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The Full Measure of Cheerfulness: Mary Ely, Weir Michell and Victorian Views on Treating Melancholia

By Lori Duin Kelly

In Management of Nervous Patients, published in 1907, Alfred Schofield lamented that "Functional nerve-disease is sweeping over civilized society like a plague" (3). Arriving at an accurate diagnosis for the constellation of disorders subsumed under the heading of nervous diseases was complicated in part because of what George Berrios has dubbed their "polymorphous symptomatology" ("Depressive" 398). This included the replication of identical symptoms across distinctly different categories of disorders and the uncertainty of whether these conditions were caused by lesions on the brain or simply a depletion of limited reserves of nervous energy in the body. Following closely on the challenge of arriving at an accurate diagnosis was the selection of an appropriate method of treatment. What worked with neurasthenia, or nervous exhaustion, might not succeed with chronically depressed patients, some of whom might well have been misdiagnosed, and suffering, in fact, from serious mental disease.

To negotiate this professional landscape, physicians were challenged with devising treatment methods that alleviated the suffering of their patients but at the same time, safeguarded their reputations should these patients not improve. This paper argues that methods of treating mental disorders that centered on the power of patient "will" arose as a response to these challenges. By assigning a central role to will, a concept also variously identified as volition and self-control, physicians carved out a new role for themselves at the same time as they assigned the primary responsibility for cure to their patients. The story of Mary Ely, a patient of the internationally renowned S. Weir Mitchell, provides a real life illustration of this process at work. Her treatment for melancholia illustrates not only the complexities--and pitfalls -- inherent in determining an accurate diagnosis. It also reveals the extent to which her physician's professional experience and understanding of mental illness contributed to his privileging of a specific method of treating it.

Mary Ely was a patient of Weir Mitchell who entered Bryn Mawr Hospital in Pennsylvania for treatment for melancholia. According to an entry in the records, Mary left the hospital with her private nurse to visit Mitchell's offices in Philadelphia, soon after which she escaped from her nurse and travelled to Camden, New Jersey where she committed suicide by placing herself in front of a train. Hospital records, which incorrectly identify the patient as 49-year-old Mary **Elizabeth** from Norwich,

Connecticut, show that she entered Bryn Mawr Hospital on January 9, 1895 and underwent treatment for melancholia for a period of ten weeks before her escape.

The fate of patient # 151--the number assigned to Mary Ely in the Bryn Mawr Hospital ledger-- was noteworthy for a number of reasons, not the least of which was the fact that her physician was the world famous expert in treating nervous disorders in women, Dr. S. Weir Mitchell. The story made its way into the local newspapers in Philadelphia, New York, New Jersey, and ultimately, Mary's hometown of Norwich, Connecticut. From these records we learn that Mary Brewster Chappell Ely was a rich socialite and the mother of four children. The *New York Times* of November 16, 1894, reported her presence at the start of the winter season in Lakewood, New Jersey, a watering spot frequented by the Elys for several years ("Lakewood's Season"). Six weeks later, she ended up in a hospital as a private patient with a diagnosis of melancholia. Unlike nervous debilitation, to which members of Mary's social class were said to be frequently prone, melancholia was "a distinctly mental state" (Schofield 186), was considered "morbid," and was classified as "a distinct form of mental alienation" (Oppenheime 6). Her assignment to a hospital for ten weeks following her admission suggests that she was, in fact, seriously ill. However, her history in the six weeks prior to her admission to Bryn Mawr complicates the medical understanding of her condition. It suggests that her illness in the period immediately preceding her admission to the hospital had undergone a marked remission which allowed her to move freely in social circles and to operate successfully within the standard practices of her social class.

