Beyond the Reproductive Body
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CHAPTER 5

Testing the Reproductive Hypothesis: Women’s Illnesses, the Environment, and Menstruation

In 1995, Lesley Doyal, a professor of health care policy, used the question “what makes women sick?” to investigate the politics of women’s health in the late twentieth century from a global perspective. In her analysis, she stresses the significance of economic, social, and cultural influences on physical and mental well-being, and explores the different facets of women’s experiences that have an impact on their health. “Instead of exploring the interior of female bodies,” Doyal focuses on “the ways in which women’s lives can make them sick.” The case histories I examined suggest the utility of a similar analysis for the early Victorian period. The remainder of this study addresses the question of what, according to the hospital and asylum patients, made poor women sick in England in the 1830s and 1840s. The medical construction of the female body assumed that women’s illnesses derived predominantly from the natural weakness of the reproductive body. Yet poor women imagined their illnesses to be produced by economic, social, environmental, as well as biological factors that interacted with their own particular understandings of an able-bodied norm.

Parliamentary investigators into employment and sanitary conditions of the 1830s and 1840s focused almost exclusively on “the interior of female bodies,” concluding that reproductive functions played the decisive role in determining female health and illness. Most Victorian medical texts agreed that the reproductive body rendered female health unstable. The patient narratives indicate that women’s understandings of their bodies were much more conflicted regarding the connections between female biology and female health. Rather than situating themselves firmly in the reproductive body, working women experienced tensions between the
reproductive and the able body. Many women represented themselves as strong, but recognized obstacles to achieving or maintaining that strength. Other women perceived their health as delicate, but understood their condition to be the exception rather than the rule of female health. Other elements of the patient narratives suggest the centrality of the reproductive functions in these women’s understandings of illness.

As Roy Porter has pointed out, “the sick too have had their own medical culture, one with profound links to the wider consciousness of their times—religious, political, moral, aesthetic.” While parliamentary investigators and medical practitioners sought to define experiences of health and illness through specific gendered categories, the women on whom they focused brought their own cultural understandings to their experiences of health and medicine. This chapter will examine women’s perceptions of their bodies, paying particular attention to the environment and menstruation—the two factors most highlighted in the parliamentary investigations as contributing to the construction of the reproductive body. Although each patient expressed her own personal experience of “what made her sick,” what emerges from my analysis is a common conception of health and illness across regions and occupations that was sometimes shared by medical practitioners and sometimes in tension with their ideas.

### The Diseases of Women

The physician Samuel Mason in 1845 expounded upon the centrality of the reproductive system to women’s overall health:

> It is well known to all in any degree conversant with physiology, what an immense influence the uterus . . . has upon the female system. . . . Therefore it will be readily conceived, that any derangement of this organ, or defect of its regular functions, must, to a certain extent, influence the general health, in fact, the growth and healthy development, of the female; and in after-life, too, health or disease frequently bears an exact ratio to the state of the uterus.

Not only was women’s physical health naturally at risk, but their mental stability depended on the normal functioning of menstruation, for as Mason argued, “so remarkable a control does [the uterus] exercise over the mind and reasoning powers, that the greater frequency of insanity, among women in this country, has been referred to the mode and regularity with
which menstruation is performed.” Medical men connected women’s propensity for illness to their reproductive bodies and the countless things that could go wrong with normal menstruation. As the authors of the *Cyclopaedia of Practical Medicine* told their readers, “there is great liability to derangements, of one form or another, in the menstrual process.” Even though the physician Edward Tilt concluded that he found “menstruation to have been perfectly regular in eighty-six per cent. of the women” in his research of one thousand, it did not prevent him from dedicating an entire book to the subject. Amenorrhea, dysmenorrhea, and menorrhagia—the absence of menstrual discharge, painful menstruation, and excessive menstrual discharge—all featured in studies of the health (or ill health) of women. Medical writings suggest, as Sally Shuttleworth has noted for the mid-Victorian period, that “menstruation acted an as external instrument, a barometer by which doctors could read the internal health, mental as well as physical, of their patients.” Although new clinical approaches to medicine stressed a reductionist understanding of disease, doctors still saw women’s diseases as predominantly systemic, produced by an easily unbalanced reproductive system. This vision of the reproductive body has dominated historical understandings of Victorian approaches to women’s health.

The evidence from the medical case histories, however, challenges this monolithic understanding of the relationship between medical theory, medical practice, and women’s health. Although there is some evidence that the doctors at University College Hospital (UCH) followed the medical wisdom of the day regarding the dominance of the female reproductive body, the most common diagnosis among the patients at UCH had nothing to do with reproductive functions. It was rheumatism. Out of 2,199 cases in which a diagnosis was clearly registered, 223 indicated rheumatism. Hysteria, considered a reproductive disease, as it was defined “essentially to consist in excitement and irritation of the numerous and important nerves supplying the reproductive system,” was the next largest ailment, with 153 cases. The next five, however, were generally nonreproductive: a group of stomach complaints related to dyspepsia made up more than ninety cases, followed by bronchitis with eighty-four, gonorrhea and syphilis (sexual, not reproductive, diseases) together made up seventy-six cases, anemia counted for seventy cases, and a variety of ulcers and ulcerations made up sixty-eight cases. Menstrual disorders of various sorts accounted for forty diagnosed ailments, while ovarian and uterine diseases made up fifteen cases. There was also one case of “climacteric” disease. In all, “reproductive diseases” made up less than 10 percent of the more than two hundred different primary diagnoses in the UCH cases.
In the Sussex registers, more than three hundred different diagnoses were noted for the patients in the sample. As in the UCH sample, a nonreproductive disease made up the single largest diagnosis: dyspepsia, which accounted for 299, or 17 percent, of the 1,759 cases where diagnosis was included. Rheumatism, which was the only disease that the parliamentary investigators worried about in the context of women’s work in agriculture, was the fifth most common diagnosis, with seventy-nine cases (4.5 percent of the total). Leg ulcers made up a similar number of cases.9 Hysteria, as in the UCH sample, was the second most prevalent ailment in West Sussex, diagnosed for ninety-five cases. Strikingly different, however, amenorrhea and chlorosis—two classic diseases connected to menstruation—were diagnosed for ninety and ninety-one cases respectively, the third and fourth most common diagnoses of the Sussex sample. Clearly, the Sussex diagnoses fit much more closely than the UCH diagnoses into the predominant model of female health based upon the functioning of the reproductive processes, and in particular, menstruation. This, of course, is ironic considering the evidence presented in chapter 1, which showed that medical concern about the reproductive body was overwhelmingly an urban, industrial problem.

