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INTRODUCTION

Pain, Subjectivity, and the Social

“Are you in pain, dear mother?”

*“I think there’s a pain somewhere in the room,” said Mrs. Gradgrind,
“but I couldn’t positively say that I have got it.”*

— CHARLES DICKENS, *HARD TIMES* (1854)

THIS BOOK DESCRIBES Victorian writers’ interest in the strange subject position that Mrs. Gradgrind inhabits in this scene: their interest, that is, in what it would mean to experience pain as something that is not self-evidently one’s own. As Dickens’s satire begins to suggest, pain is often understood as the one thing we cannot help but claim. Mrs. Gradgrind’s failure to identify her suffering in this scene seems like evidence that, on her deathbed, she finally inhabits the “view from nowhere” that her husband’s utilitarianism seeks to inculcate, and that we are to see the result as being as pathetic as it is ludicrous.¹ As the writers in this project help to demonstrate, however, this is not the only way that the “somewhere” of pain can be understood. As Ludwig Wittgenstein explains, “An innumerable variety of cases can be thought of in which we should say that someone has pains in another person’s body; or, say, in a piece of furniture, or in any empty spot.”² The Victorian writers I examine in this project explore the implications of precisely this thought-experiment—one that suggests Mrs. Gradgrind’s confusion may not be entirely unwarranted.

Although pain is a universal phenomenon, historians have long identified the period covered in this project as a watershed in the history of medical, theological, and political-economic accounts of pain. Before the nineteenth century, theological orthodoxy tended to cast pain as the consequence of Original Sin, a trial for the individual sufferer, or a punishment for transgression. Precisely because pain is not subject to human control, it can be understood as divinely ordained. Hence, whether and how an individual endures seems

to say something important about her. In the nineteenth century, the development of the first modern anesthetics, along with improvements in analgesics, new understandings of nerve function, and the introduction of vaccination, meant that, for the first time, pain came to seem potentially eradicable.³ As the anonymous author of “The Function of Physical Pain: Anaesthetics,” published in the *Westminster Review* in 1871, explained, the theological, intellectual, and emotional consequences of this new state of affairs were tremendous.

The fact of a large amount of physical suffering having . . . been made optional in all but the first pangs [by anesthetics], necessitates a complete revisal of the theories of the purposes of bodily pain hitherto held by moralists; and our notions of the cosmical plan itself must be fundamentally modified now it is known that it does not permanently include—as has been thought from time immemorial it did—the cultivation of endurance as a virtue. . . . It is much as though the economy of nature had suddenly been found so all at once altered, as that, when an easterly wind blew, you only had to do a little oiling to the weather vanes, and instantly the breezes became mild.⁴

Other kinds of pain relief had long been available, but the first uses of ether and chloroform made pain seem differently under human control. And while many followed the writer for the *Westminster Review* in welcoming anesthetics with enthusiasm, often seeing them as a guarantee of human perfectibility, others recognized the serious theological questions they raised. Both medical and religious professionals struggled with the problem of how to maintain faith in a benevolent God when one generation is made to suffer what another is able to remediate. As J. Edgar Foster demands, “Has the Author of all things created us merely to gloat over our sufferings?”⁵ For Foster, the answer is “no,” but he admits the force of the question. Once pain comes to seem eradicable, it also comes to seem superfluous—and hence, too, potentially incompatible with a loving God.

Nineteenth-century understandings of pain were further complicated by the fact that alongside anesthetic optimism existed new forms of pessimism regarding pain’s potential eradicability, thanks in large part to the work of Thomas Malthus. Even the most powerful drugs cannot mitigate the consequences of Malthus’s basic insight that population increase inevitably outstrips any increase in subsistence, and hence, that suffering and premature death constitute inescapable facts of human existence. “Population, when unchecked, increases in a geometrical ratio,” he writes, while “subsistence increases only in an arithmetical ratio.”⁶ “A slight acquaintance with numbers,” he continues drily, “will show the immensity of the first power in comparison of the second.”⁷ Rather than being vectored toward perfection, in Malthus’s account human history is defined by cycles of relative health and procreative

success alternating with the “checks,” such as famine, disease, war, and vice, that are necessary to cull the resulting surplus population. This is the basic insight that Charles Darwin adapts for his theory of natural selection: “Every being, which during its natural lifetime produces several eggs or seeds, must suffer destruction during some period of its life, and during some season or occasional year, otherwise, on the principal of geometrical increase, its numbers would quickly become so inordinately great that no country could support the product.”⁸ Profusion here comes to look like a destructive form of profligacy, and death and destruction mere indices of what Catherine Gallagher describes as “procreative vigor.”⁹

Nineteenth-century discussions of pain are shaped by the tension between the optimism suggested by the introduction of anesthetics and other medical innovations and the pessimism indicated by Malthus’s theory of population. They are also shaped by what both perspectives discover: the fundamental impersonality of pain. Theological doctrines of pain that cast it as a punishment or a trial by no means disappeared in the nineteenth century, and many commentators continued to describe physical suffering as importantly related to or expressive of the person who suffers. Yet both anesthetics and Malthus’s theory of population suggest the potential inadequacy of such descriptions: in both contexts, pain comes to seem like the consequence of a historical accident. In the case of anesthetics, this accident involves the state of medical knowledge at one’s historical moment. In Malthusian population theory, it relates to one’s position in relation to inevitable cycles of plenitude and deprivation. However, in both contexts, the disaggregation of pain from individual merit or demerit raises pressing questions not just about pain but also about the status of, and even the relative importance of, the person who suffers it. Anesthetics and Malthus both suggest that pain might ultimately be, in some sense, beside the point: an unfortunate by-product of historical processes that are in no sense “about” or concerned with human suffering.

All of the writers I examine in this book are engaged with general debates over the desirability, inevitability, and meaning of pain, whether as sufferers or caregivers, religious believers or doubters, novelists, political theorists, or naturalists. They are also interested in the impersonality of pain in the ways indicated by both anesthetics and Malthusian population theory. They are *additionally* concerned with the social status of pain in the sense of its having a collective or interpersonal existence. They are thus interested in what Wittgenstein would call the language game of pain, a formulation that suggests that even the solitude we so often associate with pain is necessarily enmeshed in social life. The writers I discuss are all concerned with the solitariness of pain: its status as one of the aspects of being that we seem least able to share. Yet they are also aware of pain as a fundamental condition of social existence—according to some, the basic justification for the existence of society in the first place. Before there are laws and contracts, Thomas Hobbes writes, “there

is no place for Industry . . . no Arts; no Letters; no Society; and which is worst of all, continuall feare, and danger of violent death; And the life of man, solitary, poore, nasty, brutish, and short.”¹⁰ Social life is premised on the fact that we exist as vulnerable, embodied subjects. Thus, even as discussions of pain tend to serve as investigations into the status of persons—as agents, as objects, and as loci of affects—they are also almost invariably questions about the nature and parameters of social life.

