CHAPTER 7

“Rather a Hard Life”:
Domestic Relationships and Health at Home

The material circumstances of their homes shaped just one of the ways early Victorian “women’s lives [made] them sick.” The unhealthiness of home could be just as much a consequence of emotional as of physical factors. In any event, the ideal relationships within families that parliamentary reformers imagined would emerge if women stayed at home were quite unrealistic. Through the causes to which the patients attributed their illnesses, the case histories construct a spectrum of domestic relationships. At one end, the patients represented their families as close-knit, loving, and healthy. At the other end, families were brutal, abusive, and dangerously unhealthy. Poverty and disappointed expectations put pressure on even the most caring of poor families. Although it is important to recognize the value of family in the survival strategies of poor women, Andrew August has pointed out that overemphasis on family strategies “obscures tensions and conflicting interests within families.”

Even if material conditions fostered women’s ability to fulfill the tasks of social reproduction, their human relationships could get in the way.

The Spectrum of Family Relationships

Despite the discomfort and physical difficulties in which they lived, many poor families must have had happy lives. Signs of harmonious relationships can be found in several contexts in the patient case histories. Grief over the death of loved ones, for example, was sometimes noted as a cause of mental and physical illness. Sixty-eight (or 9 percent) of the asylum cases of insanity were attributed to grief at the loss of a family member,
child, spouse, or sweetheart, and a number of the hospital patients blamed their illnesses on grief. The death of her father was supposed to have been the cause of Ann Chappel’s insanity, and Hannah Bailey allegedly became ill from the death of her daughter. Elizabeth Smith, a patient at University College Hospital (UCH), “fretted much” when her husband died, and she became violently ill with shaking and palpitations. Mary Goodchild, a forty-four-year-old outpatient at the Chichester Infirmary, related that she “recently lost her husband—[and was] distressed in mind.” The description of Dinah Turvey’s loss is quite moving: “About 6 years ago she lost her husband, fretted very much and has since been frequently attacked with a dull aching pain in the region of the heart.”

The connections drawn between grief and illness imply that patients felt deep loss at the death of family members, signaling strong bonds between mother and child, daughter and parents, wife and husband. Emotional and mental anxieties were described in physical terms, and doctors treated these ailments with medications and therapies (mercurial treatments, bloodletting, and purging, for example) similar to those used for more manifestly physical diseases, such as dyspepsia or rheumatism. Although the above examples indicate closeness among families, however, they also show the common presence of death in intimate circumstances.

Another context in which there is evidence of affectionate relationships is in notes concerning patients’ or relatives’ wishes in reference to a patient’s care. Elizabeth Cook, for example, entered UCH very ill. After three days, “notwithstanding the severity of her illness, this woman quitted the Hospital in the Evening; she was taken away by her husband, who considering that she was about to die, was anxious that her last moments should be passed among her family and friends.” Similarly, Sarah White, “thinking herself near her end wished to return home.” These two cases suggest that home—however basic—was a welcoming environment, and that family and friends were supportive in times of difficulty. The West Riding Asylum notes, too, contain cases indicative of warm relationships. Ann Walker’s husband, for example, visited her at the asylum and “express[ed] his great pleasure at seeing her so much improved since his last visit.” Jane Senior, a collier’s wife with two children, “raves affectionately after her husband and children,” and was described as “naturally a good, kind, hard working wife.” It appears that this comment came from her husband.

Devoted, healthy families did of course exist among the poor, and disruptions to these families seem to have caused great emotional and physical upheaval for the patients and their relatives in the samples. The evidence from the case histories, however, suggests that many familial rela-
tionships among the laboring classes were unstable and that this instability affected the health of women. Death often took away relatives, spouses, and children at early ages, but women were also faced with other familial hardships. The patients expressed much frustration and sadness in their private lives from such things as quarrels among family members and desertion by husbands and sweethearts.

In the asylum records, ten cases of insanity were noted to be caused by family disturbances and eleven cases to be caused by domestic troubles. (The term *family* seems to have been used to refer to relationships with blood relatives or children, whereas *domestic* could also refer to a spousal relationship.) Hannah Binns, a married woman with five children, indicated that she was suffering from “trouble respecting her family.” According to her sister, the UCH patient Phillis Hart Taylor “has laboured under great anxiety of mind from some family affair.” Particularly in the asylum cases, religion was noted as a cause of family difficulties. Sarah Chapman had her insanity attributed to “domestic quarrels caused by the Patients’ relatives interfering with her desire to attend Meetings for religious purposes.” Likewise, in the case of Mary Ann Mills, who had “recently attended the wesleyan Chapel... her husband attributes it as a cause of her present condition.” The fact that relatives and spouses named religion (and more specifically, conversion) as a source of illness suggests that religious belief could cause serious dissension within households. Family members may have been disturbed by the emotional and physical symptoms often associated with nonconformist—and particularly sectarian Methodist—practice among the poor.