The asylum records do not provide comparable information with regard to physical illnesses, but some other sources from manufacturing districts suggest a breakdown of illnesses in the textile district of the West Riding. The Halifax Infirmary Annual Reports, for example, contain lists of patients’ diseases for some years in the 1830s. Although the diseases are not classified separately by the sex of the patient, the Halifax Reports still contain useful comparative information. The primary health problems that brought working people to the Infirmary were contusions, fractures, and lacerations. The huge number of these injuries in Halifax is perhaps reflective of the types of employment in which people around the area were engaged, specifically textile industries. Domestic servants and apprentices were apparently excluded from admission to this institution “unless their Master or Mistress shall engage to pay five shillings per week for their Subsistence.”10 Whereas fractures made up about 10 percent of the Halifax cases, fractures made up only 2 percent of the London cases and less than 1 percent of the cases at the Chichester Infirmary, both samples where service occupations predominated. Similarly, the Leeds surgeon Samuel Smith testified in his evidence before the Parliamentary Select Committee in 1831–32 as to the comparative illnesses in London and Leeds, for he had had his training for two years in London. He commented that “the cases are very different in the London hospitals; bruises and severe contusions bear a very great proportion; in our [Leeds] Infirmary, lacerations and cuts inflicted by machinery are more common.”11
Illnesses specifically having to do with female biology are proportionately very small in the Halifax sample. In 1834, less than 2 percent of the 4,309 total male and female ailments recorded were particular to women. By contrast, a look at the various diseases with which female workers in lace manufacturing were admitted to the Nottingham General Hospital as outpatients from March 1840 to March 1841 shows the prevalence of “female problems.” (See Table 1.) Francis Sibson, resident surgeon at Nottingham General Hospital, submitted this evidence to the 1843 parliamentary inquiry into the employment of children. The rhetorical function of this information in its context cannot be overlooked, but it does address illnesses with which women were diagnosed in an industrial district. These two examples from industrial areas conflict as to the numbers of women seeking hospital aid for reproductive ailments, but they agree on the small percentage of patients suffering from rheumatism, in contrast to both the Sussex and London samples.

Although institutions existed specifically for the treatment of the insane, this does not mean that hospitals did not see their share of patients suffering from mental illnesses. Moreover, many of the asylum patients

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### TABLE 1.

Ailments Diagnosed for Female Lace Workers Admitted as Out-Patients to Nottingham General Hospital, March 1840–March 1841a

<table>
<thead>
<tr>
<th>Ailment</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Amenorrhea</td>
<td>20</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>22</td>
</tr>
<tr>
<td>* Leucorrhea</td>
<td>6</td>
</tr>
<tr>
<td>Menorrhagia</td>
<td>7</td>
</tr>
<tr>
<td>* Dysmenorrhea</td>
<td>7</td>
</tr>
<tr>
<td>Cephalalgia</td>
<td>7</td>
</tr>
<tr>
<td>Ophthalmia</td>
<td>6</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>4</td>
</tr>
<tr>
<td>Tussis</td>
<td>7</td>
</tr>
<tr>
<td>Phthisis</td>
<td>2</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>10</td>
</tr>
<tr>
<td>Broncholcele</td>
<td>5</td>
</tr>
<tr>
<td>Gastritis</td>
<td>7</td>
</tr>
<tr>
<td>Gastrodynia</td>
<td>2</td>
</tr>
<tr>
<td>Scrofula</td>
<td>8</td>
</tr>
<tr>
<td>Venereal</td>
<td>7</td>
</tr>
<tr>
<td>Fevers</td>
<td>6</td>
</tr>
<tr>
<td>Neuralgia</td>
<td>5</td>
</tr>
<tr>
<td>Internal Complaints</td>
<td>6</td>
</tr>
<tr>
<td>Pain of Side</td>
<td>4</td>
</tr>
<tr>
<td>Hemoptysis</td>
<td>2</td>
</tr>
<tr>
<td>#Hysteria</td>
<td>3</td>
</tr>
<tr>
<td>Rheumatism</td>
<td>4</td>
</tr>
<tr>
<td>Debility</td>
<td>4</td>
</tr>
<tr>
<td>Worms</td>
<td>3</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1</td>
</tr>
<tr>
<td>Pleuritis</td>
<td>1</td>
</tr>
<tr>
<td>Amaurosis</td>
<td>3</td>
</tr>
<tr>
<td>Various Other Complaints</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
</tr>
</tbody>
</table>

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* Female Diseases

# Predominantly Female Disease
were admitted with physical ailments or developed physical ailments during their stays in the asylum. Although asylum directors were considered specialists in the treatment of the insane, most early Victorian medical men cared for both physical and mental diseases. There are several cases at UCH and the Chichester Infirmary that could just as easily have been found among the pages of the asylum case notes. For example, the UCH patient Merinda Codling was a thirty-year-old widowed servant, who was diagnosed as suffering from melancholia. Her history reflects her great mental distress:

About 5 years ago while living as wet nurse at Cobham, she felt for the first time a great restlessness and depression of spirits, not attributable she thinks to being away from her own family. A great fear of being left alone then came on, and when she was by herself she had very unpleasant thoughts without however any impression of others being present. . . . [She felt a] desire to commit suicide or to attack the next person she might meet. These sensations were so troublesome that she was obliged to leave her situation and return to Town when she was attended by a surgeon who as she was complaining of a pain in the head, and vertigo bled her and gave her doses of mercury but no relief being obtained, advised her to try her native air. She went accordingly to Suffolk and stopped 3 weeks; but found no benefit from the change. Returning to Town she entered service but frequently felt a return of dizziness of the head on which occasion she always found benefit from bleeding.12

Interestingly, this patient “took alarm at the word ‘melancholia’ on her card,”13 perhaps indicating fear of insanity or the marginalization of the insane.