How Mary Ely ended up in Bryn Mawr Hospital and in the care of Weir Mitchell only six weeks after her visit to Lakewood is no mystery. Bryn Mawr had just been incorporated as a hospital in 1893. George Gerhard, a physician based in Philadelphia, led the effort to found a hospital along the Main Line, so called because it followed the main route of the Pennsylvania Railroad beginning in Philadelphia and extended into the affluent towns then springing up along the route of the railroad. Gerhard's parents lived on fashionable Walnut Street in Philadelphia, not far from Weir Mitchell's residence. Both Mitchell and Gerhard moved in the same social and professional circles. Gerhardt worked at the Pennsylvania Hospital and in the clinics at the Orthopedic Hospital (Berry 169-170) where Mitchell also worked, and both were members of the College of Physicians of Philadelphia. Struggling to make ends meet on his salary from hospital work, Gerhardt probably welcomed Mitchell's generous offer to go into private practice with him and to take on some of his affluent female patients suffering from nervous disorders. A history of Bryn Mawr Hospital suggests that Gerhardt was familiar with the trifecta of Mitchell's treatment of neurasthenia: rest, diet, and the use of Faradic current to exercise muscles. Faradic current was frequently used in treating melancholia, and its therapeutic value was recognized by a number of Victorian physicians, not just Mitchell (Beveridge 156).

As a rich socialite--Mary's father, Edward Chappell owned one of the largest coal and lumber companies in eastern Connecticut (*Modern History* 42)--both the Elys, but in particular, the Chappells, had ample resources to pay for the services of Mitchell as well as an extended stay in a facility like Bryn Mawr Hospital which included

private suites for affluent patients, complete with apartments to house their servants (Berry 8). Placement of Mary in Bryn Mawr under the care of the foremost American doctor of nervous diseases undoubtedly reassured the Elys and the Chappels that they were providing the best care possible for their relative. At the same time, the distance from Connecticut freed them of any potential stigma that could be associated with severe depression. As Janet Oppenheim has noted in her study of Victorian views of nervous disorders, the presence of private asylums, such as the one at Bryn Mawr, testified to the presence of "lunacy in distinguished social circles" (10). Physicians, moreover, especially upper class physicians like Mitchell, were profoundly sensitive "to the implications of that label [insanity] in families with social pretentions, and in order to spare them humiliation, might call 'nervous collapse' what were, in fact, the inroads of madness" (Oppenheim 10).

The records of Bryn Mawr assign Mary a diagnosis of melancholia. Because of Mary's history, Mitchell may well have assumed that her melancholia was caused by nervous exhaustion, over expenditure of energy caused by too active a participation in the social season. In *Fat and Blood*, his landmark book on neurasthenia, Mitchell argued for the importance of extended rest for patients like Mary who had led a "restless life of irregular hours" (45) characteristic of the upper classes. Mitchell's decision to treat Mary for nervous exhaustion would have reflected the understanding of many of his colleagues within the Victorian medical community. Most certainly Mitchell avoided any medical procedures that required him to plumb Mary's unconscious. Freud was just beginning to publish his work on repression and memory--*Studies in Hysteria* appeared in 1895---- but Mitchell was skeptical of its value in treating patients with nervous disorders. As he noted "Today, aided by German perplexities, we could ask the victims a hundred and twenty-one questions, consult their dreams as to why they want to go home, and do no better than to let them go as hopeless" ("Medical Department" 17).

The extent to which Mary was suffering from a serious mental disorder varies enormously in newspaper accounts of her death and complicates even further a clear understanding of her condition. An account in the *West Jersey Press* of March 27, 1895 characterizes her death as an "accident," reporting simply that Mary Ely "was killed by an express train at Newton Avenue crossing." However, earlier accounts in the days immediately following her death on March 19 add details that radically heighten and dramatize the tragedy. The *West Jersey Press* of March 20, 1895, for example, describes an eyewitness who reports that Mary Ely "apparently saw the train approaching but made no effort to get off the track." An account in the *Philadelphia Inquirer* of March 20, 1895 under the lurid headline "She Courted Death" describes Mary as "throwing herself across the track." The *Norwich Bulletin* account, on the other hand, from March 22, 1895, deliberately excludes specific details of Mary's behavior at the train crossing. Instead, the story details only the shock following the announcement of her death in a community in which she was much loved ("Mrs. Edwin Ely's Death").