The first section of this introduction describes two different recent approaches to the relation between pain and social life. The first position has been advanced most famously by Elaine Scarry in *The Body in Pain* (1985), which casts the pain of the other primarily as an epistemological problem—the thing we cannot, but most need to, know. This approach to pain, I argue, is bound up with a particular account of liberal subjectivity as self-conscious, prior to the social, and private. The second approach to pain that I discuss has been articulated within a tradition that includes such figures as Wittgenstein, Stanley Cavell, and Veena Das, and emphasizes how pain is always already part of a social world. This approach is not exactly opposed to the first, as the Victorian texts I examine in this book indicate, but it does suggest different emphases in approaching the basic problem of the unknowability of the other.

In the second section, I consider some of the terms in which Victorian medical professionals, caregivers, and sufferers understood the social nature of pain. My project here is less to provide a definitive historical context for the readings that follow than to suggest ways in which the philosophical and literary texts that I examine in the rest of the book were engaging with questions being raised in other discourses. In other words, rather than simply contributing to a conversation that was taking place elsewhere, the writers I examine were seeking to use philosophy and literature to address problems that seemed particularly resistant to other modes of explanation. Religion and medicine could not answer questions about the nature or meaning of pain. The writers that I examine in this book make a strong case for philosophy and literature as alternative resources.

In the third section, I describe what I mean by “Victorian Pain.” My goal here is to explain why this book seeks to describe not how pain was represented or constructed, but instead how pain was *used* by a range of writers at a particular time. If we are to understand pain as inevitably involving an address to another—in the form of what Wittgenstein calls a pain behavior, or what Stanley Cavell and Veena Das describe as a demand for acknowledgment—that address is never predictable or overdetermined, as the language of constructivism sometimes suggests. Nor is it separable from the pain experience itself, as the idea of representation can imply. My goal in this book is to think with a range of Victorian texts in order to consider the implications of the forms of subjectivity and sociality that the texts themselves explore and seek to produce.

Thinking Pain

Even now, over thirty years after its initial publication, Elaine Scarry's *The Body in Pain* remains the single most influential theorization of aversive physical experience.¹¹ Regularly cited by literary critics, historians, and political theorists, as well as by journalists, lawyers, and policy makers, *The Body in Pain* makes a forceful argument for what I will be calling an “epistemological” approach to pain—that is, an approach that takes the unknowability of the pain of the other as its central problematic.

Scarry makes four basic claims about the nature of pain. First, she asserts that it is defined by certitude for the one in pain and by doubt for the one who is not: “For the person whose pain it is, it is ‘effortlessly’ grasped (that is, even with the most heroic effort it cannot *not* be grasped); while for the person outside the sufferer’s body, what is ‘effortless’ is *not* grasping it.”¹² Pain thus demonstrates the transparency of the subject to itself, even as it also poses the problem of other minds in its most wrenching form: however intense the pain you endure, I can have no direct knowledge of your experience. Scarry’s second claim is that physical pain “shatter[s] . . . language” and so is inexpressible and incommunicable. “Unlike any other state of consciousness,” she explains, physical pain “has no referential content. It is not *of* or *for* anything.” It is “precisely because it takes no object that it, more than any other phenomenon, resists objectification in language.”¹³ This resistance to language is bound up with its incompatibility with social life, as well. Pain is something we have no choice but to know about ourselves, but that we have no way of communicating to others. Scarry’s third claim is related to the second, for while physical pain is unspeakable in her account, “*Psychological* suffering . . . *does* have referential content, *is* susceptible to verbal objectification, and is so habitually depicted in art that . . . there is virtually no piece of literature that is *not* about suffering.”¹⁴ Hence, physical and emotional pain are wholly distinct experiences with different ontologies, phenomenologies, and attendant ethical obligations. While physical pain belongs to the (antisocial) world of the body, psychological pain belongs to the deeply social world of the mind.¹⁵ Finally, Scarry posits that perceiving another’s pain necessarily involves wishing it to be relieved: “‘Seeing the pain and wishing it gone’ . . . is a single perceptive event in which the reality of pain and the unreality of imagining are already conflated. Neither can occur without the other: if the person does not perceive the distress, neither will he wish it gone; conversely, if he does not wish it gone, he cannot have perceived the pain itself.”¹⁶ As a result, language is under an obligation to achieve the impossible: to communicate the incommunicable so as to make it available to amelioration. “The act of verbally expressing pain is a necessary prelude to the collective task of diminishing pain,” Scarry writes; in order to encourage ameliorative intervention, “the human voice must aspire to become a precise reflection of material reality.”¹⁷ This

goal cannot be achieved; it is nevertheless one toward which it is humanity's ethical obligation to strive.

Scarry's claims have been challenged on a variety of grounds. Her equation of pain with certainty, for example, has been called into question by sufferers from chronic pain and phantom limb: for those whose pain resists medical visualization, in particular, self-doubt can be as common a concomitant of pain as certitude.¹⁸ Anthropologists, political theorists, historians, and others have taken issue with her claim that pain shatters language. As Darius Rejali explains, "It would be a mistake to confuse the empirical inability to say or think when one is in pain with a philosophical claim that pain is a preverbal sensation, a sensation that has some quality that, in principle, makes it inexpressible."¹⁹ Medical professionals, among others, have challenged the clarity of the distinction Scarry makes between physical and emotional pain.²⁰ Finally, at least some commentators on torture have rejected Scarry's claim that the perception of pain involves wishing it gone.²¹ For example, according to Peter Singer, torture is not possible unless pain is visible to the torturer: in order to "be an efficient torturer, one would need to be well aware of when one was causing pain and when one was not doing so." Rather than "mak[ing] invisible the agony of the victim," therefore, in Singer's account, torture "puts [its] victims outside the pale of humanity, thus rendering what is done to them morally acceptable."²²

The "epistemological model" has also been challenged on theoretical grounds, the most sustained critique coming from philosophers and anthropologists engaged with Ludwig Wittgenstein's notion that pain constitutes something akin to a move within a language game, and hence, that pain is something we learn as well as something we feel. These accounts do not deny the skeptical problem that lies at the core of Scarry's philosophy: they, too, admit the impossibility of knowing the pain of the other. However, they reject the notion that the problem of ignorance should or can be met with knowledge. Thus, while Scarry calls attention to the responsibility of language to articulate or "become a precise reflection of material reality," Stanley Cavell insists on the futility of such a proceeding.²³ The "slack of acknowledgment can never be taken up by knowledge," he explains. Knowledge may "fire[] the imagination," but you "cannot always know when the fire will strike."²⁴ Knowledge here is less the reason for acknowledgment than one possible motivating factor among many—one whose outcome is especially unpredictable. Specifically, once one doubts the other's veracity, or even whether she speaks as a human being, it becomes very difficult to say where that doubt may end. Cavell explores the availability of skepticism through Wittgenstein's famous parable of the picture of the steaming pot. "Of course, if water boils in a pot," Wittgenstein writes, "steam comes out of the pot and also pictured steam comes out of the pictured pot. But what if one insisted on saying that there must also be

something boiling in the picture of the pot?"²⁵ According to Cavell, the question here is not whether we are to assume there is something in the pot (i.e., whether sensations are private). Instead, "The point is to ask us to consider where the suggestion comes from that perhaps (others have it in mind that) nothing is going on inside us. Why is such a suggestion . . . so much as worth an answer, even a parable? Why is it alarming?"²⁶ Cavell thus claims that Wittgenstein asks us to consider the extent to which pain behavior is not about knowledge or reference, but instead constitutes an attempt to elicit acknowledgment that may or may not be forthcoming.²⁷ Engagement or care cannot be a consequence of knowledge, in Cavell's account; it is instead the corollary of a self-conscious refusal of skepticism.²⁸

