ABSTRACT

“STRONG PASSIONS OF THE MIND”: REPRESENTATIONS OF EMOTIONS AND WOMEN’S REPRODUCTIVE BODIES IN SEVENTEENTH-CENTURY ENGLAND

by Erin Nicole Johnson

This thesis examines the ways in which early modern medical texts presented the mind-body connection as it impacted child-bearing women in seventeenth century England. The medieval rediscovery of ancient Greek medical knowledge dominated understandings of health and healing for centuries but reached its widest audiences with the explosion of vernacular language printed materials in the early modern period. Foundational to these repurposed ancient medical theories was the belief that the mind and body interacted in complex ways, requiring frequent monitoring of emotional states to achieve good health. For practitioners concerned with women’s reproductive health, women’s emotional regulation was vital to desirable physical outcomes throughout the period of childbearing, lasting beyond modern designations of conception and childbirth. Thus, this thesis challenges assumptions of how early modern historians should mark the phases of reproduction and argues instead that childbearing, at least for women, continued through the first years of an infant’s life.
“STRONG PASSIONS OF THE MIND”:
REPRESENTATIONS OF EMOTIONS AND WOMEN’S REPRODUCTIVE BODIES IN
SEVENTEENTH-CENTURY ENGLAND

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Reader: Cynthia Klestinec

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Dedication

To my daughter, Elizabeth Minerva, who drives every decision I make and whose presence alone gives me joy and pride beyond what words can describe. And to my husband Casey, whose patience knows no bounds. Thank you for your unceasing support.
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And, of course, to my family. Thank you to my husband Casey for supporting me every step of the way and my daughter for inspiring me.
Introduction

Seventeenth-century instructions covering the proper management of the passions aimed primarily at childbearing women, but also their attendants, stressed that it was not only physical symptoms or triggers that could impact outcomes in childbirth, but emotional ones as well. In the second half of the seventeenth century, Hugh Chamberlen’s English translation of François Mauriceau’s 1668 French birthing manual Les Maladies des Femmes Grosses et accouchées, observed that “…if passions of the body cause so much hurt to a big-bellied Woman, those of the mind do no less…”¹ Written to instruct young male surgeons who specialized in childbirth in France, Mauriceau, and by extension Chamberlen, were referring to a conception of a mind-body connection in which the patient’s emotional well-being directly impacted the body’s physical states. More particularly, Mauriceau was concerned with women’s ability to closely and carefully manage their emotional states over the course of their childbearing experience, from conception through breastfeeding and infant care. Medical treatises, conduct manuals, and moralist commentaries abounded with advice on women’s appropriate emotional reactions, carefully deliberated over which passions could trigger disease or illness, and fretted over how these traits could pass from caregiver to infant, with close attention to wet nurses. The importance of the passions, the sensations that Mauriceau referred to, were fundamental aspects in not just childbirth, but in religious, political, and broader medical contexts as well. Their precise workings were hotly debated across Europe in the medieval and early modern period, and medical practitioners argued that emotional regulation became even more pressing in times of illness. However, nowhere was this philosophy so important as in the phases of childbearing.

Historical studies on childbearing tend to reflect a modern concept of the phases of child birth and almost always omit the postpartum period of nursing, unless centering the rituals of childbirth.² Likewise, works about breastfeeding rarely address pregnancy and labor. However, childbearing in the early modern period did not abide by the modern demarcations of childbirth. Instead, childbearing began with pregnancy and lasted through the first year (or so) of infant care. Though excellent works, the divisions modern scholars tend to use for early modern

childbearing distorts early modern experiences and practice. This trend is somewhat surprising, considering the well-established medical understandings of the reproductive body. For example, early moderns believed in connections or sympathies within women’s bodies, especially between the womb and the breasts. Many argued that the blood that gathered in the uterus during the course of a pregnancy and nourished the fetus throughout gestation was converted after deliver into breastmilk for infant consumption. It is because of these early modern conceptions of childbearing that this project begins with a chapter on emotions, the womb and pregnancy and ends with one addressing the physical and emotional labor tied to infant care, with an emphasis on infant feeding. This framework also serves to mirror many of the manuals utilized early modern England, which universally include comments, if not secondary books, on nursing and infant care.

While scholars have acknowledged that early modern medicine incorporated the impacts of mental states on physical outcomes, they have not yet addressed how this played out in public discourse or, more importantly, what this meant for expectations for women’s behavior and emotional expression during the rather mysterious phases of childbearing. This thesis will argue that despite the political and economic upheavals of the seventeenth century, including the effects of the English Civil War and global expansion, belief in the mind-body connection and its necessity for women’s reproductive health remained a central part of how early moderns understood the body. Following the religious unrest of the English Reformation and successive Tudor monarchs with varied beliefs, the middle of the century, from around 1645 to 1653 saw a “great overturning, questioning revaluing, of everything in England. Old institutions, old beliefs, old values came in question.”3 It may therefore seem counterintuitive to suggest a sense of stability, rather than one of change. Yet, I would argue that it indeed makes a good deal of sense. In a time of frequent turmoil, it is not surprising that long-standing medical traditions that permeated all aspects health and living persevered. I am not suggesting that there was a total lack of development in the medical field in the seventeenth century, nor do I believe that this research can get at what exactly happened in the birthing chamber or beyond. Women’s experiences are not and have never been uniform and to claim that these manuals can reveal an essentialized vision of a single “women’s experience” in childbirth would be misleading and irresponsible. However, what they can show is expectations, the model to which women were held and the

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areas that practitioners felt they fell short with sometimes catastrophic consequences for childbearing women and their children. Like Michelle Dowd has shown in her analysis of women’s work in early modern English literature, birthing manuals also presented idealized goals for women’s comportment. These expectations hint at prevailing assumptions about women’s less stable emotional regulation and the appropriate emotional expression during particularly charged periods in women’s reproductive lives.

Childbirth in the early modern period was an embodied experience, and a time when emotional regulation became especially important. It is not an overstatement to say that it was not only was the mother’s health that was of concern, but also the viability of a pregnancy and infant survival that were at stake. Even at the end of the seventeenth century, Cartesian divides between the mind and body were far from established, and the mutually reinforcing relationship between the experience of harmful emotions and negative physical outcomes was embedded in ancient Greek medical theories that dominated well into the eighteenth and even nineteenth centuries. Galenic models of the humors and the havoc they could wreck on the body when out of balance demanded that practitioners not only include but center the impact of what they called the passions. To best appreciate the relative stability of the mind-body connection in the early modern period, it helps to also illustrate the multiple contexts through which it endured.

Social, Medical, and Humoral Contexts: Seventeenth-Century England

England in the early modern period was in a state of constant flux and frequent upheavals. The first part of the seventeenth century saw social and economic challenges thanks to massive outbreaks of the plague, even in the countryside, and chronic crop failures. These posed unique threats to the landed gentry who struggled to produce wealth in the face of these difficulties. At the same time, the merchant class began to amass new levels of wealth as a result of increased global expansion and exploitation of England’s overseas holdings. Perhaps the most disruptive factors of the period were the many conflicts of the English Civil Wars, both in terms of military conflict and philosophical challenges to the status quo. The civil war had a huge number of casualties, proportionately to the population, both from armed conflicts and the

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outbreak of disease, and also resulted in increased taxation that meant that the aristocracy felt
under threat, even if they were the ones to see the most favorable long-term outcomes of the
collection. The beheading of Charles I presented entirely new challenges to the structure of society
wherein the complaints against the monarchy also contested nearly all forms of accepted
authority in patriarchal England.

Childbirth was a case in point, best illustrated by Nicholas Culpeper’s 1651 Directory for
Midwives which refused to accept the traditional wisdom of ancient medicine and the elite
creation of medical authority. But his was not the only voice. London in this period offered a
thriving medical market place in which individuals could enlist the help of various healers from
women who specialized in kitchen physic, to apothecaries, physicians, midwives, surgeons and
barber surgeons. Historians have demonstrated that the formally common description of tripartite
system with physicians at the top and apothecaries and barber-surgeons below was not
historically in place. The medical field was still professionalizing, consolidating, and generally
poorly controlled. The publication of manuals and medical treatises like the ones examined in
this project was an instrumental part of a process to gain legitimation by male practitioners in a
female dominated space. Writers most often referred to themselves as artists within their field,
rather than professionals. Entrance into the sphere of print could demonstrate not only medical
knowledge and practice, but engagement with other practitioners publishing at the same time and
even centuries before. This was especially the case for practitioners invested in childbirth,
whether they attended births themselves or sought to advise those who did. Status within the
hierarchy of the medical profession was based on a number of qualities, the most quickly
identifiable of which was education. Though not strictly enforced, physicians were generally at
the top of the order and earned the most money for their services. Physicians were trained at
universities, had acquired Latin, and were required to read the foundational Hippocratic theories
in their most original form. Surgeons received less formal education, rarely in Latin and gained
knowledge through a combination of medical literature and experience, empirical observation
and practice. From the sixteenth century, surgeons began attending births at an increasing rate,
though mostly when complications occurred. It has been more difficult to uncover the training

\[6\] Ann Hughes, Gender and the English Revolution (New York: Routledge, 2012), 2-5.
\[7\] Rebecca Laroche, Medical Authority and Englishwomen’s Herbal Texts, 1550-1650 (New York: Ashgate, 2009),
4-5.
and recruitment process for midwives, though from the examples available, there was certainly an apprenticeship-like process before they were permitted to practice on their own.\textsuperscript{8} Certainly, women practiced medicine in realms other than childbirth and treated both women and men. In spite of this relative success, or perhaps because of it, Adrian Wilson has suggested that “male medical corporations repeatedly attacked women practitioners.”\textsuperscript{9} Man-midwives, on the other hand, began to crop up in seventeenth-century France in the mid seventeenth century among the elite and the practice spread rather steadily.\textsuperscript{10} However, in the seventeenth century it was still predominately women who assisted in childbirth, though it was not until 1671 that the first English midwife published on the topic.

Women may not have been as active in publishing medical treatises on childbirth, but this did not mean that there existed a significant divide between elite and vernacular medical knowledge.\textsuperscript{11} The theories and beliefs contained in medical knowledge had the power to reach a vast audience. Literacy in general in the early modern period was on the rise, and midwives as a group were a highly literate demographic.\textsuperscript{12} In addition to expanded literacy, evidence suggests that birthing manuals were read aloud and used by women in the birthing chamber.\textsuperscript{13} In her diary Lady Margaret Hoby, though not a midwife, wrote often of reading aloud to her workmen, for example.\textsuperscript{14} The ideas contained within these works were shared in a social context. Clearly, the life of the written word did not end once read by an individual in isolation.

Considering the vast impact of the oral transmission of printed materials, is not a stretch to suggest that regulation of the passions was included in these ideas, since commentary on their influence in medical, religious, political, and social sects pervaded thought throughout the

\textsuperscript{8} Wilson, \textit{Ritual and Conflict}, 161.

\textsuperscript{9} Wilson, \textit{Ritual and Conflict}, 163.

\textsuperscript{10} Merry E. Wiesner-Hanks, \textit{Women and Gender in Early Modern Europe} (Cambridge: Cambridge University Press, 2008), 84.

\textsuperscript{11} Mary Lindemann, \textit{Medicine and Society in Early Modern Europe} (Cambridge: Cambridge University Press, 2010), 16.


\textsuperscript{14} Lady Margaret Hoby, \textit{Diary of Lady Margaret Hoby}, 1599-1605 (Boston: Houghton Mifflin Company, 1950).
century. Despite my use of the term ‘emotion’ throughout this thesis, the popular (and even relatively unknown) literature of the seventeenth century rarely used the word and when they did, it was not within the same context as modern usage used to describe inner feeling. In fact, none of the works examined here use the word ‘emotions’ in any context. The term had only just emerged in the middle of the sixteenth century and even then, it referred more to a public disturbance or a commotion than to affect. By the mid seventeenth century, ‘emotion’ also began to convey a sense of mental agitation, which is not quite the same connotation as the modern west. These early modern definitions reflect a sense of movement, unrest, discomfort, and unpredictability that help to explain why early modern medical writers described the passions, what modern readers would identify as strong emotions, as something to be carefully managed, despite their use of alternative terminology.

Rather than emotions, medical authors fretted over the experience of the passions. These constituted a vast vocabulary early moderns used to describe and define feeling and were conceptualized as something to be overcome or managed in order to achieve a sense of moderation that reflected ideals of gentility and good health. The internal regulation of the passions was a high priority because dominant models of health and healing in seventeenth-century England stressed prevention at least as much as, if not more than, treatment. A focus on preventative care was especially important for childbearing women in order to avert any of the many known complications that could arise. But the passions had meaning beyond the individual and were also “indicative of entire systems of feeling in the early modern world that structured both individual and collective identities and actions.”15 Philosophers of the period debated amongst each other the purpose of the passions and worked to identify the most important examples for study, but routinely represented pregnancy “as a stage during which children [were] mentally and physically sullied rather than strengthened by their mothers passions.”16 This study will use the terms emotion, passions, and feeling somewhat interchangeably, with the intention that they all hold these same associations of internal disruptions to conquer or overcome.

Early modern European understandings of the passions and health were grounded in ancient Greek humoral models dating to the Hippocratic writers of the 5th century BCE. Though

the intricacies of these complicated theories are unnecessary for understanding the arguments in the chapters that follow, a working knowledge of the humors, their roles and how the passions impacted humoral movement will be helpful. It was these medical underpinnings that made the regulation of mental states so important to early moderns who, like the Greeks, understood good health to be possible only through good balance of the whole body, both physical and incorporeal. Illness was attributed to an over or under abundance of one or more of the fluids, or humors, that made up the human body. The humors consisted of black bile (sometimes called melancholy, which also happened to be a ‘passion’ one could experience), yellow or red bile, blood and phlegm and could be combined in any number of arrangements. The best method by which to achieve good health, and therefore a healthy pregnancy and safe delivery, was to practice moderation in all things, but most especially the six nonnaturals of air, sleep and waking, food and drink, rest and exercise, excretion and retention, and finally the passions.\textsuperscript{17} Passions of the soul were responsible for intense feelings of sadness, anger, joy and shame all of which were of concern to childbirth practitioners because they could cause an imbalance in the humors, especially blood. The passions then had “intrinsic physical manifestations which bridge[d] emotion and action.”\textsuperscript{18}

Though every individual was said to have a unique humoral makeup, there were also prevailing generalizations based on supposed differences between men and women. For example, women’s bodies were considered colder and wetter than men’s, making them more susceptible to illness and further from the ideal state. Similar value judgements could be found in gendered concepts of women’s experience of the passions in this period. Adam Fox has observed that binary thinking used to describe differences between men and women, wherein “women were fickle where men were constant; and women were passion where men were reason” made sense in the early modern period which often made sense of the world in inverses.\textsuperscript{19} These portrayals are evident even at the very start of the seventeenth century, when Thomas Wright in \textit{Passions of the Minde in General} wrote that women’s passions “are most vehement and mutable,” meaning that they were less steadfast and more prone to dangerous extremes than were

\textsuperscript{17} Lindemann, \textit{Medicine and Society in Early Modern Europe}, 14.
\textsuperscript{18} James, \textit{Passion and Action}, 4.
\textsuperscript{19} Fox, \textit{Oral and Literate Culture}, 177.
men.\textsuperscript{20} Indeed, women were thought to be more subject to anger, a particularly hazardous passion in childbearing, as well as vengefulness and sadness.\textsuperscript{21} Similarly, Seneca, an influential ancient writer, gendered his conception of a weak mind as female and belonging to “old ladies and wretched women.”\textsuperscript{22} It is these connections between women’s expression of certain passions and the associated physical outcomes over the course of the phases of childbearing that form the foundation of my research.

This project has been influenced by several key studies in the history of medicine, emotions and women’s reproductive bodies in early modern Europe. Barbara Duden’s early work on eighteenth-century physician/patient relationships demonstrates that the body, like gender, is a social construction and is influenced by its environment.\textsuperscript{23} Her analysis of the interactions between female patients and physician Johannes Storch reveals that gender and the body were up for debate, open to interpretation and a place of hidden activity. Similarly, Mary Fissell’s \textit{Vernacular Bodies} examines the shifting meanings of women’s reproductive bodies found in cheap print published in seventeenth-century England and argues that by the end of the period, representations of women’s bodies became increasingly negative.\textsuperscript{24} Where women’s reproductive bodies had once been conceptualized as mysterious and miraculous, they eventually took on more sinister meanings and were increasingly othered. Though based in different geographic and temporal locations, Duden’s and Fissell’s works reflect the ways in which women’s reproductive bodies are socially made. My research suggests that expectations of proper emotional expression and corresponding physical manifestations were another way by which women’s bodies were given social meaning and incorporating the role of the passions in childbearing helps to give a broader understanding of the embodied experience of birth and infant care.

\begin{itemize}
\item \textsuperscript{23} Barbara Duden, \textit{The Woman Beneath the Skin: A Doctor’s Patients in Eighteenth-Century Germany} Cambridge: Harvard University Press, 1998).
\end{itemize}
Though recent scholarship has started to expand traditional historical paradigms that upturn biological essentialist views that assume sameness in the experience of childbirth, the role of emotions is still relatively unexplored. Fissell has observed that superficial periodization of medical practices and arbitrarily imposed modern boundaries of the body are too often imposed on the past, skewing our understanding of health and illness in the early modern period. A step towards a more comprehensive understanding of the expectations for bodily monitoring in the early modern period is Susan Broomhall’s examination of how emotions were understood to interact with and produce systems of thought and were enacted by individuals as social and emotional practices in everyday life. The ordering of the early modern world, according to Broomhall, relied both on the emotional realm and on reason, which she argues shaped moral and social values. More to the point for this project, she finds that emotional expression “altered as authority was performed in varying spaces and forms.” This research extends these ideas and shows how they can also be applied to the patient/practitioner relationships in the birthing chamber. Scripts for proper emotional expression, for birthing women and their attendants, were embedded in birthing manuals and moralist commentaries meant for broad consumption.