A number of the patients at the asylum attempted suicide as a result of family disagreements, as did a few women at UCH. Mary Johnson was brought to the hospital by a policeman: “About 3/4 hour before her admission, in consequence of some disagreement between herself and the relatives with whom she had resided, she was turned out of the house; at this her anger and dejection were such that she determined to destroy herself.” In a similar case, Sarah Barry took a dangerous dose of opium “in consequence of some disagreement with her relations.” Susan Broomfield, a sixteen-year-old London servant of all work, tried to commit suicide through laudanum poisoning because of bad family circumstances. According to her case history,

she states that her stepmother is unkind and makes her unhappy whenever she goes home. Was discharged from her last situation [in service] on Tuesday night, and went to her father’s lodgings but slept on the stairs fearing to enter the room because of the stepmother. Yesterday she spent at a sister’s
house who could not afford her lodging for another night, and there she contemplated suicide by means of laudanum.19

This woman saw herself faced with few choices when confronted with the combination of unemployment, family insecurity, and poverty.

**The Stresses of Love and Marriage**

Problems with relatives, however, pale in comparison to the numbers of patients who expressed problematic relationships with their lovers or spouses. In addition to the eleven asylum patients who blamed domestic troubles for their mental illnesses, thirteen noted disappointments in love, fourteen disappointments in marriage, thirteen desertion by spouse or sweetheart, six pointed simply to love, five to jealousy, and two specifically to unfaithfulness. This total of sixty-four cases needs to be added to the twenty-four cases of “ill treatment” by husbands and two by lovers. In total, troubled relationships with men accounted for 12 percent of the female cases of insanity where cause was noted. Significantly, this group of social causes alone made up 4 percent more of the asylum cases than causes connected to irregular menstruation. The case histories from UCH offer similar evidence concerning troubles at home.20

Although the expressions of spousal concern, grief, and sympathy discussed earlier demonstrate the existence of harmonious partnerships, the case notes reveal that there was a wide range of problems between men and women in the early Victorian years. The patients whose illnesses were attributed to “disappointments” generally indicated that they were experiencing frustrated expectations of some sort. For Martha Jagger, a forty-five-year-old weaver, “disappointment of marriage being rejected by her intended husband” was the registered cause of her insanity. The weaver Elizabeth Parker’s insanity was thought to be caused by “disappointment in not being married to the Father of her child.”21 Elizabeth Lynes’s case notes from her admission to UCH in 1844 state that “during the summer of the year 1841 she underwent some disappointment in a love affair and in the following October she had a severe illness.”22 By linking disappointment and illness in the same sentence, the clerk affirmed Lynes’s perception that the two were connected. The patients also expressed that disappointment could be felt after marriage, as in the case of the UCH patient Sarah Heely, who was “married, but apparently unhappy and low spirited.”23 Maryann Hodgetts, who was a dressmaker before becoming affected with bouts of paralysis, told her doctor that she “thinks that mental distress chiefly pre-
vents her entire recovery. Her husband is the cause of this distress." It is unclear from this statement, however, whether her distress was due to her husband’s treatment of her, her husband’s lack of employment, or any number of other things.

Marital disappointment was most often attributed to jealousy and adultery. Fanny Kaye’s friends reported, for example, that “while her Husband was working from home, he got connected with another Woman, whom he persuaded he was a widower; and after cohabiting with her for some time, he returned to his Wife, when the other Woman followed him, which, with his general conduct, which has been altogether inhuman and brutish, is the cause assigned for his Wife’s insanity.” The authoritative voice in this case is that of the neighbors passing judgment on a wayward husband. Likewise, Mary Hinchliffe’s insanity was thought to be brought on by her husband’s adultery. She “has not lived with her husband for 12 years or more: six monthsago he came to Doncaster, and she then raised expectations of joining him; but the other woman who lived with him rejoined him, and she was disappointed. This disappointment is supposed to have brought on her present attack.” Yet the notes continue, from someone else’s perspective, that she was “always eccentric in her behaviour; it is said that for a fortnight after her marriage she did not speak to her husband.” Although illness itself was a way for women to express their disappointment with their relationships, some patients more explicitly articulated their anger at their husbands’ behavior. Two months after Martha Holdsworth’s admission to the asylum, the attending doctor noted that he “had a long conversation with this patient, she is now rational, though excited when talking about her Husband. She states she ‘was wishful to be called by her maiden name, in consequence of his infidelity towards her and unkindness to her.’” In rejecting his name, this patient symbolically divorced herself from her husband.