For the anthropologists who have followed Wittgenstein and Cavell, attending to the "interpersonal grounds of suffering" reveals the extent to which suffering can be understood as a "social experience."²⁹ As Veena Das explains, Wittgenstein uses "the route of a philosophical grammar" to say that the sentence "I am in pain" is

not an indicative statement, although it may have the formal appearance of one. It is the beginning of a language game. Pain in this rendering is not that inexpressible something that destroys communication or marks an exit from one's existence in language. Instead, it makes a claim on the other—asking for acknowledgment that may be given or denied. In either case, it is not a referential statement that is pointing to an inner object.³⁰

Although she does not mention Scarry by name here, Das seems to have the critic's work in mind in her critique of the notion that pain "destroys communication or marks an exit of language." While in Scarry's work, social life is generated as a way to mitigate suffering that preexists it, in Das's, suffering is coextensive with social life. This move away from epistemology in discussions of pain makes it possible to discuss pain as a problem at the core of the production of social life, rather than as something to which social life belatedly seeks to respond.

Despite the obvious differences between Scarry's epistemological account of pain and Cavell and Das's social models, in the chapters that follow, these models are not simply opposed. Perhaps most importantly, although the epistemological model is clearly compatible with a classical liberal emphasis on liberty and justice, the social model is neither opposed to nor incompatible with an expanded notion of liberalism.³¹ Scarry's model of pain assumes a subject that is self-conscious, exists prior to the social, and is private; and it assumes a model of sociality mediated by a language that seeks, yet inevitably fails, to reflect preexisting states of affairs. As I discuss in the afterword, the resulting close connection between liberalism and an epistemological model

of pain may help account for the latter's longevity. Social models of pain are not simply opposed to liberalism, however, although their relation to any political formation may be complicated. The nature of this complexity becomes particularly apparent in the first chapter of this project. John Stuart Mill is often identified as the most important liberal philosopher of the nineteenth century. Yet in chapter 1, I argue that the model of pain that emerges from his *Autobiography* (1873) has as much in common with Das's account as with Scarry's. His account of pain as something that can only ever be experienced alone, but that is only ever understood through others, maintains a delicate balance between ways of thinking about pain, refusing to relinquish the guarantee of privacy and uniqueness promised by the epistemological model, even as it gives priority to social life.

This description of Mill suggests a tension around questions of privacy, which runs throughout this book. According to Cavell, Wittgenstein's rejection of the possibility of a private language suggests that "the fact, and the state, of your (inner) life cannot take its importance from anything special in it. However far you have gone with it, you will find that what is common is there before you are."³² For Cavell, this recognition is primarily a source of what he calls "interest." Yet for Mill—and then in chapter 3, for Charlotte Brontë, as well—it is also a source of great anxiety or even anguish. In Mill's nightmares of overdetermination, and Brontë's of drowning, one can see two different versions of the lament for privacy as secrecy that a social model of pain disallows. Harriet Martineau, Charles Darwin, and Thomas Hardy maintain less problematic relations to social models of pain. All three, however, still grapple with the problem of how to maintain some hold on the subject. In a view from nowhere, these writers ask, does the individual still matter? What do we give up if the answer is no?

All the writers that I address in this project thus draw on both models I have discussed thus far, moving between imagining pain as something incommunicable, private, and prior to the social, and understanding it as produced through and in the context of social life. But, as I have already begun to suggest, they are by no means limited to these two ways of thinking about pain. The alternatives they imagine take a variety of different forms. Yet consistently, what emerges at the moments of crisis that I examine is a reconfiguration of the boundaries between persons, as well as between persons and things—a reconfiguration that is often signaled by the eruption of insistently "literary" or noninstrumental language. This is not to say that pain "destroys" language; only that it rearranges common protocols, often becoming lyrical, poetic, or rhapsodic in ways that clearly call attention to themselves as literary.³³ My selection of primary texts highlights the consistency and consequences of such linguistic shifts in both fictional and nonfictional writing—and specifically, the way that discussions of pain tend to strain against the most commonly recognized protocols of language.

I will be using two terms, in particular, to describe this reconfiguration: *impersonality* and *affect*. Briefly, I take the term impersonality from Sharon Cameron's claim that representations of impersonality take as their goal "to have no preference, to see from no point of view"—a perspective akin to that which Mrs. Gradgrind inhabits when she fails to identify her pain as her own.³⁴ As a result of this perspective, Cameron writes, "representations of impersonality suspend, eclipse, and even destroy the idea of the person as such, who is not treated as a social, political, or individual entity."³⁵ The person rarely disappears entirely from the texts I discuss, although in the work of Hardy and Darwin it comes close to doing so. Yet all the writers I examine are interested in what it would mean to "see from no point of view" in the way that Cameron describes. For Mill, that possibility is both compelling and terrifying. For Martineau, it is empowering. For Darwin and Hardy, it raises fascinating questions regarding the stability of both mental and object worlds. For Brontë, as I have already suggested, it looks like drowning.

Affect and impersonality constitute closely related terms in my account, both defined by the pressure they place on the notion of the individual.³⁶ Hovering ambiguously between body and mind, irreducible to either emotion or sensation, Benedict de Spinoza's notion of affect as "affections of the body by which the body's power of acting is increased or diminished, aided or restrained" offers a way to consider feeling (with all the attendant ambiguity of that term) in the absence of personhood.³⁷ "By singular things I understand things that are finite and have a determinate existence," he writes. "And if a number of individuals so concur in one action that together they are all the cause of one effect, I consider them all, to that extent, as one singular thing."³⁸ This account of affect as tending toward the redefinition of the "thing" has not often been used to think about pain. This book suggests that this is a serious oversight, and one whose remediation requires a shift in how both "affect" and "pain" have most commonly been defined.³⁹ Pain, too, I suggest, has the potential to pull against the idea of the individual as a self-evident unit of measure or object of observation. At the very least, in the work of the writers I examine, it raises serious questions regarding where one person ends and another begins.

The End of Pain

Thus far I have relied exclusively on recent accounts to explain the distinction I make between epistemological and social accounts of pain. In this section, I shift focus and attend instead to nineteenth-century accounts of aversive physical experience. My goal is to suggest the extent to which the philosophical and literary engagements that I examine in the rest of this book constitute attempts to intervene in an ongoing conversation regarding the nature, uses, and consequences of physical suffering that was also taking place among

scientists, medical professionals, religious writers, and sufferers. This conversation suggests just how widespread were the questions raised by nineteenth-century writers.

