in charge of the fortunes of his two young nieces, Fairlie prefers to completely abandon his social duties to take care of his supposed “ill health”. He remains closeted away from the rest of the world in his own private art collection, admitting almost no one to his sight in case they disturb his delicate nerves, or bring illness with them into his presence. From his very first entrance, Mr Fairlie is seen through Walter Hartright’s narration as a singularly weak and somewhat feminine individual. His shoes are ‘womanish’, his feet ‘effeminate’, and his face beardless, suggesting a lack of the masculine ability to grow facial hair. His voice has “a discordantly high tone” (*Woman* 66), (which is remarkably similar to Doyle’s Thaddeus Sholto, who Watson describes as having a “high, piping voice” (*Four* 31)), and is usually raised only to complain about the state of his health. Hartright concludes his description of his new benefactor by remarking that “upon the whole he had a frail, languidly-fretful, over-refined look – something singularly and unpleasantly delicate in its association with a man, and, at the same time, something which could by no possibility have looked natural and appropriate if it had been transferred to the personal appearance of a woman” (*Woman* 66). In Hartright’s eyes, Fairlie is almost an androgynous creature – a bachelor with no children who refuses to take responsibility for the children of his deceased brother. Physically, then, as well as psychologically, the male hypochondriac is viewed as essentially feminine, in keeping with the dominant idea of hypochondria in males as “the homologue of [female] hysteria” (BMJ 1891:136).

As is perhaps to be expected from an author who is a doctor, Thaddeus Sholto’s form of hypochondria is markedly physical in terms of its symptoms. Closeted away from the rest of the world in “an oasis of art in the howling desert of South London” (*Four* 32), he describes himself as “a great sufferer ... a man of somewhat retiring ... refined tastes [with] a natural shrinking from all forms of rough materialism” (*Four* 34). He rarely leaves his apartments, due to what he considers to be the state of his nerves, retiring entirely from what he refers to as “the vulgarities of life” which play havoc with his nervous temperament. His nerves are perhaps the most striking symptom of Sholto’s hypochondria, and are noticed by Dr Watson before Sholto begins to speak. Watson

describes his first impression of Sholto thus: the man “writhed his hands together as he stood, and his features were in a perpetual jerk ... he shivered from head to foot” (32-33). The presence of violent tremors, perpetuated by a psychological rather than physical stimulus, was seen as a common symptom of a range of nervous conditions, including both hysteria and hypochondria (BMJ 1891:136). While Watson ascribes Sholto’s fit of trembling to “an ecstasy of fear” (*Four* 32), there are problems with this diagnosis; mainly that Sholto has no real reason to fear anything. He is heavily guarded, and faces no worse consequence for the night’s activities than his brother’s displeasure. Added to this, the fact that Watson makes this observation before diagnosing him as a hypochondriac makes it safe to assume that instead of having anything to be truly afraid of, Sholto is suffering from one of the major symptoms of any nervous disorder – uncontrollable, violent tremors brought on by an unsubstantiated fear. More than simply hysterical trembling, though, is Sholto’s classic fear of illness and death. According to the opinions of Dr. Mendel, published in 1889, hypochondria was largely characterised

by great fear of death or of some disease to which the patient is not subject, without moral or physical timidity or cowardice in any other respect ... The patient believes that some particular organ is already diseased, and really feels pain in the affected or suspected part. (BMJ 1889:1054)

Taking this into account, Sholto’s first reaction to hearing that Watson is a qualified doctor is entirely understandable, and even expected:

“Have you your stethoscope? Might I ask - would you have the kindness? I have grave doubts as to my mitral valve, if you would be so very good. The aortic I may rely on, but I should value your opinion upon the mitral.”

I listened to his heart, as requested, but was unable to find anything amiss. (*Four* 33)

More than simply fearing death from an unknown illness as Mr. Fairlie does, Sholto is far more specific in his complaints, able to locate not only the organ which concerns him, but the specific valve within it which brings him grief. Despite all of this highly medicalised knowledge and concern, Watson at no point feels sympathy for Sholto’s condition. After examining his patient, Watson describes him simply as “a confirmed hypochondriac” (*Four* 42), and, despite being bombarded with questions throughout the night by Sholto, barely listens to his complaints or questions after this. Through Watson’s treatment of Sholto, his condition is portrayed not as a deep

psychological or spiritual affliction, but as almost laughable. He is not taken seriously, and these circumstances combined with his comical, effeminate appearance, mark him, as Dillon suggests, as a clown (Dillon 5).

In accordance with the clinical, biological view that Sholto takes of his condition, his self-imposed regime of treatments is also highly medicalised. He is clinically literate, and is able to “[pour] forth immeasurable trains of symptoms, and [implore] information as to the composition and action of various quack nostrums, some of which he bore about in his pocket” (*Four* 42). In terms of hypochondriac behaviour, this is almost textbook. While usually wrong in their diagnoses, hypochondriacs, according to Chambers, never lie about their symptoms, and are eager to confide in their physicians (8). His self-medication is likewise a classic symptom. Before beginning to tell his guests his obviously distressing story, Sholto begs them to excuse him as he partakes of “the balsamic odour of the Eastern tobacco” (*Four* 34), explaining that he is “a little nervous, and [finds his] hookah an invaluable sedative” (*Four* 34). Although Chambers regards the use of opiates (a category in which he includes alcohol as well as other mood-altering substances) as detrimental due to the danger of addiction (8), the mere fact that he feels the need to mention such a treatment as being dangerous indicates that it was a common palliative at the time, and one of which Sholto appears to take full advantage.

By contrast, Mr. Fairlie in *The Woman in White* knows nothing about his condition except for the havoc it plays with his nerves. He is never depicted seeking any form of medical aid, although, like Sholto, he appears to have a host of non-prescriptive palliatives at his command, including bathing his temples in ‘eau de cologne’ to relax his nerves (*Woman* 364). Instead, Fairlie subscribes to a very different form of treatment than Sholto – total and complete isolation. While Sholto also isolates himself from the rest of the world to some extent (which shall be discussed later), Mr. Fairlie’s seclusion is absolute. There is only one point in the text where he is seen to leave his rooms², and he refuses all visitors unless he fears that they will disturb him further if they are not allowed an audience (*Woman* 362). Although mostly played for comic effect and plot convenience, Mr. Fairlie’s self-prescribed treatment also serves as a parody of the medical reforms of another prominent Victorian physician, Florence Nightingale. Often considered a hypochondriac herself, Nightingale’s theories on the ways in which a patient’s own whims should determine the course of

² While Mr Fairlie does leave his rooms at the very end of the text, it is made very clear that he only does so at Hartright’s insistence, and is so overcome by the stress of the experience that he is barely able to speak, taking refuge instead in his scented handkerchief and demanding that Hartright gives his address for him on the grounds that he is “as great an invalid as ever” (*Woman* 637).

treatment are particularly resonant with Mr. Fairlie's own "selfish affectations and ... wretched nerves" (*Woman* 67). In one of her many treatises on nursing, Nightingale claimed that the fancies of the patient are usually reliable indicators of what they need to recover, and subsequently "apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion" (Penner 25). Mr. Fairlie's constant selfish demands are almost a direct mockery of this mode of thinking, and an oddly distorted mirror of Nightingale's own circumstances. After falling ill³, Nightingale famously removed herself from the public gaze, remaining in her sickroom for much of the remainder of her life (Dillon 99-123). There are even similarities in their modes of writing, breaking off sentences to complain of suffering fits or palpitations, and being forced to resume at a later date. In a letter to Dr. Sutherland, Nightingale claimed that "after any walk or drive I sat up all night with palpitation. And the sight of animal food increased the sickness ... Now I have written myself into a palpitation" (Dillon 101). Similarly, while writing his account of events for Hartright, Mr. Fairlie's narration suddenly breaks off as he claims that "I must rest a little before I can get on any further... No, I am able to proceed, but not to sit up. I will recline and dictate" (*Woman* 364). While Mr. Fairlie's hypochondria is almost an exact parody of Florence Nightingale's sufferings, there is one distinct difference. While Nightingale used her convalescence to publish more medical texts and plan political campaigns for the welfare of soldiers, Mr. Fairlie uses it as an excuse to escape social responsibilities. In a parody of Florence Nightingale and her methods, Mr. Fairlie uses his nerves not to fulfill his social obligations, but to shun them entirely, making his complaints that much more comic and unsympathetic.

While Thaddeus Sholto can use biological data and even speak knowledgeably on both medically recognised and folk remedies to attempt to legitimise his suffering, Mr. Fairlie is quite different. Although he is described by Marian Halcombe as an 'invalid', and acts accordingly, doctors, much like Watson, can find nothing physically wrong with him. When introducing him to Walter Hartright, Marian Halcombe claims that, "I don't know what is the matter with him, and the doctors don't know what is the matter with him, and he doesn't know himself what is the matter with him. We all of us say it's on the nerves, and none of us know what we mean when we say it" (*Woman* 61). Although far less medicalised, Fairlie's complaints are remarkably similar to Sholto's. All of his physical symptoms, including nervous trembling, are attributed to his nerves, which are disturbed by a multitude of factors. These include loud sounds (including the normal pitch of human speech), light, children (even the possibility of children in his vicinity), and emotional scenes enacted by

³ It is unknown exactly how ill Florence Nightingale was at this time – some records claim that she caught Crimean Fever, others that she never suffered from it at all, but was merely suffering from hypochondria herself.

other people. He attributes his inability to handle all of these things to his “lamentable state of health” (*Woman* 67), much as Sholto complains that his inability to handle the cold and “rough society” are due to his own poor health, which leave him “compelled to be a valetudinarian” (*Four* 41). Although he does not fear that he is already physically ill, Mr. Fairlie likewise follows Mendel’s observations of hypochondria with his pronounced fear of *becoming* ill. On first meeting Count Fosco and hearing of Marian Halcombe’s non-contagious fever, his reaction is to fear the very presence of the Count despite his assurances of good health. He claims that Fosco is “too yellow to be believed. He looked like a walking West-Indian epidemic. He was big enough to carry typhus by the ton, and to dye the very carpet that he walked on with scarlet fever” (*Woman* 373). Despite previously enjoying the Count’s fresh appearance and easy manner, the thought of his carrying an infectious illness is enough to completely change Mr. Fairlie’s good humour into abject fear. While not being ill himself, Fairlie is terrified by the mere thought of illness, a trait which, similarly to Watson’s reaction to Sholto, fails to touch the sympathies of either Marian Halcombe or Walter Hartright. Upon first meeting Mr. Fairlie and being subjected to his fears for his own health and peace of mind, Hartright comes to the conclusion “that Mr. Fairlie’s selfish affectation and Mr Fairlie’s wretched nerves were one in the same thing” (*Woman* 67). His medical complaints are never taken seriously by either Hartright or Marian, but perhaps with less excuse than Dr Watson, as neither of them is at all medically trained.

However, it is not merely physical appearance which marks Mr Fairlie as essentially feminine and weak; hypochondria is more than a purely physical illness. It is behaviour, or more precisely, his lack of masculine behaviour, that truly marks Mr Fairlie as a feminine and weak, rather than simply ill, individual. The ability to prevent oneself from falling into an hysterical outpouring of feeling is a classically masculine trait, one that is displayed on various occasions throughout the novel by Walter Hartright. It is never denied that Walter Hartright of *The Woman in White* is an emotional character: he feels devotion and love for the beautiful Laura Fairlie, pity and horror for the deluded Anne Catherick, and admiration and brotherly affection for Marian Halcombe. While his depths of feelings are comparable, then, to Mr Fairlie’s, the ways in which they are manifested differ greatly. Unlike Fairlie, who falls into fits of nervous prostration when overexcited to any degree, Walter Hartright has almost perfect control over his emotional responses. When told that he must be parted forever from Laura Fairlie due to her engagement, for example, Marian instructs him to defeat his feelings of numb anguish with an order not to “shrink under it like a woman. Tear it out; trample it underfoot like a man!” (*Woman* 96). After a moment of composing himself, Hartright asserts that he has “justified [Marian’s] generous faith in my manhood – I had, outwardly at least, recovered my

self-control” (*Woman* 96). The correlation here between femininity and uncontrollable emotion, such as displayed by Mr Fairlie, and masculine self-control, is fairly evident, and through his response, Hartright proves his own masculinity in juxtaposition with Fairlie’s lack of control. Hartright’s initial response to hearing the news of Laura’s engagement, however, reads almost as a catalogue of physical, not psychological symptoms – he feels a pain like a bullet in his heart, he loses sensation in the arm that Marian is holding, and feels a dull, numbing pain while his face turns white (*Woman* 96). This, by Victorian standards, could easily be read as a version of hypochondria, or certainly of classical melancholy – physical symptoms manifested by psychological trauma. However, instead of falling into an hysterical or hypochondriac fit, Hartright’s inherent masculine self-control allows him to regain his sense, and, following his duty to society and morality, he leaves Limmeridge Hall to embark on a life of adventure, throwing himself into the world instead of shrinking from it entirely in response to his inner turmoil.

Similarly to Mr Fairlie, Doyle’s Thaddeus Sholto is also compared unfavourably with the masculine heroes of his story – Sherlock Holmes and Dr John Watson. While Holmes’ drug use and clinical detachment may not be viewed as ideal masculine characteristics by the reader, these traits are greatly admired by Watson, whose narrative voice praises Holmes as it scorns Sholto. If Watson’s narrative is to be believed, Holmes is a man who can control his own emotions perfectly, particularly in relation to other people. His claim that “love is an emotional thing, and whatever is emotional is opposed to that true cold reason which I place above all things” (*Four* 139-140) is a clear illustration not of unfeeling coldness, but of control, as he follows the sentence with the addendum that “I should never marry myself, lest I bias my judgement” (*Four* 140). The fact that he considers it possible for his judgement to be biased by emotion and therefore removes the possibility of temptation speaks not of lack of emotion, but complete, self-denying control over his own feelings – a control sadly lacking in the character of Thaddeus Sholto. However, Holmes in Watson’s eyes represents an almost unattainable ideal, “the best and wisest man whom I have ever known” (*Problem* 430). In terms of his own levels of emotional control, Watson is far more similar to Walter Hartright, and is even placed in a similar emotional situation: loving an unattainable woman. While Hartright removes himself from Laura Fairlie’s company to save both of them from heartbreak, however, Watson goes a step further. From the beginning, he attempts to hide his feelings of disappointment and sadness, congratulating Miss Morstan on her good fortune as a friend would, rather than sinking into the despair he feels. Watson’s response to hearing of Miss Morstan’s possible fortune is similar to Hartright’s, as he claims that “selfishness took me by the soul, and that my heart turned as heavy as lead within me. I ... then sat downcast, with my head

drooped, deaf to the babble of [Sholto]" (*Four* 42). It is not until after the Great Agra Treasure is lost that Watson allows himself to reveal not only his feelings for Miss Morstan and propose marriage, but the despair he felt previously, shielding and controlling his emotions and maintaining his complete control.

Even when in the depths of despair, however, Watson's behaviour is far more similar to Hartright's than Sholto's. His misery does not cause him to remove himself from society, but rather throw himself into adventure. He is determined to aid Holmes, at great risk to his own personal safety, in order to find the Great Agra Treasure, despite knowing the consequences would be deeply distressing to him if he should succeed. Sholto, by contrast, while willing to do his social duty by informing Miss Morstan of the existence of the treasure, does so at no risk to himself, despite his fear of his brother's displeasure. His desire to refrain from associating with the outside world is not impeded by his aiding Miss Morstan, nor is his health. His isolation from society and constant fears for his physical condition (brought on by what Chambers refers to as 'misery'), is a direct contrast to that of the masculine heroes of his own story, and, in comparison, paints him as a singularly weak and ineffectual character.

While an inability to control one's emotional state was considered a classically feminine failing, it is more than their nervous outpourings of feeling which condemns Mr Fairlie and Thaddeus Sholto: their very lifestyle is anathema to the role of the nineteenth century man. As socially reclusive bachelors, both men are inherently non-productive members of society, a state which was considered unacceptable by the codes of conduct by which men of their standing would be expected to conform. Culturally, nineteenth-century ideals of masculinity were irrevocably bound with the concepts of both family and nationhood (Wood 71). With the industrial revolution well underway, ideas of manliness had been reconfigured to include "principles of production, property and prosperity [on both] familial and national levels ... which marginalised both the 'effeminate' artist and the 'effete' aristocrat on the ground of their non-contribution to a national, domestic or sexual economy" (Wood 71). With these important qualities of family and social responsibility often absent from the nervous male invalid, the ideas of femininity and sickness similarly came to be grouped together, as male hypochondriacs in particular came to be associated with both physical and moral weakness as unproductive members of the new socioeconomic climate (Taylor 70). With their shared decision to withdraw from the vulgarity of society, then, Fairlie and Sholto only condemn their masculinity further.

In the case of Mr Fairlie, his decision to not only withdraw from productive society, but also to maintain his status as a bachelor, is particularly damning. Although Fairlie claims that he is simply “too considerate and self-denying to add a family of his own to an already overcrowded population” (*Woman* 367), his apparently philanthropic view is completely at odds with that of the world he inhabits. In her analysis of Mr Fairlie’s nervous illness, Jane Wood notes that in a society becoming increasingly preoccupied with ideas of wealth and productivity, Fairlie’s failure to produce children of his own places him in breach of his social responsibility (Wood 73). Men in the nineteenth century were primarily considered to be producers, with a rising culture of factories and ‘new money’ to support this new ideology of progress and production. Fairlie neither contributes to his family line, the responsibility of an aristocrat, nor to society, which is the responsibility of a working man. Sholto, too is guilty of the same crime, although he never attempts to justify his decisions with philanthropy. Although neither Sholto nor Fairlie is the primary heir of their family estates, they still bear some responsibility towards them. Fairlie, although the younger son, nevertheless becomes the sole heir of Limmeridge following the death of his brother, who produced only one daughter. Upon her marriage to Sir Percival Glyde, Laura Fairlie’s children would by law become the heirs of Glyde’s estate at Blackwater, and not of Limmeridge. His decision not to provide an heir, then, is clearly at odds with his claims that his sole responsibility to discharge is to make sure that Laura marries Sir Percival Glyde (*Woman* 367). Sholto, too is in a similar position, as his brother is likewise unmarried, and permits almost no visitors to his house (*Four* 43). With the advent of his brother’s murder, Sholto later becomes the sole heir of Pondicherry Lodge, the family home and its related fortune, although Doyle does not relate how this circumstance changes his behaviour, or if indeed it does at all.

The unmarried state of Fairlie and Sholto (Fairlie’s in particular, as it is revealed that he dies unmarried), is at odds not only with the Victorian culture of matrimony argued by Wood, but also the views implied by their own stories. Both *The Woman in White* and *The Sign of Four* end with the marriage of their masculine protagonists, Walter Hartight and Dr Watson, and the possibility of the continuation of their family lines. In *The Woman in White*, this is particularly important, as it allows Hartright’s son to become the future heir of Limmeridge following Fairlie’s death. Taking this into account, the reasons why both Fairlie and Sholto are made hypochondriac bachelors become even more apparent. For Sholto, his lack of children makes his desire to aid Mary Morstan more understandable, as he views himself and his brother as her ‘trustees’, presumably in the place of any children of his own whom he may wish to see inherit their share of the Agra treasure (*Four* 40). In Fairlie’s case, his decision not to add children of his own to the world not only illustrates his

previously mentioned dislike of infants, but also allows Hartright's child to become the established heir of Limmeridge, completing the family line through Laura Fairlie, the far more deserving heiress.

Although prominent within the nineteenth century, the concept of the impotent, hypochondriac father is not a new one. From as early as Jane Austen's *Emma* (1816) the eponymous heroine's father, Mr Woodhouse, fits the same approximate mould as Sholto and Fairlie. He is described as having been "a valetudinarian all his life, without activity of mind or body ... a much older man in ways than in years ... He was a nervous man, easily depressed ... [with habits of] gentle selfishness" (*Emma* 4-5). Unlike Mr Fairlie, however, Mr Woodhouse is known to be "beloved for the friendliness of his heart and the amiability of his temper" (*Emma* 4), traits which mean that he often worries about the health of others as much as he frets for his own. As a retiring valetudinarian with selfish habits, Mr Woodhouse is, similarly to Fairlie and Sholto, a conspicuously absent figure in the plot of his novel. Fears for his health prevent him from taking part in many of the major events of the novel, including the Box Hill picnic and the Crown ball, and his paternal influence over Emma is almost non-existent, a considerable factor in her having "rather too much her own way" in everything (*Emma* 3). He stands as both a figure of fun and an impediment to the heroine – while his constant fears for his and others' health are amusing, his intense dislike of change makes it difficult for him to accept Emma's plans to marry, at first only reconciling it to himself as an even that may happen "in another year or two" (*Emma* 360). As an impotent masculine protagonist, however, Mr Woodhouse contributes to the plot in other ways. His lack of authority or presence in the plot allows Austen's hero, Mr Knightley, to step forward as the prominent male figure in Emma's life. As advisor, confidante and friend, and also heavily involved already in the running of Hartfield (*Emma* 360), Knightley becomes the dominant male figure in the novel, and through Mr Woodhouse's impotence, the true guide in Emma's life, correcting her bad behaviour and aiding in her personal growth. While the presence of Emma's father prevents her from being an orphan and having to take on the full responsibilities of running a household, Mr Woodhouse's lack of engagement within the plot allows Knightley to be the true male figure of authority, and also the perfect match for Emma.

