What is slow to a sociologist is fast to a historian. Like qualitative sociologists, historians weave together in-depth analyses of material from disparate sources to compose a coherent narrative. Historical research also takes a long time. Especially before thousands of documents became available on the Internet, most of us traveled to distant archives and worked in them for weeks, months, and occasionally years. I thus assumed that my book *Hearts of Wisdom: A History of American Women Caring for Kin, 1850–1940* might well consume a decade. The topic was vast, compelling me not only to trace changes across ninety years but also to discuss women in diverse social positions, with very different relationships to the care recipients. Although caregiving today is concentrated on the elderly population, nineteenth- and early-twentieth-century women cared for people of all ages. I needed to examine large numbers of reports of charity workers, public health nurses, and government officials; the personal diaries and letters of a broad array of women; and slave narratives.

What I could not anticipate was that a set of personal experiences also would lengthen the process. Shortly after I began the project, my mother was diagnosed with lymphoma and turned to her five children for emotional, practical, and occasional nursing assistance during the five months she battled the disease. Her death left me and my siblings responsible for my father, who had suffered from a series of disabling strokes for over a decade. He experienced a number of major medical crises until his death six years later. Because I lived in California and my parents in New York, their care frequently involved cross-country trips. In addition, a year after my mother
died, I was diagnosed with breast cancer and lost another six months to its
grueling treatment. But if those events interrupted my project, they also
enriched it. In the introduction to the book, I wrote that as both a pro-
vider and a receiver of care, I had seen firsthand how caregiving can reignite
family conflicts, impose financial stress, and encroach on both work and lei-
sure. But I also had gained a deeper appreciation of caregiving as a profound
human experience.

Looking back, I realize that other aspects of my experience affected my
project more profoundly. The first was a brief foray into the world of religion.
When cancer struck, I had just finished writing a chapter about nineteenth-
century women’s care. It would have been impossible to miss the spiritual
component of caregiving during that period, especially when sickness led to
death. As Drew Gilpin Faust (2008) eloquently has explained, the nineteenth-
century ideal of the “Good Death” can be traced to fourteenth-century
Catholic manuals. In 1651, the Anglican bishop Jeremy Taylor published his
enormously influential book *The Rule and Exercise of Holy Dying*, which both
drew on and revised those texts for a Protestant audience. By the early nine-
teenth century, Taylor’s notion of the Good Death had spread widely through
American society, reaching people of various social and religious backgrounds.
The basic elements were consciousness and lucidity, resignation to God’s will,
and fortitude in the face of physical pain and emotional suffering. Caregivers
thus had to ensure that dying people were adequately penitent, “sensible” of
their sins, and prepared to face death with equanimity. The role of caregivers
was especially critical at the moment of death, when they were expected to dis-
cern the state of the soul and the prospect of everlasting life.

Family and friends occasionally detected signs of eternal damnation. Mary Ann Owen Sims, an Arkansas woman, could “never forget” the ter-
ror she experienced at the “death seane” of her uncle in 1843. “For he was
a wicked man and oh the agonies of a lost soul usher[e]d in to the pres-
ence of its Maker was truly heart rend[e]ring even to my youthful minde”
(1976, 150). Fortunately, such incidents were relatively rare. Although Mary
Ann Sims’s husband endured “sevier” suffering, his behavior conformed to
the cultural code. He exhibited “Christian fortidude and resignation know-
ing that he who governed the universe had done all things well,” and “not a
murmer escaped his lips” (176). Sarah Connell Ayer’s journal entry for July
10, 1827 read: “Mrs. Carpenter died. We have reason to hope that she has
exchang’d this world for a better. She suffered much pain during the last
two, or three weeks of her life, but appear’d calm and resign’d to the will of
her Saviour, and gave cheering evidence of her preparation to meet death” (1910, 274). Mary E. Sears described her sister’s death this way:

Eliza was unconscious to appearance much of the time, but always recognized the voice of her dear James [her husband], and to his questions to her readiness to go home to Jesus, she would reply in monosyllables, of ready “happy, yes, yes, happy” was Jesus calling for her? “yes, calling, calling,” when a heavenly smile would light her countenance: ah! What a sweet consolation to the stricken friends to hear from her own lips the words, “ready, willing”! . . . About four o’clock P. M. she seemed to arouse somewhat. And calling for each of us by name bade us farewell and kissed us then was soon lost. . . . God had indeed called her; and in mercy had granted her consciousness enough to recognize us for the last time on earth; for this we will praise Him, for twas indeed a consolation to hear her once more call our names so sweetly and smile so gently “don’t weep for me don’t weep.” (1970, 228)