Hysteria, which feminist historians have explored as a type of female insanity,14 comes across in the case histories as an illness that could lead to insanity, but not a form of insanity—like mania or melancholia—itself. Three asylum cases of insanity, in fact, were directly attributed to prior hysteria. Most cases of hysteria, however, were present in the hospital records, showing the fine line between mental and physical disease, and the assumption that hysteria had somatic causes. In the Cyclopaedia of Practical Medicine, John Conolly (an asylum director and expert in the moral management of the insane in England) defined the relationship between hysteria and insanity: “As the deeper shades of hysteria border upon or enter the confines of insanity, so the lighter comprehend several varieties of constitution characterized by increased susceptibility, and which, some time or other, it is found that peculiar impressions evoke some of the hysterical
phenomena.” Likewise, Anthony Todd Thomson, in his lectures on medical jurisprudence at UCH, noted that there was a risk in mistaking hysteria for insanity. He warned his students that “cases of hysteria, in which the mind is principally affected, have been not unfrequently treated as cases of mania, and the patients have been placed in lunatic asylums. Such an unfortunate diagnosis is liable to render the disease incurable.” Although the early Victorian understanding of hysteria emphasized its intimate links to female reproductive cycles, there was not as close a connection drawn between hysteria and insanity, or between insanity and the reproductive body, as would be articulated later in the century.

The patients diagnosed with hysteria did not conform to the traditional image of the hysterical woman of the Victorian era. They were poor working women responding to the diverse circumstances in their lives. The stereotype of the idle, confined, middle-class hysterical woman of the late nineteenth century did not exist in the early Victorian era, although the seeds of this image were being planted. In his casebook of 1854, for example, the East Sussex physician Dr. Ormerod indicated that hysteria was basically a middle-class disease, commenting on the case of a working-class woman that it was “one of the proportionately few instances where among the poorer classes functional nervous affections rise into serious importance.” This patient “hysterically” fidgeted with her hands to the point that her joints were distorted. Ormerod remarked, however, that “in the poorer classes this [hysterical] pain is not habitually over excited or should it be so, work is commonly at hand to remove that excitement. Tired limbs do not fidget. The richer classes have not so ready an outlet for their over-excitement, and a fidget grows into a habit into a disease.” This is clearly a class analysis of hysteria that suggests a norm of paid employment for poor women as well as men. Thomas Laycock, in his study of The Nervous Diseases of Women, noted that hysteria affected mostly young women and almost exclusively women between puberty and menopause. All but one of the Sussex hysteria cases were between the ages of twelve and thirty, and more than three-quarters of the UCH hysteria patients fit within this range. More than three times as many hysteria patients at UCH were single as were married, and, as in the overall sample, the majority were engaged in some sort of service occupation.

Just as mental illness was present in the hospital cases, so physical ailments were present in the asylum cases. Often the asylum histories note only physical changes in the patient’s health, as opposed to changes in her mental state. Emma Holden’s case is illustrative of this point. Holden, a twenty-seven-year-old Methodist from Huddersfield, was admitted to the asylum in July 1834; “an alarm and a love affair” were listed as the causes
for her insanity. In September, the first note on her progress was simply “amenorrhea,” and in November her case indicated that she “has never menstruated since her admission.” On March 4, 1835, her attendant recorded that she “complains of pain in head. Has had Leeches to her temples, and a brown powder. Catamenia have only appeared twice since admission.” Two days later she began to menstruate and “feels herself better this morning. Bowels confined cannot swallow the pills.” Brief notes on headaches, nausea, and constipation follow for the next seven years, and it was not until December 1844 that a significant comment was recorded on her mental state and behavior connected to her insanity: “Never employed: solitary, unsocial, noisy, violent, incoherent: fights: destroys clothing and is dirty.” The comment, interestingly, finished with the note “apparent good health.” She died, however, from fever in May 1848.20

Although there were well over three hundred diagnoses for the patients at the London and Sussex hospitals, there were a variety of symptoms that recurred with much frequency. Palpitations, shooting pains, and headaches were quite common indicators of a broad spectrum of illnesses, as were loss of appetite and giddiness. Swollen and inflamed joints affected many women, whether or not they were the reason for admission to the hospital. It is likely that these symptoms show up regularly because, in addition to patients describing their manifestations, clerks specifically prodded patients as to the symptoms they were experiencing. In doing so, they may have provided patients with a common language in which to describe what they were feeling. Similarly, general symptoms of insanity appear in routine fashion in the asylum cases. Violent actions, “raving” on particular topics, lassitude, and inability to control bodily functions were noted regularly.

In expressing their understandings of how various illnesses interacted with their bodies, women used active and passive language to describe their ailments. Rheumatism was one of the most active physical illnesses, attacking and seizing the patient. Catherine Anthony, describing her rheumatism, recounted to the UCH clerk that she “was suddenly seized in the middle of the night with violent pains in the back.”21 Other ailments were perceived in equally active terms. A London woman reported being “attacked with a severe cough”22 and another being “seized with sore throat.”23 Sarah Hook, a Chichester outpatient of Dr. Tyacke’s in May 1843, indicated that “last summer she was suddenly seized with giddiness which has returned several times.”24 Similarly, Fanny Davis “was seized with erysipelas of the right side of face yesterday and admitted today as an urgent case.”25 This imagery of seizure suggests the suddenness and disruptiveness of disease. Fits of whatever nature—epileptic, hysterical, or
paralytic—were also extremely active, and patients used similar language of attack and seizure to describe them. Insanity was also expressed as an attack, both by the patients and by their physicians. Colds, however, were particularly passive, always having to be caught or taken.