Yet, even with this outstanding scholarship, research in the field of childbirth and the passions is a bit dearth. Intended as a broad introduction to the history of emotions in Europe, Broomhall’s edited essay collection gives a snapshot of the current state of the field, with special attention to themes that are particularly underdeveloped. To that end, Joanne Begiato’s contribution insists that “[f]ar more explicit research is needed on the role of emotions in pregnancy and childbirth, both from medical practitioners’ perspectives and parents’ experiences…” The earliest example is Ulinka Rublack’s 1996 article on pregnancy and childbirth in early modern Germany where she seeks to contextualize “assumptions common in early modern Germany about women’s bodily sensitivity during pregnancy and child bed, and about the connection between their emotional and physical well-being.” Rublack shows that German communities instituted laws and regulations aimed at protecting pregnant women from

frights and sights that might cause harm to the developing fetus. Likewise, Alexandra Shepard’s recent chapter titled “The Pleasures and Pains of Breast-Feeding in England” in *Suffering and Happiness in England 1550-1800* shows many of the ways the emotional triggers that Rublack examines occurred in England, but specifically within the context of breastfeeding. Still, these are but two short examples. This current research seeks to more fully integrate the history of emotions with medical history and give a broader understanding of early modern expectations for achieving a desirable childbearing experience. Widespread belief in the significance of connections between the mind and body meant that by and large, both male and female practitioners (regardless of specialty) understood women to be central and vital participants in the birthing process. Though they were not solely responsible for their experience of certain passions, they were expected to properly control them.

**Sources**

Theories concerning the connections between the mind and body reached an ever-increasing audience as in the seventeenth century, as this period also witnessed a huge influx in English language printed materials, particularly on childbirth with a renewed public interest in women’s reproductive health. Translations of continental works, mostly French and usually from the preceding century, predominated the first half of the seventeenth century. It was not until the mid-century that English authored works became more popular. This expanded audience was introduced to medical knowledge based on Greek models of health and illness that was less tied exclusively to elite audiences, but rather permeated society at large. Indeed, beliefs and practices that reflected humoral theories existed much longer in popular culture than it did in medical circles. In an effort to demonstrate this reach, each of the chapters to follow will open with a quotation or vignette from outside the medical field.

A series of widely available medical texts published over the course of the seventeenth century form the foundation of the source base for this project. These varied in popularity from the single translation of Jacob Rueff’s *The Expert Midwife* in 1637, the twenty-three printings of Nicholas Culpeper’s *Directory for Midwives*, and the practically innumerable editions of

Aristotle’s Masterpiece.\textsuperscript{31} I chose the works used in this thesis first because their authors and translators showed a vested interest in instructing or commentating on childbirth. It then became clear that they were also particularly concerned with women’s emotional expression and their susceptibility to certain passions within the context of childbearing. Some works, like Helkiah Crooke’s \textit{Mikrokosmographia}, focused on anatomy and therefore contain broader references to essentialist ideas about women’s humoral makeup and its role in childbirth.\textsuperscript{32} Others who addressed practice in the field, like François Mauriceau’s \textit{The Diseases of Women with Child} and Jacques Guillemeau’s \textit{The Happy Delieverie of Women}, were more flexible and practical with advice and observations, but still stress the centrality of emotional moderation.\textsuperscript{33} The second requirement for selection was dictated by availability. All cited works were available through Early English Books Online.

That the publication of printed English language manuals exploded in the seventeenth century and authors rushed to translate works that had been available for decades or centuries had other implications as well. It meant that at the same time that Culpeper’s status-quo-upsetting publication circulated in the 1650s, 60s and 70s, so too did translations of Eucharius Rösslin’s 1513 \textit{Birth of Mankind}.\textsuperscript{34} It is not as if older translations were less popular either. To stay with the same examples, Culpeper’s \textit{Directory} was reprinted in expanded editions until the end of the eighteenth century. Likewise, Rösslin’s was a standard text for midwives until its last edition in 1654. It is worth noting, however, that later editions altered Culpeper’s initial opinions significantly on topics like wet nursing. His first iteration questioned the validity of discourse against the custom, while later editions bear no trace of this line of skepticism. There were undoubtedly changes in the medical field and no stagnant view of health and healing would be representative of a vast and complex professionalizing discipline. Yet what this argument does show is that although the exact workings might be tested and reconfigured, regulation of the

\begin{flushright}
\textsuperscript{31} According to the database “English Short Title Catalogue” through the British Library, Nicholas Culpeper’s \textit{Directory for Midwives} was printed in 1650, 1651, 1652, 1653, 1656, 1660, 1662, 1668, 1671, 1675, twice in 1681, 1684, 1693, 1700, 1701, 1716, 1724, 1737, 1755, 1762, 1766, and 1777. Meanwhile, \textit{The Expert Midwife} saw only a single translation in 1637.
\textsuperscript{32} Helkiah Crooke’s \textit{Mikrokosmographia} was first printed in 1615 and again in 1616, 1618, 1631, 1634 and finally 1651.
\textsuperscript{33} Jacques Guillemeau’s \textit{Happy Deliverie of Women} was translated first in 1612 and again in an expanded edition in 1635. François Mauriceau’s \textit{The Diseases of Women with Child and in Child-Bed} saw editions in 1672, 1673 (as \textit{The Accomplish Midwife}), 1683, 1688 (in Latin), 1696, 1697, 1710, 1716, 1718, 1736, 1739, 1752, 1753, and 1755.
\textsuperscript{34} Thomas Raynalde’s translation of Eucharis Rösslin’s \textit{Birth of Mankind} was printed in 1545, 1552, 1560, 1565, 1572, 1585, 1598, 1604, 1613, 1626, 1634, and 1654.
\end{flushright}
passions and emotional feeling was standard advice for childbearing women throughout the seventeenth century and beyond. Though women’s voices here are difficult to uncover, their words when excavated reveal that they too ascribed to these beliefs and tried to abide by the age-old wisdom.

The earliest (as it appeared in circulation in England) medical manual examined here is a 1604 edition of Eucharius Rösslin’s *Birth of Mankind* and the last is the initial 1684 edition of the sex guide *Aristotle’s Masterpiece*.35 Although Rösslin’s work was first translated into English from German by Richard Jonas in 1540 and was the first book on pregnancy and childbirth published in English, I chose to use Raynalde’s 1604 version because it was both in circulation in the period I’m focused on and contained more additions and alterations than earlier translations. Similarly, Jacob Rueff’s *The Expert Midwife* (1637) was first published in 1554 and circulated in Europe in various translations, including Latin, for at least another century. Rueff’s work borrowed significantly from *Birth of Mankind*, though this was common practice at the time. *The Expert Midwife* was presumably less popular in England than elsewhere, existing in only one printed edition.

These were certainly not the only translations. Of the eleven main medical texts examined here, only one of the first five were English-authored. After 1651 though, only one was a translation. The bulk of these imported works originated in Paris. Royal surgeon Jacques Guillemeau’s *The Happy Deliverie of Women* first appeared in English in 1612 and was one of the more mother-centered texts regarding pregnancy, labor and delivery. Guillemeau often directed the surgeon in attendance, who was his intended audience, to make the laboring woman comfortable, to encourage her when labor started to wear on her stamina, and consistently reminded them to have trimmed nails and clean hands to avoid illness and harm. This “caring” approach did not, however, extend to his accompanying treatise on breastfeeding and infant care.36 In this context, Guillemeau targeted aristocratic women using a variety of tactics in an

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35 To say that *Aristotle’s Masterpiece* was popular would be an understatement. Editions abounded not only in England, but in the North America and Scotland as well. The English editions appeared in 1684, 1690, 1692, 1694, 1695, 1697, 1698, 1700, twice in 1702, 1704, 1705, 1707, twice in 1710, 1715, 1717, 1720, 1723, 1725, twice in 1728, 1730, 1731, twice in 1733, 1738, 1739, three released in 1741, 1745, 1748, three printings in 1749, 1750, 1752, 1753, twice in 1755, 1757, 1758, 1760, 1761, 1762, 1763, twice in 1764, four times in 1766, 1769, 1771, 1772, 1773, 1775, three times in 1776, 1780, 1782, 1787, 1788, 1793, 1794, 1795, 1795, twice in 1797, 1798, and in 1799.

attempt to coerce them to nurse their own babies. As a broader and much larger text on health and the human body, the translation of Ambroise Paré’s *Collected Works* (1634) included many of the same themes regarding patient care wet nursing. This should not be surprising, as Paré mentored Guillemeau and the two reference each other in their works.\(^{37}\) The final French translation examined in detail in this thesis is François Mauriceau’s *The Diseases of Women with Child* (1672), translated by Hugh Chamberlen. However, Mauriceau’s approach was quite different from both Guillemeau and Paré. He appeared exasperated at the continued reliance on certain features of Hippocratic-Galenic that he argued observation proved wrong, but that both Paré and Guillemeau promoted. For example, Mauriceau vehemently disagreed with traditional wisdom that argued that children born at seven months’ gestation were more likely to survive than those born at eight. Further, the negative tone sometimes found in his manual was directed more towards midwives than women who chose not to breastfeed.

Helkiah Crooke’s 1615 *Mikrokosmographia* is the only anatomical work included here and the first English authored text that included commentary on women’s reproductive body. As an anatomical study, Crooke was rather silent on emotional regulation in childbearing, but did offer guidelines for sex differences in humoral makeup and the need to regulate the passions. This emotional control was especially difficult for women who Crooke argued were the most difficult to cure. Nicholas Culpeper’s *Directory for Midwives* (1651) took aim at the translated works that came before him and London’s College of Physicians to protest the elevation of medical authorities who lacked experience in birthing chambers and the systemic exclusion of midwives from centers of learning that would theoretically help them to better perform their work. Culpeper’s midwifery book was published at the conclusion of the English Civil War and represented one of the many challenges to authority that the disorders of the war spurred. In the years that followed, English authors, and especially Mauriceau’s translator Hugh Chamberlen, targeted Culpeper as incompetent and faulty. Yet with the exception of *Aristotle’s Masterpiece* (1684), his was the most popular and long-lasting manual of the second half of the century.

Both *The Compleat Midwifes Practice* (1656) and *Dr. Chamberlen’s Midwifes Practice* found little traction and only existed in few editions.\(^{38}\) Both lacked the engaging, if sometimes

\(^{37}\) Ambrose Paré’s *Works* was issued in 1634, 1649, 1665, 1678, and 1691.

\(^{38}\) Thomas Chamberlen’s *Compleat Midwifes Practice* existed in two forms: the original and an “enlarged” version. This thesis examines only the first publication, but the enlarged editions will be marked with an “E:” 1656, 1659
insulting, style that Culpeper and others before him possessed. Jane Sharp’s famous 1671 *Midwives Book* was the first birthing manual published in England by a woman.\(^{39}\) Herself a midwife, Sharp still conformed to the same medical ideologies that her male colleagues espoused and borrowed heavily from her predecessors. Whether this implies that midwives often held the same medical knowledge as her male colleagues, or indicates that this was a conscious effort to convey the same type of authority is unclear. Certainly, her French counterpart Louise Bourgeois, midwife to the French royal family of King Henry IV and to the French Queen Marie de Médicis took a much different approach than typical male authors, though she did demonstrate a knowledge of the humoral system and ancient medical theories. She was more apt than other authors to reproduce on page conversations between herself and her patients, to report aftercare following a client’s birth, and to use case studies to illustrate common complications. However, because her work existed primarily in French, her writings do not have a prominent place in this project. One exception is my use of her public letter of professional advice to her daughter which was translated and included in *The Compleat Midwifes Practice*, as well as in areas where her use of women’s words add important perspective. Finally, the last medical work included here is the earlier and less expanded 1684 edition of the anonymous *Aristotle’s Masterpiece*, which served as a vital sex guide for centuries after its inception. Because *Aristotle’s Masterpiece* was more concerned with advice on how couples could conceive, it tended to employ the language of passions to describe the womb, rather than a laboring woman.

Though not used to the same extent, the final chapter of this thesis also utilizes moralist commentaries on wet nursing as a way of both showing the wide reach of medical theories, as well as to give a broader understanding of how early modern commentators conceptualized the mind-body connection in the phase of childbearing. Aristocrat Elizabeth Clinton, for example, wrote the only female-authored seventeenth-century text specifically on the subject of wet nursing, *The Countesse of Lincolnes Nurserie* (1622). In this short work, meant to compel aristocratic women to nurse their children, Clinton described breastfeeding as both natural and comfortable, as well as “a duty, which all mothers are bound to perform.”\(^{40}\) Similarly, as an

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\(^{39}\) Jane Sharp’s *Midwives Book* was only published in 1671 and then as *The Compleat Midwife’s Companion* in 1724 and 1725.\(^ {39}\)

English clergyman and ardent supporter of maternal breastfeeding, Gouge noted that regardless of “what ranke or degree soever they be,” godly mothers were bound to nurse their own children.41 Consistent with early modern sensibilities, poet Richard Brathwaite’s slightly earlier *The English Gentlewoman* (1631) urged self-control and moderation in all things, but especially emotional feeling and expression and warned that women’s tendency towards grief would sent them to the grave.42 That an emotion or passion could result in death was more than just prose, but a very real admonishment to those who were quick to give into inappropriate feelings. These uncontrolled powerful expressions of affection, assumedly when unrequited and let loose, could alter women’s behavior and long-term health.

This thesis is divided into three chapters that mirror the divisions of the childbearing experience described in most birthing manuals. As such, the first of these focuses on the ways in which the passions were central to conceiving and carrying a child to term. It argues that women were expected to monitor their emotions and moderate their reactions over the course of their pregnancy. While this could hold them at least partially responsible if complications arose, indicating a failure of self-control, it also meant that women seemed to claim authority over certain types of bodily knowledge, especially in the early stages of pregnancy. Before ultrasounds and at home pregnancy tests, detecting a pregnancy was particularly difficult. This chapter shows that before women could report movement of the fetus, their interpretation of their own emotional states could be used to detect an early pregnancy. Other times, women could attribute the cause of a miscarriage to the receipt of bad news, for which others could be held responsible.

Chapter two centers the phases of labor and delivery, examining the dynamics between different types of childbirth specialists and the role emotional regulation during labor and delivery played to construct the roles of patient and practitioner at what was probably their first meeting. Manuals described proper emotional regulation as crucial for both the laboring woman and the practitioner who assisted, who needed to remain calm when complications presented and make clear-headed decisions quickly. The extent to which authors believed emotional feeling to

impact physical outcomes also meant that practitioners frequently described women as vital and active participants in labor, and necessary for a successful birth. Childbirth attendants were expected to monitor their own experiences of emotional disturbances in a challenging environment, as well as those of their patients. These interactions, described as the ideal relationship between professional and patient, offered an emotional script for which each had particular roles. Embedded in this dialogue were also debates over the expected roles of various practitioners and the boundaries of their responsibilities in childbirth. Helen King has observed that since the nineteenth century “gynaecology has been the branch of medicine which most strikingly manifests the inequality intrinsic to traditional patient/doctor relationships in western culture,” in which the practitioner was male and the patient female.43 I would extend King’s observation to suggest that the medieval and early modern western world saw a similar dynamic amongst practitioners, between female midwives and male medical specialists, which eventually resulted in the slow demise of the dominance of midwifery.

The final chapter takes up the topics of infant care and breastfeeding, which are typically absent from scholarship on childbirth. Since a key feature in most manuals was debate over the use of wet nurses by the aristocracy, chapter three also integrates moralist commentaries that show the extent to which wet nursing was under attack at the same time it had reached its zenith. It argues that, at their core, moralists and medical authors alike where primarily concerned with class pollution by the lower orders. Part of the justification for the demonization of wet nurses was that wealthy, aristocratic mothers by nature of their class far more so than their gender were better equipped to produce higher quality milk and to meet the educational needs of their children. Aristocratic women were considered inherently better at emotional regulation which impacted the amount and quality of the breastmilk they produced, far exceeding the abilities of women from the lower orders. Women of the aristocracy were similarly discussed as more competent at managing infant emotional expression which, combined with the temperament of the mother/nurse, had the longest lasting impact on a child’s personality development.

It might seem easy to question why research like this matters beyond the historical profession. But I would point out that many of the same questions that Guillemeau, Culpeper, Brathwaite and others grappled with remain part of many people’s understandings of health and illness. Historian of medicine Anne Harrington has also observed the pervasiveness of mind-

43 King, Hippocrates’ Woman, 1.
body discourse observing that it “does not respect the boundaries we try to set up between the professional and the popular, but that in different ways shapes the talk, work and experiences of all of us alike, be we doctors, scientists, patients, health gurus, paperback writers, journalists, or web-bloggers.”\textsuperscript{44} After all, who has not heard someone lament that they were so angry their “blood boiled,” a remnant of the humoral principal that anger heated the blood?