The first question often raised in nineteenth-century discussions of pain is that of how to define it. This is not a question to which medicine, political economy, or theology provided clear answers. As I discuss at length in chapter 1, even utilitarianism, the philosophy of pleasure and pain, provides no definitive account of what pain is, but instead consistently falls back on the notion that pain is defined by the experience of it. Physiology and medicine went little further. Although the nineteenth century was “a time of rapidly increasing physiological knowledge as well as one of great therapeutic advances,” Lucy Bending explains, “the ability to alleviate pain far outstripped medical understandings of its functioning.”⁴⁰ One can see this divergence consistently in both scientific research and medical practice: knowing what alleviates pain does not necessarily mean that one has any idea of why it does so. Victorian writers may have meant very different things when they posed the question, “What is pain?” but they nevertheless tended to agree that it is fundamentally unanswerable. As the anonymous author of “What Is Pain,” published in *The Lancet* in 1887, explained, “We think we know what it is to live and feel pleasure or pain, but when we attempt to express our thoughts by words we discover that the feat is impracticable. The answer to the question, ‘What is pain?’ must therefore be, ‘No one knows.’”⁴¹ Similar claims are repeated again and again in scientific, medical, and popular writings on pain.

Medicine clearly had an especially great stake in defining pain, particularly in the context of its breakthroughs in pain remediation. Such certainty was difficult to achieve, however, when the precise relation between the mind, brain, and nerves remained a mystery. Despite Scarry’s insistence on the unmistakable difference between physical and mental pain, nineteenth-century physiologists often move seamlessly between these categories. I discuss this refusal to differentiate between forms of suffering at length in chapter 4 on Charles Darwin. In *The Expression of the Emotions in Man and Animals* (1872), in particular, the naturalist repeatedly juxtaposes occasions of mental and physical anguish as if they were interchangeable. Such apparent confusion often looks like a deliberate refusal of the premature disaggregation of phenomena whose relations had yet to be defined clearly. One can see a similar refusal in the work of one of the most important physiologists of the time, Alexander Bain. Depending on the passage one reads, suffering—along with other mental phenomena—seems wholly attributable either to mind, or brain, or to some combination of the two. Rather than simple inconsistency, however, such shifting explanations seem like attempts to keep many different kinds of explanation in play concurrently. Lorraine Daston claims that for Bain, pain and pleasure ultimately remain “feelings, not neural tremors”: he “couched his explanations in psychological terms,” she argues, rather than

physiological ones.⁴² Yet, it is oftentimes difficult to say where the line between the psychological and the physiological might be drawn. “The organ of mind is not the brain by itself,” Bain writes, for example,

it is the brain, nerves, muscles, organs of sense and viscera. . . . When the mind is in the exercise of its functions, the physical accompaniment is the passing and re-passing of innumerable streams of nervous influence. Whether under a sensation of something actual, or under an emotion or an idea, or a train of ideas, the general operation is still the same. It seems as if we might say, no currents, no mind.⁴³

Aside from anything else, this is a far cry from seventeenth- and eighteenth-century associationism. One consequence in terms of Bain’s discussions of pain is that he often slides between accounts of physical and psychological suffering, and between describing suffering itself as a psychological, a neurological, or a physiological phenomenon.

Medical uncertainty regarding the nature of pain corresponded to an equal uncertainty regarding what pain does—and hence, the desirability of relieving it. So, for example, despite repeated demonstrations of the safety of anesthetics, many surgeons remained reluctant to employ them: Thomas Dormandy claims that approximately one third of limb amputations performed “for compound fractures at the Pennsylvania Hospital [1853–62] were still carried out on conscious patients.”⁴⁴ This statistic was due in part to medical professionals’ concerns regarding potential side effects of the drugs themselves: ether was plagued by “occasional ineffectiveness,” “accompanying sickness,” and “chest complications.”⁴⁵ Chloroform had fewer side effects, but it was still attended by the risks of addiction and the occasional unexplained death.⁴⁶ Medical professionals were additionally concerned about suppressing the potential benefits of pain. “Were it not for the stimulation induced by pain,” John P. Harrison, vice president of the American Medical Association, complained in 1849, “surgical operations would more frequently be followed by dissolution.”⁴⁷ Meanwhile, as Martin Pernick explains, “natural healers preferred to passively ‘do no harm’ rather than risk causing harm directly,” and the “heroic” professional tradition “opposed the use of anesthetics to avoid suffering” that did not endanger the life of the patient.⁴⁸ Only so-called “conservative professionalism permitted the cautious use of anesthetics, both to relieve emotional suffering and to prevent physical damage.”⁴⁹ Yet even these doctors’ use of anesthetics could be inconsistent and, from a contemporary perspective, parsimonious.⁵⁰ Pain was not simply an evil to be eliminated at any cost: it was assumed to have uses, even if those uses were not always fully understood.

Religious commentators brought their own concerns to the “anesthetic revolution.” As I have already mentioned, the potential elimination of pain led some to question the existence of a benevolent God. Meanwhile, it led others

to question the religious acceptability of pain relief. Joanna Bourke describes the concerns that arose over dying under the influence of painkillers. While some Christian physicians claimed that “sufferers were incapable of piety” and so should receive pain relief in their final illness, others were concerned that opiates “could befuddle the mind, making dying believers less capable of focusing on their otherworldly fate.”⁵¹ According to Bourke, this last concern was most relevant for Catholics.⁵² However, even non-Catholics debated whether pain relief was more likely to enable or inhibit religious devotion. The writings of Priscilla Maurice show the resulting strain especially clearly. In *Sickness, Its Trials and Blessings* (1850), Maurice acknowledges sufferers’ fear of addiction, and their “questionings whether it can be right in them to subdue the sense of pain, when God Himself has sent the pain; when Christ Himself endured such extreme suffering, and refused to drink, even in the midst of His agonizing thirst.”⁵³ Although she ultimately argues for the understanding of pain relief, too, as a gift from God, she raises a real problem: that of how to reconcile religious conceptions of suffering with contemporary medical technologies.

These questions ultimately point to a concern over how to account for the existence of pain in the first place—a problem that at least some Christian apologists sought to resolve by insisting on what G. A. Rowell called the “beneficent distribution of the sense of pain,” or the notion that pain serves certain necessary functions in relation to the individual or the community. Pain was still sometimes cast as a consequence of Original Sin, or a punishment for personal transgressions, but it was also often described as part of God’s benevolent design. As Rowell explains, “There may be pain and suffering, the use of which it may be difficult to see; but I would rather attribute this to a want of knowledge, than believe that the rule which holds good in so many cases does not hold good in all.”⁵⁴ James Hinton agreed, arguing in *The Mystery of Pain: A Book for the Sorrowful* (1866), that pain “prompts us to many actions which are necessary for the maintenance or security of life, and warns us against things that are hurtful.”⁵⁵ The notion that pain serves a protective function appealed to medical as well as to religious professionals. Particularly in the early part of the century, before the picture was complicated by theories of evolution, one can see it reiterated often in *The Lancet* and the *British Medical Journal*.