Many patients, in the process of describing what made them ill, emphasized their previous healthiness, strength, and hardiness. Mary Jubb told the clerk at UCH that “she had been fleshy and strong” before she got sick. Louisa Burcher, a shoemaker’s wife from Bognor Regis in West Sussex, “says she was a healthy woman until lately” even though she “came of a phthisical family.” Elizabeth Allen, a sixteen-year-old servant, indicated that she “has always been in good health with the exception that the catamenia have never appeared.” This statement is particularly interesting, as it suggests that this patient (or the clerk) did not perceive general health necessarily to be connected to the reproductive body and the functioning of menstruation. Ann Farrell actually disconnected her representation of health from her understanding of the nature of her body, telling the clerk that “she has always enjoyed good health (with the exception of being naturally of a weak constitution).” Similarly, the medical records suggest that the state of a patient’s health was not necessarily defined through one particular illness, as in the case of Jemima Lucas, who “for three months . . . has been subject to fits, which she has been told are hysterical. . . . She is in other respects in good health, stout and strong, countenance florid.”

Stoutness and ruddiness were taken as signs of healthiness, whereas thinness and pallor were indicative of physical decline. As we saw in chapter 1, parliamentary investigators associated health with the outdoors and the “blooming peasantry” who were exposed to nature, while the pallor of urban factory workers was well known. The significance of a body’s mass and color as indicators of health was shared across classes, as patients made their assessments of health in similar language. The UCH patients seemed to have been particularly concerned with telling their doctors that they had once possessed the marks of health. One woman who was described by the clerk as of “pale complexion” assured the transcriber that she had been “very ruddy” until a year ago. Another patient, suffering from a diseased uterus, related that “she has not had good health for 2 years, has been getting thin and pale all this time before then she was stout and had a colour.” At the Chichester Infirmary, Jane Hayners indicated that she had “never been healthy though” the clerk described her as “fat and fresh coloured.” Likewise, Martha Helmsley “has never enjoyed good health though she is very stout and ruddy.” These last two examples show that the associations of stoutness and color with healthiness, and pallor and thinness with illness, were shared by patient and doctor alike,
and that contradictions between appearance and a corresponding state of health were worthy of note.

The patients often connected strength to their bodily health, although some women indicated that they could be strong without being healthy or healthy without being strong. Eliza Prynne, a London dressmaker, told the UCH clerk that she has “been generally very healthy and strong.”35 Similarly, Elizabeth Garner, a housemaid who came to UCH suffering from paralysis and hysteria, noted that “she generally enjoys good health and considers herself strong.”36 Although Sarah Fairbanks explicitly connected strength to health, indicating that “she is liable to no diseases and is habitually strong,” Mary Ann Filler, by contrast, “considers herself to be habitually healthy but not strong.”37 The patients’ use of words such as robust, ruddy, and strong to describe themselves previous to their illnesses hints at an able-bodied identity and provides a ready contrast to images of the frail, pale, and fainting Victorian lady, as well as to the images of women workers outlined in chapters 1 and 2. Yet, as will be illustrated below, the patients’ conceptions of what made them sick led them to see their strength itself as fragile.

Although many women perceived themselves to be naturally strong, other women viewed themselves as delicate but represented this delicacy as an individual condition, not ingrained in the female reproductive body. Susannah Hull, for example, indicated that “she has been long delicate—very subject to catch cold.”38 Harriet Goddard, at twenty-one, “states that she has been very delicate for some years.”39 These women associated delicacy with ill health, not with the fundamental nature of the female constitution. Grace Stubbs, by contrast, told the clerk “that her constitution has always been delicate.”40 Interestingly, far more women from Sussex told their doctors that they were “delicate” than did those in London or the West Riding. This contrasts with the assumptions of the parliamentary investigators, who, with the medical witnesses, argued that country environments (with the exception of the assumed prevalence of rheumatism) were healthier for women than urban environments. The patients’ words suggest that they situated their normal bodily conditions on a spectrum of strength and delicacy. These terms had no inherent gender connotations—women could be both strong and delicate—but rather were used to describe each woman’s individual understanding of her body.

The Environment and Women’s Health

In all cases, whether women understood themselves to be strong or delicate, their recognition of the precariousness of good health is evident. The
patients perceived themselves to be extremely susceptible to diseases resulting from physical, environmental, and social causes. The environment itself played a key part in the ways patients conceptualized disease and the fragility of their good health. The single most prevalent cause for illness noted by the female patients in London and Sussex was the environment, and a number of women in the West Riding Asylum had their insanity attributed to environmental causes. I am using the term environment to suggest such factors as climate (indoor and outdoor), temperature, degree of moisture, and weather. The relationships between environment and health were particularly significant in humoral as well as miasmatic understandings of disease and the medical culture of which both doctors and patients were a part in the early nineteenth century. Where a patient was born, the place where she resided, and her exposure to environmental elements recognized to be dangerous were all seen to be meaningful in determining experiences of health, illness, and cure.41