Though mind-body talk is nearly ubiquitous in our culture today, this project examines medical understandings of their connection as they manifested in seventeenth-century discourse on childbirth and women’s reproductive bodies in an effort to read for the implication this commentary had on expectations for women’s comportment through the phases of childbearing. This thesis then attempts to explain theories of feeling within the context of seventeenth-century childbirth, aware that “[w]e experience our bodies by living them, but the meanings we give to that experience are cultural, so that our experiences are also being shaped by the language and concepts medicine gives us to explain our sensations.”\textsuperscript{45} These chapters take into account that the language employed in the medieval and early modern world was based in Hippocratic traditions that do not abide by modern definitions that mark childbearing only through pregnancy and delivery, but rather extend to the years of infant care and early childhood upbringing. Although the seventeenth century was one of tumultuous change and one in which all forms of authority were challenged, belief in the centrality of the management of emotions in childbearing remained relatively stable. Further, because emotional well-being was central to a healthy pregnancy, a safe delivery, and the proper upbringing of children, practitioners urged women to maintain a balanced disposition and banish what they considered harmful emotions which would require frequent monitoring and attempts at readjustment, making the passions fundamental to the experiences of childbirth.


\textsuperscript{45} Helen King, \textit{Hippocrates’ Woman: Reading the Female Body in Ancient Greece} (New York: Routledge, 1998), 6.
Chapter One

“The hazards are great for childing women:” Emotions and the Womb in Seventeenth-Century England

In January of 1536, Anne Boleyn suffered what would be her final miscarriage, losing a boy and Henry VIII’s longed for male heir. Eustace Chapuys, Spanish ambassador to the Holy Roman Emperor Charles V, recounted in his letters home the courtly conversations surrounding the cause of Anne’s loss. According to Chapuys, Anne herself claimed that she miscarried as the result of a sudden fright, at the news that her husband had taken a bad fall at a jousting tournament. The ambassador, however, disagreed and argued instead that the Duke of Norfolk had broken the news to her gently, because he was aware that such emotional upheaval could be harmful to her health and pregnancy. Fear, he thought, was far more likely to have acted as a trigger. Chapuys and others at Court suggested that rather than startling news, it was “the fear of the King treating her as he treated his late Queen…[as] the cause of it all.” This speculation endured at court because Henry had begun to show more attention to another lady-in-waiting, his third wife to-be Jane Seymour, and had recently been lavishing her with gifts.46

The discourse surrounding the episode of Anne’s miscarriage indicates that beliefs concerning the connections between emotional well-being and physical health reached beyond medical practitioners, even as early as the middle of the sixteenth century. Anne was not the only aristocratic woman familiar with the workings of the passions. Lady Margaret Hoby, in addition to performing medical procedures surgeons claimed for themselves, also recorded reading Timothy Bright’s A Treatise Meloncholie, Containing the CausesThereof (1586).47 Rather than isolated to limited medical circles, the interactions of the emotional and the physical were central to how non-specialists explained Anne’s miscarriage. Beyond revealing the anxieties surrounding dynastic futures, international politics, and implications for Anne’s upcoming trial, Chapuys’ mission also suggests that seventeenth-century beliefs rooted in humoral theory were part of a long-standing discourse that existed inside and outside the medical community, and was particularly central to the conventional wisdom and practice of childbearing.

47 Lady Margaret Hoby, 77.
Throughout the early modern period, both lay individuals and medical authorities agreed that emotional wellbeing was intricately tied to physical health. More specifically the manifestations of certain “passions” could instigate or provide testimony to disease or, conversely, could assist in the healing process.\(^48\) The language of the passions was used to express emotional feeling and reflected a closer tie to physical processes; the experience of emotions was an embodied experience.\(^49\) Though the discourse of the passions were familiar in religious contexts of suffering, with the medieval rediscovery of Greek theorists they also came to refer to varied aspects of feeling in political, corporeal, and spiritual manifestations, as well as indicators of and cures for disease.\(^50\) It is not surprising then that over throughout the seventeenth century, and arguably before and after, birthing manuals published in England represented pregnancy as both an emotional and physical endeavor. This meant that when complications arose, practitioners often considered “passions of the mind” among the first culprits.\(^51\)

While early modern notions of the passions do not directly translate to modern definitions of emotional feeling and expression, the term certainly encompassed this aspect of the human experience. The passions could refer to a broad range of ideas including affect, appetites, emotions, perturbations and sentiments, all of which could affect the process of childbearing from conception through wet nursing. Scholar Danijela Kambaskovic identifies the roots of the emotional-physical connection in the humoral model, which she argues, “offers a framework to imagine bodily liquids as causes of emotions and emotional manifestations and behaviors.”\(^52\) In the early modern period, the balance of the mind and body was considered an essential element of health and healing.

As Anne’s experience testifies, women’s failure to avoid or properly control emotional upheaval meant that practitioners could hold them at least partially responsible for cases of miscarriage and for other complications in childbed. Historian Susan James has shown that seventeenth-century commentary on the passions described emotions as both an overbearing and

inescapable part of human nature that were “liable to disrupt any civilized order…unless they were tamed, outwitted, overruled, or seduced.”53 The experience of the passions then had repercussions beyond individual experience. Prescriptive texts analyzed by historian Susan Broomhall’s suggest that emotional expression changed in response to the development of authoritative printed treatises on the passions. She argues that “the emergence of print changed the nature of the textual content…exposing new audiences to ideas about emotions…instructing readers in emotional regulation.”54 She shows that with the expansion of printed materials in the vernacular, women were exposed to varied “scripts” concerning emotional regulation. The plethora of new printed materials made these scripts widely available to a larger audience, while also giving them a mark of authority.

To a large degree, historians have yet to address the ways in which the passions were central to how both practitioners understood and women experienced childbearing. This research seeks to fill that gap and will argue that printed works on childbearing can reveal how, over the course of their pregnancies, practitioners urged women to maintain a happy countenance and banish harmful emotions, which required no small amount of monitoring and self-policing. At the same time, this emotional-physical connection meant that women could claim authority over certain types of bodily knowledge through their interpretations of their own emotional states and responses. Although fraught with complications and qualifiers by practitioners, and under stress from contemporary national and intellectual shifts, this trend endured and could lend medical legitimacy to women’s personal testimonies of emotional feeling.

**Conception & Pregnancy**

Interpretation of women’s emotional states were central to successful birthing even before conception, which enabled women to play a central role in their prenatal care. Pregnancy in the early modern period was itself exceptionally difficult to confirm, particularly before women could report the movement, or quickening, of the fetus. Indeed, previous scholarship has noted the ways in which women’s bodies were conceptualized as open, leaky, mysterious and

untrustworthy.\textsuperscript{55} This was especially true in medical texts printed throughout the seventeenth century. French chirurgeon and prolific author Ambroise Paré, whose collected works were translated in 1634, described women’s bodies as soft and watery, suggesting an insubstantiality in their tangibility.\textsuperscript{56} Similarly, Helkiah Crooke, court physician to James VI and I and author of a work of anatomy titled *Mikrokosmographia* wrote in 1615 that God, “made the one halfe of mankind imperfect for the instauration of the whole kinde, making the woman as a receptacle of the seed of which a new man was to be created.”\textsuperscript{57} Crooke reasoned that the imperfect state of women’s open bodies allowed them to perform their divinely ordained duty in the propagation of humankind. Later in the century, apothecary and radical republican Nicholas Culpeper, in his massively popular 1651 manual *A Directory for Midwives*, defined women’s bodies by how they differed from men’s, suggesting what historian of medicine Mary Fissell has described as a similar ‘otherness.’\textsuperscript{58} With this instability in the boundaries of women’s bodies, women were not always trusted to interpret the signs of their bodies correctly, or in some cases to honestly report them. Culpeper found women to be “so ignorant they do not know when they are conceived with Child, and other so coy they will not confess when they do know it.”\textsuperscript{59} Therefore, the lack of a woman’s monthly courses was just one of many signs that, when combined, might suggest a pregnancy. This meant that other methods of deduction were often desired.

Though sometimes suspect, women’s interpretations of their emotional states offered another way of inferring conception. From the practitioners’ view, women themselves may not even be aware of the change in their physicality, but may use emotional cues to uncover it. Within a list of physical signs like the emergence of freckles and pains in the lower abdomen, a 1634 English translation of Ambroise Paré’s *Collected Workes* explained that “sadnesse & heavinesse” afflicted the minds of women with child, and alternatively women may “waxe giddy in the head” as a result of the vapors from superfluous menstrual blood that accumulates in the


\textsuperscript{59} Nicholas Culpeper, *A Directory for Midwives* (London: Peter Cole, 1651), 125.
wombs of pregnant women.\textsuperscript{60} In 1665, English physician Peter Chamberlen suggested that mood swings indicated a pregnancy, and women might “suddenly grow merry, and as suddenly again sad.”\textsuperscript{61} In these examples, pregnant women’s emotional states were explained by practitioners in terms of cause, a specific physical phenomenon, in this case the retention of menstrual blood. Jacques Guillemeau, French chirurgeon to King Henry IV of France and Paré’s protégé, recited a method of detecting an early pregnancy that relied entirely on pregnant women’s interpretation of her own emotional states. Though he acknowledged that both quickening and the inspection (by a midwife) of the cervix were the surest signs of pregnancy, spouses’ emotional responses to each other’s company offered another method of detecting an early pregnancy. He implied that increased sexual desire between man and wife might be another symptom. Should a husband more enjoy the company of his wife, and if she “received an extraordinarie delight in the companie of her Husband,” she may be expecting.\textsuperscript{62} Yet just as easily, Guillemeau admitted, women with child may, “hate the companie of their husbands.”\textsuperscript{63}

Over the course of the seventeenth century, manuals depicted women’s lust for their husbands as not only natural, but desirable in the context of childbearing and reflected the ways in which authors conceptualized the embodied experience of emotions. In addition to its foundation in ancient Greek medicine, this stance on spousal desire also fell on a largely receptive audience because it aligned with English religious beliefs that incorporated Lutheran doctrine, which held that desire within marriage was a vital aspect of an ideal godly union.\textsuperscript{64} Even so, Laura Gowing has suggested that these authors created one of the few spaces where depictions of female sexual desire was deemed appropriate.\textsuperscript{65} Birthing manuals then offer a unique opportunity to examine the perceived medical benefits of women’s sexual desire thereby

\textsuperscript{60} Parey, 890.
\textsuperscript{61} Peter Chamberlen, Dr. Chamberlain’s Midwifes Practice (London: Thomas Rooks, 1665), 72. See also Jane Sharp, The Midwives Book (London: Simon Miller, 1671), 103.
\textsuperscript{62} Jacques Guillemeau, On the Happy Deliverie of Women (London: A. Hatfield, 1612), 4. See also Mauriceau 17, 35, 209.
\textsuperscript{63} Guillemeau, 4.
\textsuperscript{64} Susan C. Karant-Nunn and Merry E. Wiesner-Hanks, trans. Luther on Women: A Sourcebook (Cambridge: Cambridge University Press, 2003).
departing from more standard views offered by historians in which desire, usually excessive, was used to depict women as deviant.\footnote{66} 

Practitioners described women’s desire as required for conception, since it was, in Culpeper’s words, “the delights of Venus that opens the Womb at all times.”\footnote{67} Paré’s much earlier work contained very similar language, reflecting a continuity in beliefs about desire as requisite for conception.\footnote{68} In his Midwifes Practice, Peter Chamberlen elaborated in more detail the physical impact of desire on women’s reproductive bodies by reasoning that lust assisted in conception by opening and straightening the neck of the womb. Chamberlen’s anatomical description reveals the ways in which he believed the manifestation of emotions were able to alter physical states, having a direct consequence for conception.\footnote{69} Jane Sharp, English midwife and the first woman to publish on the topic in England, most directly connected pleasure with the clitoris.\footnote{70} This is somewhat surprising as other works, like Paré’s and Crooke’s, were far more occupied with addressing women’s anatomy and the roles women’s bodies played in conception. These, however, do little more than describe the physical traits of the clitoris, whereas Sharp emphasizes its possible function in eliciting women’s desire.

Desire was not always anatomically located, for other practitioners connected it to mental categories and concepts. Other practitioners focused on a theory that maintained desire originated in the mind, rather than the physical body. This concept is demonstrated in the enormously popular birthing manual and sex guide, Aristotle’s Masterpiece, which claimed that conception required both “the Appetite and desire to Copulation, which fires the Imagination with unusual Fancies, or by the sight and feeling a brisk charming Beauty, whose wit and liveliness may much incite and, and more inflame the Courage.”\footnote{71} The anonymous author identifies the role of the imagination, once fired up by bodily desire, as the key components. Regardless of where practitioners fell in debates over the origin of desire and despite its centrality in conception, all agreed that sexual appetite within marriage still needed to be regulated; a moderate balance was the optimal state. Aristotle’s Masterpiece rooted the cause of

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\item \footnote{66} Frances E. Dolan, Whores of Babylon: Catholicism, Gender, and Seventeenth-Century Print Culture (Ithaca: Cornell University Press, 1999).
\item \footnote{67} Culpeper, 136. See also Chamberlain, 78 and Sharp 71.
\item \footnote{68} Parey, 890.
\item \footnote{69} Chamberlain, 42.
\item \footnote{70} Sharp, 45.
\item \footnote{71} Aristotle’s Masterpiece (London: J. How, 1684), 10-1.
\end{itemize}
molar pregnancies too lustful intercourse during women’s monthly courses. On the other hand, the lack of sexual drive and enjoyment served as evidence for a “distempered wombe.” More than just an emotional response to pregnancy itself, a noted shift in sexual desire could signify or instigate a shift in physical states.

Not only did practitioners like Paré and Guillemeau offer ways of discerning pregnancy through the emotional responses of pregnant women, but some went further to describe similar methods to identify the fetus’s sex. These varied descriptions reflected the unequal values placed on a male versus female child, as well as essentialist beliefs about the nature of men and women. Women themselves sometimes apologized in letters for the birth of a girl. Guillemeau observed that a woman pregnant with a girl was splotched with red dots, pale and heavy, and had, “…a melancholique eye: she is wayward, fretfull, and sad.” Pregnancy with a female child caused the mother to be anxious and unhappy, though what exactly caused this was left unexamined. Regardless, Guillemeau’s explanation stressed the importance of monitoring the mind-body connection by asserting that a previously unknown physical state would result in an emotional manifestation. It is important to note that these elicited emotional responses were not understood to have been provoked by the knowledge of the child’s sex, but rather functioned as a method of deciphering it.

The case for pregnancies with a male fetus were quite different. Rather than emotional cues, practitioners most often described physical ones. These included the belief that male fetuses were associated with the right side of the body, testified by a more swollen right breast, for example. Conversely, a female fetus was more closely tied to women’s left side. These explanations were a feature of the Hippocratic-Galenic model that suggested male fetuses required more blood and therefore needed to be closer to the liver. Similarly, Culpeper found that women carried boys easier, while pregnancies with girls were more painful. The self-proclaimed practitioners and authors of the 1656 Compleat Midwife’s Practice agreed; not only were boys easier to bear, a pregnancy with a male fetus would make women’s faces rosier and

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72 Aristotle’s Masterpiece, 125.
73 Paré 933. See also Aristotle’s Masterpiece, 79.
74 Wiesner-Hanks, Women and Gender in Early Modern Europe, 57.
75 Guillemeau, 10.
76 Culpeper, 129.
more cheerful, rather than swarthy and drained.\textsuperscript{77} Though physical and emotional signs could indicate the sex of a fetus, most authors argued that it was primarily the strength of the seeds (both male and female) which dictated sex. This, according to Culpeper, was “the reason weakly men get most Girls, if they get any.”\textsuperscript{78} In Culpeper’s construction, strength was directly related to maleness, and weakness with femininity.

Publishing at the end of the English Civil War, Culpeper vehemently opposed most forms of authority. Yet, by and large, his work remained deeply rooted in theories developed by ancient writers and his conclusions were largely consistent with the conventional medicine of the period. For example, he frequently stressed the popular idea that heat, and relatedly desire, were required for conception. However, there are also points in his work that diverge and instead suggest a response to the civil and social unrest in which he wrote and published. 1651, the year his \textit{A Directory for Midwives} was published, was also marked by the exile of Charles II and the establishment of the Commonwealth. Historian Ann Hughes has argued that this environment transformed notions of gender,\textsuperscript{79} which is certainly corroborated by Culpeper’s commentary surrounding conception, and was reflected in his own working of the mind-body connection.