On the one hand, then, pain was often described as beneficent because of its medical function in relation to the individual. On the other—and more interestingly for my purposes—pain was also often ascribed an important function in the reconfiguration of the relation between the individual and the community. Pain, many writers insisted, is never experienced in isolation, however much it may seem as if it is. Instead, it exists in the context of social and religious relations that stand to be shaped by that suffering. Thus, some writers emphasize how pain can encourage sufferers to turn away from the

inevitable limitations of human consolations and, instead, to turn toward God. “No one can fully see the extent and details of the trial which another is called to bear,” Priscilla Maurice explains. “One comes near and says words of sympathy for one part of the trial; another for some other part; a third sees no trial in it at all; a fourth thinks it must be much less trying than some other form of suffering, or than his own. No one but the sufferer sees it in all its bearings and forms of inward suffering; no one else feels the acute pain of heart and all its throbbings.”⁵⁶ In the absence of human sympathy, Maurice urges the sufferer to turn to God, whose omniscience suggests infinite compassion. In *A Companion for the Sick Chamber* (1837), John Thornton makes a related claim, describing pain’s power to “excite a serious and most earnest concern about the salvation of the soul in those who have been totally negligent” and to show us the “utter emptiness, vanity, and barrenness of the present world, and the folly and misery of seeking our portion in it.”⁵⁷ In his account, to experience pain could also “lead us to Christ” and to a contemplation of His sufferings.⁵⁸

While some commentators emphasize the role of pain in binding sufferers to God, others stress the extent to which pain serves to consolidate human communities. Thus, even Thornton describes how the sufferer, “when raised and restored, if such be the will of God, [may] enter with feeling and tenderness into the sufferings of our brethren and fellow-men, and prepare us to make sacrifices to serve them.”⁵⁹ Meanwhile, the Reverend George Martin asks his congregation to remember the impact suffering has on witnesses, encouraging his congregation to “learn those lessons of wisdom and of truth which [pain] is calculated to teach” by allowing the spectacle of the Prince of Wales’s affliction to bring them to God.⁶⁰ Maurice, too, emphasizes the extent to which suffering inevitably takes place in relation to others. “At this very moment, many other persons are suffering, in mind, body, and estate, just as you are suffering,” she explains. “They have the same trials, the same temptations, though you know them not, and they know nothing of you.” Nevertheless,

how you suffer is very important to them, for you insensibly affect them, though you do not indeed exactly know *how*; but this you know, that every member of the Body is necessary to, and affects, the whole Body. . . . ‘I believe in the communion of Saints,’ and so I am not alone, I cannot be; my trials are not mine alone; my conflicts and my temptations are those of some other member of Christ’s Church. In fighting, I fight for them as well as for myself; in overcoming, weaken Satan’s power over them, as well as over myself.⁶¹

Here, the sufferer does not simply perform her suffering for an audience. Instead, she is encouraged to experience her own sufferings as bound up with the needs of others. How she suffers affects all other members of the community, although it may not be possible to say exactly how.

In their interest in the relation between individual suffering and that of the larger community, religious commentators are unexpectedly similar to the medical writers who were influenced by evolutionary theory. Despite the obvious differences between them, both groups assume the fundamental inevitability of suffering, both manifest great compassion toward individual sufferers, and both consistently assume that how the sufferer understands the relation between her distress and that of her community will have considerable consequences for how she experiences it. Thus, both consider the individual's experience of pain to be bound up with social life. This commitment becomes particularly clear in the context of a debate sparked by H. Cameron Gillies's article, "The Life-Saving Value of Pain and Disease," published in *The Lancet* in August 1887. As the title of his piece suggests, Gillies was a profound optimist in relation to pain, claiming that "pain never comes where it can serve no good purpose," for "pain is in direct proportion to the powers of repair—that is to the probability of recovery."⁶² Pain, in other words, always signals a problem that is available to amelioration. Therefore, when pain can "serve no good purpose, . . . there is no pain."⁶³ Gillies does admit a few exceptions to this rule, but ultimately resolves them by claiming they indicate that something is wrong with common methods of treatment. The fact that many people suffered horrendously as a result of compound fractures, for example, he sees as necessary to make clear that "*there was something wrong* in our treatment of compound fractures"—a wrong eventually corrected by Joseph Lister.⁶⁴

Nearly all of the medical professionals who responded in *The Lancet* disagreed with Gillies's assessment. Pain is *not* reliably meaningful in relation to the individual, they insisted. Nor does it always indicate a problem that can be solved. Pain, they claimed, is instead best understood as a byproduct of processes that, at this late point in the century, they often identified with evolution.⁶⁵ Thus, pain is no simple utilitarian signaling system, designed to indicate problems subject to remedy. Instead, it is often in great excess of any conceivable function. As A. St. Claire Buxton insisted, "We see in pain the expression of a high degree of sensibility in the nervous system; and we believe the nervous system has attained its present high degree of sensibility by reason of long and steady development—evolution, in fact."⁶⁶ As a result, for the student of evolution, it may be possible to see "a reason for the existence of pain, but no motive or purpose."⁶⁷ We can understand the cause of pain in evolutionary terms, but that does not mean that the pain of an individual indicates anything distinctive or remediable about her case.

Lucy Bending points out the extent to which this debate suggests that "evolutionary theory had won the battle, and Christian rhetoric was forced to shape its own arguments in the light of its claims."⁶⁸ Another less obvious implication is the continuity between religious and evolutionary understandings of the role played by a sense of the community in the sufferer's experience. Thus, Gillies was condemned for the cruelty of his claims for the benevolence

of pain, and evolutionary theory was offered as a potentially comforting alternative. “To a reverent believer in evolution,” W. J. Collins explained,

pain is more nearly comprehended in its true light and meaning, and much of its sting removed in proportion to that comprehension. . . . Here there is to be found the comfort which science affords—comfort in the knowledge that pain is in obedience to law, is bound up with the progress of the race. With this knowledge and with this hope, far more than with blind assertions as to the invariable beneficence of pain, one can “kiss the rod,” and be “patient of pain, though as quick as a sensitive plant to the touch.”⁶⁹

Evolutionary theory here becomes a substitute for Christian orthodoxy, both as a way to explain the existence of pain and as a way to use that explanation to conceive of the sufferer as part of a larger whole. Evolutionary theory does not make pain less painful, but it is imagined as consoling sufferers with the “knowledge” that there is some relation between their suffering and the “progress of the race.” However isolated sufferers may feel, both Christianity and science insist that their suffering is not simply theirs alone. In both contexts, the sufferer is imagined as, in some sense, a member of a larger community, and hence, as one whose sufferings have positive implications for others.