Some patients associated their health crises with a change of climate. Several London women played on a country/town dichotomy when assigning causes to their ailments or describing their medical histories. Harriet Henchman, a patient of Dr. Thomson's in 1837, had come to London from the country. Henchman, a maid of all work, noted that she had “enjoyed very good health till she came to London from Wiltshire about 3 months back.”42 Elizabeth Taunton, an Irish servant of all work in a satin manufactory, “attributes her illness to residing in the City, having been taken ill about three months after her first moving there.”43 Another patient explained that “at intervals she has lived in London, at such times she has been always troubled with cough but not when residing in the country.”44 Here health was directly located in the country, while the metropolis with its dangerous atmosphere was the location of illness. Similarly, Harriet Book had “always been healthy herself while living in the country but since her arrival in London, about 6 months ago, she has been subject occasionally to pains of the head and right side and shoulder.”45 These patients believed that there was something about the urban environment that was less healthy than the rural (or even the provincial) environment. Utilizing these same associations, the clerk in Sarah Adlam’s case noted the paradox that Adlam “has generally had delicate health although she has lived in the country the greater part of her life.”46 Merinda Codling, whose case I discussed above with reference to mental illness, was “advised . . . to try her native air” in Suffolk by her surgeon.47 Additionally, in the Sussex records, some patients indicated a decline in health on moving from rural areas into cities such as Chichester.
According to most of the patients, the change from country to city caused ill health. This suggests that popular conceptions of healthiness were wedded to the miasma theory of disease and ideas about the relationship between the rural and the urban. According to Andrew Wear, “the countryside was the norm, from which urban living was an unnatural departure that incurred additional health risks.” Clerks at UCH also noted whether a patient had lived in London all her life, and if not, whence she came. It was not only country and city that were associated with particular climates, for as the clerk noted about Fanny Craig, “a woman of colour [who] has been in England 14 years,” she had “always enjoyed good health not being at all affected by change of climate.” The fact that this geographical element was part of the case history shows the importance medical practitioners assigned to environment with regard to health. Like the evidence in the parliamentary inquiries, it suggests a medical aspect of the English rural ideal, which assigned healthiness to the country and disease to the city.

Environmental factors that were especially significant in the case histories were wet and cold. These were noted as such common causes of illness that the clerks often recorded when a patient “has not been exposed to cold or wet.” Male patients, too, in the select cases that I examined, also emphasized the centrality of cold and wet in their understandings of what made them sick. Charles Turner Thackrah, a medical man of Leeds, argued that doctors and their patients were far too willing to attribute illnesses to cold and wet. He complained that

In this country almost all our maladies are ascribed to the agency of wet, or to “taking cold.” Medical men adopt this notion. It is constantly heard in their expressions; it constantly appears in their writings. The people, of course, have gradually adopted the medical doctrine, and carry it even further than its founder. A reference, however, to the history of cases attributed to wet and cold, and an examination of the reasoning of the patients, are enough to expose the insufficiency of the evidence and the incorrectness of the inference. . . . [W]et and cold, without other agencies, do not produce the disorders ascribed to them.

Yet Thackrah was clearly in the minority; wet and cold as explanatory factors for disease had a long history. Prolonged exposure to these elements was thought to produce an imbalance of the entire constitution, as wet and cold were key components in humoral understandings of disease. George Hilario Barlow, senior physician at Guy’s Hospital, stressed the significance of wet and cold as chief causes of disease, particularly “active congestions
and inflammations.” Barlow explained that “the effect of cold in producing internal disease is increased by previously heating the body; and for a similar reason, it is greater when applied by drafts or currents of air, or by wet clothes (and the subsequent evaporation from them), which rapidly carry heat off the body.” Additionally, Barlow cautioned against the potential effects of drinking cold liquids, which could adversely affect the functioning of the skin and kidneys.

Barlow’s theories have strong resonances with the patients’ perceptions of cold and wet as causes of illness. “Getting wet in the feet” was mentioned as a frequent cause of the common cold, as was exposure to drafts. Catching cold, in turn, was thought to translate into further symptoms. Sarah Bryant, for example, “has been much exposed to cold and wet . . . four days since she felt pain in her knee, afterwards in her ancle [sic] and soon both legs became so affected that she could not use either; she attributes the cause to sleeping in a damp bed.” The notes from Isabella Wittey’s case show in detail how patients perceived exposure to wet could affect general health:

The present attack commenced about 3 weeks ago. The evening before it commenced she got wet from exposure to rain for about 2 hours; she was very warm at the same time, and when she came home she sat in a draught and neglected to change her clothes; she sneezed and coughed the same night. The next morning she felt great pain in the right elbow, forearm, wrist and hand. About two days afterwards she felt pain at the inner side of the right knee, slightly in the leg, but severely in the ankle, not in the foot. About 3 days afterwards she felt pain in the knee and ankle of the left leg and subsequently in the left arm.

An asylum patient, Ann Binns, had her insanity attributed to “being exposed to sudden transitions from hot to cold.” In an extreme case, Mary Toy, a fifty-three-year-old cook, connected her ailments to constant dampness: “she has been living for the last 3 months in a damp kitchen which was always full of steam, her bedroom was also very damp, and moreover, she slept all this time in the same bed with a girl who had incontinence of urine, so that she says her night dress was generally dripping wet in the morning.”

Patients tended to blame wet or cold for a wide range of illnesses. Clementina Broomfield, admitted to UCH in February 1844, was diagnosed with syphilis. Perhaps in an effort to cover over a sexual indiscretion, she attributed the spots on her body to cold and wet:
Last November she laid for four nights in a damp bed but never slept because she felt so cold. On the third night she felt a tightness across her chest—and coughed a good deal—the next two or three days she got worse—lost strength—was also attacked with headache—a few days afterwards she discovered lumps on her head and spots on different parts of her body—copper coloured—of the size of a pea.62

Several women mentioned feeling ill after drinking cold fluids, especially while they were hot or perspiring. The cook Elizabeth Pace, for example, “states that yesterday she felt very warm and was very thirsty. After setting the bread she drank a large quantity of very cold beer and in about ten minutes afterwards she was attacked with violent pain in the epigastrium.”63 Similarly, Janet Thomson told the UCH clerk that “3 or 4 years ago, she had a fit, brought on she supposes, by drinking a quantity of cold water whilst in violent perspiration.”64

Wet and cold as explanatory factors for disease were common sense to a certain extent, as they produced physical discomfort. Living under the conditions described above and understanding disease to arise from these environmental conditions, a woman would expect illness to be part of her ordinary existence. Some patients blamed themselves for their illness, for with care, they believed, they could control their environments to a certain extent, and particularly their exposure to wet and cold. Rose McGee informed the UCH clerk, for example, that she was “accustomed to hard work and an active life, generally enjoying good health, with the exception of being annoyed by cough from imprudence in exposing herself to cold.”65 Interestingly, however, heat—which also produced discomfort and played such a large role in parliamentary medical witnesses’ explanations of women’s illnesses in factories—did not serve the same functional purpose as wet and cold in patients’ understandings of the environmental causes of disease.