While obviously not themselves fathers, Mr Fairlie and Thaddeus Sholto still fall into a similar model to that laid out by Mr Woodhouse. Both function as characters who are placed in protective roles over young women, and are in general ineffective when it comes to providing for them. Despite his desires to act as a trustee, Sholto manages to send only six pearls to Mary Morstan, of a

treasure which is worth over half a million pounds. His inability to stand up to his brother and his subsequent complete withdrawal from society, however, allows the true male protagonists of his story to step forwards. As impotent in the face of his brother's will, Sholto requires Mary Morstan to bring two friends with her in order to help him keep his nerve in what he believes will be a final confrontation with his brother over rights to the Great Agra Treasure. Brother Bartholomew Sholto's death and Thaddeus' subsequent arrest leaves Holmes and Watson in full charge of the resulting case, allowing them to step forwards as the dominant masculine heroes of the text. While it could be argued that the author could easily have made the same move through the arrest of Sholto alone, the added factor of his hypochondria provides an excuse for Holmes and Watson to be introduced to the plot, as Doyle plays on the hypochondriac symptoms of misery and fear to portray Sholto as a generally weak and fearful person who would be unable to resist the bullying of the police. Despite his intentions to care for Mary Morstan, Sholto's hypochondria renders him almost incapable of doing so, allowing Dr. Watson to assume the role of trusted friend and protector, and later husband.

In regards to *The Woman in White*, much like *Emma*, it is crucial to the plot that Laura and Marian are not in charge of their own fortunes, but dependent on the whims of Mr Fairlie. As the master of Limmeridge, Fairlie is in charge of most of their lives, dictating who they can see and, in a large part, who they can marry. He is also the only person who is in a position to offer the sisters aid when Laura's husband attempts to dispose of her. His hypochondria, however, does not allow him to do so. Upon receiving Marian's letter asking for sanctuary for Laura and herself, Mr. Fairlie becomes "totally prostrated for three days" following the upset it causes to his nerves (*Woman* 368). Despite Marian's pleas for safety, Fairlie refuses to offer help due to the upset it would cause his nerves, as he determines that "[i]f I opened Limmeridge House as an asylum to Lady Glyde, what security had I against Sir Percival Glyde's following her here in a state of violent resentment against me ... I saw such a perfect labyrinth of troubles involved in this proceeding" (*Woman* 368). Similarly, his desire to keep his nerves safe from troubling influences also stops him from investigating the deception caused by Fosco and his wife, when they switch one of Marian's letters asking for help with a blank piece of paper. Although this arouses the suspicions of Marian's lawyer, Gilmore, the intended recipient of the letter, Fairlie refuses to assist the lawyer in his investigation, instead sending the man "one of [his] keenest letters" asking why he was expected to be inconvenienced by the incident unless it was an attempt by Gilmore to "alarm me as well as himself?" (*Woman* 369). When he hears no more from Marian, Fairlie is relieved rather than worried, and instead rejoices in the following "[f]ive days of undisturbed tranquility, of delicious single blessedness" (*Woman* 369). Later, Fairlie's unwillingness to be disturbed again manifests

itself in his refusal to admit Laura Fairlie to his presence, following Marian's attempts to prove that his niece is not dead, but rather still alive and in desperate need of his assistance. His response, rather than to offer his help, is to demand that they leave, and despite Marian's repeated entreaties, declares that "he will call upon the law to protect him if before the day was over [Laura Fairlie] was not removed from his house" (*Woman* 450).

In this way, Mr Fairlie differs considerably from Thaddeus Sholto. While Fairlie and his predecessor in nervous illness Mr Woodhouse are both defined by 'selfishness', Sholto is remarkably generous within his own perceived limits. Indeed, the cause of his taking rooms in London and moving away from his brother's residence was an act of protest, leaving his brother because Bartholomew Sholto refused to help Mary Morstan. In Sholto's eyes, his duty to aid Miss Morstan is an important one, and he waves away thanks with the simple statement that "[Bartholomew and I] were your trustees ... that was the view I took of it ... We had plenty of money ourselves, I desired no more" (*Four* 40). By contrast, Mr. Fairlie is constantly accused of selfish acts. Upon his refusal to shelter his nieces from the machinations of Count Fosco and Sir Percival Glyde, Walter Hartright accuses him of "selfishness, indolence and habitual want of feeling" (*Woman* 450), not of being an invalid that cannot handle the stress of such excitement. Indeed, with no medical evidence to prove that Fairlie suffers from any complaint other than a selfish desire to be left entirely alone, Wood claims that Hartright's feelings towards the indolent Mr. Fairlie were typical of his day, as he plays the part of the middle-class, self-taught man faced with a person who "arouses [within him] a repugnance akin to that found by medical men for the pitiful figures whose debility they attributed to moral weakness or lack of will" (Wood 72). As hypochondria was seen as a psychological rather than physical illness, its links with femininity made it one that was unlikely to arouse the sympathies of those who treated them, who were more than likely to see them as little more than weak men with selfish, indolent desires.

One of the key reasons behind Mr. Fairlie's isolation, then, is this same selfishness. Hartright refers often to Fairlie's "selfish affectations", and his refusal to shelter Laura and Marian, his own blood relations, due to the effect they may have on his nerves, can hardly be seen in any other light. Added to this, Fairlie shows no concern for Marian's wellbeing when he hears of her contracting fever: instead, he fears that he may catch it himself, despite never coming into contact with her. This is a clear indicator that rather than truly needing to isolate himself like Florence Nightingale suggests, Mr. Fairlie is merely using his health as an excuse to surrender his social responsibilities. Interestingly, the idea of selfishness in relation to hypochondria was not a new idea. In his lecture,

Chambers refers to the concept as a reason to prevent sufferers of hypochondria from withdrawing from society, claiming that

I am always very unwilling for a patient to give up his regular occupation; for this brings him into social relations with others, and he may think of them instead of himself. Doubtless, worrying hard work may be a severe trial, and be bad for him; but idleness is much worse ... I have had as patients two of our professional brethren [doctors], confirmed hypochondriacs, who were perfectly well and happy so long as they were engaged ... When unemployed, their misery was frightful. (8)

Isolation then, is anathema to the cure for hypochondria – by focussing selfishly on one's own misery, one cannot hope to be cured. Despite Fairlie's pleas for quiet and "undisturbed tranquility" for the sake of his "wretched nerves", his self-imposed cure is little more than an excuse for shirking his social duties – both as regards to his nieces and, in the nineteenth-century mindset, society at large.

While Mr. Fairlie and to a lesser degree Thaddeus Sholto claim that their nervous conditions make them incapable of managing their social duties, such behaviour in Victorian times was considered unnecessary in cases of hypochondria. According to Chambers, hypochondria, despite being a psychological affliction was not viewed as a form of debilitating insanity, as

[t]here is no perversion of the understanding, such as frees the insane from the responsibility of moral agency. The understanding, indeed, is usually very clear, so that it is easy, in the case of educated persons, to demonstrate to them the true nature of their malady, and to elicit evidence that it is idiopathic, and independent of, if not anterior to, the accidental causes assigned. (6)

While a hypochondriac is declared incapable of certain tasks due to their mental states, their intellect is not affected by their affliction. Mr. Fairlie's abandoning his nieces, then, is not a classic trait of a hypochondriac mind, but the actions of a selfish man. Unlike Sholto, who takes his responsibility to Miss Morstan very seriously, Mr. Fairlie's behaviour is that of a purely selfish and weak individual, rather than that of a suffering invalid.

Of all the traits shared by Sholto and Mr. Fairlie, the most suggestive is perhaps their shared

obsession with collecting art. As part of his self-enforced isolation, Mr. Fairlie is surrounded by paintings, watercolours and coins, which he cares for obsessively, far more than he cares for his own relations, whereas Sholto's rooms, when first revealed to the reader, are a haven of exotic artworks, which Sholto explains by saying that "I live, as you see, with some with some little atmosphere of elegance around me. I may call myself a patron of the arts. It is my weakness" (*Four* 33). It is interesting to note that, from the beginning, Sholto describes his art collection as a "weakness". While the collecting of antiques and treasures would earlier have been considered a correct and admirable pastime for a gentleman, the nineteenth century was beginning to frown on such activities, classing them as belonging to effeminate aesthetes (Wood 73). In his novel *Beside Still Waters*, A.C Benson uses the character of Hugh to lament the coming of such an age where "the cultivation of art, once deemed perfectly compatible with manliness, and even heroism, had become 'rather a dilettante business' which no man would pursue" (Oppenheim 179), and in all likelihood be held as a failure when compared against the record of achievements of a man of business (Wood 73). Other writers shared this view: Elizabeth Gaskell's novel *North and South* (1855) describes the moral and industrious nature of the self-made businessman Mr. Thornton as equally if not more desirable than the accomplishments of aristocratic gentlemen, while Oscar Wilde's *The Picture of Dorian Gray* (1891) (coincidentally conceived of at the same time as Doyle's *The Sign of Four*) tells the story of a young aesthete led to corruption when he is, among other things, unable to tell the difference between art and reality (Mighall xxv).

Despite this, there is nothing inherently feminine or reprehensible about art itself – Walter Hartright, the very masculine hero of *The Woman in White*, is himself an artist, although he is a producer more than an admirer of artistic works. Similarly, in Sholto's case, Holmes is an accomplished musician, and Watson an author as well as a medic. However, neither Sholto nor Mr. Fairlie is a *producer* of art, unlike their masculine counterparts. Instead, they are merely collectors, which was at the time considered a pathology all of its own. According to Emma Bielecki's study, *The Collector in Nineteenth-Century French Literature*, the figure of the collector in the Victorian era was seen and depicted as a continually desiring subject (102). Collection was a monomania, an obsession which fulfilled a gap or lost sensation in the life of the collector. As Chambers describes the chief symptom of hypochondria as misery, the correlation between the two states is fairly explicit. Both Sholto and Mr. Fairlie prefer the sanitary, clean, immaculate world of art to reality: Sholto claims to "have a natural shrinking from all kinds of rough materialism. I seldom come in contact with the rough crowd" (*Four* 33), and, perhaps more humorously, Mr. Fairlie wishes that real children were more like Rafaello's cherubs with their "nice round faces, and such nice soft wings, and – nothing

else” (*Woman* 70). In art, they see the refinement and sanctity that they do not find in life, and draw away from the outside world accordingly, enshrouding themselves with beautiful objects to hide from the vulgarity of the world around them. They value beauty over society, and are unaccountably nervous at the disruption of the aesthetic of their private chambers – Sholto refuses to admit policemen for that reason, and Fairlie refuses nearly all visitors, including the nieces he shares his house with.

In *Somatic Fictions*, Athena Vrettos posited the theory that illness, particularly in the Victorian period, was a condition that was spread as easily by word of mouth as by physical contact with disease or infection (Vrettos 1). The idea that the concept of illness is as contagious as a physical plague is an interesting one, and one that is certainly applicable to the feminised male hypochondriac. In the nineteenth century, disease was a concept that was widely talked about, both in medical texts and daily gossip, and ideas of symptoms and what it meant to be an invalid were redefined and enacted on a large scale, both within the sickroom and without (Vrettos 2). Both Mr. Fairlie, with his parody of Nightingale’s methods of confinement and patient intuition, and Sholto with his intense academic focus on his own symptoms, are the direct embodiment of this. Here, public, well-known knowledge of illness and its symptoms and treatments are parodied and internalised by the characters, creating not sympathetic or saintly invalids, but miserable, selfish, pitiable men who isolate themselves from a world whose vulgarities are simply too much for them. Instead of battling through their emotional difficulties, either with a saintly willingness to face death or a determination to fight it, they simply linger, becoming, as Dillon suggests “a malingering drain on one’s capacity for patience and empathy” (Dillon 5). Through their insistence on isolation and fear of exciting their nervous temperaments, both Fairlie and Sholto fail to meet the requirements of either an aristocrat or a working man, in much the same way as they fall between the boundaries of both genders. As sensitive collectors of antiquities, Fairlie and Sholto are firmly part of an ‘old world’ of aristocracy, as ancient and useless as the objects which they collect. In cases such as this, then, hypochondria is not viewed sympathetically – in men in particular, it is a decidedly feminine complaint, and directly opposed to the ideology of reason which Victorian culture lauded.

“A Most Dreadful Doom”

Charlotte Brontë’s Hypochondriacs in *Jane Eyre* and *Villette*

In 1837, Charlotte Brontë was 21 years old and teaching at Roe Head School. From the beginning, it was a position that Brontë did not want, having spent a restricted and unhappy childhood there as a pupil. Years later, in a letter to her friend Margaret Wooler, Brontë would describe herself as suffering at that time from what she termed “hypochondria – a most dreadful doom” (Dillon 50). She recalls in her letters her inability to either impart or receive pleasure from anything, and being continually tormented by her imaginings of “preternatural horrors which seemed to clothe existence and nature and made life a continual waking nightmare” (Dillon 51). In the modern age, hypochondria is more likely to be diagnosed by feelings of imaginary illness, the psychological symptoms which Brontë describes being far more likely to be ascribed to a form of depression. Brontë’s self-diagnosis, however, is not without a contemporary medical basis. It is known that Dr Thomas John Graham’s treatise, *Modern Domestic Medicine* (1823) was a fixture in Brontë’s father’s library (Dillon 50). Within it, Dr Graham outlines the characteristics of the illness he refers to as hypochondria, claiming that, among other symptoms,

[s]ometimes the hypochondriac is tormented with a visionary or exaggerated sense of pain, or some concealed disease; a whimsical dislike of particular persons, places or things; groundless apprehensions of personal danger or poverty; a general listlessness and disgust; or an irksomeness and weariness of life; in other instances, the disease is strikingly accompanied with peevishness and general malevolence; they are soon tired with all things, discontented; disquieted ... often tempted to make away with themselves; they cannot die, they will not live; they complain, weep, lament, and think they lead a miserable life: never was anyone so bad (quoted in Dillon 51).

While it is unknown how closely acquainted with this passage Brontë herself may have been, she appears to have named one of the principal characters of *Villette* (1853) in reference to its author, Dr John Graham Bretton, Lucy Snowe’s doctor and the son of her godmother.⁴ While Dr Bretton may share a name with Brontë’s source, however, it is Lucy Snowe and, even earlier, the titular character

⁴ Although it is unknown if Charlotte Brontë herself read this text, her father, Reverend Patrick Brontë, obsessively annotated every page of it. Under the heading ‘hypochondriasis’, for example, the Reverend recorded his own experiences of ‘depressing gloom’, and concludes that the ailment was ‘a general weakness and derangement of the nerves’ (Shuttleworth 12; 32). As a nervous disorder, then, hypochondria as a form of depression was a significant part of Charlotte Brontë’s family life and history.

of *Jane Eyre* who share her ailment, hypochondria.

While nineteenth century physicians commonly classed hypochondria as the masculine form of hysteria, the reverse was also true: hysteria, or certain forms of it, was commonly considered to be the feminine form of hypochondria, despite various calls for it to be defined as an entirely separate complaint (BMJ 1889:1054). In general, “hypochondria” in the form that Brontë uses it was considered a popular term for a range of maladies, including “low spirits” and “the vapours”, both of which traditionally encompassed feelings of isolation, loneliness and depression (Dillon 54).⁵ Despite its popularity, hypochondria as a form of hysteria was considered to be a dangerous ailment for a woman in Brontë’s time, particularly for a woman with literary leanings. As a young woman, Charlotte Brontë famously wrote to the Poet Laureate Robert Southey, expressing her desire to devote her life to literature. Southey’s response was to warn the young woman that such a dream was likely to cause “a distempered state of mind” (Dillon 49), and counselled her to “take care of over-excitement, and endeavour to keep a quiet mind” (Dillon 49).

Southey’s view was not an uncommon one. In the 1890s, Max Nordau published a pamphlet condemning the fanciful, imaginative writings of recent female authors, exploring, as many other writers did after him, the idea of “hysteria as the mental disorder responsible for literary experimentation” (Showalter 26). The term rapidly acquired a gendered perspective, applied to works of fiction which were considered to be ‘unmanly’ and ‘incoherent’ (Showalter 25). Nordau condemned writers of such ‘hysterical’ tales as suffering from a multitude of distinct symptoms, including an inability to tell fiction from reality, a willingness to be led astray by the fancies of other artists, and a tendency to lie without realising that they were doing so (25-26, cited in Showalter 25). In many ways, this description can easily be applied to the narratives of both *Jane Eyre* and *Lucy Snowe*, with their hypochondriac tendencies working both for and against them to provide alternating moments of confusion and clarity within their own stories. While previous writers afflicted their heroes and heroines with similar symptoms, such characters usually belonged to the Gothic genre, whose narratives were designed to produce chilling and dramatic effects for their readers (Vrettos 59). Brontë is the first writer to deviate from this theme: while her stories may contain Gothic elements such as supernatural forces and threatening storms, the hypochondriac, often hysterical reactions of her protagonists link the idea of traditional nervous illness with

⁵ By the late nineteenth century, the term ‘hysteria’ largely replaced the psychological, melancholy form of hypochondria entirely as the new fashionable term for such sicknesses of the mind, but at the time Brontë was writing, hypochondria was still the commonly used term (Dillon 55).

psychological realism (Vrettos 59). There is no medicine which can cure Brontë's hypochondriacs: the causes of their afflictions are deeply imbedded in their own minds, and the cure must be sought there as well.

Although hypochondria was often considered to be a distinctly feminine trait in men, it was also believed to be associated with access to the spirit world. As a traditionally defined 'nervous ailment', hypochondria and the diagnosis of the hypochondriac posed a unique set of problems in the early Victorian period. While in today's medical writings any nervous condition would be considered a psychological complaint, such a term was not available to the nineteenth-century physician. As an illness, then, hypochondria and its associated nervous complaints drew into relief the undeniable connection between the body and the mind, and by doing so defied all attempts at classification. Hypochondria could not with any certainty be classed as insanity, as there were physical symptoms, but it could also not be identified as a physical illness as it lacked any obvious external cause (Vrettos 48). However, what is most interesting about Brontë's portrayal of the hypochondriac is the narrative voice, and the ways in which the conditions of both Jane Eyre and Lucy Snowe are diagnosed and treated by other characters who often attempt to deny the more spiritual aspects of their sufferings. While Brontë approaches hypochondria and nervous illness with a far more medicalised and psychological viewpoint than previous authors, she also does not deny the spiritual, visionary symptoms of the disease, entering into a debate which was popular at the time among physicians: how the gap between the mental and the physical, apparently breached by nervous illness, influences the gap between the physical and spiritual worlds. While Brontë offers no true answers to this debate, her handling of the material in the light of it is fascinating, and one in which she took a keen interest through her researches into phrenology and mesmerism (Vrettos 58). Taking these views into account, Charlotte Brontë's semi-autobiographical accounts of hypochondria take a very different viewpoint on the illness, as she depicts it as intensely powerful rather than feminine, and often spiritually enlightening. While the character of the hypochondriac in the mystery or thriller novel such as *The Woman in White* or the works of Sir Arthur Conan Doyle exists as an obstruction to the plot or conveniently inactive invalid, Brontë uses the motif very differently.

In particular, Lucy Snowe and Jane Eyre are not only hypochondriacs, but first-person narrators. While there is heavy evidence to suggest that both Lucy Snowe and Brontë's earliest protagonist William Crimsworth are direct reflections of the author herself, even down to aspects of physical description and direct experiences, the choice of an 'hysterical' narrator for these texts is certainly

for more reason than autobiography. Jane Eyre's hypochondria in particular is a continuation of the Gothic idea of the link between nervous sensitivity and the supernatural. Her visions, (unlike Lucy Snowe's), are real, and provide a spiritual link between herself and her lover, Mr Rochester, which cannot be broken. Her visions attempt to warn her of the dangers of Thornfield Hall with its lunatic inmate, and, in the Gothic tradition, these warnings are dismissed and ignored until it is almost too late, adding a rising tension for the reader as they struggle to work through the mystery of Thornfield before Jane does herself.