One consequence of this reconfiguration is to cast medical professionals as something akin to spiritual advisers, both in the sense that they are truth-tellers and in the sense that they have the power to help patients shape their experiences in tangible ways. Thus, Gillies was not simply wrong, the physicians and surgeons who wrote to *The Lancet* insisted, he was cruel in a way wholly at odds with his responsibilities as a medical professional. “Is this the grim comfort [Gillies] would bring to a suffering woman tortured slowly to death by a sloughing scirrus of the breast,” Collins demands, “or to a man, made almost unhuman and killed by inches by the slow yet sure ravages of a rodent ulcer?”⁷⁰ E. R. Williams is even more vitriolic, citing the case of a woman whose breast cancer begins as a small tumor of which she is unconscious:

For months, may be, she is quite ignorant of the fact that she has within her the beginning of what will ultimately be her end. The tumour grows, neighbouring structures become contaminated, and pain comes on and persists, which by the exhaustion it induces hastens on the inevitable. In this stage, of what service is her pain? The diagnosis is made, the disease is to [*sic*] far advanced for operation, the patient knows that she is beyond the reach of surgery, and so, tortured with pain night and day, she waits, and prays for a speedy release. And yet the writer stoically says, “Pain is merciful.”⁷¹

The tone of righteous indignation toward Gillies is unmistakable, as is the compassion for the individual sufferer. Williams does not simply seek to prove

Gillies wrong; he seeks to evoke real pity for the woman he casts as his opponent's victim. Pain, these writers assume, is produced at least in part between doctor and patient. It is thus incumbent on those who minister to be mindful of the full extent of their responsibilities. As J. Russell Reynolds insisted in the president's address, delivered at the Annual Meeting of the Metropolitan Counties Branch of the British Medical Association in 1871, "We must ever remember that in the practice of our noble profession we have to deal with man as a whole, to examine him and to treat him as such."⁷² Reynolds's concern with the patient as a whole, and his recognition of the way in which the doctor plays a role in that patient's overall well-being, suggest a sensitivity to the patient's perspective that was certainly not universal, but was also not entirely isolated.

Particularly in the wake of Michel Foucault's influential *The Birth of the Clinic*, statements like Reynolds's might be surprising. The story Foucault tells of the replacement of patients by disease involves an effective erasure of the sick person as an object of concern. According to Foucault, in place of people with illnesses, the clinic was concerned with diseases that manifested, more or less perfectly, in cases that happened to be located in human bodies. As a result, he explains, the patient becomes the "rediscovered portrait of the disease; he is the disease itself, with shadow and relief, modulations, nuances, depth."⁷³ According to Mary Fissell, one consequence of this shift was that the "patient's narrative of illness was made utterly redundant. Hospital medicine came to focus on signs and symptoms, which provided doctors with a disease-oriented diagnosis conducive to the demands of hospital practice and reflective of its social structure."⁷⁴ Meanwhile, laboratory medicine imposed an "object oriented role system" in place of the "person oriented role system" associated with older forms of bedside medicine.⁷⁵ Foucault summarizes this system of changes in the conception and practice of medicine in terms of the difference between the question, "What is the matter with you?" with which the eighteenth-century dialogue between doctor and patient began" and "that other question: 'Where does it hurt?,' in which we recognize the operation of the clinic and the principle of its entire discourse."⁷⁶ The patient effectively disappeared behind her own symptoms and the disease they were understood to signify.

As both historians and literary critics have pointed out, Foucault's focus on France means his history cannot simply be transferred to the British context.⁷⁷ So, for example, despite the centrality of the hospital in the training of medical students and the care of the lower classes, the patient-doctor relationship remained extremely personal and personality-driven for the middle and upper classes.⁷⁸ "Sound clinical judgment needed to be backed up by other, more personal, attributes if a practitioner was to obtain the confidence of a patient," Anne Digby explains. Particularly "since their therapeutic impotence in the face of many diseases remained, practitioners continued to need

good personal qualities to retain the faith of patients.”⁷⁹ Patients may very well have been accorded decreasing authority over their care throughout the century, but the authority of doctors was nevertheless constantly challenged, particularly by patients with economic resources.⁸⁰ This balance of power is especially evident in some of the figures examined in this book: while Harriet Martineau dispensed with her medical advisers almost entirely once she thought her (unauthorized) mesmeric treatment began to take effect, Charles Darwin employed a wide range of medical professionals in order to compare and evaluate their recommendations.⁸¹

What interests me is not simply the extent to which patients retained the power to define their illness, but instead the way in which, against Foucault’s disciplinary account, suffering was regarded as *both social and* as inherent in individual, identifiable persons. Nowhere is this conviction more evident than in the context of hypochondria, an illness largely defined by the dangerous isolation of the person who suffers it. Hypochondria holds particular interest for this project insofar as it was commonly understood as a pathology of social life: a product of its breakdown, whether in the life of an individual or the community as a whole. It also constitutes one of the few contexts in which one person can say, “I am in pain,” and her interlocutor can legitimately respond with an alternative interpretation. According to Veena Das, such a refusal of belief is never acceptable: “My expression of pain compels you in unique ways—you are not free to believe or disbelieve me—our future is at stake.”⁸² In her account, the social fabric depends on a setting aside of skepticism: it requires of us the assumption that the other speaks truthfully as a vulnerable human being like ourselves. In the context of hypochondria, Victorians implicitly assume that such doubt registers the fact that the future has *already* been imperiled: the existence of the illness in the first place suggests that the stability of the ordinary has already come under threat.

Hypochondria in the nineteenth century has no single, simple definition. As Esther Fischer-Homberger has shown, in the eighteenth century, hypochondria was a “real and serious illness with its seat in the upper abdomen . . . [that] involved spiritual as well as physical pain to those who suffered from it, and . . . could be induced either mentally or somatically.”⁸³ Only in the later eighteenth and nineteenth centuries did it become usual to associate hypochondria with what Fischer-Homberger calls “pathophobia,” or the fear of illness, and even then the connection was by no means universal.⁸⁴ Hence, some nineteenth-century commentators define hypochondria in terms of the fear of illness, while others saw such an anxiety as incidental to, rather than constitutive of, the disease—as evidenced, for example, in recurring interest in “religious hypochondria,” or the belief in one’s damnation in the absence of any particular crime.⁸⁵ In his “Lecture on Hypochondriasis” (1873), for example, published in the *British Medical Journal*, Thomas King Chambers moves seamlessly between medical and religious forms of hypochondria, repeatedly

quoting John Bunyan's *Grace Abounding unto the Chief of Sinners* (1666) as "the most vivid picture extant of an [*sic*] hypochondriac."⁸⁶ Meanwhile, other writers associated the term "hypochondria" with what we might call anorexia or obsessive compulsive disorder—as in the case of Stonewall Jackson, whose "hypochondria," as reported in *The Lancet*, consisted of believing "that everything he ate went down and lodged in his left leg" and of going for long periods in which he would not eat "except by the watch, at a precise moment."⁸⁷ Jackson did not exactly think he was ill, although he clearly had unconventional ideas about the workings of his own body; nevertheless, the anxiety he attached to those workings led him to be categorized as a hypochondriac.