Anna Clark has shown with reference to the late eighteenth and early nineteenth centuries that “the infidelity of husbands had serious economic consequences for wives.” The case histories suggest that it also had health consequences. As “British society viewed a wife’s infidelity much more seriously than her husband’s adultery,” most women probably put up with their husbands’ disloyalty. This was seemingly the case with Elizabeth Heaton, who indicated that she had been depressed since her marriage and “disinclined for any exertion, as she says it is of no use working when her husband spends all the money upon different women in the neighbourhood.” The language in this medical case is very similar to that in one of Clark’s late-eighteenth-century legal cases, in which Mary Taylor “accused her husband of treating her with ‘inhumanity’ by spending all his money
on ‘naughty women’ and depriving her of the ‘necessities of life.’”30 Both of these examples link adultery to financial and household instability. In public debate, reformers were concerned with the ways women’s work created neglect of social reproduction, which caused men to seek their comforts outside the home. The above cases suggest that male behavior itself could lead to a wife’s domestic indifference. Additionally, they provide an alternative explanation to blaming working women for disrupting the family and causing a disordered household.

Like infidelity, a husband’s desertion could cause emotional (and financial) upheaval, which patients believed could lead to ill health. Several women, like Mary Booth, connected their illnesses to “domestic affliction, neglect of herself and family by husband.”31 Hannah Stephenson, a twenty-five-year-old needleworker, informed the UCH clerk that “her spirits have been very much depressed in consequence of her husband having left her three years ago.”32 The asylum attendant wrote of Jane Fowler, a forty-three-year-old dressmaker, that “she was married some sixteen years ago: her husband deserted her; it is supposed this has had a great affect upon her.”33 Desertion could contribute to a woman’s illness, just as it contributed to female pauperism, as we saw in chapter 3. In the case of Betty Richardson, a cotton picker, “having a bad husband who has deserted her is the cause assigned” for her mental illness.34 Unmarried women were similarly affected by the desertion of their partners. The London housemaid Eliza Street tried to kill herself because she kept “company with a young man who has now deserted her.”35 The weaver Mary Ann Meal’s insanity was said to be caused by “being deserted by a young man who paid his addresses to her.”36 These addresses were probably sexual in nature, and this compromised Meal’s character as a single woman. It was not only young women who had to worry about these issues. The neighbors of Elizabeth Utley, a sixty-year-old fruit seller, claimed that the cause of her insanity was that “she lived ‘sally’ with a man, and he left her and got a fresh one.”37

Some patients linked a decline in well-being specifically to getting married. This decline was associated with three main factors: childbearing, venereal disease, and mental and physical abuse from their spouses. Childbirth in the nineteenth century was accompanied by exposure to disease and risks to general health. The risks were multiplied for poor women whose homes were often unsanitary and who could not afford things such as clean linen.38 Many of the hospitals and lying-in charities in Victorian England attempted to raise money to supply poor women with the necessities for safe and healthy childbirth. With all precautions, childbirth and the mothering that followed it were still both physically and emotionally draining, and women experienced frequent pregnancies and in many cases
the deaths of their children or themselves. Although the patient records suggest the difficulties of pregnancy, childbirth, and childrearing for these women, surprisingly absent is an emphasis on the impact of numerous pregnancies and miscarriages on their health. Similarly, although the case notes and women’s parliamentary testimony indicate women’s efforts to grasp some control over their lives with reference to sanitation and general health issues, there is no mention of efforts at family limitation.

Yet the case histories illuminate the connections for poor women between maternal ill health and the bearing of children in the early Victorian period. Anne Bennett, a twenty-five-year-old woman with three children, came as an outpatient to see Dr. Forbes in 1837. She related that she was “a healthy woman until she married and had children, since then dyspeptic and nervous with palpitations.” Bennett’s illnesses were not explicitly connected to having children, but her symptoms were directly linked to marriage and childbirth. Similarly, Ann Grant, a thirty-eight-year-old woman with two children, stated that “previous to her marriage she had good health, but since then she has always been ailing owning she thinks to severe labours.” This is one of the few instances where a woman clearly mentioned a connection between her pregnancies and her health. Physicians were more forthright about associating the debilitated state of their patients with the trials of childbearing. Dr. Forbes described his outpatient Hannah Cullins as “a dyspeptic-chlorotic woman broken down by childbearing.” Harriet Mitchell likewise made an impression on her physician as “a poor sickly half-starved nursing mother.” As we have seen, reformers worried that women’s employment hurt their reproductive capacities. When women did have illnesses connected to pregnancy and reproduction, it is just as likely that poverty, poor nourishment, and disease contributed to their ill health.

The patient records sometimes read like a catalog of the death of children. For example, at thirty-four, Mary Kugh had been married twenty years: “Since her marriage she has given birth to eight children all of whom are now dead, five from hooping [sic] cough, and two from scarlatina.” Ann Platt gave birth to nine children: “the first died, and the third, fourth and fifth: the others are alive; none of those who died attained the age of 3 years.” Catherine Marcellain attributed her sensation of weakness to “great depression of mind caused by the death of her first child.” Although many of the case histories indicate how many children a patient had borne, these numbers are unreliable, as some patients counted their still-born or dead children among their children. The numbers that are registered in the cases, however, are striking evidence of the frequency with which poor women gave birth or suffered miscarriages,
which surely contributed to their overall health difficulties. Interestingly, however, these trials of the reproductive body were not highlighted either by the parliamentary investigators or by the women themselves.