His work contained no small amount of advice on methods to increase fecundity, which often relied on attainment of a balanced mind and body.\textsuperscript{80} Culpeper’s stress on the emotional and physical connection in childbearing is most evident in his understanding of the two pathways to fertility: “Exercise of the Body” and “Content of the Mind.”\textsuperscript{81} Here, he urged spouses to be content in God, as would-be parents would then be more likely to receive the child they hoped for. On the other hand, if an individual chose discontent, they were at the same time revealing dissatisfaction with God. In addition to the benefits related to religious meaning, Culpeper’s thoughts on the effect of contentment and discontent for childbearing couples were also very much steeped in humoral theory. Contentment, rather than stronger emotions like joy or sadness, was preferable because it reflected a healthier state of moderation. Likewise, he believed discontent would divert much needed heat from the womb, “wasting both body and spirit.”\textsuperscript{82}

\textsuperscript{77} T.C., I.D., M.S., and T.B. \textit{The Compleat Midwifes Practice} (London: Nathaniel Brooke, 1656), 46. See also \textit{Aristotle’s Masterpiece}, 122.
\textsuperscript{78} Culpeper, 57.
\textsuperscript{80} \textit{Gender and the English Revolution}.
\textsuperscript{81} Culpeper, 120.
\textsuperscript{82} Culpeper, 117.
Even more forcefully, Culpeper characterized discontent as “a Waster, Destroyer, Overthower, and Murderer of the Body, and its Seed and Spirit Procreative.” In this construction, discontent had devastating consequences for both men and women’s bodies.

Culpeper’s focus on the expression of contentment in one’s social status and in one’s relationship with God is an element missing from other works of this kind, and suggests a desire for stability even as he attempted to overturn the elitism he identified in the practice of medicine. For Culpeper, contentment more than any other aspect in reproduction reflected a choice women were responsible for making to achieve a healthy pregnancy. It dilated the heart and arteries, properly circulated vital heat throughout the body, and “Comforts and strengthens all the parts of both the Body and Mind.” More than solely an emotional feeling, contentment for Culpeper was a condition that individuals must choose and consciously act on in order to attain good emotional and physical health. This differed from earlier constructs of the passions and emotional feeling which were described as almost unconquerable, because Culpeper’s iteration involved a level of personal control. Rather than avoiding anger, patients should choose contentment.

Historians have aptly shown the many ways in which the English Civil War also resulted in multifaceted challenges to established sites and forms of authority. This environment created a space that allowed authors like Culpeper to more openly criticize the ancient wisdom of Hippocratic-Galenic medicine, which, if reprints are any measure, was also met by a more receptive audience. In 1615, Helkiah Crooke’s Mikrokosmographia rather subtly questioned Greek models, and yet still received a significant amount of reproach for anatomical deviations from Galenic theories, despite his position as court physician. Culpeper’s Directory for Midwives presented an undeniably confrontational approach to institutions like the London’s Royal College of Physicians as well as against ancient medicine, but was also incredibly popular and reprinted over twenty times until the end of the eighteenth century. After Culpeper, more explicit

83 Culpeper.
84 Culpeper, 118.
denunciations of ancient wisdom appeared in England. In the 1672 translation of French surgeon François Mauriceau’s *The Diseases of Women with Child*, which reproached practitioners who unquestionably followed the laws set down in Hippocratic-Galenic theories when personal experience and empirical evidence directly contradicted certain principles. For example, Mauriceau emphatically denied the ability of any practitioner to determine the sex of a child before delivery, disputing the ancient association of women’s left and right sides with male and female fetuses, respectively. Instead, he pragmatically recommended to those hounded by the parents or their families to simply discover which sex the offending parties preferred and tell them the opposite. This way, he reasoned, practitioners could avoid an opportunity for disappointing their clients. Unlike the response to Crooke’s *Mikrokosmographia*, Mauriceau’s original 1668 French publication came with the first endorsement from the College of Physicians in Paris, as well as the King’s Privilege. Just a few short years later, English man-midwife Hugh Chamberlen selected his work as not just worthy of translation, but as superior to those produced by homegrown English authors like Nicholas Culpeper and Jane Sharp. Mauriceau’s *The Diseases of Women with Child* was rather popular as well, and was reprinted until the middle of the seventeenth century. This indicates that both professional and lay audiences were more willing to entertain criticism of Hippocratic-Galenic tenets that widespread experience had long contradicted, even if these dialogues did not immediately alter the widespread practice of medicine.

However, this is not to say that there was wholesale abandonment of these ancient principles or that the mind-body connection had come under any real threat. Indeed, there were many other ways in which Mauriceau and others saw the workings of the mind-body connection in women’s reproductive bodies. Mauriceau includes an entire chapter on superfaetation, understood as a pregnancy with twins (or more) who were conceived at different times. Despite the significant space he allotted to this phenomenon, he was simultaneously careful to warn readers that superfaetation was so rare that it was practically impossible. Still, he conceded that there were exceptions. Mauriceau found that the most reasonable explanation was that when women felt an “earnest desire of copulation,” the heat could dilate the closed cervix of a newly

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86 Mauriceau, 43–6.
87 Mauriceau, note from the translator.
pregnant woman enough for a man’s seed to enter and for her to conceive a second time. Aside from the implication that because desire was required for conceptions, pregnancies from rapes were impossible, it also meant that women who bore fraternal twins could be suspected of infidelity. Mauriceau’s commentary on disagreements concerning fraternal twins suggests that accusations of adultery were not uncommon, though he remained skeptical. For Mauriceau at least, even evidence like a dissimilar likeness between twins was no proof of infidelity, since “different imaginations may cause the same effect.” While this may exonerate women accused of infidelity based on a child’s appearance, it also implies that a child who resembled a woman’s husband did not equate to proof of paternity. Aristotle’s Masterpiece remarked on the power of women’s imagination to imprint her husband’s looks on a child conceived by another man if, at the time of copulation, “fear or anything else causes her to fix her mind upon her Husband.”

Although Laura Gowing argues that it was only at the end of the seventeenth century that “concern for paternity became most pointed,” anxieties such as those reflected by Mauriceau and in Aristotle’s Masterpiece reveal a fear of women’s perceived untrustworthiness, which was also reflected in understandings of their bodies.

In addition to hard-to-explain phenomena like superfaecation, birthing manuals continued to stress the importance of governing the passions to sustaining a healthy pregnancy. Women with child were expected to monitor emotional reactions, being particularly careful “as to not be excessive angry; and above all that she be not affrighted; nor that any melancholy news be suddenly told her.” Even joy should be moderated. According to seventeenth-century authors, such reactions could have serious consequences for women’s pregnancies, often resulting in miscarriage. Mauriceau used a recurring device, the recitation of a personal story, to illustrate this point. His example is that of his aunt whose sudden sadness on hearing of her husband’s death caused the son she bore to have constant shaking in both hands from birth onwards. Though Mauriceau’s aunt was fortunate in avoiding a miscarriage, much discussion of the mind-body connection did center around the loss of a pregnancy. Paré warned that, “sudden or continuall perturbations of the minde, whether they bee through anger or feare, may cause

88 Mauriceau, 50.
89 Mauriceau.
90 Aristotle’s Masterpiece, 25.
92 Mauriceau, 65.
women to travel before their time, and are accounted as the causes of abortions, for that they
cause great and vehement trouble in the body."93 Sharp argued that in addition to moderation in
food intake, “[t]here is nothing better…to prevent abortment than…to avoid violent passions, as
care, anger, joy, fear, or whatsoever may too much stir the blood.”94 Chamberlen also listed all of
these risky emotions, but added sorrow and dread to those that could produce a miscarriage.95
Similarly, Culpeper listed anger, fear, and sorrow as causes of miscarriage within a list that also
named falls, blows, and running.96 Culpeper’s organization that mixes both physical causes of
miscarriage along with the passions suggests that physical and emotional triggers were believed
to be equally likely to result in miscarriage and were equally important to monitor. These authors
drew a very clear and direct relationship not just between the mind and body, but more
particularly between harmful emotions and miscarriage. In this context then, it makes sense that
part of the maintenance of a healthy pregnancy included, “shunning all melancholike and
troublesome” thoughts that “may vexe or molest her mind” and to endeavor to emulate a more
calm and balanced state.97 To that end, Guillemeau counselled women to refuse to give ear to
“lamentable and feareful tales.”98 Pregnant women were then encouraged not only to monitor
their emotional responses, but to be wary of the kind of stimuli they encountered.

Seventeenth-century manuals cited fear, sadness, and joy as the primary emotional agents
to censor. Simply a sudden fright as the result of a sudden loud noise could provoke a
miscarriage.99 Although so too could scolding immoderately, “crying aloud, or laughing
heartily.”100 There were many other elements to consider that impacted the risk of negative
emotional expression, as well. For example, young women were more susceptible to
objectionable emotional expressions than older, especially to the risk associated with a sudden
noise because the air stirred by the sound could more easily enter their bodies and enter the
womb.101 Culpeper associated affections of the mind with women’s longings, or cravings, which
could lead to miscarriage if handled incorrectly.102 Women had to know how much to refrain and

93 Parey, 922.
94 Sharp, 224 and 323.
95 Chamberlain, 157.
96 Culpeper, 146. See also Sharp 185.
97 Guillemeau, 26. See also Chamberlain, 160 and 202 and Aristotle’s Masterpiece, 132.
98 Guillemeau, 26.
99 Guillemeau, 22, Mauriceau, 131.
100 Mauriceau, 131. Guillemeau, 23.
101 Mauriceau, 131.
102 Culpeper, 154-5.
when to yield to achieve the ideal condition of moderation. It is no surprise then, that Jane Sharp found that “[i]f one womb in a woman be the cause of so many strong and violent diseases, she may be thought a happy woman of our sex that she was born without a womb.”

The Imagination

The distinction between emotions, the passions, and the imagination were far less definitive in the early modern period than they are defined in the modern western world. In most instances, the power the imagination could wield over the physical body was reliant on strong emotions like fear or more general feelings like surprise in order to be effective. Humoral theory dictated that emotions served as vehicles for the imagination to alter the physical development of a fetus. This did not mean, however, that the imagination was any less influential. Rather, Paré believed that, “[t]he power of this faculty of the mind [the imagination] is so great in us, that often it bringeth the whole body in subjection unto it.” In this same passage, Paré theorized on the relationship between the imagination and the passions, suggesting that their commonality lay in their origin in the mind and, when combined, their ability to exercise power over the physical body.

Making sense of how these different faculties interacted was a concern to early modern natural philosophers as well as physicians and other medical practitioners because they impacted methods for emotional regulation and treatment. Jane Sharp took pains to delineate for her readers how the passions and the imaginations differed and when they worked together. The passions, unlike the imagination, had direct consequences for the quality of blood. Sadness and fear, for example, “not only waste, but cool and corrupt the blood.” Alternatively, anger and hatred could heat the blood. Sharp also characterized the imagination as having a power to alter the physical appearance of a developing fetus. Her understanding made the imagination an entity almost outside women’s control, yet at the same time a force she must conquer. One risk was simply a longing after, and therefore imagining, a certain food, which might result in a likeness imprinted on her child. However, it was only “passions of the mind” that could alter the humors

103 Sharp, 335.
104 Parey, 897.
105 Parey.
106 Sharp, 291.
in such a way that gave power to the imagination.\footnote{Sharp, 118.} The combination of feeling startled with the experience of a strong emotion, like when receiving bad news, could be especially powerful. The “formative faculties” Sharp described in this section are also of significant consequence because of the linked souls of mother and child, and the physical implications it could have. Sharp ascribed to the principle that while the child was still inside the mother, their souls were connected. This, she reasoned, was an alternative vehicle the imagination used to affect change.\footnote{Sharp, 119.}

While historians have widely discussed the social implications of the beliefs in connections between women’s imagination and cases of monstrous births, the less astonishing examples remain understudied.\footnote{For more on monstrous births, see Parey book twenty-five, 962. For scholarly literature, see Julie Crawford, \textit{Marvelous Protestantism: Monstrous Births in Post-Reformation England} (Baltimore: Johns Hopkins University Press, 2005). Alan W. Bates, \textit{Emblematic Monsters: Unnatural Conceptions and Deformed Births in Early Modern Europe} (New York: Rodopi, 2005). Peggy McCracken, \textit{The Curse of Eve, the Wound of the Hero: Blood, Gender, and Medieval Literature} (Philadelphia: University of Pennsylvania Press, 2003).} These more mundane instances, however, illustrate how the mind required monitoring in everyday ways, not exclusively in extreme cases. Even what might seem like minor transgressions were risky, and the connection between mom and fetus was a “relationship widely represented as a source of distorting passion and bodily disfigurement which threaten[ed] the well-being of the child.”\footnote{James, \textit{Passion and Action}, 249.} Like his mentor Paré, Guillemeau accepted without challenge the idea that a woman’s imagination could impact the physical development of the fetus. Guillemeau urged women to avoid looking at pictures or people with deformed or supposedly ugly features for fear that the imagination may result in physical marks on the child, both he and later Mauriceau had other, more ordinary concerns that they considered more pressing for the development of the fetus. Employing language that reflected discourse surrounding the passions, both warned that pregnant women should avoid indulging their cravings, particularly if they craved a food that they typically found distasteful, like certain meats.\footnote{Kambaskovic, “Humoral Theory.”} However, both Guillemeau and Paré asserted that complete denial of cravings might result in early labor or physical markings.\footnote{Parey, 905.} Guillemeau cautioned that it would be far better to allow women to moderately give into their desires, rather than risk the onset of preterm labor, or cause the child to carry “the marks of some of the things they so earnestly desired and longed for.”

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\begin{itemize}
  \item \textsuperscript{107} Sharp, 118.
  \item \textsuperscript{108} Sharp, 119.
  \item \textsuperscript{110} James, \textit{Passion and Action}, 249.
  \item \textsuperscript{111} Kambaskovic, “Humoral Theory.”
  \item \textsuperscript{112} Parey, 905.
\end{itemize}
The constant yearning combined with the frustration of denial could have serious consequences on a developing child. Women were obliged to either curb their cravings and carefully monitor their thoughts, or submit just enough to keep the risk at bay.

However, by the end of the seventeenth century, practitioners increasingly warned against assigning too much power to the imagination. Rather than reflecting a fundamental shift in beliefs about the mind-body connection, these challenges reveal the effect of an environment in which translated works from the previous century remained popular and in circulation alongside new emerging works. There was never a solid consensus on health and the power of the emotions. Culpeper, for example, argued that the many so-called imperfect formations that were often attributed to the imagination were actually caused by a conception that resulted from intercourse during women’s menstruation. Similarly, in his chapter on the conditions required for conception, Mauriceau warned that the imagination “hath a power to imprint on the body of the Infant,” but stipulated that it could only alter the fetus’s development in the earliest days of pregnancy. He further cautioned that some women were known to use such excuses “for a pretext to cover their liquorishness.” That is, widespread belief in the power of the imagination meant that women could employ it as cover for morally questionable behaviors, in this case excessive alcohol consumption. Or at least men like Mauriceau feared they would. Still, in the cases in which practitioners deemed the imagination’s power valid, it surely required monitoring and primarily by the pregnant woman herself. For example, Culpeper claimed that cleft lips and cleft palates resulted from pregnant women being startled by the image or sudden apparition of a hare, or from the loss of their longing to eat the same. In this example, cleft lips and palates were caused by the sensation of surprise combined with the image of a hare in a woman’s mind’s eye. The image and feeling together acted on the developing fetus. Like superfetation and the determination of a child’s sex before birth, both Culpeper and Mauriceau remained doubtful.

Mauriceau’s personal anecdote, which recounted how he came to be born with smallpox, was used to illustrate his reservations about the imagination’s power. At the same time, it also serves to demonstrate that while he understood the mind and body as connected and mutually

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113 Guillemeau, 20 and 39.
114 Culpeper, 140.
115 Mauriceau, 15.
116 Mauriceau, 15.
117 Culpeper, 159. See also Sharp 186.
influencing, ideas about how that relationship worked were contested in the medical field. Mauriceau testified that while his mother was pregnant with him, his older brother contracted and died from smallpox within a week and throughout his illness and until his death, Mauriceau’s mother tended him. According to Mauriceau, others would have claimed that he was born with the disease as a result of his mother’s “strong imagination,” at viewing her ill son with a deepening sadness, leaving a lasting impression on the developing fetus. However, Mauriceau characterized any such claim as “irrational” and suggested instead that it was the result of, “the contagious air she breathed without discontinuance, during the whole sickness of her deceased Son, [which] had so infected the mass of her blood, with which at that time [Mauriceau] was nourished.”

The alternative theory that Mauriceau challenged implied that it was not simply seeing an individual with smallpox, but the emotional labor required for tending him that enabled her imagination to infect Mauriceau. He later tells a similar story of a delivery he attended in which a woman at birth feared she had given birth to a Moor when she first caught glance of her child. She explained that some months before, she had gazed in awe upon a dark-skinned man enslaved by the Duke de Guise, and she assumed that this experience had physical consequences for her child. Mauriceau’s anecdotes show that the extent to which he believed the imagination could exercise influence was in question. Further, because his work was both popular and printed with the endorsement of both the King and his colleagues, it seems likely that this hesitation was growing among certain circles.

**The Disordered Womb**

**Illness**

The condition of a woman’s womb was central to practitioners’ general questions about the state of women’s health, and especially because of concerns about women’s fertility. However, some authors, like Paré, Culpeper and Sharp, paid special attention to women’s reproductive health outside of the framework of childbearing. Where Guillemeau and Mauriceau focused primarily on pregnancy, labor, and the period of lying-in, others dedicated more energy to descriptions and treatments for ailments that undoubtedly impacted fertility, but were also somewhat divergent from the arrangement of typical birthing manuals. This is in large part a

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118 Mauriceau, 16.
119 Mauriceau, 231.
consequence of the different function of their works. Rather than a manual dedicated to guiding midwives or young chirurgeons practicing in the field, other manuals served as broader overviews of anatomy and theory, as well as for practice. At well over 1,000 pages, Paré’s chapters on women’s reproductive health and monstrous births were but two of over 25 ‘books’ in his collection. The inclusion of such wide-ranging topics to serve a more general purpose altered the kinds of information the author chose to include. The decisions this selection necessitated emphasized the ways in which women’s reproductive bodies, and the womb in particular, were understood as central to women’s overall health and wellbeing. Rather than the chief emphasis on the childbearing woman and her infant, the womb and its centrality to women’s health became the focus.