Significant variations also exist in the newspaper accounts of the medical explanations for Mary's behavior. The *Philadelphia Inquirer* for March 22 describes

her as having been diagnosed with melancholia, noting that "for some years past [she] has been subject to fits of mental depression, which became more frequent with advancing years" ("Death Mrs. Edwin Ely"). An account in the *West Jersey Press* of March 27 describes her as having escaped from "a private insane asylum, " while an article in the *Camden Daily Courier* of March 21 describes her as undergoing treatment "for dementia, due to nervous prostration." It also attributes her death to "grippe [which is] thought to have turned her head" ("It Was Ely"). Attribution of unusual behavior to physiological causes had precedent in medical circles. An influenza outbreak that occurred over a two years period in 1890-1892 and spread east from the Midwest to New York suggests that Mary could have been infected ("Flu Pandemic"), and moreover manifested the aberrant and unusual social behaviors often associated with the disease.

If the underlying cause of Mary's behavior was not somatic, then the evidence that she was cured would focus on two things: her willingness to reenter the social sphere and once there, to displaying particular behaviors, such as being friendly, helpful, and cooperative, while operating inside its parameters. Bryn Mawr, the hospital to which Mary was admitted, had very specific expectations for their patients. *Rules for the Government of the Patients, Nurses, and Attendants of the Bryn Mawr Hospital 1893* notes that "patients whose condition will admit of it, may be employed in such a manner as will conduce to the usefulness and support of the institution" (Berry 73). While it is unlikely that a person like Mary Ely would be expected to work in the wards, an improvement in her mood, an elevation of spirits and break from her long-term depression, would have been seized on as signifying an improvement in her condition. Meaning would attach to her resumption of what was for upper-class Victorians an important ADL or activity of daily life--the resumption of interest in shopping. Both the *Camden Daily Courier* of March 21 ("It Was Ely") and the *Norwich Bulletin* of March 22, 1895 ("Mrs. Edwin Ely's Death") note that on the day of her death, Mary Ely had gone shopping; the Camden paper even identifies a specific store, Wanamaker's, an upscale department store in downtown Philadelphia. It was from here that she escaped from the nurse who accompanied her to Mitchell's offices and made her way to Camden. While it is not known what Mary purchased--she was found, in one account, with packages -- she would have presumably needed to pay some attention to her appearance and dressed up in order to leave the hospital. Bryn Mawr explicitely prohibited patients from "leav[ing] the Hospital temporarily without the express consent of the head nurse and head physician or his assistant." (Berry 72).

Thus, the opportunity to leave the hospital and to shop was a significant departure from prevailing protocols, a notable exception to the patient rules, and a possible reward for good behavior. The *Norwich Bulletin* of March 22, 1895 describes Mary on the day before her death as seeming to be "in excellent health and spirits . . . when she went to Philadelphia to do some shopping" ("Mrs. Edwin Ely's Death.") This suggests that Mary was, at least by some accounts, manifesting behaviors required of her in the rules for patients. In other words, she appears to have learned "to submit to whatever treatment the surgeons or physicians may direct . . . ," and perhaps most importantly, "to carry out cheerfully [their] directions, and to give no unnecessary

trouble to the nurses . . . (Berry 72). Additionally, if she took pains with her attire in preparation for her outing, this would have contributed to the impression that her condition was improving. Attention to grooming and appearance frequently were used as evidence of improvement in individuals suffering from mental illness. Theophilus Hyslop's book on treating mental disorders, for example, noted that "Lower aesthetic feeling, connected with the appearance of the body, may be considerably perverted in the insane . . . with an absence of all personal cleanliness and care" (404). Indeed, case studies of patients diagnosed with mental illness frequently contrast the patient's untidiness and "careless appearance" on initial appearance on the ward (Menninger 482) with their being "well-dressed. . . appearance reassuring" following their recovery (Menninger 483). A major contributing factor to this semiotic of mental illness was the advent of photography, which could capture and document the contrast of the ragged dress and disheveled hair in before pictures of asylum patients with the cultivated appearance of patients who successfully underwent treatment (Gilman 27-32).