Despite the lack of consensus regarding its symptomatology in the nineteenth century, both medical professionals and lay commentators generally agreed upon two aspects of the illness. First, hypochondria was regarded as a disorder of the senses as much as an error of belief: the problem is not simply that the hypochondriac thinks she is ill when she is not, but instead that she *feels* ill (or damned) in the absence of any verifiable cause. So, for example, John Conolly claimed in 1849 that hypochondria originates not in the mind, but in the "peripheral extremities of the nerves; from which . . . uneasy impressions are transmitted to the brain."⁸⁸ The consequence is an "intense acuteness of smell, and extreme sensibility to the impression of the external air on the surface . . . conveying to the mind of the patient ideas of functional or even organic disease of a serious nature, when there is, at least, no structural change."⁸⁹ By this account, hypochondriacs are not exactly wrong to think they are ill; instead, they are victims of a faulty nervous system that makes them feel as if they are ill when they are not. Thomas King Chambers largely agreed, claiming in 1873 that "the patient feels all wrong but understands all right": it is their nervous systems that are disordered rather than their mental faculties.⁹⁰ "Feeling general misery," he continues, "often accompanied by local pain, [hypochondriacs] construct a theory to account for the same; and, as they are for the most part intelligent and ingenious persons, the theory runs a chance of being a very plausible one."⁹¹ The result is that they often convince not just "themselves and their friends, [but] often their medical advisers."⁹² Not all medical professionals thought hypochondria originated in the senses; many attributed it to pathological forms of self-regard. Regardless of its understood cause, however, the consensus was that hypochondriacs do experience real suffering, even if it is unaccompanied by lesion.

The second aspect of hypochondria upon which commentators almost invariably agreed has to do with the illness's relation to isolation: whether as cause or as effect, hypochondriacs were often assumed to be cut off from others. As Michael J. Clark writes of the closely related and often overlapping diagnosis of "morbid introspection," according to many experts on psychological medicine, "introspection and self-absorption, persistent abstention from ordinary social intercourse, and neglect of active pursuits all tended to weaken

the will, undermine the ‘natural’ social affections, and encourage idleness, eccentricity, and the growth of perverse or immoral tendencies. Absorption in purely ‘subjective’ states of consciousness, they argued, upset the ‘natural’ mental balance by impairing the capacity to receive and react to external impressions.”⁹³ As in hypochondria, in morbid introspection, isolation could all too easily result in emotional or sensory extravagance. As the anonymous commentator in *The Quarterly Review* explained in 1810, “Of all morbid habits, that of watching our own sensations is one of the most unfortunate; it is by this habit that the miserable hypochondriac induces upon himself the symptoms of any disease that his fancy apprehends, and endures thereby actual suffering from an imaginary cause.”⁹⁴ Self-absorption leads to an excessive sensitivity to one’s own sensations—a sensitivity that could be experienced as pain, suffering, or sensations resembling illness.⁹⁵

Such self-absorption could take many different forms. At one end of the spectrum is the literal-mindedness of W. H. Ranking, who, in 1843 identified the illness with celibacy, or of John Elliotson’s insistence in 1832 that almost all sufferers are sexually deficient: “They have nightly emissions, or excessive emissions, or no desire, or if they go to a female they ‘do no good.’”⁹⁶ At the other end of the spectrum is the frequently reproduced excerpt from Dr. Bruck’s “Hypochondria Politica in Germany,” which first appeared in 1848 in Casper’s *Wochenschrift* and was then translated for English audiences in *The Lancet*. Identifying hypochondria with “the recent violent political commotions in Prussia,” the author attributes his countrymen’s ill-health to their reluctance to become politically engaged.

Twenty-one years ago I mentioned, in a memoir on psychical medicine, that the numerous cases of hypochondria in our country among the higher and middle classes, were mainly owing to the want of interest in public affairs, and the total absence of co-operation between the citizens and the state. It is now evident that I was right, for the peculiar effects which the late political changes have produced, and from the nervousness with which we watch the events, prove that we have become more or less hypochondriacal. We are afraid of public life; all news of a political nature, which, amongst more advanced nations, are quietly discussed, has with us an immediate effect on the ganglionic system, frightens and unnerves us; the appetite disappears, sleep is disturbed, and the train of symptoms above mentioned make their appearance.⁹⁷

The failure of civil society here constitutes a problem not just for the body politic, but for the individual body, as well: an entire population becomes sick because of individual refusals to engage in public life.

Regardless of whether they located hypochondria’s origin in the nerves or in the mind, most medical practitioners prescribed social engagement as the

cure. For example, in 1825 Dr. Armstrong advised his pupils “to appeal to [hypochondriacs’] common sense, so that they may, at the commencement, withdraw the mind from the contemplation of themselves, and fix it upon some external object with interest sufficiently intense, as a diversion from the distemper.”⁹⁸ Meanwhile, William Withey Gull and Francis Edmund Anstie insisted in 1876 that “it is a fallacy to suppose that the sufferings of the patient are unreal; on the contrary, they are most vividly real, and it is impossible that he should forget them till they cease.”⁹⁹ Yet they also go on to claim that mental therapies can be salutary because “the mind has a reflex influence upon the bodily disorder, which may be as effective for good as for evil. . . . The key to the moral treatment is the breaking down of the patient’s morbid self-concentration, and this object may be achieved to some extent in many cases by a change in the course of his daily life.”¹⁰⁰ Hypochondriacs suffer from an excess of self; it is thus only reasonable to associate their cure with distraction, social engagement, and an increased sense of civic responsibility.

Rather than a purely subjective experience, or simply the product of a social exchange, suffering here appears to exist between these two possibilities. It is simply not always possible to know what we feel in isolation, doctors writing on hypochondria assume—or, rather, what we do feel can become exaggerated without the normalizing presence of others. Clearly such a recognition of the social nature of pain could be deployed so as to undermine the patient’s authority over the one arena from which medical professionals might seem to be excluded: her own experience. It could also, ironically, be used to hold patients responsible for their own physical illness—as in M. Andral’s 1833 account of how excessive attention to the nerves leads to physical lesion: “Consecutive to this delusion [of hypochondria],” he explained in *The Lancet*, “various nervous derangements may supervene, and terminate in functional disorders or organic changes in different parts of the system.”¹⁰¹ As a result, “in the hypochondriac, it is not rare to find that the attention, fixed on the lungs, has actually induced the disease which was the subject of the delusion.”¹⁰² Yet, it also suggests a far more nuanced understanding of the social experience of pain than has tended to be recognized. Such understandings could have very practical consequences for how the patient-doctor relationship was conceived. For many practitioners tasked with caring for hypochondriacs, skepticism was simply not an option, but nor was the meaning of any given statement necessarily self-evident. In this context, the claim, “I am in pain,” was deeply meaningful and expressive of a felt need. The problem for the caregiver was to diagnose the nature of that need rather than—or in addition to—search for any physical lesion.