As suggested by the case notes, when they survived, children produced both anxiety and illness for their mothers. Susannah Mission, a forty-four-year-old charwoman in London, thought her daughter’s actions contributed to her ill health, for Mission’s “catamenia stopped suddenly when she was frightened by [her] daughter having stolen a table cloth which produced a sensation of great debility and trembling after which she lost all disposition to go about her ordinary affairs.” Jane Punshon’s husband attributed his wife’s insanity to “the son’s misconduct which has broken her heart.” Several mothers’ illnesses were linked to their sons joining the army. Mary Jackson, the mother of four children, developed her mental illness because “a daughter got married contrary to her wish.”

Childbearing and children were not the only source of difficulty associated with marriage. Venereal disease also led the female patients to express connections between ill health and their marital state. Sarah Kingman “was quite well eight months ago when she married a fortnight after which she experienced pain and weakness about the loins, a thick yellow discharge from the vagina. . . . Two months after she applied to a medical man who told her she had gonorrhea.” In the case of the shoebinder Fanny Phillis, the clerk wrote that “previous to the patient’s marriage her health had been always good, was very plump and strong. . . . About 8 years since and very shortly after her marriage she contracted gonorrhea from her husband.” Sarah Crawford, an outpatient at the Chichester Infirmary in 1848, had syphilitic warts; she “says her husband gave her the disease 6 months ago.”

Although these women did not necessarily contract venereal diseases from their husbands, they represented that this was indeed the case, associating their ill health directly with their sexual activity within marriage. These cases imply that infidelity was common in working-class marriages and had physical as well as emotional consequences for women’s health.

Most historical studies of venereal disease and marriage have addressed middle-class families, predominantly in the late Victorian and Edwardian periods in England. An aim of social purity and feminist campaigns from about 1870 until around the first world war was to expose husbands who brought syphilis and gonorrhea home to their wives. The evidence from the patient records suggests that venereal disease was a problem in early Victorian working-class marriages and had a significant impact on poor women’s lives. Those who were admitted to the hospital, for example, could not pursue their domestic or wage-earning employments. The treatments, usually a course of mercury that caused excessive salivation and sores in the
mouth, were unpleasant enough to hinder women’s regular duties. There is little evidence in the cases, however, about how these women dealt emotionally with contracting syphilis and gonorrhea from their spouses, except in some cases, through denial. More work needs to be done regarding how poor Victorian women responded to venereal disease and how it affected working-class marriages.

Of all the evidence in the case histories regarding connections between women’s ill health and marriage, none is as powerful as that concerning abuse by the patients’ spouses. Historians who have explored domestic violence have generally used evidence from court records and other legal sources to ground their analyses; the evidence from medical case records supports and expands upon these analyses. The prevalence of alcohol in incidents of spousal violence, the public nature of domestic abuse, and connections between economic instability and domestic violence, which Nancy Tomes, A. James Hammerton, and Anna Clark, among others, have discussed with regard to abusive situations in working-class households, are all present in the patient narratives. As mentioned earlier, twenty-six cases of outright domestic violence are registered in the asylum records. Additionally, eighteen case histories from UCH include overt evidence of spousal abuse.

The case histories contain the stories of patients such as Betty Wise, who “consider[ed] herself ill treated by her husband.” “Ill treatment” was the phrase most commonly used to indicate instances of domestic violence; it is unclear whether this coded language was the woman’s own or the clerk’s translation of the patient’s words. A forty-eight-year-old woman with thirteen children, for example, complained that “ill treatment from her husband” caused her to live “rather a hard life.” In some cases, the patients were more precise about their ill treatment. Mary Anne Hinge’s husband “has been in the habit of ill treating her during the last 12 months, by him she has been frequently beaten and turned out of doors for hours together.” Ann Smith, who was admitted to UCH in 1835, had been “pushed while pregnant against a table by her husband and miscarried.” Another woman came to UCH with a contusion of the head, and “states that two days since her husband beat her violently about the head and face and the day she was admitted he kicked her violently in various parts of the body.” Unmarried women, too, suffered at the hands of their lovers. Mary Cawthorn, a millhand with three children, “was beaten on the head by one of her sweethearts,” while Martha Emswort received “ill treatment from the man who is father to the child.”