Mitchell's diagnosis of melancholia was a medically challenging one, and one that exceeded the famous doctor's expertise. However, in this he was not alone. Physicians in the period 1850-1890 were divided in how to explain psychopathologies like melancholia. Conventional wisdom in medical circles was that mental disease was caused by a substantial loss of nervous energy or a severe strain on that system. However, some medical experts, like the French researcher Albert Mairet, used brain localization studies to determine specific sites that could account for complex psychiatric states. Mitchell's training as a neurologist aligned him with those physicians who sought a somatic origin for mental disease. Like these somaticists, Mitchell held that every body had a limited amount of nervous energy to drive it. Specialists in diseases like neurasthenia maintained that life events--disappointment in love, reversals of fortune, along with overwork required in the competitive climate of the late 19th century-- contributed to a dramatic rise in nervous disorders in the period by draining these reserves of energy.

Mary's history in the years leading up to her suicide would have fit nicely into this explanatory paradigm. The first setback in her life involved the work history of her husband, Edwin Ely. Edwin, who died a year after Mary of a heart attack, was a long term invalid whose poor health had wrecked havoc on his business career. Unlike Mary's father, Edward Chappell, who had won and lost hundreds of thousands of dollars in his career, but who ultimately rose to millionaire stature to triumph over all his financial reversals, Edwin's health required him to sell his interest in the Reade and Obenauer paper company after his health broke in 1889 (*History New London* 221-222). Oppenheim has noted that "severely depressed patients frequently revealed totally unwarranted fears of financial ruin or the expectation of financial grace" (7), and Edwin's setbacks, along with the contrast with her father's ability to recover from them, could certainly have contributed stresses to Mary's life.

Edwin's absence from the 1894 winter season--his name does not appear with Mary's, nor do those of other family members in the list of arrivals -- suggests that his illness had progressed to a point that it interfered with his ability--or willingness--to

accompany his wife to New Jersey. By 1896, a year after Mary's death, Edwin had succumbed to heart failure, leaving behind four children, evidence that the debilitation that began early on in their marriage had, in fact, progressed.

Besides the stress of an invalid husband, Mary also suffered the loss of her beloved father, Edward Chappell, who died in 1891. Edward Chappell bought Mary's house for her in Norwich, and upon his death, according to a report in the Philadelphia Inquirer of March 22, 1895, she inherited $500,000, ample funds to pursue the kind of social life she obviously relished "Death Mrs. Edwin"). Edwin's declining health, however, along with the domestic responsibility of raising four children probably imposed restrictions on the extent to which she could pursue that life. The obituary for Edward Chappel in the Norwich Bulletin of October 14, 1891 lists Mary as the first to leave for New York when her father died, followed, on separate trains, by her father's business partner, Arthur Brewer, and finally, her husband ("Death Edward.") This suggests that Mary's bouts of depression, alluded to in some of the newspaper accounts, were not constants in her illness. Depending on the variability in the intensity, duration, and alternation of her mental states, Mary could have been diagnosed with anything from neurasthenia (nervous collapse) to dementia, each of which would have initiated very different forms of treatment.

The transition from the winter season in Lakewood in November 1894 to the hospital for treatment of melancholia was rapid: six weeks. While Gerhard founded and ran Bryn Mawr hospital, it is clear that Mitchell, who insisted on hiring a private nurse for his patient and on scheduling visits for her to his office in Philadelphia, was still very much in charge of her case. However, what becomes apparent from reading his publications concerning treatment of melancholia is that Mitchell was woefully out of his depth in treating an illness that medical dictionaries defined as "part of the cycle of a form of circular insanity" (Oppenheim 30). In an article in *Transactions of the Association of American Physicians* in 1897, Mitchell, who was trained to look for underlying somatic causes of disorders, acknowledges an inability to detect any pattern of causality, relapses, or recovery from melancholia. The data he cites, 3,000 cases gathered from all over the East Coast, reveals no clear pattern in either seasons of the year or the onset of the climacteric in women as contributing factors to the disease. In *Clinical Lessons on Nervous Diseases* published in 1897, two years after Mary Ely's death, Mitchell acknowledges the enormous variability in symptoms as well as unpredictability in rates of recovery and relapses. He notes "Melancholia is especially troubling because of its tendency to spring up suddenly and disappear." (25). Mitchell's frustration with identifying the causes of melancholia in fact extended to the whole realm of mental illness, evident when he opines that the treatment of serious mental disorders remained "one of the least satisfactory of the varied problems with which we have to deal" (*Clinical Lessons 2*5).