Throughout *Jane Eyre*, Jane presents many of the symptoms which Lucy Snowe of Brontë's later work *Villette* also reports: feelings of repression, loneliness, a desire for companionship and affection, and a restlessness which cannot be satisfied through normal feminine duties. Much like Lucy Snowe, Jane also experiences nervous attacks, or 'hypochondriac fits', which lead to a period of hypochondria that would most likely be attributed in modern times to clinical depression. As a child, when locked in the red-room as punishment for her passionate temper, Jane believes she sees the ghost of her recently departed Uncle Reed. Rather than simply feeling faint or afraid, Jane regales the reader with an intense, almost clinical description of what physically befalls her as she experiences the ghostly encounter:

My heart beat thick, my head grew hot; a sound filled my ears, which I deemed the rushing of wings; something seemed near me; I was oppressed, suffocated: endurance broke down; I rushed to the door and shook the lock in desperate effort ... I suppose I had a species of fit: unconsciousness closed the scene. (*Jane Eyre* 14)

All of her symptoms, particularly her raised heartbeat and encroaching fever, are intense, physical symptoms brought about by emotional pain and fear. Here, Jane's hypochondriac symptoms do not focus on physical ailments, but mental ones: in this case a feeling of desperate melancholy reminiscent of Chambers' assertions of hypochondria and its link with misery (6). Falling ill following her encounter with the ghost, Jane does attempt to relate her physical symptoms with her mental suffering, however, although she claims her psychological symptoms to be worse than any bodily pain:

I felt physically weak and broken down; but my worse ailment was an unutterable wretchedness of mind, a wretchedness which kept drawing from me silent tears; no sooner had I dropped one salt drop from my cheek than another followed. Yet, I thought, I ought to

have been happy... (*Jane Eyre* 17)

Jane ceases to be able to take pleasure in things that usually amuse and distract her. Her favourite book remains unread, her favourite foods uneaten, and even being served dinner on a plate which she has always longed to examine fails to incite her pleasure, as it appears to her to be colourless and uninteresting through her misery (*Jane Eyre* 17). However, it is not the blow to the head she received earlier from her cousin that causes her to cry, nor the prospect of having met a ghost. Rather, the young Jane asserts simply that “I cry because I am miserable” (*Jane Eyre* 20). In 1873, over twenty years after the publication of *Jane Eyre*, Thomas King Chambers’ lecture on the topic of hypochondria revealed much the same information as was already apparently in the public consciousness:

Misery is abnormal; a disease, a terrible disease, as those who have felt it know well. It is a constitutional disease, idiopathic, not dependent on external circumstances for its origin. Disappointment, loss of wealth, loss of husband, wife, children, friends, of health, character, or social position, are often alleged as causes, and sometimes they may be the final excitant; but shrewd observation will show that usually they are mere pretexts, offered in explanation of a mystery. (6)

Although not unfounded, due to the way she is treated by her adopted family, it is nonetheless fairly difficult to diagnose a distinct cause for Jane’s “misery”. It manifests itself in physical symptoms which were common for hypochondriacs, especially loss of appetite, which was considered a product of “imperfect innervation” or a fault in the nerves (Chambers 6). Jane herself is unable to truly articulate or analyse what makes her feel this misery, or what has made her feel it so acutely now, although she eventually manages to put it down to her lack of relations and ill-treatment at the hands of her adopted family. Despite this explanation, Jane’s misery apparently runs deeper than this, as these have been constant factors in her life for many years and have only now caused her to have a hypochondriac episode. While the incident in the red-room may have been “the final excitant” (Chambers 6), the true cause of her misery lies far deeper. It is this cause which her attending physician (or in this case apothecary, as she does not warrant the care of a qualified doctor in the eyes of her aunt) attempts to cure, rather than the physical symptoms of lack of appetite and tearfulness. His immediate diagnosis, much like Dr John’s of *Villette*, is that “the child [Jane] ought to have a change of air and scene... nerves not in a good state” (*Jane Eyre* 23). Much as Dr John’s medical prowess is helpless in the face of hypochondria and stretched nerves in *Villette*, Jane Eyre’s

own attendant finds himself in similar circumstances, facing an opponent in the shape of a formless “misery” which defies even Jane’s attempts at solid definition.

Used almost interchangeably with the term “low spirits” and “overstretched nerves”, Lucy Snowe’s illness in *Villette* is officially diagnosed as hypochondria by Dr. John Graham Bretton, whose authority the reader is directed to trust. Indeed, the thread of hypochondria runs throughout *Villette*, not just in the case of Lucy Snowe. The arrival of Dr John (as Graham Bretton is unofficially called) to the Rue Fossette is occasioned by the school’s usual doctor being called to the side of “a rich old hypochondriac ... and upon his prescribing change of air and travel as remedies, he was retained to accompany the timid patient on a tour of some weeks” (*Villette* 161). Upon diagnosing Lucy following her nervous collapse, Dr John claims that there is little he can do for her as a physician, as “medicine can give nobody good spirits. My art halts at the threshold of Hypochondria: she just looks in and sees a chamber of torture, but can neither do nor say much” (*Villette* 257). The fictional Dr John’s diagnosis of hypochondria fits well with that of his namesake Dr Graham’s as a nervous complaint characterised by low spirits and “a whimsical dislike of particular persons, places or things; groundless apprehensions of personal danger or poverty; a general listlessness and disgust; or an irksomeness and weariness of life” (Dillon 51). Twenty years prior to Thomas King Chambers’ lecture at St Mary’s hospital wherein he clarified hypochondria as a disease characterised by “misery”, Brontë already depicts her characters as suffering from this effect above that of any other symptom. Very different from the fears of illness and disturbance that leave the hypochondriacs of Collins and Doyle’s novels housebound, Lucy’s hypochondria is a “strange fever of the nerves and blood” (*Villette* 231) which causes restlessness, nightmares, and even hallucinations. While modern medical practice would treat this as a psychological reaction to her isolation, Lucy devises a physical explanation for her malady, which is accepted by Dr John when he later treats her:

I suppose it was all the fault of what you call my ‘nervous system’. I cannot put the case into words, but my days and nights were grown intolerable; a cruel sense of desolation pained my mind: a feeling that would make its way, rush out, or kill me – like (and this you will understand, Dr John) the current which passes through the heart, and which, if aneurism or any other morbid cause obstructs its natural channels, seeks abnormal outlet. I wanted companionship, I wanted friendship, I wanted counsel. (*Villette* 258)

In this way, Lucy manages to conflate both physical and emotional symptoms into one single,

medically recognised complaint. Her heart serves as both a figurative seat of pain and physical, scientifically recognised organ. It channels raw feeling like an aneurism, which threatens her physical wellbeing through her nervous system.

Lucy's conflation of physical and emotional symptoms is not, however, a new literary development. From as early as the writings of Jane Austen, the physical symptoms of nervous illness have passed into the public consciousness firmly enough to leave traces in the fictional literature of the time. In her second published work, *Pride and Prejudice* (1813), the traditionally impotent nervous sufferer Mrs Bennet practically begins the novel by complaining to her husband that "you have no compassion for my poor nerves" (*Pride and Prejudice* 3) and later complains in moments of stress that they cause her to "have such tremblings, such flutterings, all over me, such spasms in my side, and pains in my head, and such beatings at heart" (*Pride and Prejudice* 248). It was not until the late-nineteenth century that the concept of a solely psychological cause for nervous illness became the accepted diagnosis, and even then the theory appears to have taken even longer to permeate the public consciousness. Published in 1909, Frances Hodgson Burnett's *The Secret Garden* features the child hypochondriac Colin waking cured one morning to feel "as if tight strings had loosened themselves and let him go. He did not know that Dr Craven would have said that his nerves had relaxed and loosened themselves" (*Secret Garden* 158). During the nineteenth century, both medical and psychological causes for nervous conditions such as hypochondria were considered interchangeable by physicians. Early medical theories focussed on the nerves as a physical basis for emotional distress, where stretched nervous tissues caused stress and excitement in patients. Later theories did not entirely overrule these early observations, but also allowed the idea that perhaps it was overexcitement that stretched the nervous tissues in the first place, reassigning the labels of cause and effect but not abandoning the link between physically stretched nerves and emotional reactions (Vrettos 51). Following in this tradition, Lucy Snowe's own hypochondria in *Villette* is frequently described by this baseline, as she cites stretched nerves as a physical cause for her underlying illness: "I really believe my nerves are getting overstretched: my mind has suffered somewhat too much; a malady is growing upon it – what shall I do? How shall I keep well?" (*Villette* 231).

The answer to Lucy Snowe's question, interestingly, is psychological rather than physical. While Dr John agrees with Lucy that the cause of her complaint is her 'overstretched nerves', his reasoning for why this event has occurred is psychological: her forced isolation while the rest of the school was on vacation. Here, Dr John follows the medically recognised advice of the late Victorian

physicians with this claim, deciding that the cause for her stretched nerves is emotional, rather than simply an emotional response being caused by a physical ailment. Similarly, the cure he prescribes, a change of air and scene, is also a psychological one. He issues no relaxing drugs, unlike those which are used by Thaddeus Sholto and Mr Fairlie, and believes that exercise and good company are the answers to Lucy's distress. While Lucy attempts to medicalise her feelings of isolation and melancholy, describing them in terms of an aneurism (a literal, physical defect of the heart), Dr John treats the illness as predominantly psychological, refraining from using medical terms and instead proposing to treat the true cause of the problem: Lucy's emotional state. The clinical descriptions Lucy attempts to place on her feelings of discontent are largely unsupportable. There is nothing physically wrong with her that can be cured with medicine. Her misery and isolation, the true cause for her mental collapse, is a disease in itself, and must be treated separately to cure her physical afflictions.

Lucy Snowe's inability to differentiate physical and emotional suffering echoes perhaps one of the most complex issues which faced the Victorian physician. While the main problem with diagnosing nervous illness was its disturbing ability to link the mind with physical suffering, this same characteristic made it a point of fascination for the nineteenth-century physician. If illnesses such as hypochondria proved that there was a relationship between the body and the mind, Victorian physicians theorised that there must then be ways in which religious or spiritual experiences could breach the gap between psychic and psychological symptoms. In the same way that doctors argued whether overstretched nerves caused hypochondria, or if hypochondria caused the nerves to become overstretched, the same confusion around cause and effect plagued physicians whose patients claimed to have been witness to supernatural encounters. Studies were conducted which alleged that divine visions foreseen by Catholic women were symptomatic of hysteria, and therefore provided conclusive proof of either nervous breakdown or sainthood. In an 1845 study called *The Philosophy of Mystery*, British surgeon Walter Cooper Dendy outlined and analysed a variety of supposedly spiritual happenings for the purpose of finding a conclusive scientific theory which explained the phenomenon. In his work, he investigated such happenings as visions, demonic possession and religious ecstasy, and found normal, physical explanations for them which ranged from hysteria to indigestion (Vrettos 55). Similarly, physician Jean-Martin Charcot examined patients who claimed to have experienced religious visions, and determined that "all forms of ecstasy might be a function of neurosis and that the visions and miracles of saints could be subjected to rational, medical, and scientific explanation" (Vrettos 54). While many physicians refused to acknowledge the presence of spirituality in their work, others sought to unify the two fields, eventually allowing the symptoms of

nervous illness to include supposedly psychic phenomena (Vrettos 54). Despite arguments from some scientists that such a study served only to deny the existence of God and spirituality, many physicians claimed the opposite: that by attempting to rationalise such occurrences, it lent physical proof to the existence of the higher powers (Vrettos 54). It is this divide that can be seen to be illustrated so clearly by the behaviour of both Lucy Snowe and Jane Eyre, as Brontë attempts to apply a scientific and rational framework to what can easily be read as quintessential Gothic tales.

Often referred to as the literature of the subconscious, the Gothic genre has long been associated with both the supernatural and high emotion. In particular, impressionable, innocent young females are usually exposed to horrors which induce feelings tantamount to hysterical excitement, with the heroine of the Gothic genre fulfilling the role of “the classic hysteric” (Sedgewick vi). Some critics, however, take exception to this rule. Elaine Showalter argues that to call a Gothic heroine ‘an hysteric’ in the medical tradition is to imply “that she only imagines that she is being threatened and that the menacing or seductive figures she describes are only projections of her own repressed desires” (30). In the case of *Jane Eyre*, Showalter’s argument certainly rings true. As a Victorian novel, *Jane Eyre* borrows a large number of motifs from the Gothic genre: the novel contains a Byronic hero and a virtuous heroine, a mysterious old manor house with hidden secrets, and even, in one memorable scene, the possibility of a haunting. A few nights before her intended wedding to Mr Rochester, Jane finds herself unable to sleep peacefully. Waking from disturbed dreams, she is confronted by a spectre which reminds her unaccountably of “the foul German spectre – the Vampyre!” (*Jane Eyre* 341). Unlike a ghost, the creature is purple, not pale, and physically tears Jane’s wedding veil in two before departing. The visitor, Rochester’s wife Bertha Mason, is a real, physical being, and her actions, though seemingly crazed, are similarly real, unlike the imagined threats of repressed desires scorned by Showalter. Although Rochester firmly denies that the encounter took place, claiming that the visitation was merely “the creature of an overstimulated brain” (*Jane Eyre* 341), Jane herself is adamant that “[her] nerves were not in fault; the thing was real: the transaction actually took place” (*Jane Eyre* 341). Despite Rochester’s attempts to diagnose Jane’s experience as little more than an hysterical outburst, Jane’s ghostly visitor, while not truly a ghost, is nonetheless real, and not the hypochondriac hallucination which Rochester claims.

However, Jane is still prone to hypochondriac dread. Much like Lucy Snowe’s later hallucinations in *Villette*, Jane receives a disturbing dream filled with symbolic resonance, which turns out to be a premonition of future events. On the second to last night before her wedding, just prior to the entry of Bertha Mason, Jane dreams of Thornfield Hall as “a dreary ruin, the retreat of bats and owls. I

thought that of all the stately front nothing remained but a shell-like wall” (*Jane Eyre* 339). Upon telling her vision to Mr Rochester, her husband-to-be is openly dismissive. He claims that her visions are a form of “hypochondria”, brought on by over-excitement, and counsels her instead to “[f]orget visionary woe” (*Jane Eyre* 339). His insistence that Jane’s visions are merely the product of a physical ailment – over-stretched and over-excited nerves – is very different to what Jane believes and the text presents as the reality. For Jane, in the tradition of the earlier saints, her nervous tendencies have rendered her capable of experiencing true visions.

Despite Rochester’s attempts to attribute her suffering to physical causes – predominantly over-excitement and nerves, both classic hypochondriac failings – Jane believes them to be something more, and is justified in doing so. When she returns to Thornfield at the end of her narrative, Jane discovers that the house has been burned to the ground, and exclaims that, “the front was, as I had once seen in a dream, but a shell-like wall, very high and very fragile-looking, perforated with paneless windows: no roof, no battlements, no chimneys – all had crashed in” (*Jane Eyre* 515). It is ambiguous, however, as to what degree Rochester believes his own explanations for Jane’s malady – while he would have no reason to deny that she is capable of visions, he has every need to conceal the presence of Bertha Mason within his house. However, whether or not Rochester believes in his explanations or not, he expects them to sound plausible to Jane, to whom he constantly refers as being a rational, sceptical person. The relationship between nervous hypochondria and spiritual visions appears to be an incredibly close one, with apparently the same physical symptoms.

While it is revealed at the climax of the narrative that Jane’s ailment is spiritual rather than physical in nature, with both her vision of Thornfield being correct and her spiritual connection with Rochester as proof of this, the evidence at this stage of the text is still murky. Jane’s nervous sensibilities and repressed passionate nature are widely discussed throughout her childhood, causing her to faint in the red-room and fall into violent misery when alone and friendless at Lowood. In the red-room, it is accepted that the ten year old Jane had not seen a ghost, but only “a gleam from a lantern some one [sic] carried across the lawn” (*Jane Eyre* 13). Her reaction to meeting the supposed “goblin-shape” of Bertha Mason is identical to that of her suspected meeting with the ghost of Mr Reed: to fall into a faint, and feel protracted misery and nervousness upon awakening, desperately needing the company of others. However, the great difference between the two attacks lies in Jane’s psychology. While she claims to have been miserable in Gateshead before her encounter with the ghost in the red-room, she has known nothing but happiness in Thornfield. As soon as she has the visionary dream, however, this changes. The late arrival of Mr Rochester forces

her to become “seized with hypochondriac foreboding... The event of last night again recurred to me. I interpreted it as a warning of disaster” (*Jane Eyre* 333). While her childhood experiences with hypochondria are marked by nervous fits and what her doctor refers to as ‘babyish’ tendencies, her adult passions have a far more spiritualised framework. Throughout the text, Jane exhibits various signs of being connected with Mr Rochester on a spiritual as well as emotional level, particularly in instances of high and passionate emotion. When angered into “something like passion” at the idea of Mr Rochester marrying Blanche Ingram, Jane opens her heart to him, concluding with the sentiment that “I am not talking to you now through the medium of custom, conventionalities, nor even of mortal flesh; – it is my spirit that addresses your spirit; just as if both had passed through the grave, and we stood at God’s feet, equal...” (*Jane Eyre* 303). Similarly, at the climax of the novel, when Jane is confronted with the choice between accepting the proposal of St. John Rivers and rejecting him, she claims to feel “excited more than I had ever been; and whether what followed was the effect of my excitement the reader shall judge” (*Jane Eyre* 508). What occurs next is one of the most openly spiritual moments of the book: Jane asks for God’s advice, and instead hears the voice of Mr Rochester, calling her name from miles away. Jane’s excited, passionate nerves, then, mature throughout her life to allow for the accuracy of not only precognition, but of true spiritual connection with others, leading her not into nervous prostration, but almost exalting her through saint-like visions. Previously, Jane’s ghostly visions have occurred as a reaction to her hypochondria. Now, the relationship between the two events, while still present, has suffered a change: her hypochondria is now reimagined as a reaction to her visions.

Similarly to Jane’s spiritual connection to Rochester, Athena Vrettos hypothesises in her reading of *Villette* that, far from obstructing the plot, Lucy Snowe’s hypochondria actually enhances her narrative power. Due to her sensitised emotional state and hypochondriac sufferings, Vrettos suggests that Brontë endows Lucy Snowe with the power to better read and understand individuals through her ability to “read the subtle symptoms of human emotion” (66). While there is no contemporary medical evidence for such a phenomenon, it can perhaps best be explained as a continuation of *Jane Eyre*’s own spiritual connection with Mr Rochester. Lucy Snowe’s strong emotions enable her to almost transcend the necessity for physical observation, and view others on a spiritual, soul-deep level. Indeed, Lucy often refers throughout the text to hypochondria being a ‘ghost’ which haunts her, and “has that wont, to rise in the midst of thousands – dark as Doom, pale as Malady, and well nigh strong as Death” (*Villette* 290). As she believes she is able to see the ghost of the nun which supposedly haunts the Rue Fossette, Lucy also is able to witness the visitation of another spectre which haunts her alone: Hypochondria itself. Perhaps the most powerful example of

this ability is featured when Dr John and his mother take Lucy to attend a concert, presided over by the royal family of Labassecoeur. When the King enters the box, Lucy finds her gaze drawn from the concert and crush of attendees to the King himself, who she recognises instantly as a fellow sufferer of hypochondria – a kindred spirit haunted by the same ‘ghost’. Her description of him in this moment is insightful and compelling, and she appears to be the only witness to his inward depression:

There sat a silent sufferer – a nervous, melancholy man. Those eyes had looked on the visions of a certain ghost – had long waited the comings and goings of that strangest spectre – Hypochondria ... Full mournful and significant was that spectacle! Not the less so because, both for the aristocracy and the honest bourgeoisie of Labassecoeur, its peculiarity seemed to be wholly invisible: I could not discover that one soul present was either struck or touched. (*Villette* 290-291)

Lucy’s hypochondria not only allows her to recognise the King’s ailment, but makes her the only one in the audience able to do so. Similarly, there are various other instances wherein Lucy Snowe is the only person able to read the true personality of her acquaintances. Ginevra Fanshawe, for example, is described by Lucy as vain, coquettish and exploitative of Dr John, who courts her attentions. He, however, is blind to all of her faults, and reads her cold, mercenary methods of gaining presents from him as an enchanting mixture of naivety and politeness. Although he is eventually undeceived, Lucy is never taken in, and even goes so far as to consider an inability to read people as a sign of the worsening of her illness, removing her sensitivity to see them clearly and replacing it with a desire to romanticise them (Vrettos 66). At the point wherein her hypochondria is at its most extreme, Lucy reveals that “Ginevra gradually became with me a sort of heroine. One day, perceiving this growing illusion, I said, ‘I really believe my nerves are getting overstretched: my mind has suffered somewhat too much...’” (*Villette* 231). Lucy’s hypochondria is a double-edged sword: it enhances her perceptions of people, but is also in danger of clouding them when taken to extremes.

Despite Lucy Snowe’s abilities to read the emotions of others, her hypochondria also makes her other observations less than reliable. Nordau’s description of hysterical narratives as featuring an inability to tell fiction from reality and a tendency to lie without realising it are certainly both traits of which Lucy Snowe could stand accused. Later, Freud would notice a distinct correlation between his own studies of hysterical women and these narratives, commenting on how similar the parallels

were between the two (Showalter 26). The main symptom is the hysterical subject's inability to tell a consistently ordered narrative, due to what Freud thought to be sexual repression (Showalter 26). It is this aspect of hysteria which is perhaps most interesting when investigated in the case of Lucy Snowe. From almost the very moment in which she leaves for France, Lucy sets herself up to be a highly unreliable narrator, at war with her own imagination (Johnson 326). Although she often sets herself out to be one of a sensible, not sensitive temperament, she is unable to reflect this in her own narrative voice as she leaves England for Labassecoeur:

In my reverie, methought I saw the continent of Europe, like a wide dream-land, far away. Sunshine lay on it, making the long coast one line of gold; tiniest tracery of clustered town and snow-gleaming tower, of woods deep-massed, of heights serrated, of smooth pasturage and veiny stream, embossed the metal-bright prospect. For background, spread a sky, solemn and dark blue, and-grand with imperial promise, soft with tints of enchantment-strode from north to south a God-bent bow, an arch of hope.

Cancel the whole of that, if you please, reader – or rather let it stand, and draw thence a moral – an alliterative, text-hand copy – Day-dreams are delusions of the demon. (*Villette* 117-118)

Her self-editing and denial of her own artistic sensibilities mark her as a repressed individual, and throws into doubt the rest of her narrative – how much can the reader believe what she says if she herself refuses to admit what she truly sees? Her emotional repression not only casts her narrative voice into doubt, but is also the cause of her hypochondria, which hides important facts from her nervous gaze.