In most instances, the reasons behind the violent attacks do not come through clearly in the content of the case notes. For some, however, we can
infer causes for abuse, as in the case of Sarah Rose, whose aunt accompanied her to the asylum. The aunt related that Rose had “for a long time past received brutal treatment from her husband. . . . Three months ago, she became depressed in mind, partly it is supposed from the unhappy nature of her husband, and partly from the distress caused by want of work: Tho’ evidently becoming insane, he continued to use her violently and to taunt her weaknesses.”68 Studies of nineteenth-century domestic abuse show that husbands’ violence toward their wives was often exacerbated by unemployment or generally poor economic circumstances. Although the domestic ideal that positioned men as the primary earners and women as their dependents was supposed to create harmony within families, it engendered tensions when the reality was that men could not provide and women had to work.69 In Rose’s case, her aunt linked the abuse to economic distress to suggest a cause for her illness. The husband’s physical cruelty to his wife was joined to emotional abuse, as he seemingly blamed his wife for her own illness. In this case, as in others, there was an explicit link between emotional and physical well-being. Spousal abuse, like other domestic causes of illness, would have been seen to contribute to an imbalance of the emotional and physical health of the body.

Alcohol played a part in many of the cases of domestic violence. Hannah Dixon’s insanity was attributed to “the intemperance of her husband who often beats and abuses her.”70 Many more men than women in the asylum had their insanity directly attributed to “intemperance.”71 Male indulgence in alcohol, however, appears to have been an indirect cause of female insanity. A patient at UCH, the dressmaker Sarah Green, suffered economically from her husband being out of work and mentally and physically from the abuse brought on by his drinking. She “has had but little food or drink this last month; her husband being out of employ . . . her husband seems to have caused uneasiness, for when intoxicated he beats her very much.”72 One woman used her occupation as a strategy to stay away from her drunken husband. As a nurse, she “always endeavoured to keep her situation as long as possible, in order to avoid living with her husband who is a great drunkard and is in the habit of treating her very ill.” She indicated that her illness, hysteria, was brought on with marriage, since which “she has been subject to fits which occur at regular intervals.”73

In an extensively detailed narrative, the UCH patient Ann Bryant described the incident that led to her cut throat:

About ½ past 11 o’clock last night she was standing in her room alone, when her husband entered very much intoxicated as was his habit. There
was a light in the next room. Her husband went into the next room, lighted a candle, and brought it into the room in which his wife was. Not finding a candlestick he got into a passion and threw the candle on the floor by which the light was extinguished. He then advanced towards his wife, as she believed, to strike her, as had been his custom when she was unfortunate to be in his way at such times.  

This passage contains several elements that historians have identified as common to situations of domestic violence. First, as discussed above, is the role of alcohol. Bryant’s narrative reveals that she was accustomed to her husband arriving home drunk late at night. Second, his inability to find what he wanted—a candlestick—was blamed on his wife, for she was the one supposedly responsible for maintaining domestic order. Finally, Bryant anticipated a beating and stated that violence was not an uncommon part of her life. Her narrative continues:

[Her husband] seized her by the neck and inflicted several cuts with a sharp instrument which she understands was a razor; it being dark she did not know what instrument it was. She did not observe him bring it into the room at the time he held the candle in his hand.

On being wounded she fainted and fell to the ground and remained in an insensible condition till brought to the Hospital. She states that she had not herself taken more than one or two pints of porter that day.

It is unclear who actually brought Bryant to the hospital. Her comment on her own alcohol consumption suggests two possibilities: that she wanted to alert her doctors that alcohol was not to blame for her fainting or “insensibility,” or that she wanted to assure them that she had not behaved irresponsibly—for example, misplacing the candleholder—because she was drunk. She went on to offer suggestions as to why she was beaten:

She states that her husband was jealous of a single man lodging in the house, though she adds, “without occasion.”

Her present husband is an Irishman; and she has been married to him three and a half years. Her former husband was a Carpenter by whom she had one child. . . . She states that her husband when sober uses her kindly.

Bryant both blamed and excused her husband; he was guilty because he accused her unjustly of infidelity, but he was excused because he was drunk. In the end, rather than indicting her husband for mistreating her,
this patient blamed the alcohol. By identifying the husband as an Irishman, the clerk highlights an assumed link between the man’s drunken, abusive behavior and his nationality.

Anna Clark has argued from legal evidence that “women often found themselves blamed for the violence they endured.” She uses the example of a magistrate who told a woman that she could prevent abuse if she maintained her husband’s domestic comforts. This resonates all too clearly with the reports of parliamentary investigators who blamed women for their husbands’ abuse of alcohol and inattention to their families. In connection, although the evidence speaks to the seemingly common nature of domestic violence in poor women’s lives, the medical attendants could be skeptical of a patient’s claim of abuse. The notes on the case of Mary Ann Wilson, for example, suggest such skepticism: she “says she has been much beaten by her husband, but there are no marks of injury.” The cause of her insanity was, however, recorded as “distress of mind from ill treatment by her husband.”