The diagnosis and treatment of ailments of the womb using the interpretations of the passions reflected certain moral assumptions about women’s emotional constitution and behavior. Of primary concern to practitioners were the causes, symptoms and cure for what they termed “the suppression of the courses,” which were understood to cause numerous experiences of ill-health for women. This complication referred to the retention of menstrual blood that resulted from the cessation of menstruation without a pregnancy. Paré traced the cause to, among other things, strong passions like fear and sorrow. Culpeper similarly listed care, fear, sorrow and grief as possible triggers. Chamberlen noted that shunning these same emotions, adding only hatred, worked as a treatment for this ailment. One of the most dangerous illnesses that the suppression of the courses was said to cause went by several names. Paré used “strangulation of the wombe,” which he cited as often deadly.\textsuperscript{120} Chamberlen referred to it as “\textit{hysterica}” or “fits of the mother” and warned that it “induceth many passions.”\textsuperscript{121} Jane Sharp used the phrase “Hysterical Passions” for the same disease.\textsuperscript{122} Regardless of the label employed, practitioners described the physical traits of this complaint as a visibly swollen womb, containing harmful humors and vapors that were unable to be released from the stopped up womb.

Successful treatment relied on the practitioner’s ability to identify the type of humor gathered in the womb, which caused varied emotional and physical symptoms. If the humor contained therein was melancholic, Paré found that it would cause a “heavinesse, fear, and

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{120} Parey, 940-1.
\item \textsuperscript{121} Chamberlain. 38.
\item \textsuperscript{122} Sharp, 317.
\end{enumerate}
\end{footnotesize}
sorrowfulnesse, that party that is vexed...shall thinke that shee shall die presently.”

This did not imply that knowledge of having the illness caused emotional turmoil, but rather that the illnesses caused an irrational depression that was practically impossible to cure. The causes were likewise related to emotional unrest. Sharp named a sudden fear and bad news in particular, noting that “by this Melancholly gets the mastery of them.” Sharp reflected that this is one reason men should “forbear relating any sad accident” to women with child, suggesting that prevention relied on avoidance.

On the other hand, if the humor contained in the woman’s womb was of a choleric nature, the afflicted would display symptoms of a madness called *furor uterinus*, or “agitation of the uterus.” Chamberlen connected this malady with puberty, suggesting that a young woman’s unrequited affections would elicit rage. Similarly, Sharp noted that “maids and widdows…are troubled with the rage of the womb, that they will grow even mad with carnal desire.” Symptoms included the divulgence of secrets, “a giddinesse of the head,” and fluctuations between intense laughter and equally intense weeping. Chamberlen associated this ailment exclusively with the melancholic humor, because the emotional causes like sudden frights caused melancholy to “overcome the bodie.”

Green sickness, another example of the disordered womb, most often characterized by emotional irregularity. Sharp noted that this illness, which could lead to infertility, was “always attended with disgust and loathing of good nutriment, and longing after hurtful things.” What is perhaps most telling is the suggested cure for the retention of the courses, for Strangulation of the Womb and for Green Sickness. In cases where the womb was in a fit of fury or rage, Paré recommended spousal intercourse as the most promising remedy. He notes that it was not only pleasant, but far more effective than other curative options like fumigation of the womb. Sharp similarly recommended marriage for treatment of green sickness.

Much like the ways pregnant women were expected to curb their food cravings, women’s sexual desire existed in an instable state as both dangerous and curative. Practitioners

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123 Parey, 140.
124 Sharp, 321.
125 Chamberlain, 69.
126 Sharp, 324.
127 Parey, 140.
128 Chamberlain, 249.
129 Sharp, 257.
130 Sharp, 944-5.
characterized women’s lust as natural and sexual intercourse as healthy within marriage, while at the same time portraying an abundance of either as damaging to women’s health and reproductive capabilities. Women were expected to be able to navigate these nuances not only to reflect their morality, but also to achieve good health. That both a surgeon and a midwife named intercourse as curative, while also centering women’s pleasure (“let her…bee strongly encouraged by her husband”) indicates that women’s sexual desire, once properly contained or channeled in the confines of marriage, was normal and acceptable. However, this is not to say that for married women, sexual intercourse was always viewed in a positive or curative light in the medical field. Rather, it was just as likely to cure as it was to cause harm. Paré found that women who too often engaged copulation with their husbands would experience an “immoderate fluxes of the flowers,” or excessive menstrual bleeding.\textsuperscript{131} Practitioners described female desire within marriage almost with ambivalence, breaking bad when it led to disease or harm, and breaking good when it served as a cure or resulted in pregnancy.

Despite of the health risks associated with too frequent sexual intercourse that practitioners detailed, \textit{Aristotle’s Masterpiece} preferred that parents encourage courtship and provide husbands for their daughters, remarking that women were lustful and needed the protection of the institution of marriage as a safe outlet for their desire.\textsuperscript{132} Abstinence, on the other hand, was understood as more likely to result in reproductive disorders. Or, women who remained unmarried might “satiate their desire in unlawful Love.”\textsuperscript{133} Single women’s experience of the same passions that were promoted in married women were instead characterized as shameful. Jane Sharp declared that “[m]odest women will die of consumptions, when they have this rage of the womb, rather than declare their desire, but some women are shameless.”\textsuperscript{134} Desire, even in the case of illness, was the purview of married women. Moreover, this commentary suggests that while passions like anger and sadness could initiate or exacerbate disease, others like desire and pleasure worked as curative agents, and were therefore vital to women’s whole-body health and well-being. Marriage was then considered vital.

\textit{Infertility}

\begin{itemize}
\item \textsuperscript{131} Parey, 640.
\item \textsuperscript{132} \textit{Aristotle’s Masterpiece}, 5.
\item \textsuperscript{133} \textit{Aristotle’s Masterpiece}, 6-7.
\item \textsuperscript{134} Sharp, 325.
\end{itemize}
While practitioners in their works often stated that both men and women could be responsible for infertility, they also stipulated that women were more likely to be at fault. Failure to conceive or carry a pregnancy to term was often understood as a women’s health issue, which could result in so much grief for women that it manifested in other distempers. In these discourses, attraction and lust played a central role in understanding women’s ability to conceive. In tackling the subject, Culpeper found that, in part, it was the “Want of Love between man and Wife” that caused what he described as natural barrenness. Or, phrased another way infertility resulted when, “Men and Women come to the School of Venus....so frigidly” that they cannot conceive. He maintained that because the seed of both men and women were vital to procreation, love was required to unite them. In part, he blamed parents who forced their children to “marry against their minds” because “such beginnings usually, bring sorrow enough to all parties as use them, or have a hand in them.” His proposed cure was the use of aphrodisiacs. For example, he suggested the consumption of sparrows, partridges, and quails in particular because they were “addicted to Venery, and they work the same in those men and women that eat them.” Of course, much of this diet would be available only to a privileged aristocracy and not to the vast majority of the population.

Despite the importance of encouraging desire to combat infertility, Culpeper was also careful to warn that too much copulation might hinder conception. More specifically, he taught that satiety “gluts the Womb” making it “unfit to do its office.” In this passage, Culpeper revealed that he was an adherent to the theory that the womb had an agency and will of its own, as well as to the commonly held belief that prostitutes were unable to conceive or carry a child to full term. It was not simply the too frequent act of sex that made women supposedly unable to bear children, it was the lack of desire in the womb that resulted from over gratification. Culpeper stressed that the timing of copulation needed to be appropriate, since the fear of

135 Culpeper, 89.
136 Aristotle’s Masterpiece, 78.
137 Culpeper, 87.
138 Culpeper, 85.
139 Culpeper, 86.
141 Culpeper, 87-8.
142 Culpeper, 121.
surprise could just as easily hinder conception. In theory, the key to a conception in the seventeenth century was heavily reliant on moderation.

**Conclusions**

State policy often reflects concerns about childbearing, which tend to come to the fore in times of disruption. The seventeenth century in England was no different, and in fact it witnessed a startling amount of political, social and religious upheaval. Culpeper, writing at the end of the English Civil War, clearly articulated his view of the state’s concerns directly by reasoning that the government should financially assist poor mothers financially because “the more Childrens lives are preserved, the more Soldiers will they have when they need them.” But the state had a vested interest in childbearing long before the outbreak of the war.

James VI and I ascended the throne of England in 1603 following the death of a childless Elizabeth I and under his reign, legal changes regarding the definition of and consequences for infanticide played out in the lives of childbearing women. The Infanticide Act of 1624 made infanticide a capital offence, and mandated that cases no longer be tried in ecclesiastical courts. It also gave legal definitions to likely suspects, namely unmarried women. Single women who bore their child without a witness and claimed they were stillborn were presumed guilty of infanticide and were required to prove their innocence, disproportionately impacting women in the service industry. The statute required that unwed mothers provide a witness, usually a midwife, to testify that the infant was indeed born dead. This was complicated by the fact that unmarried mothers-to-be were viewed as a financial burden to communities, and midwives could refuse service. Married women accused of the same crime had no such burden, but instead evidence was required to demonstrate the infant was born healthy in order to reach a guilty verdict.

Garthine Walker has persuasively argued that the implementation of the Infanticide Act allowed for more leniency in infanticide cases by constructing a gendered legal structure that

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143 Culpeper, 121.
144 Moderation in the seventeenth century was largely based on Aristotelian theories. James, *Passion and Action*.
145 Culpeper, 153.
147 Gowing, *Common Bodies*. 

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enabled women to pull from established discourses to cast themselves in the best possible light. However, the legal code still enshrined single mothers as the perpetrators of infanticide and was successful in that manner, making them targets of this legislation. These birthing manuals hide this experience as they assume that their patients are married women, often referring to them by the title “wife.” While ostensibly authors envisioned a varied audience, ranging from midwives and chirurgeons to all women, the advice in the text spoke primarily to a married aristocratic patient. Similarly, pregnancy was rarely acknowledged as possible without consent. Culpeper serves as a representative example of discourse surrounding nonconsensual sex, who argued that “there never comes Conception upon rapes,” a consequence of the belief that desire was a requirement for conception. The only work to have argued the contrary was Aristotle’s Masterpiece. In cases of rape, it was not desire, but “through fear and surprise” that women were overtaken. In the author’s opinion these “poor silly Girls, struggling to defend themselves in case of such violence, and not in such fear and perplexity regarding the nicety of containing their Humor, the Seminary Vessels by an natural proneness will open” and result in a pregnancy. Essentially, the fear and surprise women would experience in the event of rape would distract women from being able to control the reflex of the womb to open. This author’s assessment did not, however, reflect the legal definition of rape, which required an abundance of evidence and invasive searches.

In the years immediately following the Infanticide Act, Charles I inherited the throne. The civil unrest that plagued his reign would last for nearly ten years and culminate in his beheading and the formation of the English Commonwealth. These years saw religious turmoil, vicious factional infighting, and large-scale violence. It also witnessed tests to traditional sites of power, most forcefully demonstrated in Nicholas Culpeper’s 1651 Directory for Midwives. From the Preface to the final pages, Culpeper was unwavering in his criticism of London’s College of Physicians for their inadequacy and selfish hoarding of knowledge, and of traditional Hippocratic-Galenic theories for their failure to adequately account for observable experience.

149 Culpeper, 85. See also Jane Sharp, 99.
150 Aristotle’s Masterpiece, 73-4.
Culpeper’s work denotes another noticeable change in the publication of birthing manuals in England during this period. By and large, the works published in the first half of the seventeenth century were translations, many of which were first published in French or German and Latin. In this sample spanning the years 1612-1684, of the first five published works before 1650, only Helkiah Crooke was an English author. Of the six manuals published after 1650 only François Mauriceau’s 1672 *The Diseases of Women in Childbed* was a translation. The English Civil War evidently signified a shift in publishing trends, at least in regard to birthing manuals. The seventeenth century was marked then not only by the massive expansion of print in the English language, but by the increasing number of English authored medical manuals that dealt with women’s health and childbearing.

Still, despite this tumultuous disorder and in spite of ongoing challenges to ancient models of knowledge, belief in the mind-body connection did not waiver. It was modified by practitioners like Crooke and Mauriceau, but the foundations remained stable. Preserving a healthy emotional state by banishing harmful passions like sadness and anger, vigilantly monitoring the appropriate response to emotional stimuli like receiving of unpleasant news or viewing upsetting images, and carefully measuring the proper amount to acquiesce to longings and cravings were all central to women’s reproductive health. The labor this would require was not small, and it certainly extended beyond the initial stages of conception and pregnancy. In the often more challenging setting of labor, the need for emotional regulation continued wherein ancient medical theories were recommissioned for the purposes of a regulatory regime that extended across all phases of childbearing.
Chapter Two

To Comfort and Cheer: The Emotional Work in Labor and Delivery

“Fear,” warned Louise Bourgeois, midwife to the Queen of France “disorders the senses” and made practitioners more likely to make mistakes, to fail to act in time and, from the patients’ perspective, made childbirth more difficult for women.152 While these words of caution came from a short public letter of advice to her daughter on entering the practice of midwifery, the sentiments contained within show just how different Bourgeois’ approach to patient care was from that of her male counterparts. Where male authors often promoted their ability and attempted to demonstrate their expertise, Bourgeois stressed the responsibility of midwives to their patients, methods of networking, and obstacles presented by more prevalent male authority in childbirth. Where she and her colleagues agreed, though manifested in different ways, was on the import of emotional management, both of the patient in labor and the midwife in attendance. Few historians would question that fear played an important role in the experience of childbirth for early modern women and their families. Though the risk of death in childbed was relatively low, dread of the possibility and of the inescapable pain were frequent features in women’s letters, diaries, as well as in birthing manuals.153 What not many have yet considered, however, is what the experience of not just fear, but the range of passions in childbirth, meant for practitioners, their relationships with their patients in the birthing chamber, and the impact it had on increased male authority in childbirth.

Philosophers of the age, just as the Ancients of centuries before, described the passions as nearly unconquerable, but that did not excuse individuals from the responsibility of trying. Nowhere was this more taxing than in the throes of childbirth. Susan Broomhall as noted that the expression of emotion was also a performance, socially constructed, and sometimes to meet an end.154 This dynamic is evident in the relationship between practitioner and patient; by enacting a calming if commanding presence, a midwife or other practitioner might produce a more confident and composed patient. Yet male authors tended to describe midwives as often having the opposite effect. Many complained that rather than soothing a laboring woman, midwives in

152 The Compleat Midwifes Practice, 224.
154 Broomhall, Authority, Gender and Emotions, 13.
fact inspired fear. By suggesting that midwives were changeable, impulsive, and overconfident, male practitioners were also implying that they were less capable of managing the passions of their patients and themselves. And because the passions might also “express the relationships between cooperating hierarchies of authority of men to regulate communities,” claims of poor emotional management might have served as a method of legitimizing male authority in childbirth.  

To claim that midwives were less skilled at the emotional labor required of their profession also reflected the early modern framework of perceived gender differences in the ability to control the experience of troublesome passions. Women were represented as quicker to anger and more unstable than men, which would make them poor bedside companions. Midwives displaying these qualities would be especially troubling, as often-cited Cicero noted that speech could be used as “an instrument for exhortation and persuasion, for consoling the afflicted and assuaging the fears of the terrified, for curbing passion and quenching appetite and anger.” Thus, scripts for emotional expression and claims of midwives’ inferiority at properly performing them served tools for attempts at regulation.

Historians typically link the rise of man-midwifery in England to developments in medical training and public knowledge of the Chamberlen family forceps invention. I suggest that another equally important factor to consider is the accusation that midwives failed to properly manage the emotional expression of her patients and herself. The experience of certain emotions was not only theoretically restricted for birthing women, but also for practitioners themselves. Hippocrates argued that practitioners should be sure to comfort their patients, while Galen argued that physicians earned confidence and trust through their use of rhetoric. Although women were often associated with talk and gossip and men with action, this did not extend to rhetoric for the public good. This phase, characterized by the fear it seemed to inspire in birthing women, also required the surveillance and adjustment of emotional states and responses as methods to promote a healthy birth for both mother and child. The practitioner’s role here was then not only to assist in the physical delivery of the baby, but also to manage the emotional states of laboring women.

155 Broomhall, Authority, Gender and Emotions, 13.
157 Wiesner-Hanks, Women and Gender, 85. Wilson, Ritual and Conflict.
Since most believed that men were able to cope more competently with dangerous passions, and because early moderns believed that women were more susceptible to the same, midwives were considered less qualified than emerging male specialists to handle such an emotionally charged environment. While it was certainly not the only reason that male authority came to dominate in childbirth, these deeply held beliefs about gender differences in the control of the passions played a role in the rhetoric meant to give male practitioners legitimacy and which eventually led to male-dominated obstetrics and gynecology.