But if I could not avoid knowing intellectually that religion had a major place in nineteenth-century caregiving experiences, I could not understand it experientially. Thus, I tended to agree with historians who argued that accounts of peaceful deaths bore little relation to reality. Lawrence Stone (1978), for example, asks rhetorically, “How many were so physically ravaged by pain and by disease that they were either beyond caring or a foul-smelling embarrassment to the onlookers?” Although the linguistic turn in scholarship might have encouraged me to try to understand the cultural values that shaped contemporary accounts rather than to discern the truth about how people actually experienced death and dying, I assumed most descriptions of death had little meaning.

I also misinterpreted the spiritual work in which nineteenth-century caregivers engaged after death occurred. A vast “consolation” literature arose in the nineteenth century. Many authors were ministers, but others were women who wrote primarily for other women and typically focused on the death of children. Both groups urged the bereaved to accept the death as the will of God and express gratitude that the patient was now free of suffering. In addition, survivors were told to find comfort in knowing that they could look forward to ultimate reunions in heaven.

In private letters and journals, many survivors couched their chronicles of family deaths in conventional religious rhetoric. “God has again called
my only son,” wrote Mary Adams to her mother in April 1863, “and now our little Frankie sings with his angel brother the new song of redemption.” After recounting the events that occurred during the terrible days preceding his death, she described the final evening. Mary “took him on a pillow on my lap and held him till he breathed his last mortal breath. . . . In all his life he never went to sleep easier or waked up happier. I was so glad the Savior so gently took him.” She urged, “Do not grieve for me, Mother. I am quite well.” Reading that letter, I assumed that the language was simply formulaic. Only the wail at the end sounded genuine: “Oh, how can I live without him?”

After many months of illness, I no longer dismissed all spiritual expressions as inauthentic. Having grown up in a Reform Jewish household in the 1950s, I had not immediately assumed that religion might have something to offer when I received a cancer diagnosis. My own experience seemed to support the theory of the secularization of society, which argues that confidence in scientific theory gradually eclipses faith in religious authority. I was quite confident that neither of my parents had even remotely considered consulting a rabbi as the end approached. Judaism, after all, was what my father had most wanted to flee when he left his immigrant parents’ home to seek higher education. The headache that descended whenever he could not avoid a family bar mitzvah was our only indication that Judaism still had some hold over him. Although my parents enrolled me in a Reform Jewish Sunday school, they also encouraged me not to take it too seriously—and, indeed, it offered little of real substance or meaning. The few relatives who still kept kosher seemed like throwbacks to an earlier, unenlightened era. Now that a life-threatening illness had greatly intensified my sense of vulnerability, it seemed especially imperative to place my faith in the certainty of science and endow my physician with almost miraculous powers.

But immersion in sickness also compelled me to confront a new set of issues. I had always assumed that a job at a major research university meant that no significant intellectual current could pass by me by. Suddenly I could not think of any way contemporary academic theory could help. While scientific medicine tried to fix my body, perhaps religion would enable me to participate in different conversations and thus make some sense of my terrifying experience.

What I then undertook was far too tentative and disorganized to deserve the name “spiritual quest.” I read the books a friend who was a Unitarian
minister recommended, participated in meetings of a group of women from diverse faiths seeking to integrate feminism and religious doctrine, attended a few evening classes conducted by a somewhat offbeat rabbi, and even flirted (for a day or two) with the idea of joining a congregation. Two close friends and I then organized a Torah study group and held occasional Shabbat dinners together.

Although all those activities gradually dwindled away, I gained some understanding of what religion could offer people confronting serious illness and death, either as patients or as family members. When I returned to my manuscript after my cancer treatment ended, I ripped up what I had written about the nineteenth century and began again. I now saw that many women understood their care experiences within the framework of religion, even as they struggled against it. To be sure, many bereaved relatives often acknowledged that intense grief retarded efforts to fulfill pious expectations. Fannie Tenney described her response to her husband’s death this way: “I could not look away from earth to heaven as I want to. It all seemed so terrible to me. I do say ‘God’s will be done.’ But I cannot look up as I want to” (quoted in Hampsten 1982, 141). And in a few instances, religion deepened rather than attenuated despair. Some bereaved parents berated themselves for having become too attached to their children. Others feared that the intensity of grief revealed the insufficiency of faith. “This shadow of death should not rest upon our spirits if we truly believed,” Mary Wilder Foote confided to her sister. “The bursting life around me should remind me of immortality instead of calling up sorrowing thoughts of the precious bud.” (Foote and Foote 1918, 95).