Drawing on his expertise with long term neurasthenics, Mitchell employed a treatment method for melancholia that ultimately directed responsibility for a cure away from him and to his patient. Like his contemporary, Theodophilus Hyslop, Mitchell argued that modification of the behaviors of patients like Mary resided in harnessing the power of the patient's will, defined as "the active concentration of

attention upon an object or idea . . . directed to some end" (Hyslop 409). One consequence of this focus on will was a corresponding reconfiguration of the role of the physician to a coach advocate. Physicians trained their patients to develop strategies for redirecting their thoughts from excessive introspection to more positive consciousness, and to cultivating "mental qualities that are recognized as curative agents" (Schofield 140). Patients learned to turn to "diversionary tactics" (Schofield 126), such as walking briskly or soaking in a warm bath to redirect their thoughts from the morbid preoccupation with self that was seen as a central feature of melancholia. In addition, patients were coached in ways to employ autosuggestions not only to control harmful impulses, but also to shape what they wish[ed] to be or become" (Schofield 126).

Closely associated with the power of will was the cultivation of a positive outlook toward healing. While he acknowledged variability in individual temperaments, Mitchell nevertheless shared Hyslop and Schofield's views that a mental attitude of cheerfulness was key to the therapeutic process in the treatment of melancholia, and as such, this attitude "can be combated or fostered . . . until it becomes habitual. . . " (*3000 Cases* 27). In *Fat and Blood*, his classic book on treating neurasthenia, Mitchell defines being "happy, industrious, and capable" (34), regaining a sense of "duty and will-power" (35), in general, a restoration to "the full normal of cheerfulness" (31), as steps to a cure in the treatment of melancholia, a disease associated in the popular imagination with varying degrees of sadness and depression. Cheerfulness, in particular, has a special place as a curative agent in the therapeutic process, with patients living "below the normal level of that happiness which comes of natural cheerfulness . . . foredoomed to have, at irregular intervals, attacks of melancholia, and to be always nearer to suicidal temptations than the rest of mankind" (Mitchell, *Clinical Lessons* 27).

The Camden account of Mary Ely suggests that she suffered from periodic bouts of depression that were frequently in remission. At times, as her trip to New York following her father's death there suggests, she was able to emerge from what was termed "the dark cloud "and function competently and independently. Events like her trip to New York or even her participation in the New Jersey social season a few weeks before her admission to Bryn Mawr Hospital may have complicated Mitchell's understanding of the severity of her illness. Indeed, even Alfred Schofield, a contemporary of Mitchell's conceded that "There are cases. . . of delusions, melancholias, etc., that cross the line and become the care of alienists [psychiatrists]." At the same time, he argued that "There is no need of great hurry in handing these over. Wait at any rate until you are convinced, not only that the symptoms are, or have become, clearly mental . . . that there is not reasonable hope for a restoration to health under your care" (240).