In addition to this, Lucy Snowe's unreliability as a narrator is heralded by her inability to accurately record chronological events. Various critics have pointed to the frustratingly vague and incoherent ending to *Villette*, but few have read it in the light of Freud's analysis of hysteria: as a lack of consistent order within the structured narrative. The only physical description we are given of Lucy Snowe occurs as a direct address to the reader, where she describes herself as having "hair which till a late period withstood the frosts of time, lies now, at last, white, under a white cap, like snow beneath snow" (*Villette* 105). With this description comes the addendum that she is writing this narrative retrospectively, remembering events long past. Further evidence of this fact is supplied at the end of the text, where she is able to recount the full lives of Madame Beck, Paulina and Dr John. However, when she reaches the end of her narrative and attempts to describe the night in which her

husband-to-be M. Paul was to return to her, her narrative suddenly leaps to present tense, and leaves the reader with a thoroughly ambiguous ending. Lucy Snowe describes, in present tense, a great storm on the Atlantic which wrecks many ships and leaves many widowed, but fails to tell the reader whether or not she is among that number. Instead she leaves the reader with the desire to “trouble no quiet, kind heart; leave sunny imaginations hope. Let it be theirs to conceive the delight of joy born again fresh out of great terror, the rapture of rescue from peril... Let them picture union and a happy succeeding life” (*Villette* 596). Not only does the change of tense give the passage a distorted sense of time, but the ambiguity of Lucy Snowe’s language leaves it vague as to what the outcome of the storm was: is it the emotion of sadness and bereavement that Lucy shies away from here, or the joy of being reunited with the one she loves?⁶ In regards to M. Paul, Lucy Snowe’s sense of timing is often flawed. It is only at the end of the book that the many kindnesses he has paid to her are revealed, as for the majority of the text she prefers to dwell only on his negative traits as perhaps, similarly to Dr John’s letters in a bottle, she attempts to bury and hide her emotions within the pages of the text, even many years later. While she can read a person’s character clearly, Lucy Snowe does not allow the reader the same privilege, as her desire to be free from strong feeling shelters the reader from knowing her true opinions of the two men she cares for the most.

In regards to Dr John, his entire identity is kept a secret from the reader for a large section of the narrative. Lucy claims to have recognised him as far back as Chapter X, when she catches sight of his profile and stares at him for a long moment, but does not reveal the recognition to either the reader or Dr John himself until Chapter XVI. At this point, some months have passed in the chronology of the text, and she has had numerous professional and social situations in which to reveal herself as his mother’s goddaughter. While she claims that the revelation of her identity would “make little difference” to her old friend, this explanation is less true than the reality: she fears that the revelation would make too great a difference to *herself*. After re-establishing the acquaintance of Dr John and his mother, her greatest fear is of relying too greatly on their friendship, and being disappointed by not having it returned – she wishes above all to be “tranquil: quite tranquil!” (*Villette* 251), and in order to do so denies not only the identity of her old friends but also of herself, for as long as she possibly can. While Jane Eyre’s hypochondriac and nervous tendencies lead to an illumination of the plot for the reader, offering tantalising hints of future

⁶ While some critics claim that there is no ambiguity to the ending at all, Brontë herself meant for the story to end on a “little puzzle” (Lilly 622). When asked by two of her readers to explain the fate of M. Paul, Brontë replied to them in such a way as to “leave the matter pretty much where it was” (Lilly 622), determined not to state either way what happened to Lucy Snowe’s lover, or explain the odd incoherence of this part of her narrative.

events and providing a happy conclusion through the spiritual, emotional connection between Jane and Mr Rochester, Lucy Snowe's hypochondria has the opposite effect. Her emotional reticence leads her to lie to herself and to the reader, and adds a general air of confusion to the story as the sense of narrative time is completely disregarded. Lucy may be able to read other people well, but she remains a mystery to both herself and the reader through her continued attempts to hide her emotions from all parties.

This is not the only way in which Lucy Snowe's hypochondria works to cloud her judgement. While Lucy's emotional sensitivity enables her to understand and read people's motives and intentions, it also clouds aspects of the wider narrative from her gaze. Her often hysterical reactions and severe emotional repression (consequence and cause of her hypochondria respectively) have the effect of making her a classic unreliable narrator. While *Villette* is not a 'mystery' or sensation novel like the works of Collins and Doyle, there are nevertheless mysteries present within the text: the identity and purpose of the ghostly nun, the story of M. Paul's life, and even the identity of Dr John is, for a while, considered a secret from the reader. Far from illuminating these secrets, Lucy's hypochondria is often the reason why they remain undiscovered. In her wide-ranging analysis entitled *Charlotte Brontë and Victorian Psychology*, Sally Shuttleworth explicitly connects the 'hypochondria' experienced by Brontë's first and only male protagonist, William Crimsworth, with feelings of pronounced sexual anxiety (142). In Brontë's earliest work *The Professor* (published posthumously, despite predating her earlier novels), William Crimsworth suffers from 'hypochondria' twice in his life, in a similar fashion to Jane Eyre: firstly as a child, and secondly only a few days before his wedding to his 'chaste pupil' Frances. Despite Crimsworth's confusion as to why his boyhood fears should return to him when he has finally secured himself a happy future, Shuttleworth notes that, by securing himself a wife "Crimsworth shatters the fragile equilibrium of his psychic structure that was grounded entirely on restraint" (141). In other words, by acknowledging and admitting his willingness to act on his desires for Frances, Crimsworth has opened himself to all of the ensuing anxieties which bound the nineteenth-century male: namely, fears of the loss of self and identity inherent by becoming sexually active (Shuttleworth 142). While Shuttleworth argues that "forebodings of death, and loss of a sense of purposive existence, were commonly linked to sexual fears within the ideological nexus which bound the male in his role of producer" (142), the hypochondria of women appears to be bound up in a similar state of repression.

According to Elaine Showalter, it was commonly received in scientific literature that hypochondriac, hysterical women "left out, distorted and rearranged information because of sexual

repression. And this incapacity ... was not simply characteristic or hysterics – it was the meaning of hysteria” (26). This view, like many others, was quickly engaged with by authors. As the brother of the well-known hypochondriac Alice James, Henry James’ *The Turn of the Screw* (1898) features a governess not unlike Jane and Lucy, who is (ambiguously) in love with her employer and claims to have visions of ghosts. While it is never fully revealed as to whether or not the ghosts exist, critics commonly suggest that the apparitions which supposedly threaten the children under the governess’ charge are merely the fantasies of “a neurotic, suffering from sex-repression” (Wolff 1), who has transposed her own desires onto the ghostly forms of her predecessors. In much the same way as James’ unnamed governess experiences ghostly encounters as an outlet for her repressed emotions, Lucy Snowe’s visitations appear to follow the same pattern. As a “minute history of unsuccessful repression” (Millhauser 176), Lucy Snowe’s narrative is one which is filled with failed attempts to internalise and hide her feelings of desire – firstly for the uninterested Dr. John, and later for the irascible M. Paul. While Lucy begins the book by denying that she has an “artistic temperament” or is at all prone to nervous excitement, she later recants this, likening her staid manner to a grey cloak which conceals ideas and emotions that she fears would brand her a zealot if they were known (Millhauser 178).

Although Steven Millhauser comments at length on Lucy Snowe’s failure to repress her emotions, calling the book a tale which moves in “alternating rhythms of restriction and eruption” (Millhauser 176), he does not note the relationship between the visitations of the ghostly nun and Lucy’s attempts to contain her unwanted desires. Throughout *Villette*, Lucy has five encounters with what she believes to be the ghostly form of a nun, all of which occur at moments which are fraught with emotional disturbance for the nervous protagonist. The first time Lucy sees the ‘ghostly nun’, she is hiding in the attic late at night, reading a letter sent to her by Dr John. Her reactions to receiving the letter earlier in the day are puzzling, verging on what she later describes as ‘monomania’ – she is determined to read the letters in private, and is willing to share them with no one. Although she never admits to harbouring romantic feelings towards Dr. John, her raptures upon finding the letter to be written in kindly tones are extreme. Merely finding that the letter speaks of the times they have shared makes her believe that it was written from a desire to “not merely gratify *me* – but to gratify *himself* ... A passing seraph seemed to have rested beside me, leaned towards my heart and, and reposed on its throb a softening, cooling, healing, hallowing wing” (*Villette* 324-325). Her reaction to receiving a single letter borders on hysteric, as she “prized it more than the blood in her veins” (*Villette* 327), and it is at this moment of heightened emotion that the ‘nun’ first reveals itself to Lucy. Lucy herself is terrified of the apparition, and believes it to be the spirit of a nun killed by

Catholic priests for failing to keep her vows: "Say what you will, reader – tell me I was nervous, or mad; affirm that I was unsettled by the excitement of that letter; declare that I dreamed: this I vow – I saw there – in that room – on that night – an image like – a NUN" (*Villette* 325). It is interesting to note that the first excuse Lucy thinks to denounce for her vision is that of nervous sensitivity – her hypochondria, caused by the 'excitement' of receiving what is little more than a kindly worded letter from a friend. The connection is perhaps made most evident, however, when Lucy sees the 'ghost' for the third time, after burying her bottle of Dr John's letters in the garden (which have previously been the subject of her self-confessed 'monomania'). Unable to gain complete control of her emotions, she attempts to symbolically bury her feelings for her friend by enclosing his affectionate letters to her in a glass bottle and sealing them underground with cement. It is at this moment, when the bottle is finally buried, that Lucy sees the ghostly nun for the third time, walking across the garden. In her state of emotional upheaval, Lucy is unable to tell that the nun is not an apparition, but a flesh and blood man in disguise, and her conviction that it is a ghost, brought about by her hysterical fear, leaves her blind to any other possibility.

As a classic Gothic trope, ghostly visitations are almost to be expected: Lucy, who is fighting against her repressed desires for the unattainable Dr. John, sees a vision of a ghostly nun who supposedly met her end by failing to keep her vows of chastity, a dark mirror of her own situation; whereas Jane, days before her wedding, is visited by a spectre which tears her bridal veil in two, signifying the danger of her union in a similar fashion to the dread experienced by her predecessor William Crimsworth. If real, both ghosts would perform a function similar to those of *The Turn of the Screw*, standing in for the psychologically repressed desires of the protagonists. However, both ghosts are in fact real people – Bertha Mason and Colonel DeHamal. This adds, in James' terms, a third turn of the screw, as the ghosts as living people mirror the desires and fears of Jane and Lucy equally well. Jane's ghost, Bertha Mason, is Rochester's true wife, and represents what Jane fears she may become: a woman whom Rochester once loved, and eventually abandoned for a string of mistresses. In the same way, Colonel DeHamal is an odd mirror for Lucy, as he uses the nun's habit as a disguise to visit his lover Ginevra Fanshawe. While Lucy imagines the nun as a woman who broke her vows of chastity, DeHamal is quite literally a representation of the desires which she goes to such lengths to hide.

While the ghostly spectre of the Nun which haunts Lucy Snowe is eventually unmasked as a man in disguise, the way in which Lucy Snowe and Dr John separately deal with the possibility of Lucy receiving ghostly visions is intriguing, and highly reflective of medical attitudes towards nervous

psychic abilities. Much as Mr. Rochester claims that Jane's visions are merely "hypochondria", the first diagnosis which Dr John applies to Lucy's ghostly experience is that "this is all a matter of the nerves" (*Villette* 329). Lucy's initial reaction to this diagnosis is to accept the psychological explanation for her ailment, asking Dr John if "you think then ... she came out of my brain, and is now gone in there, and may glide out again at an hour and a day when I look not for her?" (*Villette* 330). The relationship between spiritual vision and nervous ailment here is clear: the two are almost indistinguishable, and the reactions of both doctor and patient represent clearly the two opposing ends of what in Brontë's time was a serious and long-running debate. As a rationalist, Dr John believes that Lucy Snowe's first sighting of the nun in the attic came about as a direct result of her overexcitement. He ascribes physical and mental symptoms which herald the nun's presence, claiming it to be "a case of spectral illusion: I fear, following on and resulting from long-continued mental conflict" (*Villette* 330). When Lucy receives a vision of the nun for a second time as she prepares to attend an evening concert with Dr John, he realises that she has seen the vision again before she speaks of it: "She has been, as sure as I live... her figure crossing your eyes leaves on them a peculiar gleam and expression not to be mistaken ... The old symptoms are there ... a particular pale, and what the Scotch call a 'raised' look" (*Villette* 338). Dr John views the ghost as both symptom and object of Lucy's continued hypochondria (Vrettos 68), and is determined to cure her of the disorder. He sets himself up in personal competition with the apparition, determined to make his medical diagnosis rule out over the spiritual explanation. Dr John's battle with the personification of Lucy's mental and physical ailment places Lucy herself as a prize in a greater battle: the proof that nervous spirituality as defined by the much-maligned Catholic faith is a myth. By this stage, however, Lucy herself has taken the opposing viewpoint, and sees Dr John as oblivious to what is truly going on:

He was so obstinate ... Of course with him, it was held to be another effect of the same cause: it was all optical illusion – nervous malady, and so on. Not one bit did I believe him; but I dared not contradict: doctors are so self-opinionated, so immovable in their dry, materialist views. (*Villette* 338)

By having the ghost be neither a symptom of hypochondria or a true, spiritual vision, Brontë neatly sidesteps the debate which so confounded the professionals of her time. Lucy Snowe's hysterical visions are the products of her mind, but (in contrast to Dr John's claims) are based on a true event, much as Jane sees Bertha Mason in a "goblin-shape" and mistakes her for a vision of disaster. As a hypochondriac, Lucy Snowe (and, by proxy, the reader) believes she has been given the powers that

many other sufferers were recorded scientifically as having possessed, fulfilling the literary tradition of the Gothic heroine encountering spectral forms. Through subverting this Gothic trope, Brontë is able to surprise the reader with the true revelation at the end, and centre the story in a clearly more realistic realm by applying a scientific framework to the classic ghost story. By offering both a scientifically rational and deeply spiritual explanation of the night's events, Brontë guides the reader to expect that either one or the other is correct. Following on from the tradition of *Jane Eyre*, the reader's expectations would quite easily coincide with the beliefs of the narrator rather than her physician. As Rochester attempts to deny Jane's spiritual insight, the diagnosis which is offered by Dr. John and rejected vehemently by Lucy Snowe would almost appear to follow in the classic tradition of scientific men denying the spiritual abilities of women (Shuttleworth 221). By supplying ample evidence to scientifically support the theory of Lucy's hysteria (as even Lucy Snowe does not deny her feelings of nervous excitement and hypochondriac dread), the reader is lured to believe that either Lucy Snowe or Dr. John is correct, but never to suspect that both may be wrong.

While detective fiction and sensation literature both focus on the hypochondriac as an impediment to plot, Charlotte Brontë's approach is markedly different. By focussing on the deeper psychology of the hypochondriac rather than solely cataloguing their neurotic symptoms, the character ceases to be a figure of fun and becomes a serious protagonist. Both *Jane Eyre* and *Lucy Snowe* are central to the plots of their stories and the sole narrative voice of their tales. Their hypochondria simultaneously clears and distorts the mysteries which surround them: Lucy Snowe's hypochondria makes her sensitive to the emotions and motives of those around her, but also inhibits the reader from believing the physical evidence she sees. *Jane Eyre* as well is a good judge of people, but her spiritual visions make her invaluable as a narrator. The only flaw in this regard is that her hypochondria makes her visions unreliable – can the reader believe her when she says she has had a vision when we know that she has earlier had the same reaction to a man crossing the lawn with a lantern? Their hypochondria, far different from the nervous fears of illness of Sholto and Fairlie, takes the form of sheer misery, as Charlotte Brontë herself experienced it. They are isolated, unhappy, restless and repressed, at war with their passionate natures which produces melancholy effects. Caught somewhere between overstretched nerves and spiritual enlightenment, both Jane and Lucy suffer from an ambiguous condition that stretches the boundaries between mental and physical pain, and physical and spiritual suffering. Although never treated with contempt, both protagonists are often characterised by confusion as they try to come to terms with their illness surrounded by people who wish to diagnose them. While Brontë never truly stakes her claim on either side of the

metaphysical debate between nerves and spirituality, she does offer her own comments through the symptoms of her protagonists. Tormented, frustrated and emotionally repressed, Brontë's hypochondriacs navigate and narrate their stories with a mixture of startling insight and staggering blindness, caught between spiritual insight and traitorous physicality. While treated with respect and compassion by those around them, unlike Mr Fairlie and Thaddeus Sholto (a possible reflection on their gender), Lucy Snowe and Jane Eyre are no more reliable than their masculine counterparts when they are forced to narrate their own mysteries to their readers.

“Practically a Raving Maniac”

Brain Fever in *The Woman in White* and the Detective Fiction of Sir Arthur Conan Doyle

When Percy Phelps loses an important state document in Sir Arthur Conan Doyle’s short story “The Naval Treaty” (1893), his feelings of hopelessness and despair manifest themselves into physical suffering as he comes to the conclusion that

I was ruined. Shamefully, hopelessly ruined. I don’t know what I did. I fancy I must have made a scene. I have a dim recollection of a group of officials who crowded round me endeavouring to soothe me ... The doctor most kindly took charge of me, and it was well he did so, for I had a fit in the station, and before we reached home I was practically a raving maniac ... Here I have lain ... for over nine weeks, unconscious, and raving with brain fever... in my mad fits I was capable of anything. (397)

Thought of as striking suddenly and crippling on the event of a severe emotional shock, “brain fever” is perhaps one of the most common medical ailments to strike in nineteenth-century fiction, affecting both men and women indiscriminately with attacks of intense delirium and insensibility. As is to be expected from its prevalence in literature, perhaps, the illness also enjoyed a rich life in the medical textbooks of the period. In his 1850 treatise entitled “Practical Observations on Delirium”, Thomas Salter defined the ailment as one of

[t]he most dangerous cases of delirium ... those in which it is found connected with inflammation of the membranes, or substance of the brain, commonly spoken of as *phrenitis*; in this disease the delirium is of a violent character, and for the most part comes on suddenly, accompanied with much heat of the surface, flushed countenance, injection of the conjunctiva, with a frequent, strong, and full pulse, and very commonly a red and dry tongue, with a dislike to a strong light and loud sounds. (667)

While it may seem strange to a modern reader to believe that a person who had until moments earlier been of a perfectly sound mind could suddenly fall into such a delirium, the medical writings of the time indicate that it would perhaps not have been so to a reader of the nineteenth century.

To the Victorian physician, the term ‘fever’ did not necessarily denote a specific rise in temperature, but more generally referred to the presence of illness, as did the term ‘brain fever’. In many cases,

according to influential physician Thomas Southwood Smith, epidemic diseases in particular were caused by either a “pre-disposing” or “exciting” cause (Halliday 114). A “pre-disposing” cause was usually related to the lifestyle of the patient, such as their diet and place of residence, whereas an “exciting” cause could be a disease agent such as smallpox bacteria (Halliday 114), or, in some cases, even be emotional, such as a severe shock (England 186). As a malady in its own right, the term ‘brain fever’ evolved from ‘phrenitis’ or ‘phrensy’, meaning an inflammation of the brain (Peterson 446). Much like the name, the advent of such a fever occasioned by sudden emotional shock or excitement is also verified in the writings of contemporary medical experts. In 1833, Alexander Tweedie wrote a dissertation on the nature of fever, in which he claimed that among other causes, fever could be perpetuated by events which cause “a severe shock to the nervous system. The various kinds of mental emotion - fear, anxiety, disappointments, long continued watching on a sick bed, intense study, want of sleep may individually be ranked among the predisposing causes of fever” (189-190, cited in Peterson 448). Tweedie concluded that “any undue mental fatigue ... powerfully aids the operation of the exciting causes of fever ... [which leads to] the violence of the disease [falling] on the brain and nervous system, producing what is emphatically known as *brain fever*” (193, cited in Peterson 448).

Working in an age before the discovery of micro-organisms, eighteenth and early nineteenth-century physicians were severely hampered by a lack of information on what made people fall ill. While not entirely ignorant as to the nature of contagion and the effects of squalid habitation, physicians were equally likely to ascribe an emotional pre-disposing or exciting cause for fever as they were a physical. An article from *Bell's Weekly Messenger* in 1800, for example, warned its readers that “the brain fever is extremely prevalent at present, and we fear that it is likely to continue during the present hot weather ... The best preventative against the complaint are temperance ... and to keep as much out of the vertical rays of the sun as possible” (*Bell's Weekly Messenger* 225). Barely a month later, a young woman was reported in a similar newspaper attempting to commit suicide after being turned out of her lover's house. The emotional shock of this incident prior to the attempted suicide led to “brain fever, which had the effect of confining her nearly three months in the hospital” (*London Chronicle* 6479). Much like hypochondria, then, with its combination of physical and psychological causes and symptoms, brain fever as a complaint was defined in at least two entirely different ways.