Nevertheless, women also testified to the support religious teachings provided. Although Fannie Tenney failed to “look up” as much as she wished, she emphasized that “there is no other for me to go to but to God. If I did not know that there is help in him I should despair” (quoted in Hampsten 1982, 141). After blaming herself for having loved her daughter “too well,” a Georgia woman continued, “The thought of being reunited with our darling is indeed a blessed, comforting one it weakens the pang of present separation” (Lines 1982, 207). As novelist Catharine M. Sedgwick wrote to a sister whose oldest son had died, “The Holy Spirit is your comforter, and let us acknowledge the ineffable consolation with which he has softened your calamity” (1871, 110). If religion could not entirely stifle unbearable emotions, it could “weaken” or “soften” them, thus enabling the bereaved to gain at least a modicum of critical distance.\(^3\)
Participation in a support group gave me a window on a different feature of nineteenth-century caregiving. The very idea of joining such a group initially had been anathema. If the other members were close to death, they would be intimations of my own mortality. And some undoubtedly would have the wrong politics or lack the extensive education I considered prerequisite to the acquisition of wisdom. But when a rabbi said that he considered sharing one’s life with others to be a spiritual act, I thought I could try at least one meeting. And then, on that first night, I found myself saying that my new awareness of life’s contingency had made me hesitate to return to a long project; perhaps I should just write a series of articles. The next speaker was a woodworker who said he understood; he had been able to undertake only small projects since his diagnosis. Others then described the ways a heightened sense of uncertainty had transformed their lives. Suddenly, I realized, these are my people.

I previously had written about nineteenth-century obligations of neighborliness primarily as burdens. Because mutual aid was often a requirement of participating in social life as well as a form of insurance, sickness among members of a broad community pulled women away from their homes, often for extended periods. Housework accumulated and children were left alone. Caregiving also reopened wounds. Women who had endured intense physical pain during childbirth had to tend other women laboring in agony. During epidemics, mothers nursed neighbors’ children through the same illnesses that had struck their own offspring.

My support group experience suggested that if caring for a large social network forced women to reexperience losses, it also helped them make sense of suffering. The widely distributed consolation literature encouraged women to transcend suffering by reaching out to others. According to the biographer Joan D. Hedrick (1994), Harriet Beecher Stowe offers one example. When her fifteen-month-old son Charley died of cholera in 1849, Stowe turned for support to her friend Mrs. Allen, who had sustained a similar loss. After giving birth to another baby, she asked, “How is it with you in your heart of hearts when you think of the past—I often wonder how your feelings correspond with mine” (199). Three years after suffering a second crushing blow—the drowning death of another son—Stowe sent a letter to a friend who had just lost a daughter. “Ah Susie,” she wrote, “I who have walked in this dark valley for now three years, what can I say to you who are entering it? . . . I know all the strange ways in which this anguish will reveal itself—the prick, the thrust, the stab, the wearing pain, the poison
that is mingled with ever bright remembrance of the past—I have felt them all—and all I can say is that, though ‘faint,’ I am ‘pursuing,’ although the crown of thorns secretly pressed to one’s heart never ceases to pain” (278–82). Hedrick notes that Stowe’s novels depicted “an informal ‘priesthood’ of women who have suffered” (316). Once again I had to revise a large section of my work.

Barbara Ehrenreich (2002), one of the most trenchant critics of today’s relentlessly upbeat breast cancer culture, reminds us that the costs inflicted by the disease far outweigh whatever benefits it confers. In her view, the possibility of personal transformation has been greatly exaggerated. But if breast cancer does not lead automatically to spiritual renewal and new forms of human connectedness, it can enhance our understanding of the experiences of the many groups in the past who lived in extremely close proximity to serious illness and death. For that, a historian must be grateful.

Notes


2. Mary Ann Weber to her mother, June 11, 1871, Parker Family Letters, in the possession of Marianne Parker Brown, Santa Monica, California.

3. I also discuss these issues in my book The Inevitable Hour: A History of Caring for Dying Patients (Baltimore: Johns Hopkins University Press, 2013).

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