**Menstruation and Women’s Health**

Although the diagnoses indicate that reproductive illnesses may not have been the central ailments sending women to medical institutions, the case histories suggest that patients linked problems with their menstrual cycles to their primary illnesses. For the female hospital and asylum patients, irregular menstruation played a fundamental role in understandings of disease as both a sign of illness itself and as a cause of other ailments.
Menstruation, however, was never associated with inherent weakness or debility, as it was in much medical literature, and was almost always linked to social and environmental causes. Patients paid close attention to their menstrual cycles, noting in detail the ways in which the environmental conditions under which they lived affected their reproductive bodies. Even when menstruation was not noted as a direct cause of illness, the case histories show that patients and their medical practitioners worried about menstrual health.

In the asylum records, fifty-eight cases out of the 760 (or about 8 percent) where cause was registered cited some form of irregular menstruation as the cause of the patient’s insanity. In terms of nineteenth-century understandings of the links between the reproductive functions and the mind, this is a low figure. Nevertheless, considering the overall breakdown of causes in the asylum cases, it is an important number. The most significant menstrual disorder in the asylum was amenorrhea—suppressed menstruation—which accounted for twenty-six cases. Ann Darwent, for example, had been suffering from amenorrhea for six months, which “appears to be coexistent with mental derangement.” These links between mental and menstrual disorder were readily available to asylum doctors, as the female reproductive system was thought to be intimately connected to the nervous system. In Ann Wood’s case, insanity was attributed to “suppression of the Catamenia. . . . Previous to this period [of insanity] the catamenial discharge was regular and natural.” This allusion to a “natural” menstrual cycle recurs throughout the records. Interestingly, Ann Wood did not menstruate at all during her entire time in the asylum, yet she was discharged “well . . . [and] in good bodily health” eight months after her admission. Connected to worries about menstruation, assumptions about the instability of the female body at puberty come across in some cases. Sarah Wild of Leeds, for example, came into the asylum in November 1839. Her notes reveal that she “has been subject to mental derangement since the age of puberty and has been occasionally very violent . . . it is believed that her medical attendants have generally supposed her Insanity to have had its origin in irregularity of the menstrual discharge.”

Doctors also discussed amenorrhea with chlorosis. Chlorosis—or the green sickness—was a disease associated with female adolescence. Medical historians have identified chlorosis as iron deficiency anemia, and women suffering from this disease were recognized, in Barlow’s words, “by the white lips and white cheeks, with sometimes a sallow, greenish hue, the pearly conjunctivae, the dark araeola around the eye. . . . There is general weakness and inability for exertion.” According to Barlow, amenorrhea
combined with chlorosis “is most common in towns, and is no doubt much favoured by the want of pure air and sunshine.” Michael Ryan was even more explicit on this point. Chlorosis, he argued, “attacks girls of pale complexion, and but seldom those who reside in the country, and take active exercise in the pure open air. A sedentary life renders girls debilitated, and subject to chlorosis, as we observe in manufactories, and in situations in which they are too much confined and overworked.”

The case histories reveal, however, that regionally more country than town women were brought down by chlorosis; the disease was diagnosed by name only four times in the UCH sample, whereas it was diagnosed ninety-one times in the Sussex sample. In the Sussex records, chlorosis appeared consistently alongside irregular menstruation, and the clerks noted such things as “the catamenia have not appeared for 8 months consequently she is now suffering the usual symptoms of chlorosis.” In the case of Sarah Chitty, “the catamenia have been irregular and scanty for some time and during the above time she has suffered from the ordinary symptoms of chlorosis.” And in that of Ann Newstead, “during the last six months the catamensial function has been very indifferently performed and for the most part not at all. This is also an exceedingly well marked case of chlorosis.” Lack of menstruation was equated with a chlorotic appearance, and clerks noted when this equation did not add up. Ann Merritt, a maid-servant from Chichester “looks quite chlorotic but she says the catamenia are regular both as to time and quantity.” Sarah Smallwood was described as a “wretched chlorotic looking girl yet with regular though pallid catamenia.” A naturally ruddy woman could masquerade as healthy, for her appearance covered over the presence of chlorosis. Matilda Royes, for example, had had “extremely scanty catamenia of a pale colour,” but “she is naturally of a florid complexion and therefore at first does not look very chlorotic.”

With or without chlorosis, any woman could be susceptible to suppressed menstruation, for as James Blundell, lecturer on the diseases of women at Guy’s Hospital wrote, “the catamenia with women in the full vigour of life, acting month after month with the utmost regularity, may, from some accidental cause, it may be a fright, or cold, or the like, cease to flow.” Edward Tilt added that among the possible risks to regular menstruation (defined as the “monthly type”) were changes in environment, particularly moving from country to town, or town to country. Michael Ryan listed a catalog of causes of suppressed menstruation: “application of cold and humidity to any part of the body, but more especially to the hands or feet, strong mental emotions, low diet, impure air, and every thing capable of injuring the general health, and debilitating the uterine system.” As
will be discussed below, the patients appealed to many of these sources in describing their menstrual irregularities.