**Practitioners & Authority**

For Helkiah Crooke and many others, order was inspired by heaven and reflected in the commonwealth. He felt that this same sense of hierarchy and order should be reflected in the division of the healthcare professions. Crooke imagined his specialty of barber-surgeon as more of an art than a science, as most practitioners in the medical field viewed their work. He showed little interest in encouraging increased male involvement in the birthing chamber, instead suggesting that “the Nature of women seemeth to be more intent upon generation then that of man, even from the very beginning; witnesse the childish disports of young Girles in making of Babies, Nursing, and lying-in, as we say, and such like pastimes, wherein they are occupied even from their infancy.” According to Crooke, women were more naturally inclined to the work of midwifery. Crooke’s opinion, however, did not prevail and was not universally shared. Instead, seventeenth-century commentary in printed medical manuals served to elevate all categories of practitioners, with the notable exception of midwives. Understanding the debates among practitioners, through which the centrality of the passions survived, shows just how embedded these beliefs had become and reveals coinciding claims to superior emotional regulation from male practitioners.

That there was a hierarchy (if mutable in England) of practitioners in the early modern period is evident in vernacular medical texts of the seventeenth century. The views they espoused should be read mindfully, as the vast majority of works on childbirth and women’s health were published by male practitioners of various levels, some without ever having attended a birth in person. Male practitioners throughout the sixteenth and into the seventeenth century were still working to justify their presence at childbirth, and increasingly defending their

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superiority over midwives in non-emergency births. Ambroise Paré addressed his collected works, first published in French in 1575 and later translated in 1636 by Thomas Johnson for English readers, to surgeons who he saw as vital healthcare providers, especially for women. Surgeons, while not yet prominent in typical births, did often treat women who suffered complications related to childbirth or other reproductive ailments, like the falling of the matrix, that required surgical intervention. Though his opinion was not universal, Paré argued that in the case of a difficult labor, it was the surgeon who “shall know that the childe is dead” by interpreting various signs he carefully laid out.\(^{160}\) Paré’s was an early assertion of the necessity of male specialization at childbirth, with many more practitioners depicting women as fully capable of this task.

By frequently demeaning and attacking midwives’ supposed lack of skill and insufficient regulation of the passions, male authors implied that their own involvement was necessary for maternal and fetal health. These accusations helped male practitioners gain ground in their slow encroachment on the traditional role of the midwife. Male practitioners often alternated between urging midwives to avoid rushing a delivery in order to allow nature to take its course and insisting that male presence was ensured by calling for a surgeon at the first sign of complication. Paré recommended that his readers take the council of physicians when assisting with difficult births, and warned that in case of maternal death “there must then be a Chirurgian ready at hand,” so that he may safely delivery the child.\(^{161}\) Nicholas Culpeper likewise encouraged midwives to allow the waters to break on their own time, observing that “Dame Nature knows when the true time of the Birth is, better than they and usually retains the Water until that time.”\(^{162}\) Culpeper found that when birth was rushed, which midwives often stood accused of, further complications tended to arise. These observations refer to what modern practitioners call “cascading effects following intervention” wherein researchers have found that when interventions occur in childbirth, often more interventions of greater scale are required.\(^{163}\) By demanding male presence in cases with the slightest complication requiring skill to navigate,


\(^{161}\) Parey, *The Workes of that Famous Chirurgion*, 923.


male authors whittled away at female authority in childbirth and further implied that not only were midwives currently unable to perform the duties required in childbirth properly, but were also incapable of learning the skills that intervention required.

Many male authors characterized midwives as misleading as well as incompetent, hinting at assumptions about their inadequate emotional regulation. In his discussion of the practice of discerning a woman’s virginity, Paré was skeptical of many typical methods of physical inspection midwives utilized like the examination of the hymen and bloody bed linens following the consummation of a marriage. Under his scrutiny, midwives appeared to lie about the utility of using the hymen as a measurement of virginity in a manipulative and dangerous effort to retain a form of power and authority. In another of Paré’s examples, prostitutes and common harlots would fake “womanlike cryings, and the crocodiles teares” to convince their new husbands that they were still “pure virgins.” Here, Paré casted women as employing the physical signifiers of passions in attempts at manipulation. Midwives and sometimes their patients were intent on deceiving powerful men, whether magistrates or husbands.

Writers further discredited midwives by charging them with obstructing women from receiving appropriate care, and used examples of midwives’ mistakes to promote their own abilities. Midwives’ failures were often juxtaposed next to male surgeon success in attempts to promote male authority and credibility. Paré relayed one anecdote in which several midwives were unsuccessful in their attempts to help a postpartum woman who was unable to urinate, but once a surgeon’s intervened by cutting the hymen, she was cured. It was also midwives’ inaction that kept women from help. Mauriceau stressed that childbirth could not be rushed, but also lamented that midwives failed to call an expert at the first sign of a complicated birth. He complained that midwives actively avoided calling for surgeons in cases where their skills were necessary because of midwives’ dual fears of losing patients and appearing incapable. Other midwives, Mauriceau claimed, were “so presumptuous, as to believ[e] themselves as capable as the Chirurgeons to undertake all.” In an effort to hold on to their authority, he found that midwives “put such a terrou and apprehension of the Chirurgeons in the poor Woman, characterizing them like butchers and hangmen, that they choose rather to dye in Travail with the

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166 Mauriceau, *The Diseases of Women with Child*, 182.
167 Mauriceau, *The Diseases of Women with Child*, 182.
Child in their Womb, than to put themselves into their hands.”\textsuperscript{168} Midwives’ concerns over reputation and business caused “extream violence to the Woman, which is also the death of the Child.”\textsuperscript{169} To get the outcome they desired, midwives manipulated the passions of parturient women, inciting fear rather than creating a calm environment, offering encouragement, and calling for the help. Many authors, like Guillemeau and Paré, saw midwives’ responsibilities and capabilities in childbirth ended the moment a complication presented. The actual work of midwives, as Mauriceau saw it, was so simple even the “meanest Midwives are capable,” which minimized their value and increased in number the circumstances under which a man-midwife or surgeon should be called.\textsuperscript{170}

Although most practitioners agreed that male intervention in childbirth was necessary, other works seemed to squarely place the responsibility of assisting women in childbirth in the hands of midwives. Often, these attitudes are found translations of much older works that also assumed that it would always be a midwife who delivered a child. Even so, their commentary showed contradictions within the all-female framework that demanded male presence. In describing the proper means of delivering the afterbirth, Jacob Rueff maintained that “These Secundines or infolders of the infant, shall be by no other meanes unloosed and expulsed, than by the hand of the Midwife.”\textsuperscript{171} At the same time, however, this same author modified his assertion later by digressing, “Yet for all that, let nothing be done without the counsell of a skilfull Physician.”\textsuperscript{172} The English translator of Rueff’s work identified this particular point, of consulting a male practitioner, as one to highlight by reiterating it in the margins for readers quickly perusing. Another apparent contradiction in Rueff’s later chapters, which were meant to instruct practitioners in difficult births, were all addressed to midwives, assuming that she would be the one to perform even difficult labors that required manual and surgical intervention. The only situation Rueff demanded physician or surgeon presence was when the infant presented feet first, and only then if the midwife was unable to turn them properly. Indeed, in the case of twins presenting feet first, Rueff showed confidence in midwives’ abilities saying, “such a birth is very dangerous, but to be remedied and corrected by the wisdom of the Midwife.”\textsuperscript{173} Similarly, after

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\textsuperscript{168} Mauriceau, \textit{The Diseases of Women with Child}, 182.  
\textsuperscript{169} Mauriceau, \textit{The Diseases of Women with Child}, 183.  
\textsuperscript{170} Mauriceau, \textit{The Diseases of Women with Child}, 192.  
\textsuperscript{171} Jacob Rueff, \textit{The Expert Midwife} (London: E.G., 1637), 90.  
\textsuperscript{172} Rueff, \textit{The Expert Midwife}, 94.  
\textsuperscript{173} Rueff, \textit{The Expert Midwife}, 132.
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suggesting one particular position for the laboring woman that would enable the midwife to perform work that required instruments, Rueff also offered “if another way shall please, and seeme more commodious to the Midwife, let her bring the woman to her bed…” which presumed midwife was authoritative and competent in decision-making processes that male authors typically derided her for. The authors of *The Compleat Midwifes Practice* agreed, offering very similar (and probably borrowed) advice on how the midwife should reposition infants presenting feet or bottom first. But this approach was not unanimous consensus in the medical community, especially concerning a midwife’s use of instruments. Mauriceau and Chamberlen via in-text notation argued that “it is not a Midwifes work to use the Crochets,” and those who did, often cost “many lives.”

174 It is worth noting that despite the continental success of Rueff’s work, the first translated edition did not appear in England until 1637, which was also its only printing. Rueff was firmly in the sixteenth century, and his assumptions about midwife’s roles at childbirth were whittled away throughout the seventeenth century.

The diminishment of midwives’ capabilities in childbirth was a slow and uneven process. Nicholas Culpeper’s popular 1651 *Directory for Midwives* was also addressed to midwives, but Culpeper went further and critiqued institutions that were built to keep knowledge among limited elite all-male groups.175 While he seemed to argue in his dedication that women’s bodily and practical knowledge belonged to midwives and women, he also seemed to argue that men were the producers of such knowledge while women were simply the recipients. As an apothecary, Culpeper pointed the finger at doctors and surgeons who he claimed “denied you [women] admittance.”

176 This, he thought, boiled down to profits saying, “if they can get mony, they have gotten their desire...how they shall raise their Fees from Ten shillings to Twenty.”

177 This is not to say that Culpeper was a crusader on behalf of midwives. He had harsh criticism for the state of the profession and midwives’ skills in handling complicated or delicate procedures. In his discussion of the falling out of the womb, Culpeper blamed the “unskilful drawing out [of] the Child…by MOTHER-CARELESS when she turns MIDWIFE.”

178 Here Culpeper could either be disparaging poorly trained midwives or the intervention women outside of the profession could

177 Culpeper, *A Directory for Midwives*, 60.
make. In one example, Margaret Hoby recoded in her diary that a tailor’s son had been brought to her who had been born without a fundament and “had no passage for excrements but att the Mouth.”\textsuperscript{179} She was then “earnestly intreated to Cutt the place to se if any passhage could be made, but althought I cutt deep and searched, there was none to be found.”\textsuperscript{180} This procedure was one Guillemeau strictly reserved for surgeons.

Still, male presence at childbirth was never a given, and the debates within birthing manuals show careful deliberation about the precise situations in which the use of male practitioners was appropriate. Like Rueff, Culpeper promoted the custom of midwives’ authority in the delivery of infants who died in utero, provided the right steps were taken to ensure they were indeed already dead.\textsuperscript{181} Surgeons like Paré and Guillemeau disagreed, arguing that the intervention was too reliant on expertise that only trained surgeons received. Even these trained individuals were a risky lot, according to Culpeper who warned that some women he had known had recently “fallen into the hands of such Creatures, that they had as good have sent for a Butcher to deliver them.”\textsuperscript{182} Even so, Culpeper seemed aware that there were contentions over male presence in traditionally female dominated spaces. After directing midwives in the proper handling of laboring women, Culpeper defended his intervention in the field saying, “I have not medled with your Callings nor Manual Operations, lest I should discover my Ignorance.”\textsuperscript{183} Culpeper’s work was incredibly popular and reprinted into the eighteenth century. So although his arguments did not reflect majority opinion among male practitioners, they certainly held traction.

Sometimes authors hit an uncomfortable balance in promoting an idealized version of a midwife, while also critiquing a supposed majority. The compilers of \textit{The Compleat Midwifes Practice} (1656), who imagined their work as one that incorporated all the most current and up to date trends in childbirth, used the image of the French midwife Louise Bourgeois to sell their work. Though she had published her own birthing manual in France in 1609, the first of its kind, only short selections of her publications were chosen as worthy of translation in the early modern period and even these were all but anonymously tacked on to the end of this larger work.

\textsuperscript{179} Hoby, \textit{Diary}, 184.
\textsuperscript{180} Hoby, \textit{Diary}, 184.
\textsuperscript{181} Culpeper, \textit{A Directory for Midwives}, 165.
\textsuperscript{182} Culpeper, \textit{A Directory for Midwives}, 167.
\textsuperscript{183} Culpeper, \textit{A Directory for Midwives}, 172.
Throughout *The Compleat Midwifes Practice* midwives are frequently presented as inept, but at the same time the compilers were also fully aware that midwives continued to perform the same work as male surgeons, much to their chagrin. The authors characterized England’s need for their manual as quite urgent remarking, “how many have been lost by the unskilfulnesse of those that attempted this great work; nor should we have prostrated our reputation and private experiences, but to correct the frequent mistake of most Midwifes.” Yet throughout their work, midwives and surgeons are shown performing the same sorts of tasks. Divisions between practitioners were blurry and generally unenforced, and the assertions in birthing manuals about the proper roles of each specialist were also attempts at creating more codified and legitimized barriers. Margaret Hoby’s procedure is just one illustrative example. That the authors only included a translation of Bourgeois’ advice letter to her daughter suggests that they approved of her words of guidance, most probably her encouragement to work along with surgeons and physicians and to defer to them when needed. This was not, however, a full endorsement of Bourgeois or of the practice of midwifery, as the work did not include translations of her descriptions of the work she actually performed. Instead, they chose a piece that was centered on midwives’ comportment to encourage certain types of supposedly suitable behavior.

What is evident in Bourgeois’ advice to her daughter, and is also confirmed in her birthing manual, is that her approach differed dramatically from the instruction given by male practitioners. These points of contrast suggest different methods of gaining and asserting authority. Bourgeois urged her daughter to be diligent, always learning, and humble. Male authors seemed to assert their authority based on the knowledge they had already amassed, never suggesting that there was more to be gained. Bourgeois also openly stressed the significance of networking for business, and the importance of sharing recipes and other types of knowledge that could benefit childbearing women. This more active collective approach is apparent only in Guillemeau’s work, where the team-based nature of a royal appointee sometimes emerges. Yet the need to maintain and develop a clientele was absent from other works of this kind entirely. Her letter also revealed that Bourgeois herself perceived that midwives were very much under increased public attack, for which she at first seemed to show little concern. Instead, she argued that an overabundance of good midwives would oust the bad. Yet at the same time, she observed

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that “There are few Women now a dayes that do give that respect [to midwives], or have that kindness for them as in former ages.”

Rather, midwives had to resort to “artifice” to please their clients, especially younger ones who “many times do make election of men to bring them to bed.”

She disagreed entirely with the choice and “blushed” when speaking of the trend, finding it “of imprudence to have any recourse to them, unless it be in a case of very great danger.”

According to Bourgeois, even husbands found male presence shameful because it meant that other men had gained sight of their wives. In an illustrative anecdote, Bourgeois recalled an case in which she sent for a surgeon at the insistence of her patient’s family, consenting only with the promise that “she [the laboring mother] might not see him; for I was fearful lest she should dye with apprehension and shame.”

The passions male sight could trigger in women were deadly. Moreover, rather than beneficial to maternal health outcomes, she felt that too frequent and unnecessary calls to surgeon resulted in more harm to laboring women and their infants that would have been easily avoided if the skillful midwife was left to her work.

Bourgeois was without doubt concerned with the plight of the poor women she treated, but she by no means described an environment of universal female solidarity. She was the only author to explicitly urge her readers to treat both the rich and the poor and give them equal care. In caring for the poor she said to “take nothing; for to them a little is a great deal: visit them also afterwards with diligence, that for the small time wherein they keep their bed you may be assisting to them in strenghning and recovering of their healths.”

At the same time, her munificence did not extend to women with venereal disease, who she vehemently refused to treat.

The only other seventeenth-century midwife to publish on childbirth was the Englishwoman Jane Sharp, who seemed to have far more in common with her male counterparts than with Bourgeois. Indeed, she wrote her book to right the “many Miseries Women endure in the Hands of unskillful Midwives…without any skill in Anatomy, which is the Principal part effectually necessary for a Midwife.”

Rather than seeing a few bad midwives, Sharp seemed to

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191 Bourgeois, *Diverse Observations*, 123.
find them everywhere. This was also an interesting claim from a midwife in part because anatomical knowledge of the kind taught at the universities of the period was relatively unnecessary for their work, and if this argument were to take hold, as it did, it would entirely undermine midwives’ authority in childbirth. Like Culpeper complained, women were kept from these centers of learning and many practitioners felt that women were incapable of acquiring the sorts of knowledge Sharp was advocating. However, she did point out that “though we women cannot deny, that men in some things may come to a greater perfection of knowledge than women ordinarily can, by reason of the former helps that women want; yet the holy Scriptures hath recorded Midwives to the perpetual honour of the female Sex.”

Biblical descriptions of childbirth made no mention of man-midwives, and so implied that the profession should be handled solely by women. Perhaps for Sharp, this was a subtle push for women’s inclusion at centers of learning.

This is not to say that male practitioners were not also targets. They certainly were, just at a much smaller scale and usually without such wholesale disapproval. Mauriceau complained of “some Politicians, who would rather suffer a poor Woman to dye without assistance than undertake a doubtful Operation.”

This criticism differs significantly in nature from complaints against midwives. Where midwives were condemned for trusting their own judgement and skill, surgeons were disparaged for being overly cautious. Another point of contention was whether to save a mother’s or infant’s life in dire circumstances. Mauriceau urged choosing the mother “since the Infant cannot avoid death neither one way nor the other.”