Some women did manage to get out of abusive relationships. Forty-six-year-old Elizabeth Gall indicated that “she has always been in good circumstances till her marriage 2 years ago . . . since which time she has suffered much from privation from the intemperate habits of her husband being often much exposed to cold; he treated her very cruelly, but she has lately been separated from him.” She explained that four months before her hospital admission, her husband frightened her to the extent that “the menses stopped and have not recurred.” Ellen Gibbon, twenty-eight years old in 1835, had “been married about two years; until then had very good health. Her husband treated her ill which had much effect on her spirits. She is now separated from him. . . . Has not menstruated since her marriage.” It is interesting in these two examples that women blamed their irregular menstruation on their husbands’ ill treatment. Marriage itself, in the women’s point of view, contributed to the malfunctioning of the reproductive body rather than its fulfillment.

Although in the large majority of cases spousal violence was perpetrated by the man, the case histories demonstrate that women, too, could be violent. Some of the asylum patients expressed their insanity through violence (or were thought insane because of their violence), trying to injure their husbands or children before their admissions. For instance, Mary Wright, a steam loom weaver, “threatened to destroy her husband” previous to her admission. Hannah Clark’s insanity was “supposed to have been caused by disappointment in marrying a person whom she thought was worth a considerable sum of money, whereas he was not worth any.” She took out her disappointment on him, for “she has a long
time behaved harshly and unkindly to her husband, never managed her house very prudently."82 This example is telling, as part of Clark’s unkindness was her neglect of domestic duties. The UCH patient Jane Pengelly’s husband reported that “for nearly 2 years [Jane] has been in the habit of occasionally talking at random and acting violently towards others as well as herself and that he has himself often been endangered by her violence.”83 Violence against a husband or child would be taken as the epitome of unfeminine behavior, signaling something seriously wrong with a woman.

As the above case demonstrates, women were also violent to themselves. More than thirty women in my UCH sample came to the hospital as a result of attempts to commit suicide, usually by poisoning. Many of these attempts were connected to the patients’ domestic relationships.84 In June 1836 Susan Yeldham took laudanum “in consequence of a quarrel with her husband.” Her statement that “she had never done such a thing before”85 suggests that this was not the first quarrel with her husband, and that the quarrels were severe enough to warrant extreme emotional distress. Eliza Street, a nineteen-year-old housemaid, tried to poison herself because the man she had “kept company with” had deserted her.86 Mary Andrews’s case is more specific about the connection between her domestic difficulties and her suicide attempt: “it appears that her husband, being a dissipated man, ill treated her in various ways and about 3 weeks ago ran away from her for three days. She determined to commit suicide.” She purchased laudanum, “but was prevented from taking it by some of the other lodgers in the house. On the 27th her husband again left,” and she purchased laudanum again “from two different shops and drank it off.” She died after being brought to the hospital by neighbors.87

The evidence from the medical case histories supports interpretations of domestic violence as being an unexceptional part of working-class life. The fact that the UCH and asylum patients discussed domestic violence with such forthrightness and with male medical practitioners is interesting in itself. Yet the female patients’ reactions to abuse—physical and mental illness and attempted suicide—demonstrate not only that they lived in a culture that was physically dangerous to women but that there were boundaries of acceptable violence beyond which women could not function in their domestic and working lives. The patients experienced domestic violence as causing both emotional and physical ailments. It was not just the material circumstances of their private lives that prevented poor women from achieving a comfortable domesticity. Parliamentary investigators who blamed women’s work could have found alternative explanations for disordered households.
Community

Women’s health at home was also affected by their wider communities. Neighbors and friends figure prominently in the asylum case histories both as causes of illness and as helpers when a woman was ill. In addition to assisting women suffering from domestic abuse, neighbors provided other means of aid. From a number of cases, it is clear that neighbors and friends often took responsibility for caring for each other in times of illness. Although Martha Hunsworth was married, it appears her friends were her primary caregivers. Her case notes indicate that “her friends state that they have observed a great difference in her temper and disposition since her last confinement. . . . A short time ago her friends had considerable trouble keeping her in a cleanly state: is now much better.”88 This case shows intimacy; it was her friends who worked to keep the patient clean. The language also suggests that Hunsworth’s friends were the ones who related her history to the asylum doctors. In another example, Ann Bentley had “been affected [with insanity] once before, last year, for 10 weeks, but recovered under the care of her friends.”89 Mary Jowett’s friends supported her in a private asylum but ran out of money to continue to do so.90 Financial support from friends was forthcoming even in poor communities. As this evidence suggests, families in industrial areas relied on community support networks to share such things as child care, financial burdens, and medical care.91

Although neighbors could be a source of comfort to an ailing woman, the case histories suggest that patients also saw neighbors as a source of illness. The West Riding Pauper Lunatic Asylum records make especially clear that a woman’s relationships with her community had quite an impact on her self-perception and her mental and physical health. A number of women indicated that their illnesses were brought on by disagreements with their neighbors or problems in their communities. Simple “variance with some of the neighbours” was registered as the supposed cause of Mary Ann Feather’s insanity.92 For Sarah Stamp of Hunslet, however, difficulties with her neighbors went further. Her case notes include the information that she “has always been very violent in temper, quarrelling constantly with her neighbours: her husband has repeatedly been under the necessity for removing to a fresh locality, from the discord and dissension which she invariably produces wherever she is. . . . Quarrelling with neighbours [was] the cause assigned” for her insanity.93 Maintaining neighborly relations was not to be taken for granted.