The case histories reflect a preoccupation by doctors and patients with menstrual regularity. The menstrual discharge could be scanty, profuse, pale, and excessive according to the language in the patient records, and indeed the records are vague as to what constituted a normal flow or how this normalcy was established. Whether the clerks supplied the patients with a language to describe menstruation or whether the language was the patients’ own is unclear. It is, however, plain that the patients themselves made judgments as to the normalcy of their menstrual flows. Some women indicated that their experiences of menstruation were normal even though they understood themselves to have “profuse” discharge. Hannah Walls, for example, related that she was “long subject to profuse menstruation but not more than regular lately.” Her analysis was based on her own observation over time. Elizabeth Acland’s asylum case indicates that “she is liable to excessive flow of the menstrual discharge.” These women believed they were healthy even though they understood themselves to have heavy menstrual discharge. By contrast, the West Sussex inpatient Caroline Jones’s menstrual discharge was recorded to have “never been in proper quantity or of a normal colour,” implying by the language that this state was associated with abnormality and/or ill health. The case notes suggest, however, that this perception may have come from previous medical attendants rather than the patient herself.

Other cases show clearly that women saw changes in their menstrual flow to be indicative of ill health. Louisa Budd, for example, was admitted as an inpatient to the Chichester Infirmary, suffering from chlorosis. She recounted that she “had always good health till about 8 months ago when her menses (which had appeared regularly previously) ceased.” Elizabeth Hands came to see Dr. Williams at UCH in March 1840: she “enjoyed very good health till 3 years ago when the catamenial discharge became very profuse and caused great debility and loss of flesh.” This patient associated the weakening of her health with a loss of menstrual fluid; the loss of blood was in effect draining her well-being. Menstruation, in the narratives of the patients, was a visual experience, described by color, quantity, and when the menses made an “appearance” or an “attempt,” as in the case of the servant Eliza Collins, who told her medical attendant that “the catamenia made ‘an attempt’ in August and have not since appeared.” Excess or scantiness when described by the patients was based on the woman’s experience with her own body. Patients referred to a specific history of personal experience, rather than an abstract norm of the female reproductive body.
In some cases, the patients seemed to confirm medical wisdom concerning the dangers of puberty and the onset of menstruation. Ellen Donnoughue, a twenty-year-old housemaid admitted to UCH with amenorrhea in 1840, indicated that the “catamenia appeared for the first time about three years ago—at that period her health became deranged.”91 Sarah Voller, at seventeen, had “enjoyed good health until seven weeks ago, when for the first time there was a show of catamenia.”92 Similarly, Eliza Ransom at eighteen “was a healthy girl until 7 months ago when the catamenia appeared.”93 These female patients clearly associated the onset of menstruation with larger health problems. It is unclear from these cases, however, whether “deranged” health was connected solely with the process of menstruation or with other bodily systems as well.

Likewise, the case histories show that “the change of life”—menopause—was a difficult time for women’s health. Ann Giles, for example, stopped menstruating about twelve months before her admission to the Chichester Infirmary: “There was a good deal of constitutional disturbance at the time and an eruption of psoriasis diffusa appeared over the arms and one leg.”94 The significance of this statement does not rest in the symptoms themselves, but rather in the fact that an outbreak of psoriasis was connected to menopause. Jane Viney also connected her ailment to menopause: “Says she was taken in a fit 6 months ago without previous warning and remained unconscious for 2 days. Has never been well since ... and thinks this illness owing to change of life.”95 A surgical outpatient in Sussex “has an inflamed leg owing to the change of life.”96 Twenty cases of insanity in the asylum records were attributed to the “change of life.” The patients’ and doctors’ attention to the menopausal period as a precarious one for female health contrasts to the absence of menopause in the parliamentary commissioners’ investigations of female health and work. Menopause did not matter to reformers worried about women’s ability to reproduce, but the medical cases show that women themselves experienced this aspect of the reproductive body as troublesome.

In a few instances, the patient narratives appeal explicitly to medical connections between the humors and the evacuation of bodily fluids. It was not unusual in neo-Hippocratic medicine to read a bloody nose or the vomiting of blood during the menstrual period as a substitute for menstrual bleeding. This illustrates what Thomas Laqueur has called “a physiology of fungible fluids.”97 According to Laqueur, “what matters is losing blood in relation to the fluid balance of the body, not ... the orifice from which it is lost.”98 Laqueur’s analysis, however, applies to medicine before 1800, around which time he locates a fundamental shift. Yet this understanding of menstruation was still present for doctors as well as patients in
the early Victorian years. Manuals on the diseases of women, for example, addressed “vicarious menstruation.” In 1837, James Blundell explained that

sometimes women throw up blood month after month, to the amount of one or two pints at a time, not to mention larger quantities. It is not always that the effusions are of monthly occurrence, nevertheless there is frequently a tendency to periodical return; and in some cases you will find the discharge takes place with such regularity, that the disease may be properly enough called the vicarious menstruation.

This matter-of-fact linkage between vomiting blood and menstrual periods clearly reflects neo-Hippocratic understandings of the body.

The patients’ cases expressed similar understandings. Seventeen-year-old S. A. Slaughter’s illness, for example, was connected with the absence of menstrual bleeding:

Says that 2 years ago had great pains in the head: and that blood came from her eyelids, nose, ears, and vomited from her stomach also. Has continued ever since. She now passes blood in the same manner: coming on about once a fortnight. Complains of pain in her head: and great pain in her stomach, not worse after taking food. Has never menstruated. The blood seems to oose [sic] from various parts: and has come on from the time the menses should have appeared.

In order to keep bodily balance, the patient had to release blood in a way that replicated menstrual discharge. The UCH case notes indicate that when Sarah Hendle suddenly stopped menstruating at the age of twenty-six, “she suffered very soon from drowsiness with head ache and has had frequent bleedings from the nose but not at regular periods. She also coughs up a great deal of blood at times.” In Amelia Morse’s case, the patient came to UCH with “haemorhage from the nose.” The clerk recorded that the patient “has always been irregular in the menstruating periods. The menses have never been in sufficient quantity for the last 3 years. Haemorrhage always accompanies the menses,” suggesting that the patient’s bloody nose made up for the insufficient amount of menstrual discharge. Substitution of a different type was present in the case of Margaret Summers, who at age seventeen came as an outpatient to the Chichester Infirmary with pains in her left breast. Dr. Tyacke noted that “not having menstruated at her age; it is a question, whether this lump in her
breast may be an abscess forming; or whether it be entirely connected with
the want of menstruation, that is, a case of Hysterical Breast.”