Unfortunately, the illness is no clearer in the period's literature than it is in its medical texts. A character falling ill from a sudden shock is not always termed ‘brain fever’, for example, much as

the term was not always used by physicians. However, the motif of an unexplained fever, usually accompanied by delirium and nervous collapse as a result of severe stress or emotional shock is commonplace, and would easily have been easily recognisable to the nineteenth-century reader. Not only was it easily recognisable to a reader, however, brain fever was also a convenient tool for the author due to its “dramatic onset and long duration” (Peterson 449) which allowed characters to be briefly put out of action for a section of the plot, only to later return to the story healed and able to contribute once again to the story. According to Jane Wood, brain fever usually functioned not only as a convenient way to kill characters (as brain fever in reality was most often considered fatal) but also as “a mechanism whereby the literary victim usually survives to ‘continue to function in the narrative’ although altered irreversibly by the experience” (193). While there is certainly evidence to support this fact in the narratives of many Victorian literary figures (such as Dickens’ Pip in *Great Expectations* and Richard Swiveller in *The Old Curiosity Shop*), in other cases it has quite a different purpose. Earlier in her work, Wood refers to the literary prevalence of hysteria among women as a feminine fear, a revealing of their secret, emotional selves that should be hidden from the world in an age which admires the virtue of self-control. Wood claims that

“[i]f verbal expression is impermissible for women, the narrative revealed by the body is the only one available... The fear that one’s emotional secrets might be read, or inadvertently given away, through body language, or worse, misread and misrepresented in the public domain, unsurprisingly led women to be ever vigilant of their bodies.” (36)

While the idea of a woman (or any person) losing control of their emotions in public, and possibly being misread and betrayed by their own body is a frightening one for the character, it could almost be considered a blessing for the author. While characters which fall into fits of emotion for no reason are considered effeminate and weak, such as Mr Fairlie and Thaddeus Sholto in *The Woman in White* and *The Sign of Four*, having a medical excuse such as brain fever legitimises the complaint, allowing the characters to be removed from the plot without suffering from any negative connotations. Forcing a character to succumb to brain fever allows the reader a glimpse of the affected character’s passionate, diligent and hard-working nature in a way that would have been considered socially acceptable at the time. As a medicalised complaint, to be overcome by your passions to the extent of suffering physical damage is almost an expected occurrence, as confirmed by its popularity as a plot device in the nineteenth century. Both Marian Halcombe in *The Woman in White* and Sherlock Holmes from Doyle’s series of short stories and novels fall victim to emotionally induced illnesses to interesting effect: for Marian, it is a chance for Collins to allow the

plans of the villainous Count Fosco to come to fruition without shaming her, whereas for Holmes, it is an excuse to place other people off-guard so that he may investigate suspects while confident that they are underestimating him.

After overhearing Count Fosco and Sir Percival outlining their plans to dispose of her half-sister Laura Fairlie for her inheritance money, Marian Halcombe falls into a sudden and lengthy illness that bears many similarities with brain fever, despite never being given the name. While it may be claimed that Marian's poor health is caused by her prolonged exposure to the rain rather than any mental anxiety, the text offers clear indications that her emotions play a key role in her illness. Her own account of the onset of the fever, beginning from when she came out of the rain and ending in unintelligible scribbles as her thoughts become more and more distracted, hints at a psychological cause rather than a physical. She continually references "the feverish strain and excitement of all [her] faculties", as her writing becoming "faster and faster, hotter and hotter", suggesting that her emotions are certainly, as Tweedie would suggest, a predisposing cause for her illness (*Woman* 356).

As well as emotional excitement, medical texts also put forward the theory that, particularly in women, brain fever could result from excessive study and the overuse of the mind (Peterson 454). In 1854, Mary Grove Nicholls reported a case where she had cured a young woman, a teacher of mathematics and music, when her excellent qualities of perseverance and energy made her succumb to a nearly fatal case of brain fever (Peterson 455). In general, ladies were considered to be more susceptible to this form of brain fever than men, a theory that was so accepted that Sophia De Morgan, (a woman instrumental in founding the Ladies' College of the University of London) believed these reports to the extent that she became "doubtful about the wisdom of higher education for girls [due to the fact that] hard work and examinations might bring on attacks of brain fever" (Tillotson 22, cited in Petersen 454). There are two reasons then, why a nineteenth-century reader would associate Marian's condition with brain fever: mental and physical exertion, and sudden emotional shock. In 1842, William England recorded a case of a man (anonymously referred to as Mr S--) who later died of a "fever caused by mental anxiety" (185). According to England and his associate Mr Weatherhead, the undetermined fever was caused by Mr S-- "being a witness to some peculiar circumstances connected with the indisposition of one of his neighbours, [after which] he evinced strong feelings of emotion, and being obliged to journey to London was overworked mentally and bodily" (185). Brain fever, then, was often thought to be caused by a combination of mental, emotional and physical exertion, all of which are certainly applicable factors in the case of Marian Halcombe.

Sir Arthur Conan Doyle's Sherlock Holmes stories provide a myriad of examples of brain fever: the unfortunate Percy Phelps in "The Naval Treaty" loses an important state document and is delirious for almost nine weeks; Alice Rucastle in "The Copper Beeches" falls ill from the combined stresses of being denied access to her lover and pressure from her father; Dolores Ferguson falls into a high fever as a result of "mental and nervous excitement" (865) after being accused of trying to kill her child in "The Sussex Vampire"; Rachel Howells, the maid who murdered her lover, suffers from a fit of brain fever in "The Musgrave Ritual"; Sarah Cushing suffers from "brain symptoms of great severity" (259) after her sister receives a pair of severed ears meant for her in "The Cardboard Box"; and Mrs Barclay, who, after witnessing her husband's stroke when confronted by her old lover, is rendered "temporarily insane from an acute attack of brain fever" (349) in "The Crooked Man". Added to this, there are a wealth of characters who suffer sudden and violent strokes in response to emotional and physical stress: Mr Trevor, the father of Holmes' university friend in "The Gloria Scott"; Colonel Barclay in "The Crooked Man"; and Major John Sholto in *The Sign of Four*. In each case, the symptoms and purpose are almost identical. Intense emotional stress renders the character exempt from further participation in the plot, providing a vehicle for the story and then considerably fading out to allow the protagonists to take over and finish the narrative without their interference. Witnesses to crimes such as Sarah Cushing, Mrs Barclay, Alice Rucastle and Rachel Howells are rendered incapable of giving evidence due to their lack of emotional control, and even male characters such as Percy Phelps are excused further involvement in their own stories due to the strength of their own emotions. Similarly to *The Woman in White*, emotionally induced illness is a valid, medical excuse from bowing out of your own story, and even Sherlock Holmes himself is not immune to the temptation. Much as the hypochondria of Thaddeus Sholto and Frederick Fairlie highlights their weak, effeminate natures and provides an excuse for their inactivity within the plot, the same technique is used with the brain fever of Holmes and Marian. For both protagonists, their illness is all but symptomatic of their depths of feeling and diligence, and forms an important function in the plot: removing Marian, and, contrarily, allowing Holmes greater freedom in solving his cases.

As Marian Halcombe's brain fever could almost be described as symptomatic of her diligent and passionate nature, much the same could be said of Holmes' own nervous illness. In the short story "The Reigate Squire", Watson is called to Holmes' sickbed after the detective has finally succeeded in solving a long and complicated case – one which has taken two months of fifteen hour days to complete (328). Watson finds him in a state where his "iron constitution ... had broken down under

the strain”, and caused Holmes to fall into a state of the “blackest depression” accompanied by an unshakeable “nervous prostration” (“Reigate” 328). Much like England’s own patient, Holmes’ symptoms are concurrent with that of Mr S--, who suffered from a combination of mental, physical and emotional strain leading to an ultimately fatal illness (England 185). Holmes’ nerves are “all in shreds” (“Reigate” 329), and Watson’s remedy is to remove his patient to the countryside, believing that “[his] friend would be much the better for a change” (“Reigate” 328). From Watson’s account, the most important aspect of Holmes’ symptoms is his depression, which remains unshaken despite the praise he receives from around the world regarding his success.

In much of this, Holmes’ illness bears many similarities to what Charlotte Brontë defines as ‘hypochondria’ in *Villette* (1853). Both the symptoms of depression and the prescribed cure of rest and a change of air could almost hint that the two illnesses were the same, were it not for the physical aspect of Holmes’ condition. Unlike Lucy Snowe, whose ailment springs from her isolation alone, Holmes’ illness is physical as well as mental, as he is ill in both body and mind and requires recuperation for an extended period rather than simply a change of air and company. Most importantly, Holmes’ depression springs from his illness, rather than the other way around. Indeed, depression was seen as an integral part of brain fever and its associated nervous delirium. According to Salter’s studies, two of the main aspects of such illnesses are “great nervous susceptibility and excitability, accompanied in some rare instances with a tendency to undue vascular action of the membranes or substance of the brain; and, secondly, an exhausted and depressed condition of the brain and nervous system, [of which the] latter is its *most characteristic feature*” (678, emphases added). While Lucy Snowe and even Jane Eyre confess to becoming ill because of their misery, Holmes’ depression comes from his illness and is completely unfounded – his room is “literally ankle-deep with congratulatory telegrams” and “Europe was ringing with his name”, but neither fact is able to shift his depressed mood (“Reigate” 328).

While Holmes’ original condition is perfectly genuine, his later symptoms are largely either exaggerated or feigned.⁷ While other characters become inactive due to their ailments, Holmes is the opposite, using his symptoms to further his goal by catching people off-guard. The medical nature of his complaint allows him to move freely in society without being censured as effeminate

⁷ While feigning illness is a commonly-used tactic for the detective in Doyle’s work (see “The Dying Detective” and “The Resident Patient”), “The Reigate Squire” is unique among these as the only time where Holmes is truly ill, and merely exaggerates the symptoms for his own purposes. While criminals often pretend to be invalids in an attempt to make themselves appear unthreatening or sympathetic (e.g. “The Resident Patient”, “The Man with the Twisted Lip”) Holmes in his capacity as a crime-solver uses the same trick here in a similar fashion.

or insane, a convention which he uses to great effect. In accordance with contemporary medical thinking, Holmes imitates what England would have undoubtedly described as “a rigor”, which was a common symptom of a brain fever relapse (England 185). At one point in his investigation, he attempts to stop a police investigator from revealing a vital piece of evidence to a suspect by mimicking the symptoms of such a nervous collapse. Watson describes the attack as a severe one:

“[Holmes’] face had suddenly assumed the most dreadful expression. His eyes rolled upwards, his features writhed in agony, and with a suppressed groan he dropped on his face upon the ground. Horrified at the suddenness and severity of the attack, we carried him into the kitchen, where he lay back in a large chair and breathed heavily for some minutes. Finally, with a shamefaced apology for his weakness, he rose once more.

“Watson would tell you that I have only just recovered from a severe illness,” he explained. “I am liable to these sudden nervous attacks.” (“Reigate” 334-335)

Although Holmes later confesses that these symptoms are in fact only imitations of a nervous breakdown, they are all medically accurate, to the extent that he is able to fool not only an Inspector of the police, but also Watson, who has been his attendant physician for the entire course of his illness. Watson even goes so far as to claim that the imitation was “speaking professionally ... admirably done” (“Reigate” 342), making it reasonable to assume that such symptoms were to be expected of a patient suffering from a clinical nervous ailment. Although Holmes does not go so far as to imitate the delirium which Marian Halcombe experiences, he does pretend to have his faculties impaired. In an attempt to get a sample of handwriting, Holmes deliberately writes the wrong time of murder on an advertisement, a mistake which Watson claims to be a sign that “his recent illness had shaken him ... he was still far from being himself” (“Reigate” 336). Although at this stage of the text Holmes’ symptoms have ceased to be genuine, the fact that both of his supposed slips can be blamed upon his illness to the extent that even his physician believes them to be “admirably done” proves the accuracy of Doyle’s interpretation. More than that, it is a useful tool for Holmes and a part of his strategy to catch people off-guard. While Marian’s illness is debilitating, Holmes can dramatize aspects of his own suffering to further his goals, much as (in the opposite way) Mr Fairlie uses his own illness to avoid social responsibility.

In terms of Marian Halcombe’s symptoms, Collins offers a list composed by Marian herself in the pages of her diary, as she struggles to complete her transcript of the night’s events while simultaneously being overcome by fever:

Why do I weary my hot eyes and my burning head by writing more? Why not lie down and rest myself, and try to quench the fever that consumes me, in sleep?

I dare not attempt it. A fear beyond all other fears has got possession of me. I am afraid of this heat that parches my skin. I am afraid of the creeping and throbbing that I feel in my head. If I lie down now, how do I know that I may have the sense and the strength to rise again? ... I am shivering again – shivering, from head to foot, in the summer air. Have I been sitting here asleep? I don't know what I have been doing.

Oh, my God! Am I going to be ill? (*Woman* 357-358)

In the space of a few paragraphs, Marian's writing becomes indecipherable, and she is discovered a few hours later by Mrs Michelson the housekeeper "walking about her room with a pen in her hand, quite light-headed, in a state of burning fever" (*Woman* 379). Later, after being confined to her bed, her symptoms change as she "wavered backwards and forwards between a sort of sleepy exhaustion, which was half faintness and half slumbering, and attacks of fever which brought with them more or less of wandering in her mind" (*Woman* 387-388). In terms of emotionally-induced brain fever, these symptoms, while vague, share many parallels with the contemporary medical accounts. Ten years prior to the publication of *The Woman in White*, Thomas Salter published an article comprised of a series of accounts called "Practical Observations on Delirium", wherein he described a case of a naval officer who suffered from a sudden attack of a "disordered mind" (680). In Salter's opinion, the illness was in part the result of "excitement operating upon a brain and nervous system, whose powers had been greatly depressed, and natural irritability much augmented, from the effect of a serious and somewhat lengthened attack of [typhus] fever" (680), which had passed by the time his delirium came into effect. The sailor's symptoms, much like Marian's, include both a raised temperature and delusions, as Salter describes his patient being "in a state of violent delirium, singing and praying alternately at the top of his voice, bathed in perspiration, and with a rapid but soft pulse" (679). Salter's patient was similarly unable to sleep, but was, much like Marian, completely cured following a prescribed course of emetics and opiates.

Interestingly, both Salter's naval officer's case and Marian's share another commonality: typhus fever. According to the consulting physicians, the greatest danger that can befall Marian during her illness is that the fever may "become infectious" – which it does – by turning into typhus fever (*Woman* 390-393). For a large part of the nineteenth century, the terms typhus fever and typhoid fever were all but interchangeable, the distinction that they were in fact two separate illnesses not

being made official until 1869 (Halliday 69). Typhus fever and typhoid fever were common afflictions – in the decade in which *The Woman in White* was written alone, 14,084 cases of typhoid fever were recorded in England and Wales (Halliday 58). This figure later dropped with the invention of the public bath and other health reforms, with only 29 cases of typhus and 5,591 of typhoid fever recorded by the end of the century (Halliday 58). Interestingly, typhus fever and brain fever were also closely related, and similarly considered to be almost interchangeable. In 1867, an article published in the *British Medical Journal* highlighted a number of terms which had been used to describe an outbreak of fever in Dublin. Referring to the work of Dr T.H Squire, an American physician, the article claimed that the medical terms “Congestive Fever, Pernicious Fever, *Typhus Potechialis*, Spotted Fever, Cerebro-Spinal Meningitis, and *Brain Fever*” (BMJ 1.37.1867 698, emphases added) were all to be considered equally valid diagnoses for the illness. In this way, typhus could be both a cause of brain fever, and something which brain fever later developed into. In his case of fever caused by mental anxiety, for example, William England expressed little hope for his patient’s recovery, noting from the start that “there was no little probability of typhus gravior being the effect of the primary lesion of the nervous system” (186). His prediction was later confirmed by the 26th day of the fever, when “for the first time, the tongue became dry, and of a reddish brown typhoid character” (England 186), confirming the presence of typhus. Concluding his report, England noted that while the mental anxiety in itself may not have been the outright cause of his patient’s death, his “attention [was] called to the mental origin of the fever, anxiety and emotional feeling acting as a predisposing, if not an exciting, cause” (186). It was not the emotional turmoil itself then, which caused the death of his patient in England’s opinion, but the mental anxiety that Mr S-- experienced that somehow made him susceptible to catching the fatal illness.

The concept of brain fever and emotional excitement being a predisposing cause for other, more serious illnesses such as Marian’s typhus was apparently readily received into the public consciousness. In Charlotte Brontë’s *Shirley* (1849), the concept is made clear that people do not die from heightened emotions, but by inherent medical problems that are worsened by the extreme emotional states brought about in the sufferer. When Caroline Helstone is abandoned by her lover, for instance, Brontë notes that

[Caroline] was now precisely in that state when, if her constitution had contained the seeds of consumption, decline or slow fever, those diseases would have been rapidly developed, and would soon have carried her quietly from the world. People never die of love or grief alone; though some die of inherent maladies, which the tortures of those passions

prematurely force into destructive action. (*Shirley* 191)

Similarly, Marian Halcombe's unknown fever "becomes infectious" and endangers her health by turning to typhus. It is not the force of her emotions which threaten to kill Marian, but a medically recognised illness that she is made susceptible to by her weakened emotional state. While the rain may have triggered Marian's fever as Count Fosco claims,⁸ it is unlikely that it would have been so serious had she not already been placed under physical and emotional strain from the preceding circumstances – listening to Count Fosco's plans to possibly murder her half-sister, and furiously, literally feverishly, recording the details of the exchange until reaching a state of mental exhaustion. It is not the brain fever in itself which is inherently dangerous, then, but the threat of the illness that it may turn into – in this case, typhus fever.

In her comprehensive article of the nineteenth-century treatment of brain fever in literature, Audrey Peterson is almost disparaging of contemporary authors' methods of dealing with the realism involved in the medical treatment of brain fever. Peterson's claim that "[t]he vision of those impeccably dressed ladies who sit by the bedside and allow no one else to assist in nursing the loved one does not correspond with the usual treatment, consisting of copious bleedings, purges, and emetics" (450) is not without truth. Nor is her amendment, that "[s]uch evasions are understandable, however, given the limitations imposed by public taste upon even the most realistic of nineteenth-century novelists" (450). However, while authors may be required to draw a veil over the exact nature of the happenings in the sick room, the hints that they drop indicate that many writers, and by implication their readers, knew exactly what details they were being denied. In the case of Marian Halcombe, the only indication supplied as to the nature of her treatment is given by Mrs Michelson, the widow of a clergyman and chief housekeeper of Blackwater Park. Her natural reticence toward describing intense medical details to a gentleman of Count Fosco's stature is certainly understandable, and the only comment that she makes on the topic is to say that "the treatment was of the kind described as 'saline' and that the symptoms, between the attacks of fever, were certainly those of increasing weakness and exhaustion" (*Woman* 383). This however, is more than sufficient to work from. In many cases of brain fever, the first step taken by physicians was to apply, as Peterson notes, purgative draughts. In the case of Mr S--, his first attending physician supplied him with "a purgative draught, with saline diaphoretic mixture" (*England* 185). Three

⁸ In a story where Collins is medically accurate in every other detail, from heart aneurisms to hypochondria, the advent of Marian's severe fever taking place not more than a few hours after her exposure to a heavy shower of rain is somewhat incongruous. It is likely, then, that Fosco is lying when he voices this theory to Mr Fairlie, as he is highly unlikely to admit the true reason why Marian may have succumbed to typhus through brain fever.

weeks later, after experiencing “a rigor” and feeling no better, England prescribed “mercurial and saline cathartics” with the intention of “evacuating the bowels” (England 185). The fact that Collins is able to allude (however indirectly) to the type of treatment Marian is undergoing hints at a knowledge of the correct sickroom procedures, despite no direct or disturbing references being made to the exact nature of the course taken.

The treatment of Marian’s illness also differs from the traditions of brain fever literature in one other way: the nature of her attendants. Traditionally in nineteenth century fiction, it is a lover, close friend or relative to whom the duty of caring for the sufferer falls. In Charles Dickens’ *Great Expectations* (1860), for example, it is Pip’s father figure and brother substitute, Joe Gargery, whereas Richard Swiveller is placed under the sole care of the diminutive Marchioness in *The Old Curiosity Shop* (1840), a woman whom he later marries.⁹ Ruth insists on caring for her beloved Mr Bellingham in Elizabeth Gaskell’s *Ruth* (1853), and Percy Phelps’ betrothed Miss Harrison tirelessly cares for his wellbeing in Doyle’s “The Naval Treaty”, both prime examples of the “impeccably dressed ladies” of which Peterson is so dismissive. For Marian Halcombe, however, this is not the case. While Laura Fairlie, Marian’s affectionate half-sister, is determined that “nothing will induce [her] to lose sight of [Marian]” (*Woman* 385) she is generally considered to be an incompetent nurse. Mrs Michelson describes her often affectionate conduct as being “[s]carcely a judicious proceeding in a sick-room, with a patient whom it was highly desirable not to excite. But Poor Lady Glyde [Laura Fairlie] knew nothing of nursing – nothing whatever I am sorry to say” (*Woman* 385). Indeed, the only contribution which Laura makes to her sister’s recovery is causing Mrs Michelson to fear that she will have “every apparent chance ... of having Lady Glyde to nurse next” (*Woman* 383). Interestingly, this is also a distinct possibility – in his treatise on brain fever, Tweedie claimed that the “long, continued watching of a sick-bed” was a prime example of a predisposing cause for brain fever, as well as “fear, anxiety and disappointments”, to all of which Laura, with her naturally nervous temperament, is prone (189-190 cited in Peterson 448).

Laura Fairlie is by all accounts a terribly ineffectual nurse: she is not present when Marian’s condition worsens by becoming infectious, and even fails to notice the change as she lies “completely overpowered by exhaustion, on the sofa in the sitting room” (*Woman* 390). Instead, Marian is placed in the care of firstly Mrs Michelson, and later Mrs Rubelle, a nurse of Count Fosco’s choosing, who is nonetheless medically qualified and approved of by Marian’s physician.