But within that same translated text was an embedded note from Hugh Chamberlen arguing otherwise, showing clear divergence in practice. Though not translated in the early modern period, Bourgeois’ claimed that her manual was written to address common mistakes with advice on how to right them. These mistakes, she wrote, were often unknown “to very learned Physicians and surgeons, because of the intimate nature of a mid-wife’s work.”

Regardless of these differences, there was undoubtedly a gradual, if uneasy, increase in male presence at childbirth. Despite these differences and contestations, practitioners across fields maintained that one of the fundamental duties of a birth attendant was to monitor both their patients’ and their own emotions.

194 Mauriceau, *The Diseases of Women with Child*, 205.
195 Mauriceau, *The Diseases of Women with Child*, 228.
Patients & the Mind-Body Connection

Much of the passion-talk around male practitioners’ interaction with female patients centered on women’s responses to male sight, an obstacle that prevented their intervention in typical births. Many authors in the early parts of the seventeenth century observed women’s discomfort and changed behavior when male practitioners entered the birthing room. This reaction may in part be explained by the fact that male presence typically meant that the birth was not going according to plan, but the consistent language of shame authors used to describe women’s responses seems to suggest that it was more than an association with negative outcomes. Authors named women’s discomfort with male sight of the female body as the primary impediment to receiving proper care, which they also found was disruptive enough to require emotional management. Paré proposed that discomfort with male presence (or, not to be overlooked, the “hate of some woman there present”) was a cause of a difficult or painful labor.197 Extending beyond pregnancy, negative emotional responses could increase the likelihood of negative physical outcomes for laboring women.

One of the primary ways to combat the pitfalls that the experience of dangerous passions could cause was for the practitioner to adequately manage their patient. Not all individuals were considered qualified for such work, and descriptions of the ideal midwife throughout the seventeenth century consistently incorporated demands concerning her mind, ensuring she was “wise, discreet, and witty, able to make use of sometime of faire and flattering speeches.”198 Likewise, she should also be “cheerful and pleasant, that she may the better comfort her Patients in their Afflictions.”199 In defending midwives, Jacob Rueff claimed that the anatomical knowledge he included would help them perform their duties better. For how, he asked, could midwives “comfort other women, which by reason of ignorance, shall be her selfe more timorous and feareful than they? How shall she help, succor and comfort the labouring woman, to whom she is not able to give any profitable Precepts because of her ignorance?”200 According to Rueff, midwives needed to understand the workings of anatomy to best redirect patients’ passions. In his chapter on the office of the midwife, one of the first duties he named was to “comfort and

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199 *Aristotle’s Masterpiece*, 100.
200 Rueff, *The Expert Midwife*, 44.
cheare up the labouring woman, and let her chearefully exhort her to obey her Precepts and admonitions.”

Clearly, the work of the midwife was both physical and emotional.

Rueff was not the only author to place such an emphasis on emotional management as part of the practitioner’s role in childbirth. Peter Chamberlen urged midwives to “refresh” a woman in labor with “comfortable words, encouraging her with hopes of a speedy and good deliverance.” It was not only laboring women who the midwife was responsible for, but also the other women present to whom she should give “good exhortations…especially devout prayers to God.” This command of the room was useful in her role in encouraging women through an especially difficult labor. Of course, a midwife should be wise and discreet in her care of a laboring woman, but she should also be able to lighten a tense mood and bolster her patients’ confidence by making encouraging speeches full of compliments. According to Guillemeau, birthing women, for their part, should obey their midwives and their gossips, whom he identified as her kinsfolk and friends. The laboring woman was to allow herself to be managed and always “calling upon God for helpe, since it concerns both her own life, and the childs.”

The regulation of the passions was regularly employed for pain management in childbirth, which was dramatically increased by the experience of fear or sorrow. The ability to cope with pain and the passions that exacerbated them was especially important because, as Guillemeau warned, women who were naturally “weake of constitution, nice, tender, timerous, and afraid of pain” would feel the pains of childbirth more keenly, and would hinder their labor. Just how women were expected to cope with this pain varied based on class differences, wherein most women were encouraged to cry out at the pain, while queens and aristocratic women were exhorted to bear the pain in silence. Irrespective of the differences in coping expectations, the experience of pain itself was to be embraced rather than avoided. It was these trials that allowed for salvation and signified a cleansing and the recovery of health. Indeed, when a mother’s fear of the pain was evident “she must be advised, that it is the will of God it

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201 Rueff, The Expert Midwife, 78.
202 Peter Chamberlain, Dr. Chamberlain’s Midwifes Practice (London: Thomas Rooks, 1665), 108.
203 Rueff, The Expert Midwife, 78.
204 Guillemeau, The Happy Delieverie of Women, 90.
should be so, and that her Labour will not be so bad as she imagines, perswading her to submit to the necessity.”  

Mauriceau observed that because women could not, though more to the point should not, avoid the pains of childbearing the best way to mitigate their effects was to encourage them to “endure them with patience, in the hope of being suddenly delivered from them by a fortunate labor.”  

The practitioner, whether midwife or surgeon, assist by “cherishing her with good hopes, assuring her that her travaile will bee very easie, and promising her, that she shall have either a sonne or a daughter, according as you know she desires…flattering and soothing her as much as you can, without chiding or giving her any crosse speeches at all.”  

The translator of Guillemeau’s Happy Deliverie of Women referred to these promises of a fast delivery as “a good deceit,” a fib that benefited a laboring patient.  

The standard advice was to encourage women to overcome any negative emotions as a means of preventing possible complications, but also as a means to salvation.  

The impact of the passions on women’s reproductive health was evidenced in their effects on blood flow resulting from the passions’ general impact on humoral movement and the importance of proper purification and circulation of blood throughout the phases of childbearing. Guillemeau argued that excessive postpartum bleeding was attributable to “passions of the mind” and the cure was to “shun anger, melancholie, griefe, and other such passions of the mind: Let her keep herselfe quiet, not much stiring or troubling her bodie.”  

These strong passions could heat the blood and instigate more heavy bleeding. Conversely, Guillemeau named the “outward” causes of the retention of blood in the postpartum period as “sadness, griefe, suddain apprehension of some ill newes, feare, frighting, and such like passions of the mind.”  

Passions like fear could cause the humors, which should have been purged in the month following delivery, to retreat into the body and cause numerous complications that could cost women their lives. The cure, combined with a moistening diet, was for the woman to “be plasant, and make herselfe, as merry as she can.”  

That is, if a woman retained blood that should have been

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208 Mauriceau, The Diseases of Women with Child, 199.  
209 Mauriceau, The Diseases of Women with Child, 178.  
210 Guillemeau, The Happy Delieverie of Women, 117.  
211 Guillemeau, The Happy Delieverie of Women, 117.  
212 Guillemeau, The Happy Deliverie of Women, 224.  
213 Guillemeau, The Happy Deliverie of Women, 228.  
214 Guillemeau, The Happy Delieverie of Women, 229-30.
purged because of a sudden fear or because of anger, she should suppress that emotion and instead feel merriment and happiness.

The experience of unsuitable passions could cause any number of “unnatural” or difficult deliveries and postpartum complications with corresponding cures that featured emotional moderation. For example, if the labor was evidently slowed by some passion that she could not overcome, the laboring woman should at least endeavor to moderate it. If she felt shameful or concerned with her modesty, the offending party should leave the room. For a difficult labor in which the child was turned wrong, Guillemeau urged the surgeon, who he believed should attend these births, to allow her to rest a while, but at the same time to deceive her by telling her that her child was well placed. Lies like these were meant to put women at ease, to keep fear at bay so that both she and the infant might see better physical outcomes. The falling down of the matrix (uterus), a postpartum complication, was triggered by immodest female desire. Paré seemed to ascribe to Aristotle’s belief that for many women, the falling down or turning of the womb was caused by “the desire of copulation that they have, either by reason of the lustinesse of their youth, or else because they have abstained a long time from it.” In a parallel fashion, the way that fear made the humors like blood retreat into the body, desire and the associated heat made the womb do the opposite. All of these situations encouraged a muted emotional response from women, creating a limited appropriate emotional repertoire for childbirth.

The responsibility for ensuring that a laboring woman maintained a healthy emotional state was shared among the mother herself, her practitioner, and her gossips. In order to bring forth the afterbirth, Culpeper instructed midwives to “Comfort up the Woman: it is a more fitting practice for you than to sit telling Gossips Tales.” Evidently, women could just as easily arouse discontent as often as they could comfort. Culpeper went further to lecture, “I hope I need not bid you not terrifie Women in that case, knowing that they have endured pain enough before: if you are Midwives shew your selves Women.” For her part, the laboring woman should “banish all griefe and heavenesse, having regard only for her health, and to be merry, praising God for her delivery.” Managing the laboring woman’s experience of negative passions was a

215 Guillemeau, The Happy Deliverie of Women, 238.
216 Parey, The Workes of that Famous Chirurgion, 934.
217 Culpeper, A Directory for Midwives, 184.
218 Culpeper, A Directory for Midwives, 185.
219 Guillemeau, The Happy Deliverie of Women, 194.
shared responsibility, giving women an opportunity for a network of support and while the child’s father might also have had some obligation in this respect, his role was rarely mentioned in birthing manuals.

Differences between how male surgeons and midwives communicated with their patients is difficult to decipher, given that the vast majority of manuals were male-authored. However, the translation of Louise Bourgeois’ letter to her daughter offers a unique perspective as the only first had account of a midwife’s emotional labor on behalf of her patients. To a much greater degree than other authors of the period, Bourgeois often used stories to illustrate an important concept, giving more context for the role of the passions in childbirth. Bourgeois recounted an instance at the beginning of her career when she allowed two women to labor at her home, something she warned her daughter against. Bourgeois recalled that she “had better have kept a herd of swine” as the women often fell into “fists of despair” that Bourgeois “Could hardly bring them out of again.” Likewise, their commotions caused such disruption “into the brest of a Midwife; for her minde ought to be free & at peace.”220 Bourgeois’ remark confirms that it was not only the laboring woman who needed to monitor her emotional state, but the midwife as well. She urged her daughter to “Never be dismayd if every thing go not wel, for fear disorders the senses, and a person that keeps her wits together, without suffering them to be scattered by fear, is capable of giving assistance in weighty affairs.”221 The author of *Aristotle’s Masterpiece* agreed, urging the midwife to remain calm in the face of a difficult labor, so she might “chear up the Woman” and offer her consolation, though she may become “unruly in her pangs” which could “destroy both her self and her Child.”222

**Lying-In**

During the lying-in period, which varied significantly among women based on socioeconomic status and the time women could afford to be away from work, marked alterations in emotional states could result in serious complications. Bourgeois asserted that she was “horrified for the poor women I see suffering from this condition [a postpartum complication], who cannot afford to rest and get the treatment necessary for revocery; yet if they

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222 *Aristotle’s Masterpiece*, 102-3.
cannot earn their bread, they cannot survive, and so they languish for the rest of their days.”

Clearly, not all women enjoyed the same treatment. For the wealthy with flexibility, the length of time for their lying-in period was also dependent on women’s interpretation of her own strength. It would not be too much of a stretch to suggest this included evaluation of emotional well-being. Practitioners revealed that the standard patient in birthing manuals was an aristocratic woman by often writing with the assumption of an extended period of lying-in, whereas Bourgeois pointed out that most women were only able to keep to their bed for a few days after labor because of work obligations. Guillemeau in his chapter on the postpartum month of women’s lying-in offered several recipes that were meant to speed recovery and offer better outcomes. Many included expensive luxury ingredients like powder of pearl and leaf gold, combined with complicated instructions that were clearly time and labor intensive. Even Guillemeau realized that this “Curiosity, is for Princesses and great Ladies.” There were, however, practitioners who offered more appropriate advice that could apply to most women recovering from childbirth, and these guidelines often included recommendations for emotional management. Culpeper, for example, warned women to avoid sadness, “together with trouble of mind” and instead urged them to thank God for a safe delivery.

Gossips and neighbors, according to male practitioners, could either offer recuperating women comfort and assistance, or on the contrary, discontent owing to their sometimes disruptive presence. For a successful recovery, Guillemeau suggested to encourage recently delivered women to “speake as little as may be, and have no noise made about her, nor suffer her to be much visited, but by her friends and kinsfolks, excluding all such tatling Gossips, as may tell her any thing to trouble her or make her sad.” Culpeper agreed, warning that while lying-in “Gossips tales do Women little good in such a case.” For Culpeper, this seemed to be a thinly-veiled warning against gossips’ supposed tendency to spread stories of births gone wrong, causing fear in the recovering mother. Mauriceau similarly urged newly delivered women to rely on friends and family for household duties and demanded that these women “let no ill news be

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223 Bourgeois, *Diverse Observations*, 165.
brought to her, which may affect her; because all these things do cause so great a commotion or perturbation of her Humours, that Nature not being able to over come them, cannot make the necessary evacuation of them, which hath been the death of many.”230 In short, the failure to monitor the information recovering women received could prevent the necessary evacuation of humors and result in maternal death. The midwife was also responsible for ceremonial duties post-delivery, including recording the day of the child’s conformation. Mauriceau complainED in particular about the practice of a quick post-delivery baptism, after which friends and family “have a Collation in the Child-bed Room.”231 Mauriceau fretted that this activity would require a still weakened mother to entertain and increase the risk of loud noise, meant that others were using her bedpan, and the chance for the delivery of unpleasant news.232

Touch

Guillemeau’s work, which differed from many other manuals of its kind at first publication by targeting male practitioners, underscored the importance of touch in their work with laboring women. Where other authors used language that could apply to both male and female practitioners or was pointedly directed at women, Guillemeau aimed at an exclusively male audience (at least in theory). He was perhaps influenced by fellow French surgeon and mentor Ambroise Paré who also addressed his larger volume to male practitioners, defending his use of the vernacular by arguing that surgeons needed access to books of learning. Even the ancients, he argued, needed only to learn one language rather than the two or three required of educated physicians in early modern France.233 The instructions contained in these manuals rarely acknowledged that one of the most prominent complaints against these male surgeons was concern about male touch of the intimate parts a female body. In his directions for how to turn a child who presented wrong in the womb, Guillemeau pointed out that the work required knowledge gained through touch. To discern the child’s position, the surgeon should “perceive both by his feeling, and by wagging and stirring the child up and down.”234 Likewise, nearly a century later French surgeon François Mauriceau wrote for country surgeons away from the learning centers of major cities. However, unlike Paré and Guillemeau, Mauriceau also noted

230 Mauriceau, The Diseases of Women with Child, 299.
231 Mauriceau, The Diseases of Women with Child, 299.
232 Mauriceau, The Diseases of Women with Child, 299.
233 Paré, To the Reader.
that midwives would find “that which they ought to know, to enable them the better to exercise their Art, and undergo the Examination.”  

As numerous historians have demonstrated, the midwife’s knowledge was gained by touch.\(^{236}\) This went beyond the delivery itself and included manual work like repositioning a laboring woman and pushing down on her abdomen in hopes of speeding a delivery.\(^{237}\) However, inter-sex touch was common between women healers and male patients, as well. Chamberlen recounted a story of an Englishwoman treating men’s illnesses. He claimed that “when any of her Men-servants complained of any distemper, she would judge of his disease by feeling how his stones hung; for if they did ascend up at her gentle touch, she concluded no danger of the disease, but would administer a present Cure.”\(^{238}\) Yet here there was no discernable association with shame or embarrassment by either party, suggesting women’s shame was tied more strongly to receiving men’s touch within the context of childbirth and their reproductive bodies.

**Conclusions**

Emotional labor was expected from all types of practitioners, regardless of gender or specialty. Just how midwives and surgeons were supposed to monitor themselves and their patients was generally standard in this period, too. Different guidelines were not given to men or women working with a laboring woman. There was a difference, however, in perceived ability. Perhaps because men were considered more skilled at moderation and inherently less fickle, they were in a better position to claim superior ability on this front. Midwives, though, often out of professional competition and job insecurity, were depicted as more likely to inspire fear and dread in their patients. Rather than seeking help for their patients, manuals often showed midwives risking women’s health by demonizing male surgeons and withholding their assistance by failing to call on their services quickly. Commentaries promoting male medical knowledge over midwives and lament over midwives’ failure to carefully monitor laboring women’s emotional health were dominant features in birthing manuals, reoccurring with increasing strength throughout the seventeenth century.

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\(^{235}\) Mauriceau, dedicatory.  
These medical authors, predominately men, were actively engaged with each other’s works, constituting a loose network of sorts. Frequently authors relied on each other for content, borrowing generously without naming the original author, or utilized each other’s reputation for authority and consensus. Sometimes, this reputation came under fire and references to fellow practitioners was a method meant to refute the worthiness of their work, exposing competition for adherents and for authority. Peter Chamberlen named Nicholas Culpeper a fool.\(^{239}\) Hugh Chamberlen’s letter to the reader concerning his translation of François Mauriceau’s *Traité des Maladies des Femmes Grosses et Accouchées* singled out Mauriceau’s work for translation because he felt its quality far exceeded both Sharp’s and Culpeper’s. Mauriceau himself cited specific passages from Jacques Guillemeau’s work several times throughout to support his arguments concerning timely surgical intervention, as well as in defense of certain cures for dropsy. At the same time, he showed respectful disagreement with the validity of some of Paré’s observations.\(^{240}\) Authors were familiar with the works that came before them, and used them to either bolster the need for their own addition to the genre or to strengthen their own approach to various reproductive illnesses.