Although menstruation alone was central to patient understandings of
female diseases, the intersection of menstruation with environmental ele-
ments was particularly significant in patients’ descriptions of their ailments. Many patients linked menstrual problems to getting their feet wet
or being exposed to cold, supporting the medical writers’ perspectives on
this point. At the Chichester Infirmary, Elizabeth Fogden noted that she
“has not menstruated regularly for six months; ascribes it to working con-
stantly in the wet and damp.” Her occupation, however, was not regis-
tered. Eleanor Hurst, a patient of Dr. Tyacke’s, recounted that “a fortnight
since was exposed to wet and cold while the catamenia were present which
caused their suppression,” which in turn brought on a sequence of ails-
ments. Mary Collins stated that “five years ago caught cold from getting
wet through, the catamenia which were present at the time were
stopped.” In contrast, but still illustrating the connection drawn by the
women between menstruation, environment, and illness, Julia Thompson
indicated that her menses “have not always appeared regularly, but lately
they have done so, and have been rather excessive in quantity—very much
so at the last period which was just before the occurrence of this illness. She
knows no cause for it, but says that she remembers getting her feet wet
about a week before the commencement of the attack” of rheumatism.

Menstrual problems and other illnesses intersected in a variety of ways.
The cessation of menstruation itself could be taken as a sign of illness.
Maria Rutherford, who was admitted to UCH in 1835 for amenorrhea,
“caught cold from walking with bare feet on a brick floor about a year ago,
since which the catamenial discharge has ceased.” In some cases, it is
clear that a patient thought an illness itself resulted from the fact that she
was menstruating at the time of being exposed to cold or wet. Mary Calry,
for example, “caught cold from being drenched with water, during men-
struation.” Although most women stressed a connection between sup-
pressed menstruation and catching cold, Sophia Brook’s notes indicate that
she “caught cold at the last catamenial period. The flow increased in con-
sequence.” Margaret Leary stated that a few months before her admis-
sion “she supposed she caught cold, for the catamenia suddenly
stopped.” The reverse also obtained; Anne Carpenter of Littlehampton
had “not menstruated in two months, to which cause she attributes her
present illness,” dyspepsia. Anne Usher told the Chichester Infirmary
clerk that “during the last month she has been subject to headache which
was relieved when the catamenia appeared.” These cases reflect the
patients’ understanding of the interconnected nature of their bodily systems. The blockage of menstrual fluid could translate or migrate to another part of the body, causing disease or discomfort that could only be cured with the release of the obstructed evacuation. This understanding has clear resonances with humoral perceptions of the body. The body’s processes—reproductive and nonreproductive—were thought to respond to the environment in certain ways which then produced rheumatism, fevers, and other illnesses. These examples signify that the patients connected regular menstruation to a healthy condition. When their menstrual cycles were interrupted, the patients assumed a bodily imbalance, in many cases based on exposure to wet or cold. (From an early-twenty-first-century perspective, it is more likely that poverty and poor nutrition caused their irregular menstrual periods.)

The case histories suggest the fragility of “normal” menstrual cycles, and indeed the fragility of good health. Not only could menstruation be interrupted by stepping in a puddle or standing in a cold room, but this in turn would affect the entire body. The ease and frequency with which women imagined wet and cold affecting their bodies is in tension with their understanding of themselves as strong and robust. There is no indication, however, that women or their doctors believed that menstruation kept women workers from their employment or from going about their daily lives, even though they believed that normal menstrual cycles were important to their overall health. This finding differs from Nancy Theriot’s study of female insanity, in which she concluded that nineteenth-century “women most often related their illness to their female bodies.”

Although it is indeed true that “women experienced their reproductive lives as troublesome,” the patients’ understandings of their illnesses both supported and challenged the conventional medical wisdom that women tended naturally to ill health due to their reproductive biology, and principally due to their menstrual cycles.

The patients at UCH, the Chichester Infirmary, and the West Riding Pauper Lunatic Asylum shared similar understandings of health and illness. Their representations of their illnesses reveal the persistence of humoral understandings of disease and the significance of environmental factors in popular conceptions of illness. The patients’ descriptions of their bodies previous to their illnesses challenge the picture of Victorian women’s health as inherently unstable due to the reproductive body. Although the prevalent image of the Victorian woman is one of weakness, pallor, and
delicacy, the patients stressed an able-bodied norm of health that included strength, stoutness, and ruddiness. The possession of these attributes was something that these women hoped to attain, for, as we will see, their sense of self was bound up in their bodily ability to work.

The patients perceived their reproductive functions, and menstruation in particular, as having a significant impact on their well-being, but they did not define their health or their bodies as solely reproductive. The doctors and their patients approached the reproductive system—and specifically the menstrual cycle—as one system intertwined with the other systems in the body; disruptions to the normal functioning of one could affect the functioning of others. This analysis affirms a class-based approach to Victorian women’s bodies. Although Victorian medical theories concerning the centrality of the female reproductive body seem to have developed in conjunction with the articulation of a middle-class norm of domesticity and the complementary roles of the sexes, the reality of poor patients’ lives created tension between the theory of the reproductive body and the practice of working women’s everyday experiences. Irvine Loudon has shown in a study of midwifery care that at least by the late nineteenth century, some doctors had differing ideas about the relationship between the reproductive body, women’s overall health, and the class of the patient. The obstetrician Robert Barnes, for example, “offered the explanation that the ‘physical organs’ of working-class women were ‘in better working order, and are not subjugated and enfeebled by the excessive cultivation of the emotional and intellectual elements.’” The medical case histories of poor women in the 1830s and 1840s seem to suggest a similar conclusion. Additionally, the patients firmly situated their health experiences within an environmental context, and, as the following chapters will illustrate, within social and economic contexts as well.