Victorian Pain

The past few years have seen a proliferation of historical studies on sensation and emotion—one consequence of which has been a lively debate over the best ways to describe the historical status of experiences that can so easily seem to have no history. According to Joanna Bourke, pain can best be understood as an “event” in the sense that “people are active in its construction in sensual, cognitive, and motivational terms.”¹⁰³ This definition has the benefit of resisting what David B. Morris calls the “Myth of Two Pains,” or the notion that “physical pain” can be clearly distinguished from “mental pain.”¹⁰⁴ Further, the “event-ness of pain . . . points to the fact that the individual’s perception of what she signifies as a pain-event can also be profoundly affected by environmental interactions.”¹⁰⁵ Describing pain in these terms, however, threatens to make pain seem like something that involves only sufferers rather than something in which their interlocutors also participate. This is a problem Javier Moscoso seeks to resolve in his description of his object of study as a “social drama”: “Pain mobilizes all the elements of theatrical representation. The experience of harm has its actors, plot, stage, costumes, props, scenography, and, of course, its audience.”¹⁰⁶ Moscoso’s theatrical model makes clear that pain requires an audience. Yet the notion of pain as a kind of performance places sufferers behind an imaginary scrim, rather than casting them as engaging with their interlocutors in what Veena Das helpfully describes as “transactions.”¹⁰⁷ In writing this book, I have often relied on Das’s model of pain, but I have also sought to heed her warning: “The absence of any standing languages of pain is perhaps symptomatic of the fact that I cannot separate my pain from my expression for it—another way of saying this is that my expression of pain compels you in unique ways.”¹⁰⁸ Part of what I take this to suggest is the multiplicity of ways in which a “transaction” can be conceived or inhabited. Part of my project, therefore, has been to tease out writers’ own understandings of pain’s social status, rather than attempt to impose a model from without.

The first two chapters of this project address the problem of social suffering in the context of liberalism. Specifically, they seek to demonstrate the deep commitment on the part of two of the period’s most important liberal thinkers to the non-self-evidence of precisely that sensation ordinarily understood as most private. The consequence is a revised notion of liberal subjectivity, not as prior to the social, but instead as inevitably enmeshed within it. Chapter 1, “John Stuart Mill and the Poetics of Social Pain,” describes Mill’s attempt to redefine sensory experience as a way to reimagine the social order posited by the utilitarianism of both his father, James Mill, and Jeremy Bentham. While James Mill describes pain as profoundly personal, interiorized, and private—and so imagines society as a more or less simple aggregate of essentially isolated individuals—in his *Autobiography*, John Stuart stages his

famous mental crisis as a way to introduce a different model of pain that casts it as something we learn as well as something we feel. Pain is something each of us may experience alone, Mill concludes, but we only ever understand it through our encounters with others—encounters ideally mediated by poetry. Ultimately this notion of pain suggests a model of liberal sociality organized like a Wittgensteinian language game in which the terms of the discussion may be endlessly renegotiated among individuals who share the same fundamental pain of self-alienation.

Chapter 2, “Harriet Martineau and the Impersonality of Pain,” argues that one of the most famous invalids of the age—and one of the most important political theorists—used her many writings on illness to imagine a model of impersonality uniquely well suited to the responsibilities of legislation. The relation of the legislator to the community represents a recurring problem for utilitarianism: if self-interest is the only reliable motivation, it becomes difficult to account for the legislator’s—and hence, the ideal citizen’s—supposed commitment to the common good. In Martineau’s account, only the enlightened sufferer is able to regard all persons as equally valuable, and hence, her or his own pain as of no greater or lesser consequence than that experienced by anyone else. Working with a radical version of Hartleyan psychology, Martineau insists on the extent to which all sensation—including all painful sensation—has the potential to be attached to new associations, experiences, or beliefs. What makes pain unique, however, is the license it grants the sufferer to retreat from the world of face-to-face encounters. As a result, the sufferer comes to constitute the ideal legislator, albeit one who is prohibited by her condition from acting in the world.

Chapter 3, “Pain and Privacy in *Villette* (1853),” shifts away from politics to the novel, yet remains focused on pain’s ability to configure the relation of the subject to the social. Specifically, this chapter argues that Charlotte Brontë’s novel uses the phenomenology of pain as a way to imagine the compatibility of privacy—offered as the locus of the individual’s value—with community. Here, I am particularly interested in Lucy Snowe’s practice of using the language of physical sensation as a substitute for any account of the precise nature of her emotional trauma. In this chapter, I argue that these carefully staged refusals of readers’ sympathy constitute an attempt to offer recognition and acknowledgement—here, counterintuitively couched in terms of the painful sensations of the body—in place of an implicitly normalizing fellow-feeling. We may not be able to enter into one another’s feelings, Brontë insists, but we can nevertheless recognize that we all possess them. Such a model may preclude intimacy, but it enables a form of compassionate coexistence that has a family resemblance to that which Martineau and Mill imagine as the grounds of liberal sociality.

Although still connected to the issues of social life that inform the first three chapters, chapters 4 and 5 home in on the particular questions raised by

Darwin's engagement with Malthus. Chapter 4, "Charles Darwin's Affect Theory," considers how Darwin's meditations on pain complicate the optimism not just of his own historical moment but of some of the recent affect theory that claims to depend on his work. Specifically, Darwin's use of the idea of pain to ambiguate the relationship between the biological and the cultural, and to interrogate the basic unit of analysis, leads to a strange phenomenology in which it is often difficult to say who or what suffers: a person, a population, a species, or a limb. As such, it offers a model for a version of affect theory that refuses to take the individual for granted as its object. This chapter suggests the radical revision Darwin offers to any account of the social that naturalizes an autonomous subject as its starting point. It additionally indicates how Darwin's work on the expression of pain might prove useful for a renovated version of affect theory, albeit one devoid of the political optimism sometimes taken for granted by recent theorists.

Chapter 5, "Wounded Trees, Abandoned Boots," explores Thomas Hardy's post-Darwinian accounts of pain that hover ambiguously between and beyond subjects, that are attributed to no malign agent, and that hold no hope of prevention or remediation. Such accounts tend to be troubling in their vividness as well as in the profundity of the sorrow they describe and convey. They can certainly be called "pessimistic" in the sense that they offer no clear path for either action or catharsis; however, this chapter argues that for that very reason they invite us to consider the disposition that might be at issue in the reading practices they encourage: affectively engaged practices that ask us to experience ourselves less as potentially responsible observers of pain than as fellow sufferers. However much Hardy's work may seem like a retreat from the political, therefore, it nevertheless suggests an account of the social, grounded in the recognition of universal and yet differential relations to suffering.

Throughout *Victorian Pain*, I argue that "modern pain" is characterized by its imbrication with the social. In the afterword, I offer a very brief account of what epistemological accounts of pain can look like when conceived in isolation from social life. This way of thinking about pain does not originate in the nineteenth century, but it is importantly reformulated during this period. In the afterword, I describe the nature of this reformulation and begin to point to the consequences of its lingering pervasiveness. As I have already begun to suggest, *Victorian Pain* asserts a basic compatibility between a model of atomistic individualism often identified with liberalism and an exclusively epistemological model of pain. The afterword "The Fantasy of the Speaking Body" attends to a few symptoms of this compatibility.

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