Frustrated by a disease with enormous variability in both its onset and recurrence, and puzzled that it did not fit into any known somatic models of illness, Mitchell fell back on a method he had used in treating neurasthenic women and one which simultaneously compensated for the vulnerability of his position as a medical scientist. In *Fat and Blood*, first published in 1878, Mitchell had urged physicians to

use their "force of character. . . [In order to] direct the thoughts of . . . patients to the lapse from duties to others and to the selfishness which a life of invalidism is apt to bring about" (45). This conceptualization of the role that physicians were expected to play in the sickroom is closely tied to his view of the female patient as complicating--rather than aiding-- the process of diagnosis, as generating reports whose content was "magnified. . . owing to a life of attention to their ailments" (*Fat* 47). This had been an especial--and frequent-- concern in Mitchell's work with female neurasthenics. Because of what he viewed as his patients' penchant for hyperbole in discussing their symptoms, Mitchell concluded that it was "hard to separate the true from the false" (*Fat* 47). As a result, "we are thus led to be too skeptical as to the presence of real causes of annoyance" (*Fat* 47). Because the accurate reporting of symptoms was crucial to the process of diagnosis and treatment, patients who hyperbolized reports of their conditions had the potential to compromise, even imperil a physician's ability to cure them. In addition to explaining why some doctors would be reluctant to take on such patients, this also explains why some of them, like Mitchell, may have assumed an authoritarian role in the sickroom, and chosen to minimize or eliminate the patient's voice. This approach would privilege the physician's understanding over the patient's and empower him to prescribe rather than negotiate with his patients on what behaviors they needed to adopt in order to be deemed "cured."

Mitchell's skepticism about the reliability of what his patients were telling him extended to those with serious conditions, such as Mary Ely's. Like Schofield, who quotes Mitchell extensively in *Management of Nerve Patients*, Mitchell approached treatment of melancholia with a belief that "anything and everything that weans from introspection and morbidity [are] agents for good" (Schofield 231). He viewed his role as physician as urging his patients to retain by every possible means their "self-control" (*Fat* 40) as well as that "healthy mastery which every human being should retain over [their] own emotions and wants" (*Fat* 31). Consistent with such a view, tears, a likely manifestation of melancholia, were "dangerous . . . and should be restrained" (Schofield 125). Moreover, if nervousness came on, "anything and everything should be done to avoid a breakdown, which always paves the way and makes it easier for a second" (Schofield 126). As these prescriptive statements suggest, the doctor's role was to advocate for "mental therapeutics," to urge patients to exert the force of their minds over their bodies, to train them to form habits which could calm the mind in its excited state. In addition, doctors were charged with teaching their patients to cultivate thoughts which could arouse feelings of joy, hope, and especially in the diagnosis of melancholia, of cheerfulness. Thus, any patient who hoped to be cured was obligated to play an active role in their treatment, as this approach to treating mental diseases assigned failure to thrive to a single source: patient will. At the same time that it provided a role for the physician as social disciplinarian, this treatment method provided a convenient out for him should it fail.

If indeed Mitchell chose to employ this method as his publications on melancholia suggest he well might have, it is clear that he failed with Mary Ely. Clever enough to finesse her way out of Bryn Mawr Hospital and into a department story,

Mary was equally clever enough to find her way to Camden and to that train crossing where she met her end.

Although lacking many specifics, the reconstruction of Mary Ely's case from newspaper accounts and the Bryn Mawr records nonetheless yields insight into how the Victorians, and in particular, established and well-regarded Victorian physicians like Weir Mitchell, treated mental illness that was both long-standing and resistant to easy treatment. Mental illness was a stigmatizing diagnosis, particularly to upper class families. Because of the uncertainty in what caused it, as well as the enormous variability in how to label and treat it, patients with this diagnosis frequently encountered physicians who were frustrated at the challenge to their professional judgment that a complicated diagnosis like the one assigned to Mary Ely presented. By insisting that the cure for serious mental disorders ultimately resided with the patient, doctors found a way to initiate treatment without, at the same time, imperiling their professional reputations when dealing with a category of patients whose conditions they freely admitted they did not fully understand.

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Lori Duin Kelly is Professor Emeritus of English at Carroll University, with a special interest in the intersection of gender and medical issues in the 19th century. Her work in this area has appeared in *Journal of Medical Humanities, Southern Studies, Legacy,* and *Studies in Popular Culture* as well in a collection of essays on the body, *Bodily Inscriptions: Interdisciplinary Explorations into Embodiment.* She is currently working on a study of neurologist S. Weir Mitchell's work with Civil War soldiers.