⁹ The phenomenon of illness as a levelling agent between classes, and the function of the care of the companion as a force to make the hero realise their true worth shall be discussed in a later chapter, in reference to both of these texts.

While realistic, Collins' choice of nurse has further implications on the plot of the novel. Marian's illness, with its deliriums and ravings, places her in a very vulnerable position, forced to be watched day and night by nurses and attendants. For Count Fosco and Sir Percival, it gives them both the chance to keep a close watch over Marian's activities while she is vulnerable and unable to protect her half-sister. While Mrs Rubelle, whose husband is a close associate of Count Fosco's, is technically qualified to care for Marian, she is also equally qualified to spy on her, and the removal of Laura Fairlie to be replaced by Mrs Rubelle adds an element of danger to the plot where it would otherwise have been comforting, as the protector finally becomes the protected with Laura caring for Marian.

While Doyle's depictions could be considered less medically accurate on the subject of nurses, this is not entirely the case. Although an account of exactly who is caring for the afflicted person is not always given, when the details are provided, they are usually realistic. Many of Doyle's brain fever victims are placed in hospitals, such as the unfortunate Mrs Barclay in "The Crooked Man", and in many more cases complete isolation is prescribed, to the extent that not even Holmes is not allowed to interview them, providing further frustration for the plot as witnesses are unable to be questioned. In two cases where such information about who is nursing the afflicted is given, however, the facts appear to be as medically accurate as Collins'. Holmes, for example, is nursed through his own nervous prostration by Watson, who, as well as simply being his friend, is also a qualified medical practitioner in his own right, a neat combination of both trusted friend and physician. Interestingly, while Holmes often calls on more qualified surgeons to cure him when his condition is serious, such as in "The Devil's Foot" wherein he seeks the advice of a Harley Street specialist in order to avoid a breakdown similar to that which he experiences in "The Reigate Squire", his illness in the latter adventure is handled exclusively by Dr. Watson. By doing so, Doyle combines both the medically accurate with the sentimental, as Watson fulfils the roles of both close friend and medical practitioner, allowing Doyle to send Holmes to various locations outside of London "for his health", such as Cornwall and Surrey, with Watson to act as both ever-present doctor and chronicler.

While this may be seen as Doyle simply continuing the classic, somewhat romanticised tradition which Peterson speaks of, there are times when, much like Collins, the presence of a medical practitioner advances the plot. In "The Naval Treaty", the afflicted Percy Phelps' fiancé, Miss Harrison is given sole credit for nursing Percy Phelps "hand and foot these two months back" (391) by her brother, providing the image of the well-dressed young woman tending her beloved which Peterson claims to be medically inaccurate. However, Phelps later reveals that there is in fact a

qualified nurse in the house, who shares a room with him at nights in case his condition worsens ("Treaty" 406). In this case, having the nurse present is not only a medically accurate detail and an observance of the proprieties of society (as it would be unfitting for Phelps' fiancé to share a room with him at night), but also invaluable to the plot. The titular missing treaty has in fact been stolen by Miss Harrison's brother, and hidden in Phelps' room (which, until the advent of Phelps' fever, had belonged to Harrison). Phelps' illness, coming on suddenly and taking over two months to heal, prevents Harrison from gaining access to the room to retrieve and sell the treaty as he intended. While Phelps himself is not too much of an obstacle to overcome in his weakened state, the presence of his sister during the day and the trained nurse at night make it impossible for Harrison to enter the room in secret. While Peterson argues that Phelps' brain fever is invaluable to Doyle's plot due to its "duration of time [and] abrupt onset following emotional shock" (460), the presence of the nurse is equally useful, as it provides a situation wherein "there were always at least two [people] there to prevent [Harrison] from regaining his treasure" ("Treaty" 413). Both Collins and Doyle, then, use the role of the ever-present surveilling nurse in the same capacity, but with different effect. For Doyle, the nurse is a protective figure, both against Phelps' 'mad fits' and his murderous brother-in-law, whereas Collins uses the same figure to far more sinister effect.

Unlike Marian Halcombe, whose brain fever is brought about by her hard work and shocked protective instincts, many females in nineteenth-century fiction suffer from brain fever and madness due to disappointed or thwarted love. Catherine Linton of *Wuthering Heights*, for example, falls into such a fever when asked by her husband to choose between himself and Heathcliff (Peterson 451), and Caroline Helstone nearly does the same when separated from her own lover in *Shirley* (Wood 35). Marian's character, however, is quite different from that of the traditional female. As the main protagonist for much of the novel, Marian takes on the role as her sister's protector, and as such, is an incredibly masculine character. Like her effeminate Uncle, Mr Fairlie, Marian is almost androgynous, and certainly sexless: she, like Mr Fairlie, has no aspirations of marriage, desiring nothing more than to stay with Laura and Walter for the rest of her life (*Woman* 641). Even her enemies claim that she "has the foresight and resolution of a man" (*Woman* 346), and her physical appearance reflects this. The first introduction the reader is given to Marian is through Walter Hartright, just prior to being introduced to Mr Fairlie for the first time. The juxtaposition between the effeminate man and the masculine woman of the house is clearly intentional. Much like Mr Fairlie with his appearance suggestive of "something singularly and unpleasantly delicate in its association with a man ... which could by no possibility have looked natural and appropriate if it had been transferred to the personal appearance of a woman" (*Woman* 66), Marian Halcombe is

similarly caught in her physical appearance between two genders. Hartright first sees her with her face averted, and notes that she has an attractive, womanly shape. When she turns around, however, he quickly revises his opinion:

The lady's complexion was almost swarthy, and the dark down on her upper lip was almost a moustache. She had a large, firm masculine mouth and jaw; prominent, piercing resolute brown eyes; and thick, coal black hair, growing unusually low down on her forehead ... altogether wanting in those feminine attractions of gentleness and pliability ... to be charmed by the modest graces of action through which the symmetrical limbs betrayed their beauty when they moved, and then to be almost repelled by the masculine form and masculine look of the features in which the perfectly shaped figure ended – was to feel a sensation akin to... helpless discomfort. (*Woman* 58-59)

The rest of Marian's characteristics continue in much the same vein. While Laura Fairlie is a beautiful, gentle, competent musician and artist, Marian is instead accomplished in the more masculine pastimes of cards and billiards, albeit with self-confessed "feminine drawbacks" (*Woman* 61). She speaks negatively of her own gender, admitting that "I don't think much of my own sex" (*Woman* 60) upon her first meeting with Mr Hartright, and continually disparages female conversation, abilities and lack of emotional control. When she cries, it is to shed "miserable, weak women's tears of vexation and rage" (*Woman* 203), which are further denounced by her claims that "it is my weakness that cries, not *me*" (*Woman* 454). For Marian, loss of emotional control is an essentially feminine characteristic and a sign of inherent weakness, no matter what the circumstances may be. This is a view which the novel itself shares as a whole. As discussed previously, Walter Hartright's masculinity is confirmed by his ability to control his emotions "like a man" (*Woman* 96), whereas Mr Fairlie's lack of control marks him, in Hartright's eyes, as essentially feminine (*Woman* 66). In light of this, madness in general and its association with loss of control can be read within the novel as an essentially feminine complaint. In terms of Marian's brain fever, then, this is an awkward realisation. Her fever, which causes "wandering in the mind" and delirium, is the antithesis of the ordered control indicated by her scrupulous diary records, which even Count Fosco admires as showing her "wonderful power of memory" and a testament to her skill for "the accurate observation of character" (*Woman* 358). This dedication to meticulous fact in many ways makes Marian similar to Holmes, who likewise prides himself on his faculties of observation and memory. Again, these faculties are also undermined when Holmes imitates the symptoms of brain fever, particularly when he makes such mistakes as writing down the wrong time

of death in a murder investigation.

Marian is not the only person within her novel to suffer (albeit briefly) from a form of madness. Indeed, throughout the text, it could almost be described as an inherited characteristic of the Fairlie family. Anne Catherick, the illegitimate daughter of the elder Mr Fairlie, is placed in a mental asylum, whereas Mr Frederick Fairlie is a confirmed and effeminate hypochondriac. Even Laura Fairlie suffers from mental instability to a certain extent, becoming fragile and insensible after being freed from her unjust confinement in the same mental asylum that once held Anne Catherick, her half-sister. However, while such loss of control may be frowned upon in a masculine character (as is the case with Mr Fairlie), having a medical reason for such behaviour changes the associated stigma. In his work, Salter clearly defines the difference between delirium, or medically induced insanity, and mania, which is an inherent loss of control, and socially unacceptable:

Maniacal insanity may sometimes be confounded with true delirium, but the circumstance of the former being a chronic disease, taken together with the history of the case, will ordinarily be a sufficient distinction ... Delirium and insanity may sometimes be confounded; still in most cases the distinctive signs are sufficiently well marked. The insane patient generally retains all his senses as well as the powers of digestion and locomotion; his faculties are perverted, but not extinguished, and the error of mind in the insane is frequently limited to a single faculty. Delirium is generally associated with much well-marked bodily disease, whilst insanity is often attended with apparently unimpaired health; moreover, delirium is in the majority of instances, an acute, and insanity a chronic affection. (677-678)

As opposed to true, inherent insanity, then, delirium caused through a physical, medicalised complaint such as brain fever does not have the same social stigma attached to it as madness did. Even Percy Phelps is clear to make the distinction that, even when caught up in the grip of brain fever, his actions are only that of “*practically* a raving maniac” (“Treaty” 397, emphasis added) – the precise nature of his illness apparently makes all the difference. In this way, both Holmes and Marian are able to avoid the social stigma of what was medically termed ‘mania’ through the presence of their illness (in one case genuine and in the other exaggerated), which separates them both from this class. While Marian is bedridden and insensible (much like Laura Fairlie later becomes), she is not rendered effeminate, merely ill, and retains the respect of her main antagonist Count Fosco. Holmes also, while acting as if he is under much mental strain (and often inexplicably,

such as disappearing at crime scenes and falling into fits of what Salter would term “nervous rigors”), never arouses anything but sympathy in his observers. Watson and his other friends feel ‘sympathetic’ shame, but are not themselves ashamed of his actions, which would otherwise be frowned upon. Mr. Fairlie and Thaddeus Sholto for instance, who also suffer from their nerves being “all in shreds” (“Reigate” 329) are rendered effeminate, whereas Holmes is not. The difference here is that Holmes’ delirium is supposedly brought about by overstretched nerves, but is medically treatable and can be explained away as such. Brain fever induced mania, then, even for men, is able to be tolerated if there is a medical cause, and not merely a symptom of an effeminate or weak personality.

Not only men, but women also can have mania explained and made socially acceptable by the onset of brain fever. In Doyle’s short story “The Copper Beeches” (1892), Alice Rucastle is struck down by brain fever after being harassed by her father to both sign over her inheritance money to him, and to cease seeing her lover. Although the story is clearly a traditional detective narrative, with Holmes accepting a case from a client where she asks him to explain the strange circumstances surrounding her employment, the story has clear Gothic overtones, particularly in the treatment of Alice Rucastle. In a genre wherein “the mind and the senses falter and fail, and the passions overwhelm” (Tracy 3), insanity and madness are a key feature in the classic Gothic story. In her comprehensive list of Gothic plot devices, Ann B. Tracy records an astonishing 68 stories which contain emotionally induced illness, and 58 which involve emotionally induced deaths (198-201). While perhaps not described as brain fever in a medical sense, the idea of strong emotions causing a physical illness, and even a fatal one, is certainly a view which nineteenth-century medical professionals took on the illness, and also a key Gothic motif. Emotionally induced madness, such as that which (according to many critics) influences the unnamed governess in *The Turn of the Screw* (1898) is a common trait, and one which Gothic writers used extensively during the eighteenth and nineteenth centuries (Wolff 1).

Taking this into account, “The Copper Beeches” can easily be read as a quintessential Gothic tale: a young woman, Miss Violet Hunter, who is an orphan with no family to advise her, is approached by a man who wishes to hire her as a governess. The pay is more than adequate, but the condition that she cuts her unusually coloured hair “quite short” before she arrives makes her uneasy. However, the money proves too great a temptation, and she takes the position in an isolated country house caring for a young boy whose rather alarming pastimes including killing cockroaches and tormenting small animals. Aside from cutting her hair, her new employers also require her to, on

certain mornings, sit in a particular window and wear a particular blue dress, which shows signs of having been worn before despite fitting her perfectly. Another shock is given to her when she discovers, in the locked drawer of her dresser, a discarded coil of hair identical to her own, which she was forced to cut off when she took the position. The house itself is rundown, “all stained and streaked with damp and bad weather” (“Beeches” 214), with a wing which the young heroine is forbidden to enter. When Miss Hunter does enter it, she sees a shadow moving behind the locked door, and runs in terror as her “overstrung nerves must have failed her” (“Beeches” 219). Upon exiting the forbidden wing, she meets the owner of the house, who threatens that if she ever enters the rooms again, she will be thrown to the mastiff, a massive, uncontrollable dog which roams the grounds at night to catch intruders. In the end, the heroine discovers that she has been the unwitting double of her employer’s daughter, a young woman named Alice Rucastle, who has been driven insane through her father’s refusal to allow her to marry her beloved and his continued insistence that she sign her inheritance over to him and his new wife. The story is filled with Gothic motifs: dark, old houses, powerful men who exercise control over their families, the doubling of two innocent young girls, massive uncontrollable dogs, forbidden rooms, locked chests, and madwomen imprisoned in attics. The casting of a young heroine who fits Tracy’s model of a person “stumbling alone, sometimes in foreign countries, through appalling complexities of decision and action, obliged to find their own solutions or go under; [estranged] from all family ties” (5) only adds to this, creating a story that is clearly meant to be read as a Gothic. Although not set in a traditionally Gothic country (which traditionally take place in foreign, European countries such as Italy), Doyle even takes care to transform the safe English countryside into a darker setting, by having the usually unemotional Holmes comment on the horrific nature of the area. In an unsettling move, Holmes claims that “[y]ou look at these scattered houses and are impressed by their beauty. I look at them, and the only thought which comes to my mind is a feeling of their isolation, and of the impunity with which crime may be committed there ... They always fill me with a certain horror” (“Beeches” 213). The reader is encouraged, then, not to read this as simply a sensation tale or mystery, but to remember the genre’s predecessor: the Gothic novel.

More than that, the plot shares many Gothic elements with another literary predecessor, Charlotte Brontë’s *Jane Eyre*. Both stories feature governesses working for powerful male employers, who end up doubling for imprisoned ‘madwomen’ that the employer has locked away from sight. In both stories, the governess unknowingly supplants their position in a courtship plot (although Violet Hunter never actually meets the man she is unknowingly fooling, whereas Jane is an active participant in the romance between herself and Mr. Rochester). In this way, Alice Rucastle can be

read almost as a double for the woman Jane herself is unwittingly supplanting, Bertha Mason. Both Alice and Bertha are women who suffer from some form of insanity, and are locked away from sight – one intentionally abandoned by their husband, and the other kept hidden from her unknowing lover. However, while Bertha Mason's insanity is hereditary, with her mother "shut up in a lunatic asylum", her younger brother "a complete dumb idiot" and possessing an elder brother who "will probably be in the same state one day" (*Jane Eyre* 368), Alice Rucastle's is not. Brought about by the mistreatment caused by her father, Alice's brain fever and its associated insanity and infirmity are not symptomatic of mania, but of medically explicable delirium, with an associated treatment. According to the housekeeper, Alice's father "kept on worrying her until she got brain fever, and for six weeks was at death's door. Then she got better at last, all worn to a shadow, with her beautiful hair cut off" ("Beeches" 223), causing her to be locked in an attic, away from the sight of her fiancé and any other influences. Interestingly, Alice Rucastle is never actually seen in the text, functioning almost as a ghost-like figure and unseen double, much as Bertha Mason is first only glimpsed by Jane in a "goblin shape" in the middle of the night, and heard through her insane laughter. Despite the obvious parallels, the reader is never encouraged to feel anything but sympathy towards Alice Rucastle. While Mr. Rochester is arguably justified in keeping his wife imprisoned, Mr. Rucastle clearly is not, as Alice is not dangerously deranged, but merely ill and recovering.

Perhaps the most classically horrific moment of "The Copper Beeches" is the discovery of Alice Rucastle's discarded hair, which is identical to Miss Hunter's own, locked in the bottom of an old chest. While providing a chilling moment for Miss Hunter, the finder of the hair and Alice's double in appearance, the moment is also both medically explicable and accurate. In cases of brain fever, bleedings and the application of leeches were considered a normal part of the emetic treatments. In the case of Salter's naval officer, for example, he recommended that "ten leeches were to be applied to the temples, a blister to the back of the neck, and a cold lotion to the head" (680). In order to have the best possible access to the affected organ (the brain), medical specialists such as John Mason Good claimed that the head of the sufferer ought to be shaved immediately, to better accommodate the application of leeches, blisters and cooling lotions (Peterson 460). More so even than Holmes and Phelps, Alice Rucastle's brain fever is highly medicalised, with specific treatments alluded to that make her delirium not simply the sign of a dangerous insanity, but of medical suffering. Alice's hair has multiple purposes: it is medically accurate and chilling, a vital clue that Holmes uses to determine Rucastle's plan which also provides a scare for both Violet Hunter and the reader.

Brain fever could almost be described as the ideal illness for nineteenth-century writers. It strikes quickly and cripplingly, and is inextricably linked with sudden emotional shocks, providing both an excuse for a character to be gracefully removed from the plot and a touch of drama to an emotional revelation. While it could almost be considered akin to an emotional breakdown or sign of weakness, the medically recognisable traits of brain fever are capable of removing this stigma. Masculine characters are not rendered feminine through such an emotional breakdown if it is medicalised – only if it has no physical cause. In this way, strong characters such as Marian Halcombe can be removed from the plot with dignity. Holmes is slightly different, able to use his illness to further his cause, but only because his illness is considered socially acceptable in a man; a medical, not emotional complaint despite its links with “sudden emotional shocks”. Even the Gothic tradition is subtly altered by the transition to sensation and detective fiction, as the madwoman in the attic becomes medicalised, an object of pity rather than fright. Alice Rucastle is in many ways a descendant of Bertha Mason, albeit a sympathetic one, but people suffering from delirium are no longer feared when their condition is medicalised and explained away, and can attribute the same effects to the plot – the mysterious woman locked in the attic, far from an object of fear, is now simply a mystery to be solved so that she can be freed. Similarly, the effeminate hypochondriac is no substitute for the brain-fever struck masculine hero, who has physical symptoms to justify their emotional weaknesses. Their deliriums are neither to be feared or seen as a sign of weakness, and through catalogues of physical symptoms and the approval of physicians, brain fever becomes something that is not feared or shameful, but almost symptomatic of the character’s personality. For Alice Rucastle, it is a symptom of her enduring love and strong will, whereas for Holmes and Marian it is almost literally a reaction to their diligence and (certainly in Marian’s case) passionate protectiveness. While characters cannot voice their opinions and thoughts freely due to Victorian censures placed on displays of high feeling, brain fever is a useful tool to get around this stigma. As a medically recognised illness, it sets in quickly, forces a character to be inactive, and is a socially acceptable way of revealing a character’s true feelings.

Curing Criminality

Redemptive Fevers in Charles Dickens' *Great Expectations* and *The Old Curiosity Shop*

When Kit Nubbles is placed under arrest in Charles Dickens' *The Old Curiosity Shop* (1840), the turnkey guarding him is comically unable to comprehend the despair of his friends and relations. In a brilliant turn of phrase, Dickens explains that the jailer was not cold-hearted, but instead "had come to look upon felony as a kind of disorder, like the scarlet fever or erysipelas: some people had it – some hadn't – just as it might be" (*Curiosity* 446). The idea of crime and physiological disorders being somehow connected is one which resonates through a number of Dickens' works, particularly as a motif embodied in characters who have evil intentions: Daniel Quilp for example, who is often described as a demon, is physically impaired in *The Old Curiosity Shop*, whereas Monks, the main antagonist for the earlier *Oliver Twist* (1839) is an epileptic. While not all ill characters are evil – one could certainly not ascribe that trait to the saintly Little Nell, for instance – there is nevertheless a strange link between wrongdoing and disease permeating Dickens' work. While it is easy enough to read Quilp and Monks' physical deviations as outward symbols of their inner defects, other cases are more difficult to decipher. While many cases of this phenomenon in Dickens' work can be explained away by the difference between being born with an illness such as dwarfism or epilepsy which somehow hint that evil is inherent within the character from birth, and being afflicted with an illness through innocent means, there are cases when illness has an entirely different effect. Illness, it seems, can also have the function of rehabilitating the not-so-terribly bad. In both *The Old Curiosity Shop* and *Great Expectations* (1860), principal characters are struck down by brain fever at crucial points in their own stories, only to emerge reborn from their delirium several pages later as wiser, more moral figures. Both Richard "Dick" Swiveller of *The Old Curiosity Shop* and Pip, the protagonist of *Great Expectations* fall victim to a form of brain fever which is not only medically accurate but also heavily symbolic, as through their slow process of recovery they are able to cut ties with the immoral behaviours that have harmed them in their pasts.¹⁰

As an author, Dickens was no stranger to the workings of illness. The sudden fever and death of his sister-in-law, Mary Hogarth, had a profound effect upon his writing, inspiring both the tragic fate of Little Nell and the illness of Rose Maylie (*Oliver Twist*), two of Dickens' most angelically ill

¹⁰ While no discussion of medical matters in *Great Expectations* should be complete without a mention of the injury and resulting mental confusion suffered by Mrs Joe Gargery, her case has not been included here. While medically accurate, Brain argues that her injuries are physical rather than nervous, and have been diagnosed by physicians as a perfect example of a focal contusion of the brain rather than a 'brain fever' as is discussed here (1553).

heroines. In the nineteenth century, an article in the *British Medical Journal* published in 1892 may have derided his portrayal of death by spontaneous combustion in *Bleak House*, (BMJ 1892:32) but more recent criticism has found his portrayals of more recognisable ailments to be more than satisfactory. Sir Russell Brain, writing in the same journal in 1955, claimed that

[Dickens] was not content with vague diagnoses like brain fever, which figure in the works of some of his contemporaries, and even of those who wrote much later. Dickens looked on disease with the observing eye of the expert clinician, and he recorded what he saw, and what the patient told him, so that he often gives us accounts which would do credit to a trained physician. (1553)

While Brain is correct that Dickens never actually uses the term ‘brain fever’ to describe the illnesses of either Pip or Swiveller, both do suffer from an ailment perpetuated by emotional and mental strain, characterised by fever, delirium and sleeplessness which a nineteenth-century physician would easily have diagnosed as brain fever (Peterson 454). What is more interesting though, is the way in which both characters contract the illness, and how Dickens uses the affliction as a device to not only aid the plot, but also complete the personal journeys of both Swiveller and Pip. While both characters are essentially good, they nevertheless are heavily involved in the criminal world. For Pip, criminality forms the basis of his identity, as he obtains the means by which to become a gentleman through the convict Magwitch, and one of the defining moments of his childhood involves the stealing of food from his sister in order to aid the criminal in his escape. Swiveller is much less innocently involved: he swindles food from eating houses and refuses to pay bills, living a carefree existence which belies the worry and despair he feels for his squalid state of living. He is also heavily involved in the schemes of Sally and Sampson Brass and their leader, Daniel Quilp, however unwittingly, and is forced into serious crime through their actions which nearly result in the disgrace and transportation of an innocent man. As Peterson argues, Pip and Swiveller’s redemption from these less than ideal circumstances comes in the form of brain fever, which acts as a symbolic rebirth, purging them of their previous associations with crime and guilt and allowing them to reach a new phase of maturity (454).