Community relationships could be fairly nasty, especially regarding the circulation of rumors. Gossip—or the perception that one was the subject of gossip—worried several of the asylum patients. In the case of Mary Ann
Ferrand of Bradford, the patient “fancies the neighbours are making mischief and telling tales about her,” making her ill.94 “An evil-disposed neighbour using abusive language towards her”95 was blamed for Eliza Charlesworth’s insanity. Gossip could be a powerful tool of acceptance or rejection in laboring communities. A woman was expected to fit into the moral culture of her neighborhood and to behave accordingly. Anna Clark’s work on the late eighteenth and early nineteenth centuries has shown that unmarried cohabitation and unmarried motherhood could be acceptable facets of working-class morality, but the patients’ narratives support her contention that by the early Victorian period, the emphasis on domesticity had altered the acceptability of these practices.96

Rumors about improprieties circulated within families and around neighborhoods, and women and their doctors believed these could make the subjects of the rumors ill. Accusations concerning sexual behavior could be especially damaging to a woman’s moral character and mental health. Mary Nixon’s medical attendant attributed her insanity to “a report of her being in the family way which was not true.”97 Similarly, Sarah Greenwood, a recent widow, was worried about a “rumour of being in the family way.”98 The case of Hannah Bunting is especially interesting, suggesting she used a fear of rumor to cover over an infidelity. She claimed that she discovered she was pregnant after her husband had gone to London looking for employment. Afraid that she would be accused of adultery in becoming pregnant when her husband was absent, “she took some means to cause abortion and has ever since been progressing in further symptoms of her malady.”99 The weaver Elizabeth Heaton’s insanity was attributed to “some immorality of which she was accused before marriage, which seems to have preyed upon her mind, and to have reduced her to her present state.”100 Character preoccupied some of the patients, like Anne Trudd, a washerwoman from Wakefield, who “raves particularly about persons taking away her character and her life.”101 Stripping a woman of her character could in fact mean taking away her livelihood, especially in service occupations for which women relied on character references for employment.

Comments on a patient’s character—her regularity, temperance, and sobriety—were regular features of the casebooks, indicating that character was a category doctors connected to health. Moral, mental, and physical health were intertwined. Nowhere is this clearer than in mentions of venereal disease. Some women adamantly denied that they had venereal disease, although the physical evidence indicated that they were suffering from gonorrhea or syphilis. Margaret Hawkins, a married coster monger, was diagnosed with syphilitic lepra. However, “she strongly denies any syphilitic affection,” and, falling back on neo-Hippocratic explanations of
illness, “attributes it to drinking a draught of cold water while very hot.”
Olivia Meares, a married woman, was admitted as a surgical patient to the
Chichester Infirmary with a swelling in her groin. Mr. Dodd noted that
“the ulcer has all the appearance of a venereal sore but she persists that she
never had syphilis.” These denials in the cases of married women suggest
the possibility of sexual activity with men other than their husbands.

For single women, evidence of sexual activity was explicitly connected
with issues of character. Martha Helmsley of Chichester arrived at the
infirmary with venereal warts but insisted that “she has always borne an
excellent character and denied having had any discharge.”
Lucy Courage, a fifteen-year-old Chichester girl, “was apparently affected with syphilis
about August but she denies it.” Eighteen-year-old Elizabeth McCaw was
hesitant to reveal the nature of her illness in front of her mother. She was
first admitted to UCH under the care of Dr. Williams, and her case notes
state “that her mother being present she could not say what was really the
matter.” Upon a second admission under Mr. Liston, “she admitted in
answer to questions which [the clerk] put to her that living at Greenwich
as a servant, she had on occasion of the Fair on Easter Tuesday had [sic]
allowed the communication of a Gent, as she described him, and in conse-
quency was soon troubled with great pains in the genitals.”

Her reticence to speak before her mother is indicative of the fragility of character even
within the family and her self-perception that she had indeed done some-
thing that crossed a moral boundary which had affected her body.

The case of Mary Dickenson, an asylum patient first admitted in 1840
and then readmitted in 1846, was recorded entirely through the lens of
character. In 1840, the cause assigned for her illness was intemperance, and
her case notes indicate that she had a child before her marriage. In 1846,
she was identified as a laborer’s wife, forty-six years old, with no religion,
whose insanity was caused by intoxication. The notes on her readmission
are explicit:

She was married to her husband, Dickenson, about 20 or 30 years ago: he left
her (the overseer thinks he sold her) after living with her a year or little more:
he sold her because her character was so bad: he took the son, brought him
up, and they are both (Father and Son) worthy persons, and live about 2 miles from Aberford.

Mary Dickenson, bears the worst character: she has long lived with a
man of bad character called Dick Smith, and who keeps a lodging House:
she is prone to drunkenness, lewdness and swearing: She has been accu-
tomed to Field Labour and House Labour. . . . Has many bruises on the face,
arms and legs.
It is telling that the “worthy” man in the story is worthy even after selling his wife. His worthiness was probably measured by his desire to be rid of a difficult woman. Additionally, the presence of bruises suggestive of abuse is effaced by the fact that the woman was of bad character.

Many of the single patients at the hospitals and the asylum had children, and some cases offer rich information regarding the impact having a child outside marriage had on a woman’s perception of her character. Elizabeth Wilson’s insanity was thought to be caused by “fretting at having had 2 illegitimate children.” Ellen Livesey, a forty-six-year-old unmarried washerwoman, was suffering from “straitened circumstances,” but “her having had 3 illegitimate children has caused her to be regarded with indifference by her friends and those who should have assisted her.” This community shunning reflects a morality whose bounds the patient had crossed. Martha Taylor, a single domestic servant from Leeds, gave birth to a stillborn child seven weeks before her admission to the asylum. Her insanity was attributed to giving birth to an illegitimate child, and she fretted that “she has brought ruin upon her Father and all the Family.” This woman clearly internalized the moral sanctions regarding premarital pregnancy. Mary Sarah Brookfield, a servant from Sheffield, “seems to feel most intensely the altered position she now finds herself in since she was discarded by the Father of her child.” Her “altered position” probably included both her ruined character and financial difficulty brought on by the desertion of a prospective husband. According to scholars such as John Gillis, Anna Clark, and Françoise Barret-Ducrocq, women would often consent to sexual relations with a promise of marriage. These promises, however, were frequently broken, and women were left to bear the consequences of unwed motherhood, which seemingly affected their health in negative ways.

The understanding of character was significant in the patients’ lives and in their beliefs about what made them ill. It is possible that character also affected their health care. Some of the cases discussed above suggested a woman’s reluctance to admit to an illness—most often venereal disease—for fear of being accused by her community of irregularity. This implies that other women neglected to seek help from hospital doctors for ailments they assumed would compromise their reputations. It is also possible that a doctor’s perception of irregularity in a patient could complicate his treatment of her. The issue of character, shaped by gender, class, and sexual norms, should thus be viewed as a factor in working women’s health care choices.
Although there is much evidence of caring and healthy private lives among the patients in my study, the majority of the cases that discuss “home” reveal emotional and physical difficulties that patients believed contributed in a significant way to their ill health. The noxious fumes, anxiety about poverty, and trying domestic relationships that women faced on a daily basis certainly call into question the assertions of reformers and politicians that women were better off at home. Patients and doctors believed in the interconnections between physical and emotional well-being in maintaining the body’s balance of health. In this context, distressing domestic relationships detracted in important ways from healthy living.

This examination of the private lives of poor patients shows that the holes in the ideology of domesticity were different depending on class. Historians have focused on middle-class women’s frustrations with the idle existence prescribed by the domestic ideal and the ways these women struggled to find alternatives to their confined lives. Poor women were confronted with a different series of problems, as basic as how to keep a house clean and how to negotiate the time devoted to domestic responsibilities with outside employment for financial survival. Additionally, although the conclusions of the parliamentary inquiries suggested that women’s employment was, at base, responsible for disrupting the healthy home, the medical records tend to position men as primarily responsible for unhealthy private lives, most often through their drinking and violence. In the few volumes of male case histories that I sampled, there is little mention of female intemperance or abusive wives. Domestic causes of illness were simply not as central to the health of men. If female health was a principal concern of politicians, it is interesting that there is little mention of abuse in the parliamentary inquiries. Indeed, the same arguments could have been made about working women being responsible for being abused as were made about them being responsible for their husbands’ drinking—that through the creation of an unhealthy home, women brought it upon themselves. Yet neither criticism nor calls for reform were present on this issue.

Women’s relationships with their families, spouses, lovers, and communities all contributed to their health and illness experiences at home. The case histories illustrate that there were many tensions in women’s private lives and many sources of anxiety that promoted ill health. In her classic study on female insanity, The Female Malady, Elaine Showalter argues that the numerous middle-class women suffering from various forms of insanity in the late nineteenth century can be understood in one way as an expression of protest to escape the confinements of domestic life. When a
woman was ill, she did not have to obey the rules of feminine behavior and
domestic responsibility, and thus obtained a measure of freedom, however
limited.114 There are ways this argument can be reformulated in the context
of the women in my study. Few of the hospital or asylum patients expressed
worries about the confines of domesticity. If anything, many would have
hoped to attain the comfortable space—financially and emotionally—in
which to be able to devote themselves to home. Many patients, however,
did suffer from emotional and physical hardships, and perhaps it was a
need to escape these circumstances that brought on their ailments. Women
literally became sick from their conditions of living; bodily as well as men-
tal health problems could be a way out of their difficult domestic lives.