As a recognised comic character in *The Old Curiosity Shop*, Richard Swiveller’s brain fever is often considered by critics in a humorous context. Audrey C. Peterson claims that the moment of crisis occurs when “the absurd machinations of Dick Swiveller appropriately cause him to fall ill. The ‘spiritual excitement of the last fortnight’ proves too much for him; he is stricken with a raging

fever, accompanied by a 'distempered brain,' and has no recollection for three weeks" (461-462). While Peterson's diagnosis of brain fever in this instance is essentially correct, the cause is far more serious than her flippant reading suggests. From the beginning of the text, Swiveller as a character is heavily involved in victimless crime: he orders food that he does not pay for, and is certainly both heavily and cheerfully in debt. While being in debt may not have been seen as a serious crime in Swiveller's time, his methods of cheating the various eating houses and clothiers that he is indebted to could at best be described as morally dubious, and at worst highlight the beginnings of criminal tendencies including lying and theft. However, it is only when he becomes involved in the criminal proceedings of Kit's trial later in the story that Swiveller is truly affected by the criminal world. In the course of the legal proceedings, Swiveller is forced to come to terms with the fact that Kit's assertions of his employers' guilt may be correct, and for the first time begins to "half suspect his affable employer of some deep villainy" (*Curiosity* 462). More than that, Swiveller has also witnessed his own words being twisted to ensure Kit's imprisonment in open court, and has become party to the plot against someone whom he believes to be of good character. Taking this into account, his feelings of being "big with grand designs for the comforting of Kit's mother and the aid of Kit himself" (*Curiosity* 464) are quite understandable, as he sees himself as an unwitting part of a plot to wrong an innocent man. It is this determination, to somehow undo the wrongs he has helped perpetrate against Kit, which appear to trigger his brain fever:

But the lives of gentlemen devoted to such pleasures as Richard Swiveller are extremely precarious. The spiritual excitement of the past fortnight, working upon a system affected in no slight degree by the spirituous excitement of some years, proved a little too much for him. That very night, Mr Richard was seized with an alarming illness. (*Curiosity* 464)

While both physicians and writers in the nineteenth century often describe "brain fever" as an illness which strikes suddenly and with debilitating effects, this was not always the case. According to nineteenth-century physician John Mason Good, brain fever was often less of a response to a sudden and unexpected shock (such as Percy Phelps and Marian Halcombe experience), but could develop gradually over a period of time (Peterson 447). In cases such as this, gentlemen such as Richard Swiveller were often seen to be far more susceptible to such an illness. As far back as the eighteenth century, medical writers believed that the privileged lifestyles of the upper classes made them more likely to suffer from nervous attacks. According to the physician Thomas Trotter, the sedentary and gluttonous habits associated with the gentry made their mental faculties more prone to retaining disturbing images or memories, thereby dwelling on them to the extent that any one

shocking event could later disrupt the impressions already embedded in their minds and cause a complete nervous collapse (Engelhardt 147). In Swiveller's case, this certainly appears to be the form which Dickens is imitating. It is not simply the event of Kit's trial which causes his fever, but the events of several years before this, which reach back further than the book relates. Swiveller's involvements in morally dubious acts, if not crime, are many, and often written humorously: the list of streets that he cannot walk down during hours of business because of the debts he owes the shopkeepers, the various schemes Trent has attempted to involve him in that have not worked out and his ill-treatment and final loss of Sophy Wackles, all add to a list of misdemeanours which culminates in his first involvement in actual crime.

Despite this, great pains are taken to show that Swiveller is not at heart a bad person: he cares enough for the future of Sophy Wackles that, even when in love with her, wishes to leave her with enough of a chance to gain another husband; he tries to convince Kit to run away from Brass when they are escorting him back to the office under suspicion of theft; and even attempts to supply Kit with comforts during his wrongful incarceration. As a gentleman with a naturally imaginative nature, finally finding himself in the centre of a conspiracy and seeing, for perhaps the first time, the consequences and misery associated with the criminal world that he has become a part of is the final piece of "spiritual excitement" (*Curiosity* 464) which catalyses his illness. His determination to aid both Kit and Mrs Nubbles after viewing for himself their misery in the jail, and finally suspecting his and his employers' own part in it, is enough to send Swiveller into his redemptive fever.

Unlike Dick Swiveller, whose brain fever is a sudden shock to both himself and the reader as events catch up with him, Pip's illness in *Great Expectations* is seeded long before it finally eventuates. The first hint the reader is given as to the possibility of his becoming ill strikes the day before Magwitch's escape. The "mental wear and tear" (*Expectations* 443) provided by Pip's confrontation with Orlick, wherein he nearly loses his life, combined with his terror of the task of aiding Magwitch renders him into a state by which "my [Pip's] burning arm throbbed, and my burning head throbbed, and I fancied I was beginning to wander ... I would say to myself with a start, 'Now it has come, and I am turning delirious!'" (*Expectations* 443-444). While the sudden shock of being captured, injured and nearly killed by Orlick, compounded with the effects of the "unnatural strain" (*Expectations* 443) which Pip is placed under by the looming event of Magwitch's escape would be more than enough to qualify an attack of brain fever from a medical viewpoint, the added factor of Pip's prior injuries (both from saving Miss Havisham and his confrontation with Orlick) is an interesting one. In one of Salter's case studies of delirium, he recounts the tale of a medical student

of a passionate disposition similar to Pip's, characterised in this case by the assertion that he was "addicted to hard study" (Salter 680). Upon receiving an abscessed wound to the foot, the patient became both restless and delirious, and was unable to be calmed by any of the usual methods of treating brain fever – bleeding, purging and applications of cold cloths to the head (Salter 680). While brain fever is primarily an affliction to the mind, it appears that physically stress and pain were also medically recognised as contributing causes for the ailment.

Similarly, it is a combination of mental stress and physical pain which causes Pip to fear that he will become delirious, and for a time to experience similar difficulties in sleeping. Throughout this near illness, Pip also exhibits several other symptoms which would be considered symptomatic to the advent of an hysteric or nervous fever. He experiences difficulties in telling how much time has passed, and fears, similarly to those of Jane Eyre, that his nervous state has granted him precognitive abilities, giving him the knowledge that "[Magwitch] was taken; that there was something more upon my mind than a fear or a presentiment; that the fact had occurred and that I had a mysterious knowledge of it" (*Expectations* 443). In Dickens' time, readers may well have expected Pip's precognitive or perhaps telepathic abilities to be correct, as a precedent was set for this kind of behaviour associated with nervous sensibility both in fiction and reality. The titular protagonist of *Jane Eyre* (1847) and Lucy Snowe of *Villette* (1853) both fall prey to (or appear to suffer from) nervous visions, as does Marian Halcombe in *The Woman in White* (1860), written by Dickens' friend and contemporary Wilkie Collins. However, Pip does not fall into this category, and his nervous condition excites not precognition, but only further anxiety on his part, and even that of the reader, who may well expect his delirium-altered thoughts to be correct. It could even be argued that Pip's certainty that their cause is lost is perhaps a foreshadowing of later events in the book – that Magwitch is destined, from this moment, to be caught through the machinations of Compeyson, or maybe that Pip has somehow gained clairvoyant knowledge of Compeyson's informing the police at the exact moment it happened. Dickens does not elaborate further upon this point, however, and Pip's fever, while introspectively enlightening, functions only as a means of heightening tension for the reader, and not, apparently, adding to the plot.

With this prelude to fever, then, Dickens completely subverts his readers' expectations. Not only does Pip's mysterious knowledge of Magwitch's capture prove false, but his fever in the end amounts to nothing. His fears of illness preventing him from aiding the convict's escape would be considered a legitimate concern in almost any other novel of the period. For example, Wilkie Collins' *Woman in White*, the immediate predecessor of *Great Expectations* in Dickens' magazine

All The Year Round, features Marian Halcombe's delirium serving this exact purpose. After hearing of Count Fosco's machinations regarding her half-sister's fortune, Marian fears that she will become "ill, at such a time as this!" (*Woman* 356) and therefore be rendered unable to assist Laura Fairlie in escaping his plans. This eventuality does arise, and as a consequence, Laura is severely wronged by the Count. However, this is not the case with Pip. While the reader may be encouraged to expect such an occurrence, it never eventuates, and Pip is able to force back the illness and continue on his course of action.

While providing tension for the reader, Pip's ability to set aside his brain fever and focus on the task at hand is also a clear indication of his changing character. While brain fever was a convenient and not unmasculine way of removing an important actor from the plot, having Pip master his own nerves (with the aid of his friends' care) places him in a strong position in the eyes of the reader. His passionate nature and the terrible stress that his faculties are forced to endure are clearly highlighted through his fears of becoming delirious, as the chief cause for his concerns revolve not around his own wellbeing, but that of Magwitch. The level of his caring is one of the key aspects which cause his fever, illustrating to the reader not only the precarious situation Pip is in, but also the way that he has developed as a person. Through his suffering, Pip is finally beginning to rid himself of his selfish affectations that render him a 'gentleman' and becoming once again the young Pip who came into his identity helping an escaped convict on the marshes of his home. Indelibly tied to his fever, Pip's return to his childhood state of innocence and 'true' identity is a process which begins here, but does not fully eventuate, as Pip forces himself to recover through strength of will to continue his duty to Magwitch. Much as Sherlock Holmes claims to be cured of his own brain fever by work ("Reigate" 344), Pip's ability to push aside his nervous illness also hints at his inner strength of character. While there is no shame in having brain fever in the Victorian literary tradition, overcoming it adds an entirely different level of prestige to a character's mental and physical strength.

While Pip may be able to delay his brain fever, however, he is not able to rid himself of the ailment entirely. Following Magwitch's death, Pip falls into both debt and fever simultaneously, and within days is insensible to the rest of the world. Perhaps the most obvious reading of this occurrence is to relate the cause of Pip's fever to his falling into debt, as an allegory for the evils of Pip's careless expenditure and dalliances in society nearly, quite literally, destroying him through the resulting nervous fever. In the nineteenth century, writers of fiction were eager to take advantage of the theories of physicians which seemingly validated the link between gentlemanly habits and brain

fever on a larger social scale. In accordance with Trotter's earlier theory of the habits of gentlemen making them more susceptible to overstretched nerves, nineteenth-century medical writers were beginning to notice a direct relationship between large numbers of people inhabiting a small space (most noticeably dance halls), and the spread of disease (Engelhardt 135). Molly Engelhardt cites several examples of the correlation, particularly in regards to romance and Gothic fiction which seek to highlight links between the body and the mind, and the natural and supernatural realms (153). Social gatherings, particularly those frequented by the upper classes, were beginning to be configured as places of incubation not only for the sensibilities and culture of young gentlemen, but also of disease. While the concept of contagion caused by bacteria would not be widely accepted until after the 1880s, the idea of the lifestyle of a gentleman being a precursor to contracting illness was circulating within both the medical and fictional worlds, and could easily be applied to Pip's sudden decline in health. Trotter even claims that men who suffer from nervous shocks are most likely to do so due to "disappointments in public life, mostly financial and business" (Trotter 87, cited in Wilson 277), which again links to his ruined finances as a cause for his illness. However, while Pip claims that the state of his finances caused him to become "seriously alarmed" (*Expectations* 470), he later qualifies this statement, claiming that "I ought to write that *I should have been* alarmed if I had had energy and concentration enough to help me to the clear perception of any truth beyond the fact that I was falling very ill" (*Expectations* 470, emphases added). By the time he recognises the extent of his debt, Pip's illness has advanced to the state that he is no longer able to feel alarmed by it, making it an unlikely cause for the outbreak of fever.

While Harold Bloom argues that it is Pip's (mostly undeserved) guilt which forces his brain fever, as he is the unwitting source of bad luck for not only Magwitch, but also his sister, Miss Havisham, Pumblechook and Estella (Bloom 1), this theory is similarly problematic. Bloom himself admits that Pip has no true reason to feel guilt, as he never acts to hurt any of his unfortunate 'victims'. Pip's own admissions, then, are a far more reliable source for the cause of his illness. In his mind, the illness does not eventuate from any single or recent event, but has in fact been present within him for a long time, and simply overtakes him now that he has no reason to continue fighting against it:

I was falling very ill. The late stress upon me had enabled me to put off illness, but not to put it away; I knew that it was coming on me now, and I knew very little else, and was even careless as to that. (*Expectations* 470)

It is perhaps the eighteenth-century physician Thomas Trotter whose ideas best fit what has

happened to Pip: the culmination of a slow build-up of disastrous events causing mental strain that can simply no longer be contained, and is only alleviated through succumbing to brain fever. As an illness which first eventuates with Pip's fears for Magwitch's safety and his own ability to aid his benefactor, and finally overtaking him only once the convict has died, Pip's brain fever is linked not solely with his guilt over his sister, Miss Havisham or Estella, but also with the fate of Magwitch, and the related events which have forced him on the path his life has taken, a path which, by all accounts, he is quite dissatisfied with.

The cause of Pip's fever is made even more apparent when the symptoms he embodies are analysed. Aside from his exhaustion and lethargy, Pip also experiences delirious wanderings which force him to revisit the places which he associates most intimately with Magwitch: the Garden-Court, to look for the boat which Magwitch would use for his escape and the stairs where he first met with the convict when he revealed himself to be Pip's benefactor (*Expectations* 470). In 1850, Thomas Salter, fellow of the Royal Medical Society, noted a case of delirium occurring in a patient which left him in a similar state, with the patient "raving all the night, not having had any sleep whatever, and that great difficulty had been experienced in keeping him in bed" (Salter 679). While sleeplessness and delirious wanderings incurred by brain fever were seen as a medical fact, Dickens adds extra significance to the clinical symptoms by using them to reveal the true cause of Pip's distress. Throughout the text, Magwitch has been a key figure in the construction of Pip's identity. It is their first meeting, when he is introduced simultaneously to Magwitch and crime, that Pip claims to have gained his "first most vivid and broad impression of the identity of things" (*Expectations* 35), linking Pip's ideas of identity, including his own, with Magwitch and the criminal world (Stange 11). Later, Magwitch again becomes instrumental in constructing the second stage of Pip's identity, making him into a gentleman, again through the workings of the criminal world as the money used to create Pip's fortune comes from the earnings of the convict. In his visit to Newgate Prison, even while still unaware of the cause of his sudden change of status, Pip claims to feel "contaminated" by having been so close to criminality, and muses on

how strange it was that I should be encompassed by all this taint of prison and crime; that in my childhood out on our lonely marshes on a winter evening I should have first encountered it; that, it should have reappeared on two occasions, starting out like a stain that was faded but not gone; that, it should in this new way pervade my fortune and advancement. (*Expectations* 284)

Pip further goes on to attempt to “beat the prison dust off [his] feet ... and I exhaled its air from my lungs” (*Expectations* 284). In Dickens’ time, miasmatic theory, or the theory of illness being caused by inhalation of putrid and decaying matter, was popular knowledge, and many believed that the surest way for contaminants to enter the body was “via the nose rather than via the throat” (Halliday 218). Pip’s attempts here to remove the miasmatic air of Newgate Prison from his lungs symbolise a medical method of ridding himself of a metaphorical disease: the contamination of the criminal world. If criminality then, in Pip’s mind, is configured as a contagion that needs to be excised, his eventual brain fever is perhaps the most obvious way of doing such: purging him of his associations with crime so that he may start afresh following the loss of Magwitch to claim an identity of his own making. Early theories of medicine dating back from the late 1600s dictated that fevers were “nature’s way of expelling harmful influences from the body and ... that the physician should work with the grain of an illness rather than against it” (Halliday 56). While medical science had moved on significantly by the nineteenth century, the theory was still regarded as a useful one, and marked the beginning of physicians using symptoms of an illness to diagnose its cause. In this case, it is a theory which certainly applies to Pip’s later illness.

In terms of symptoms, Richard Swiveller’s attack of brain fever is usually considered to be a somewhat more humorous version of Pip’s, although this reading is, in many ways, not entirely accurate. Perhaps the most comic sentiments expressed during the course of Swiveller’s illness are expressed by his nurse, the Marchioness. Although she herself is obviously distressed, her claims that Swiveller “tried to jump out o’ winder, and if you could have heard how you used to keep on singing and making speeches, you wouldn’t have believed it ...” (*Curiosity* 469) are hardly akin to the torments experienced by Pip. While singing and ranting were both recognised symptoms of brain fever (Salter 679), the humorous act of Swiveller attempting to jump out of his window is also a recorded occurrence among victims of brain fever. In 1796, an article in the *Morning Chronicle* announced that

Mr Benson, of the Theatre Royal, Drury Lane, flung himself from the top of a house in Bridges Street, Covent Garden, where he lodged, and his head pitching on the kirb stone, his brains were dashed in the high-road. This lamentable circumstance is said to be attributed to Mr B. having been afflicted with the disorder of a brain fever, but was supposed to have been recovered. He had not the least article of clothes on, and he attempted to get out of the two pair of stairs window, by breaking a square of glass, but not being able to open the window, he got out of the garret window. (*Morning Chronicle* 8303)

Not only does the victim of this case of brain fever share symptoms with Swiveller, but was also associated with Drury Lane, the same street where Swiveller lodges (*Curiosity* 52). In Dickens' time, Drury Lane was particularly associated with actors and those of an artistic temperament, which Swiveller with his comic quotations certainly embodies. The other interesting note is the lack of clothing, an affliction which Swiveller also shares. In the text, the Marchioness' act of selling Swiveller's clothing to pay for medicine (which is never identified) forces him to send her in his place to warn Kit's friends of Quilp's conspiracy, thereby cementing her place as his partner in the eyes of the reader. By doing so, the Marchioness proves herself to Swiveller as somebody who deserves to be made "a Marchioness in real sober earnest" (*Curiosity* 481), but also manages to echo a strange historical precedent.

However, while this aspect of Swiveller's delirium is largely read as comical, his hallucinations are far more serious. There is no clear description ever given as to the nature of the visions which Swiveller receives, but it is made clear that throughout the course of his illness, he is

constant still to one everpresent anxiety – to a sense of something left undone, of some fearful obstacle to be surmounted, of some carking care that would not be driven away, and haunted the distempered brain, now in this form, now in that – always shadowy and dim, but recognisable for the same phantom in every shape it took, darkening every vision like all evil conscience, and making slumber horrible. (*Curiosity* 464)

His obligations to both Kit and Mrs Nubbles haunt him throughout his illness, present as an "evil conscience" that refuses to let him rest. The weight of responsibility that he feels for his actions regarding Kit's imprisonment is a heavy one, and his hallucinations of being haunted by an insurmountable obstacle and care are an indication of just how deep his guilt lies.

Through Swiveller's state of delirium, Dickens enters into a debate which was previously taken up by authors such as Charlotte Brontë and Dickens' own friend and contemporary Wilkie Collins, that of the connection between the physical and conscious selves. In the nineteenth century, delirium was often characterised as being a somewhat more spiritual state of common dreaming. In 1853, William Benjamin Carpenter defined the sensation in his work *Principles of Human Physiology* as one wherein the normal perceptive senses have "an existence external to the mind ... the illusory visual and auditory perceptions having all the force of reality" (385, cited in Wood 130). Dickens

himself first entered this debate in 1852, when his magazine *Household Words* published an article entitled “New Discoveries in Ghosts” which claimed to shed light on the mystery that existed in the gap between the physical world and the psychological, spiritual world (Wood 110). With the advent of Swiveller’s fever, however, Dickens is able to explore this theory in detail. Although Swiveller never truly speaks of his feelings of guilt at any point in the text, his determination to aid Kit and his mother is a deeply embedded desire, far more than a casual whim, as it reaches through his conscious mind and embeds itself in his fevered hallucinations.

While Collins and Brontë used nervous illness as a way to presage the future events of their novels, Dickens uses it differently, as a tool to decipher the mind of his protagonist. Rather than simply using Swiveller and Pip’s hallucinations as a convenient way to remove them from the plot as Collins and Doyle do, Dickens’ use of brain fever here allows for a further exploration of Pip’s identity in the wake of his sudden loss of fortunes, as his hallucinations allow him to examine his own identity in a way which is, as Carpenter suggests, “external to the mind” (385, cited in Wood 130). Insensible delirium, which “comes on suddenly, accompanied [by a] flushed countenance” (Salter 677) was generally considered to be one of the most common symptoms of brain fever. While medical documents of the time give little evidence as to the exact nature of the hallucinations experienced by the sufferers, Dickens’ emphasis on this aspect of Pip’s condition is an interesting one, and hints more at the personal development of Pip as an individual than it adds to the plot of the text.

From the opening lines of the novel, Pip’s identity is revealed to be a central preoccupation for both the character and the story as a whole. As Pip asserts to his readers that he “called [himself] Pip, and came to be called Pip” (*Expectations* 35), his identity is given to the reader as a primarily self-constructed one. Over the course of the novel, this construction changes rapidly. Although Magwitch insists that Pip keeps his name, all other aspects of his identity are stripped from him through the process of becoming a gentleman. Pip is taken from his home, his family and his friends, and taught new habits and customs which are utterly foreign to his life at the forge. His fevered state allows Pip, for the first time, to acknowledge this change of identity, as his subconscious mind rebels against the position that he has been placed in. Over the course of his fever, Pip experiences a great sense of confusion as to his identity, thinking at times

that I was a brick in the house-wall, and yet entreating to be released from the giddy place where the builders had set me; that I was a steel beam of a vast engine, clashing and whirling

over a gulf, and yet that I implored in my own person to have the engine stopped, and my part in it hammered off; that I passed through these phases of disease, I know of my own remembrance, and did in some sort know at the time. (*Expectations* 471)

Unlike Richard Swiveller, Pip is able to clearly recall the exact nature of his hallucinations, which primarily centre around a sense of disassociation from his own identity, and a dissatisfaction with the identity that his hallucinations have imposed upon him. Occurring just after he has lost both his fortune and his friends with Herbert's departure for Cairo, Pip is at last in a position to evaluate his place in society. It is a position which his delirious mind appears to interpret as unfavourable. His associations between himself and "a brick in the house-wall ... entreating to be released from the giddy place where the builders had set me" (*Expectations* 471) hint not only at the distracted state of his fevered mind, but more specifically at his feelings of powerlessness and manipulation. While Swiveller's hallucinations are moral and spiritual, hinting at phantoms and promises, Pip's are highly industrialised, centering on images of being bound up in machinery and construction. His unconscious distaste for these man-made states is a direct contrast from his innocent rural beginnings, which indicate his inner knowledge of the degeneration which his London lifestyle has brought him. Similarly, his hallucinations of being "a steel beam of a vast engine, clashing and whirling over a gulf, and yet that I implored in my own person to have the engine stopped, and my part in it hammered off" (*Expectations* 471) hint at a feeling of entrapment and loss of agency. In both delusions, Pip envisions himself as part of a larger, functioning and greatly unpleasant whole, and begs to be removed from it, as (explicitly in one case) he has been placed there by others, and not himself. Pip's identity as a gentleman has been forged by many hands: Miss Havisham and Estella's, who took him to Satis House and taught him to feel shame for his upbringing, and later Magwitch, who took from his place at the forge in order to make himself "the owner of such ... a brought-up London gentleman" (*Expectations* 339). Pip's delirium is not only indicative of his desire to rid himself of crime, but also of the false place he occupies in society, a position which he has not created for himself or desires to hold any longer. It is only after this fever that he is at all able to make his own way in the world as Herbert's clerk, allowing, in Dickens' own words, "the one good thing he did in his prosperity [to be] the only thing that endures and bears good fruit" (Calder 495).

Unlike Doyle and Collins who strive for realism, albeit a little watered-down in their sickroom management, both Swiveller and Pip receive a traditionally idealised form of treatment. As a novelist known for skirting the boundaries of propriety to the point where scenes of spousal abuse

and brutal murder are all but expected, it is odd that Dickens would choose to draw the traditional veil over these scenes, as Peterson suggests that it would offend the sensibilities of the day (Peterson 450). While Dickens' other works are correct down to the details of head injuries, cerebral arteriosclerosis and symptomatic epilepsy, to name only a few (Brain 1553-1554), it is unlikely that Dickens was simply unaware of the sickroom procedures involved in treating a diagnosis of brain fever. Aside from the Marchioness' vague mentions of "the things that was ordered for you" (*Curiosity* 473) however, the fact remains that the reader is given no further clue as to the form of Swiveller's treatment. Briefly, Dickens mentions the Marchioness struggling to make Swiveller a "cooling drink, with the address of a score of chemists" (*Curiosity* 470), which hints that she has been consulting with physicians as to his care, as she also mentions the advice of a doctor several times. The fact that a medical professional has been consulted is of course realistic, as is the cooling drink, which was a cure-all remedy assigned to every illness from mental agitation to mercury poisoning. However, little description is given as to the full nature of Swiveller's treatment, and there is certainly no mention of the purgings, bleedings and blisters that one would expect from such a case of fever. Granted, the entire scene is conducted from the invalid's perspective, who would have little reason to know or ask such a question – indeed, Dickens never chooses to write from the Marchioness' perspective except once in the entire course of the narrative, placing her in the position of one who is both observer and observed, but never quite known, a link perhaps to her mysterious and ultimately omitted backstory. However, the omission of the sickroom details does in fact serve a purpose in the narrative. Rather than focussing on the illness as a medically recognised belief, Dickens instead uses it as a way to present what Holly Furneaux refers to as "a microcosm of the ideal home" (Furneaux 39). According to Miriam Bailin, Dickens' sickrooms are characterised by being "[s]weet smelling, orderly, companionable, peaceful, and remote from worldly care and want... [they] resemble those encountered in Victorian fiction generally, though at times surpassing them in the particularly Dickensian degree of their coziness and conviviality" (80, quoted in Furneaux 39). In the case of Richard Swiveller, the description is certainly a true one.

From the beginning of the novel, Swiveller has been in search of love: firstly with Miss Sophy Wackles, then (albeit with mercenary rather than romantic motives) Little Nell, and finally with the Marchioness. Looking back, there are many similarities between the two from their first meeting which indicate that Swiveller and the Marchioness are destined to be a pair. Both live in wretched circumstances, and survive them purely through the strength of their imaginations. The Marchioness spends her days drinking water with orange peel, and pretending it is wine, while Swiveller does the

same with cold gin and water. In order to be Swiveller's friend, according to Dickens, "you must reject all circumstantial evidence, all reason, observation and experience, and repose a blind belief [in his imaginings]" (*Curiosity* 52). Swiveller drops his theatricality for one person only: the Marchioness, upon their first meeting. Interestingly, it is at this time that he begins to notice similarities between the Marchioness and Miss Sophy Wackles, as they both play bridge "all fours" (*Curiosity* 424), he spends the night switching between playing mournful elegies for Miss Wackles on the flute and soliloquising about the Marchioness (*Curiosity* 425). Despite this, it is not until Swiveller falls ill that any relationship between the pair becomes viable. Prior to his illness, it has been Swiveller who has provided for the Marchioness, teaching her cards and alleviating her suffering briefly with sustenance and company. It is clear that she needs his "roseate imagination" (Barickman 130) in order to survive her beaten existence, but it is not until later that it is revealed that Swiveller is in an equal state of dependence. According to Richard Barickman, Swiveller's illness and subsequent reliance on the Marchioness for care "suggests, in turn, that his apparently blithe life has actually skirted fears of real destitution. His elaborate euphemisms have, in fact, been efforts to avoid the squalid conditions of his life - sparse food, contemptible companions, barren room, and raw gin" (130-131). When the pair are first introduced to each other, Swiveller's befriending of the Marchioness becomes the first completely unselfish and gentlemanly action he has performed in the history of the text. Seeing the miserable state of her existence, Swiveller takes it upon himself to provide her with beer and spend time with her, teaching her cards and talking to her as if she were a real marchioness (although these antics confuse her somewhat). In true moralising fashion, Dickens rewards Swiveller for his act of kindness by having it reciprocated: as he once came to her aid, the Marchioness now reappears to save Swiveller's life.

The sudden reversal of roles, with the Marchioness becoming ultimately responsible for Swiveller's survival, proves the pair's reliance on each other, and sets them up in the eyes of the reader to fulfil the domestic roles which the story so sorely needs. Upon awakening from his delirium, Swiveller notes that the Marchioness has made herself "thoroughly at home" (*Curiosity* 468) in his house, and has taken on the roles of both cleaning and cooking for him, as well as nursing him back to health. Although the revelation that she has run away from the Brasses and now lives in his house is a shocking one for Swiveller, it is one that he never argues against, giving her unspoken permission to remain with him until he sends her to school so that she may, eventually, become a proper wife for him, cementing their alliance. Her treatment of Swiveller, and the domestic setting she creates while nursing him reveals to Swiveller and the reader her worth as a potential wife, as she saves his life at great sacrifice to her own comfort and security. Swiveller is forced to acknowledge the worth of the

Marchioness beyond simply being the ‘small servant’, but also as his rescuer, and later, Kit’s as well. While dangerous, Swiveller’s fever effectively cleanses him completely of his associations with crime. Upon awakening, he has been thoroughly abandoned by the Brasses and Quilp, and finds himself in what he believes to be “an Arabian Night” (*Curiosity* 465), surrounded by medical aid and, most importantly, the Marchioness herself.¹¹

Throughout Swiveller’s recovery, Dickens places great emphasis on the tenderness and care that the Marchioness shows towards him, even as he (realistically) highlights her lack of skill: at one point she helps Swiveller to sit up in bed “if not as skilfully as if she had been a professional nurse all her life, at least as tenderly” (*Curiosity* 468). The Marchioness, for all her exaggerated care of her patient and rigid insistence of sticking to the advice of the consulting doctors, is not a skilled nurse herself. It is her tenderness and loyalty which is highlighted here, not her medical skill, and through this Dickens hints that it is only through these traits of her personality that she is able to save Swiveller’s life. While his brain fever allows the Marchioness to show her devotion to Swiveller, it likewise provides an opportunity for him to do the same. While usually a flippant and overly dramatic character, Swiveller’s illness strips away this mask and allows him to show his feelings. At one stage, the Marchioness begins to cry at the joy of seeing Dick Swiveller recovered from his brain fever. According to Dickens, “Mr Swiveller (being very weak) felt his own eyes affected likewise” (*Curiosity* 466), and when he next speaks to her, does so with “a trembling lip” (*Curiosity* 466). Dickens’ explanation here is an interesting one: it is not permissible, it seems, under normal circumstances, for Dick Swiveller to be moved to tears by the joy of seeing his friend so overcome with relief. Such a display of emotion is only rendered acceptable by Swiveller’s illness and state of recovery. Much as characters such Frederick Fairlie and Thaddeus Sholto are shunned for their hysterical emotions, Swiveller also must keep his in check, but, as with Doyle’s Percy Phelps, fever acts as a catalyst for making emotional displays acceptable.

In the tradition of detective and sensation fiction, Swiveller’s illness catches up with him at an inconvenient as well as spiritually enlightening time. With his fever eventuating the very night Kit is convicted, he is unable to offer aid to his wronged acquaintance, despite his fervent desire to do so. His fever leaves him insensible for three weeks, during which time Kit is very nearly transported in his absence, providing a necessary tension for the reader as the plot comes to an end. However,

¹¹ The trope of class barriers being broken by the illness of a gentleman is a common one in nineteenth-century literature, and not only in the works of Dickens. As Jo and Pip are able to temporarily reconcile after Pip’s injuries due to the change in power between invalid and nurse, so too are Jane and Rochester aided in their own romantic relationship in *Jane Eyre*, and similar situations are abound in other texts.

while Swiveller's illness renders him impotent, it also enables him to complete his goal, and is perhaps the only way in which it would have been possible. Although Swiveller's fever may have symbolically cleansed him of his associations with the criminal world, it is only upon his awakening that he is able to fulfill the final step: undoing his unwitting part in the conviction of Kit by providing the evidence that will secure his release. Exiled from Bevis Marks following the Brasses' success in convicting Kit, Swiveller would have otherwise had no access to the only person who was aware of their machinations, the Marchioness. With her propensity for listening at keyholes, she is the only sympathetic person from whom Swiveller could have extracted the story of Quilp's plan, and it is only because of her loyalty to him that he is able to gain the required intelligence from the small spy. Through his initial act of kindness to the Marchioness, Swiveller secures not only a marital partner of great worth, but also manages to purge himself entirely from his associations with criminal activity.

Consistent with other nineteenth-century writings, including Dickens' own former works, little information is given in regards to the treatment of Pip's brain fever. Earlier in the text, when fever threatens but does not overtake him, he is provided with ambiguously described "stuff" for his injured arm, but nothing specifically to treat the encroaching fever. This Pip defeats himself through tricks of memory, counting to high numbers and repeating memorised prose passages (*Expectations* 443). While there is no ready medical evidence to support the effectiveness of his strategy, the emphasis Dickens places here is not on scientific accuracy, but Pip's strength of mind. Without the aid of his friends (for both Herbert and Startop are conveniently absent for this event), Pip is able to combat his fever through sheer strength of will, showing his convictions and renewing his agency after previously needing to be rescued by his friends from Orlick. His passionate temperament may cause him to feel fear for Magwitch's safety, but he is still strong enough to put aside his terror to help others, much as he did when he first met the convict on the marshes. In the later stage of his fever, however, much more detail is put into the telling of how Pip regains his health. While Dickens again offers little medical information as to his cure, great emphasis is placed on the presence of Pip's nurse, Joe Gargery.

While it is nothing new to say that Pip's brain fever is the final turn of his redemptive arc, it is difficult to say exactly what about his behaviour needs redeeming, or how the fever in itself functions as an important aspect of his moral rebirth. The most important aspect of Pip's fever, perhaps even superseding that of his delirium, is the nursing he receives during this period by Joe Gargery. While any number of illnesses could have required him to need Joe's care and attention,

brain fever is perhaps the most appropriate, as it is the most linked with Pip's inner self and identity. Unlike other illnesses that require an external exciting cause, brain fever and other nervous ailments were inalienably linked to the internal and emotional life of the sufferer (Vrettos 52). While Dickens could arguably have excised Pip of his criminal associations by having him catch an illness from his time spent tending to Magwitch in Newgate Prison, the significance of brain fever, an illness which comes from Pip's own body and not an outside source, links it far more closely with his struggle for independence from the machinations of others. On a more personal level, however, Pip's illness does not only eradicate the traces of criminality that still ensnare him, but also allows for him to reconnect with his innocent childhood, before the arrival of Magwitch. Joe's presence at Pip's sickbed allows for a reunion which destroys the reservations between them, as Joe ceases to call Pip 'sir' for a brief time as his vulnerable position allows for, as Bailin claims, "barriers between hitherto estranged loved ones, or between aspects of their own divided selves, [to] collapse under the levelling power of physical distress" (79, quoted in Furneaux 39). Much as Swiveller is finally able to see the Marchioness' true worth as she tends to him, Pip's illness breaks down the social barriers between himself and Jo, as his reliance on the former places them once again in a position of equality. Dickens is not the only nineteenth century author to do this. Charlotte Brontë uses much the same tactic in *Jane Eyre* to force a reconciliation between Jane and her estranged Aunt Mrs. Reed. While it is unsuccessful, as Mrs. Reed cannot bring herself to love Jane, Jane is able to forgive Mrs. Reed for her cruel nature much as Joe is able to forgive Pip for his abandonment. Unlike Swiveller, who is rewarded for his good actions in aiding the Marchioness in having her appear to him as a nurse, Pip's treatment of Joe does not warrant such care. Instead of reinforcing a connection between invalid and nurse, Joe's ministering to Pip breaks down the barrier that class and embarrassment has placed between them, and allows them to reconnect to a past long since eroded. In Dickens' notes, Joe's role in this scene places him in the position of "Ministering Angel" (Calder 495). In this role, Joe provides a vital link between Pip's innocent past, before his corruption at the hands of civilisation, crime, and his own mishandled fortunes, providing a link away from the ruinous city of London and back to Pip's humble, rural and untainted beginnings. The medical causes for Pip's fever both spring from his good actions: the physical wounds to his arm which were incurred when saving Miss Havisham, and the mental strain produced from helping Magwitch. Forming from these good causes, then, as well as his psychological horror and guilt at the way his life has linked to the criminal world, Pip's fever is ultimately a purging one, and eventually leaves healing in its wake.

However, it is not Pip's kindness towards others which helps him through his illness, but Joe's enduring goodness. The friendship that Pip and Joe maintained before his rise in fortunes saves him by bringing Joe to his side, whose care and nursing allow him, in the words of critic Harold Bloom, to "[return] to an improved infancy with the Gargerys and their child, his godson, little Pip" (Bloom 1). As another imagining of the sickroom as parallel for the domestic sphere, Pip is placed by Joe once again in the category of infant, and is able to return, briefly, to a time where he was not tainted by criminality, completing his cure. Interestingly, Joe provides a cure for both problems which face Pip: he nurses him through his brain fever *and* pays off his debt, curing him of the hold society has over him and allowing him to start afresh. His role as 'ministering angel' does not end with psychologically helping Pip start afresh, but also financially, providing for his future even as he returns him to his past. In terms of the plot, Pip's fever is a vital point: it allows him to escape the custody of the debt collectors, as he is simply too ill to be moved, and allows for Joe to be the one who returns him to his previous, unsullied childhood state.

As an illness which causes dramatic and purgative fevers, criminality in the minds of Dickens' characters is a condition contracted by both Pip and Swiveller at a young age. However, not all illness is symptomatic of evil: Little Nell, for instance, faces a nameless sickness which quietly removes her from a world which it is heavily implied that she is too good for. A painless death is her reward for aiding her grandfather and restores her to a heaven that she deserves. For both Pip and Swiveller, their illnesses are such that must be fought and survived, ending in a symbolic death rather than a physical one as they must go on to take a further place in the plot. Pip must learn how to be a gentleman in other ways than simply having wealth, and Swiveller must learn to find happiness through legal and real means, disregarding his previous fantasies and crimes for the real world. Although most brain fevers occur quickly at the advent of a sudden shock, Dickens uses it here as a way of summing up the entire lives of two characters, configuring criminal associations as a contaminant which has haunted both Pip and Swiveller since their earliest memories. While Pip is saved through the goodness of Joe and Swiveller is resurrected through the one kind act he has perpetrated, both find redemption in the form of their introspective fevers, which purge them of their past wrongs and prepare them to face their futures as responsible members of the society they have previously wronged.

Conclusion

In 1853, the poet Matthew Arnold referred to nervous illness as “this strange disease of modern life”, a statement which not only indicates its prevalence within the period, but also the preoccupation that authors had with this new way of defining and expressing emotions (Wood 4). In particular, both hypochondria and brain fever were considered to be largely psychological illnesses, and heavily associated with melancholy, shock, fear and disappointment. It is because of this that the illnesses were pounced upon by Victorian authors who used them as ways to advance both the plot and the personal development of their characters. While Athena Vrettos claims that the suffering body is an ideal way for an author to illustrate social concerns, it is also a far more personal tool, allowing a writer to show the depths of a character’s emotions without damaging their ability to socially interact within the story. There are a number of illnesses which can conveniently remove a character from the plot, but only a nervous illness can do so in a way which is not only culturally acceptable to a society which values emotional control, but also hints at the deeper passions of a character’s soul.

While different genres may have different expectations of a nervous sufferer, these expectations are always met. A hypochondriac will be secluded, isolated, and miserable, unreliable or exalted by nervous visions which may or may not be premonitions of the future; a sufferer of brain fever will be insensible and bedridden, only to rise again from their sickbed at a crucial moment to redeem themselves in the eyes of their reader, be it by a moral rebirth or through their sheer perseverance and stout-heartedness. While the modern reader may not recognise brain fever or hypochondria as a viable plot point, questioning whether or not such illnesses even existed outside the pages of fiction, the idea of illness as a means of altering a plot or revealing information about a character is not an uncommon one today. The recently emerged yet popular genre of ‘sick-lit’, encompassing such novels as *The Fault in Our Stars*, uses illness in a similar way, playing with the current public knowledge of diseases such as cancer in much the same way a Victorian author may have used brain fever or consumption. In the same way, by incorporating the social lives of ‘popular’ illnesses within their stories, nineteenth century authors entered into a popular dialogue which was as powerful and entertaining as any ‘Arabian Night’. Inscribing medical symptoms with social meaning, literary representations of nervous illness in the nineteenth century interacted with the wider sphere of public knowledge to create new stereotypes and reinforce old ones, as both physicians and authors alike sought to understand and reveal crucial elements of the body and mind.

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