Yet, despite these signs of professionalization and consistently disparaging midwives, even towards the end of the century, the legitimation of male presence at childbirth process was slow-going. Physicians were not especially well-respected, often considered untrustworthy and unknowledgeable.\(^{241}\) The first edition of *Aristotle’s Masterpiece* (1684) suggested surgeon or physician intervention only in dire circumstances, and otherwise assumed midwives would have authority in childbirth. Still, while it was by far mostly women who delivered infants, already in the seventeenth century the stigma associated with male sight was diminishing. While male authors would preface their works with perfunctory claims about the avoidance of male sight of the female body, much of the work required by surgeons would certainly require them to use more than touch. Birthing manuals contributed to a slow chipping away at perceptions of midwives’ responsibilities and capabilities, including their handling of their patients and their own passions.

\(^{240}\) Mauriceau, *The Diseases of Women with Child*, 106.
Chapter 3

“The Vices of her Body and Mind”: Emotions and the Bonds Between Infant & Nurse

*Lady Capulet:* Marry, that marry is the very theme
   I came to talk of. Tell me, daughter Juliet,
   How stands your dispositions to be married?

*Juliet:* It is an honour that I dream not of.

*Nurse:* An honour. Were not I thine only nurse
   I would say thou hadst suck’d wisdom from thy teat.

*William Shakespeare’s Romeo & Juliet: Act I, Scene III, 1597*

“I will not choose any but Catholics to nurse or educate the children who shall be born, or do any other service for them…”

Henrietta Maria, consort of Charles I, to Pope Urban VIII 6 April 1625

Though from very different contexts, these excerpts convey the extent to which the power of breastmilk and infant feeding permeated early modern thought. The first example is an exchange between mother, daughter, and wet nurse in Shakespeare’s *Romeo & Juliet.* Juliet’s mother has proposed marriage for her young daughter, Juliet, who seems resistant to the possibility. But it is the comment of Juliet’s nurse that is revealing for our purposes. On hearing Juliet find the prospect of marriage rather unappealing, her nurse agreed, and went further to suggest that had she not been Juliet’s only nurse, she would have thought that Juliet had drank in her wisdom along with her breastmilk. Nurse’s quick reply proposes that wisdom, and presumably other traits, could be contained within breastmilk, and therefore imbibed by nurslings. It may be tempting, from a modern perspective, to dismiss this exchange as symbolic. However, the power of breastmilk infused early modern family dynamics and medical manuals and moralist literature, which contained identical notions of Hippocratic-Galenic understandings of the body in this phase of infant development.

These beliefs extended beyond the literary and into personal and political exchanges, as well. Shortly before her marriage to Charles I, Henrietta Maria promised the Pope in Rome that only Catholics would surround any children that her marriage produced. Here, the nurse was an important enough figure that Henrietta Maria felt the need to name her in particular. This exchange is revealing in another sense, as well. By promising that only Catholics would nurse
her children, Henrietta Maria assumed that she would not perform this work. Similarly, Juliet’s nurse is comfortable enough to refer to the intricate bonds between wet nurse and nursling even in the presence of Juliet’s mother. Of course, Nurse’s wise self-deprecating approach may soften the blow. It is worth noting that while the word “nurse” in the early modern context could also mean infant care more generally speaking, it seems in this case that Henrietta Maria was referring to both wet nursing and associated infant care. Many times, among the aristocracy, the woman who provided the physical care for the infant was also responsible for breastfeeding. Regardless, the woman responsible for the nursing of aristocratic infants was of concern, in no small part because of the impact women’s breastmilk had on infant development.

Though the present literature on wet nursing and breastfeeding constitutes an excellent corpus of studies on infant feeding in early modern England, historians have not yet fully synthesized the interaction between physical and incorporeal effects for nursing women and the development of their nurslings. As the quotes above demonstrate, the two were inextricable. This chapter will argue that wet nursing was under attack from such varied groups as moralists and medical practitioners in large part because of class-based fears that the lower orders, who often performed this work, could exercise too much influence over the development of aristocratic children. The image of the wet nurse was held as symbolic of all that could go right in motherhood if performed properly and, at the same time, the horrors that could occur when caregivers crossed the boundaries of what commentators considered ‘natural’ in motherhood. When wet nursing was done right, they took over the role of mother and their nurslings might transfer their love and loyalty over to their caregiver. When performed incorrectly, children were harmed at the hands of a neglectful or malignant wet nurse. These contemporary claims transcended differences like religion and profession and were reliant on beliefs in the connections between the mind and body manifested in complicated interpersonal relationships: between mother and the child she nursed, between mother and the child she sent to be wet nursed, and between a wet nurse and her charges. At the heart of the debates over the appropriate choice of wet nurse was the belief that the mother was better equipped to manage her emotions and health, and not just because of her relationship to her infant but because of her social status.

The debate about wet nursing was in large part a field in which the construction of the identity of the ruling class played out, attempting to distinguish itself from the merchant class and even from the lower orders. A common and logical explanation for this need of the
aristocracy to further distinguish itself is the shifting economic landscape of England and the
Atlantic world. The merchant class was on the rise with the new influx in wealth, thanks to the
expansion of slavery and extraction of good like tobacco from the New World. While economic
shifts certainly played a part in class-based fears, questions of health were at least equally
important. Here, the discourse of health and healing were the dominant ones that had their own
associations to class difference. It might be easy to Atlantic and local economic trends with
classed discussions in medical discourse, but that would risk minimizing the ways in which class
had infused the practice of medicine in general, and childbirth in particular.

This chapter takes an unusual approach by considering a broad scope of seventeenth-
century sources including moralist commentaries, conduct manuals and birthing manuals to
address the topic of breastfeeding in this period. Moralists who couched their arguments in
religious validations and medical practitioners who called on ancient medical knowledge are
most frequently studied in isolation of each other, which tends to obscure important
commonalities. A method that examines both is useful because it can uncover links across genres
that hint at both the wide circulation and reception of medical theories as well as the
undercurrents of other socio-religious beliefs that were oftentimes hidden in birthing manuals by
the use of apparently ‘neutral’ medical language. Analyzing them together helps to reveal how
these genres worked to reinforce expectations of motherhood, particularly for aristocratic
women. Moralist commentators took up medical understandings and incorporated more direct
moral implications when the aristocratic women failed to nurse their infants.

Much like the management described in the earlier phases of pregnancy and labor,
women’s proper monitoring of their emotional feeling was central to successful breastfeeding.
Quite apart from, though inextricably linked to, women’s ability to carry and deliver a child was
the influence practitioners believed women possessed on the temperament of their children.
Practitioners varied in their belief of the formative power of what they called the “female sperm”
at conception, but no matter where they fell in these debates, the power practitioners believed
women wielded in the formation of an infant’s personality traits during pregnancy was limited.
Certainly, physical attributes described in chapter one like chronically shaking hands or a cleft
pallet could be imparted at this stage. But these traits were largely external and visible, rather
than the internal makeup of the individual. The period of nursing was markedly different and
signified a new phase of infant development. As the exchanges between Henrietta Maria and the
Pope and between Juliet’s nurse and her patrons illustrate, the postpartum period marked the development of an infant’s temperament and behavioral traits. Breastfeeding was central to this process, one that constituted a second reproduction in which women were thought to exercise an unprecedented level of influence in child development.\textsuperscript{242} The significant impact of breastmilk and associated infant care helps to explain the long-sustained passion with which moralists and certain practitioners attacked the custom of wet nursing and the women who performed the work as less capable, unable to properly curtail negative emotional responses and provide the appropriate level of care.

\textit{Backdrop}

Pre-Raynalde (1604) medical and birthing literature rarely attacked the custom of wet nursing. Manuscripts were more concerned with gynecological issues and the role of the male practitioner in childbirth than with the dynamics of wet nursing. In the fifteenth century especially, male medical writers began to “move beyond their fairly passive levels of involvement in women’s medicine to more active, creative roles.”\textsuperscript{243} In this period, what used to be short passages in medical writings grew significantly, and the “taboo on male sight and even touch of the external female genitalia has finally been breached.”\textsuperscript{244} Midwives were still the only practitioners “allowed to insert their hands into the female body, but male practitioners were now equipped with a variety of tools that literally opened up the living female body for inspection.”\textsuperscript{245} Therefore, the rise of printed materials and shift from medieval to early modern did not necessarily constitute a break with theory, but instead a continuation and intensification of male authority.

What did change, however, was the focus on the category of wet nurse. Seventeenth-century commentaries picked up on Hippocratic theories that dealt with the connections between breastmilk and child development and applied them to uniquely seventeenth-century circumstances. Newfound class-based fears and a desire to distinguish landed wealth from the lower orders played out in medical texts, particularly in birthing manuals with a focus on infant

\textsuperscript{244} Monica Green, \textit{Making Women’s Medicine Masculine}, 26.
\textsuperscript{245} Monica Green, \textit{Making Women’s Medicine Masculine}, 26.
care, were also adopted by moralist literature circulating at the same time. Although the themes of class and wealth are evident in texts of this nature in their descriptions of the ideal patient, it is unsurprising that the more explicit fears manifest in discussions of wet nursing. That is because this period was marked by the entrance of another party, of a wet nurse, whose milk and care had the capabilities to impact the long-term development of the infants they cared for. This element of childbearing was the most salient place for debates about class corruption. Class then was the category that made emotional management equally imperative as physical aspects of infant care.

Considering medical authors in light of moralist commentary unveils widespread beliefs about wet nurses and the women who hired them. Seventeenth-century moralist authors tended to lament that wealthy women’s refusal to breastfeed was a failure to set the proper example for the lower classes, and at the same time argued that it reflected a moral deficit. Specifically, they claimed that the reasons women chose not to nurse their children also meant that they were sinful in nature and more akin to what aristocratic author and moralist Elizabeth Clinton called “step-mothers” rather than “true mothers.”246 Much more than a sinful deed in need of correction, a mother’s refusal to nurse her children was a “sinne of the Higher,” a symptom of a sinful lifestyle and hinted at a personal moral failing. Women who did not nurse their children were also guilty of “unmotherly affection, idleness, desire to have liberty to gadd from home, pride, foolish fineness, lust, wantonnesse.”247 In an example of this pride, seventeenth-century poet and author Richard Brathwaite condemned the choice to hire a wet nurse because he felt that women “think this to bee either a disgrace to their place, or a blemish to their beauty.”248 In other words, wet nursing was the privilege of the wealthy and doing otherwise diminished their social standing. Unlike moralists who were seemingly unanimous in their loathing of the custom and fervent in attempts to convince readers of its many ills, medical authors were not universally opposed to wet nursing. Rather, they often viewed it as a necessary service that necessitated skill, but one that also required careful monitoring. Practitioners tended to make more frequent exceptions for aristocratic women which included maternal illness or an insufficient or contaminated milk supply. Early moderns widely agreed that successful breastfeeding required skill to avoid some of these pitfalls.

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Still, by all accounts, an infant’s mother’s breast was best and the failure to provide aristocratic children with aristocratic milk indicated a failure of a woman’s duty to bear children, which lasted long past labor and delivery. Instead, it included the mother’s role in nourishing her infant outside of the womb and raising a child with the right religious and educational foundations.249 Moralist clergyman William Gouge thought that mothers were much better suited for this work, which was demonstrated by their children who were supposedly “more cleanly, and neatly brought up, [and] freer from diseases.”250 Transgressing these guidelines and sending a child away to a nurse was “contrary to Gods order in nature.”251 All creatures, after all, breastfed their own offspring. More to the point, it sent children who would eventually inherit power and influence to women who were unqualified and capable, whether intentional or otherwise, of toppling the current status quo. Gouge particularly remarks that a mother’s early influence had sticking power and urged women to raise their children well, so they could in turn to well for the commonwealth.252

Medical authors, regardless of how impartial they appeared, argued that “the true Mother, though not the best Nurse, should ever be preferred before a Stranger.”253 While English physician Thomas Raynalde’s 1604 much-edited translation of The Birth of man-kinde, otherwise named the Woman’s Booke conceded that “the mothers milke is the most holesome for the child,” he also spent the bulk of his section on infant care on an outline of qualities to look for in a wet nurse and laying out her many duties.254 Compared to others like the French surgeon Jacques Guillemeau, his approach to the topic seems to suggest that wet nursing among the elite was inevitable and not entirely harmful for infants. Rather than morally based arguments about women’s sinful behaviors, Raynalde argued that the milk produced by the mother was more agreeable and nourishing for an infant, noting that it was the same blood they consumed in utero, only converted to milk.255

The idea of milk as digested and further refined blood was common enough, but breastmilk could have harmful consequences as well. For example, Guillemeau argued that

249 Clinton, The Countesse of Lincolnes, 6.
251 Clinton, The Countesse of Lincolnes Nurserie, 9.
252 Gouge, Of Domestival Duties, 560.
255 Rösslin, The Birth of Man-Kinde, 153.
measles and smallpox were caused by “the reliques of the impurer part of the bloud, wherewith
the child was nourished in his Mothers womb.”256 The more blood consumed via breastmilk and
in utero, the worse the case. These illnesses triggered by impurities present blood converted to
breastmilk reflected Hippocratic writings that stressed the importance of digestion. The process
by which the body converted blood to milk was generally thought to purify it. However, most
medical writers urged mothers to wait at least 24 hours, usually a few days, before nursing their
children. The colostrum that mothers produce in the hours following childbirth was thought to be
unpurified and therefore more difficult for infants to digest. Advice usually followed that
permitted temporary wet nursing or goat’s milk as supplement. Mauriceau was the notable
exception, arguing that there were no observable complications when mothers nursed
immediately after delivery. Whether aristocratic women followed this conventional wisdom is
unclear, though it is likely that the vast majority of women who did nurse their children breastfed
shortly after childbirth.

In contrast to Raynalde’s pragmatic approach, Jacques Guillemeau in his 1612 The
Happy Delieverie of Children, expressly attacked aristocratic women’s refusal to breastfeed and
gave readers a multifaceted argument that claimed that aristocratic women putting their children
out to nurse was akin to murder and risked unqualified supplements being put in their place.
These arguments then reveal concerns over the usurpation of power by the lower classes. Not
only did this aim to make mothers suspicious of their children’s caretakers, it warned that the
substitute child would be over a lower social class. Or, if a wet nurse was good at her work, the
bond between mother and child would be harmed by her absence. The infant’s love would
instead be for their wet nurse, while the mother’s heart would harden by distance. Guillemeau’s
wet nurse was a dangerous figure in another way, with her ability to infect a child with “some
bad conditions or inclinations” or “communicate some imperfection of her body into the
child.”257 The dialogue between Shakespeare’s Juliet, her mother, and her nurse likewise hint at
the bonds between Juliet and her nurse, while Lady Capulet feels distant and cold.

Other seventeenth-century medical authors wrote in defense of wet nursing, but even
then, class-based fears become evident. Nicholas Culpeper’s 1651 Directory for Midwives draws
reader’s attention to the debate as a whole, summarizing opposing views then dismissing them as

illogical and unfounded. Indeed, Culpeper’s section on wet nursing begins with exasperation, “OH! what a Racket do Authors make about this! What wharting and contradicting, not of others, but of themselves?”

Culpeper doubted the conventional wisdom which dictated that because infants inherited their mother’s temperament her milk was most suitable and scoffed at the claim that mothers who used wet nurses were beasts incapable of loving their children. His conclusions seem to be based on personal experience rather than medical understandings of the connections between the wet nurse and her charges. He admitted that his loss of many young children “caused [him] to fix [his] thoughts upon this business.”

His skepticism not only enabled women to choose a wet nurse, but to do so without too much fear of the influence this ‘second mother’ could have on her child. French surgeon Francois Mauriceau took a similar approach to the moral implications of wet nursing for ‘natural’ mothers. While Mauriceau agreed that the mother’s milk was always concocted best to suit the needs of her infant, he allowed without evident moral judgement that some women were unable or simply unwilling to nurse their children. Despite Mauriceau’s apparent concessions that seemed to allow for a benign wet nurse, descriptions of the ideal candidate highlight fears that were sometimes implicit or hidden beneath the surface.

**The Ideal Wet Nurse**

The selection of a good wet nurse was then vital for women who could not “give the Infant suck herselfe, either for because of sicknesse, or that her breasts be sore and her milke corrupted” and included both physical and emotional qualities. Raynalde’s description, like all practitioner’s, of the qualities of a good wet nurse reflected what Alexandra Shepard has described as a wholesome image of “female vitality.”

![Image](image-url)

She should have a good color and complexion, and be of average height and weight. How far out from childbirth mattered as well, and it too should be, “not too soone ne too long.” Preferably she would have had a male child, as milk concocted for a male infant was better made because, “the heate of the male childe doubling

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259 Nicholas Culpeper, *A Directory for Midwives*, 204.
the mothers heate." Many authors warned explicitly against women with red hair, who were thought to be of choleric disposition and whose milk could cause ulcers in infants mouths because of its acidity. All of these external signs were indicators of the quality of milk she produced, which were hard but important to decipher.

Just as imperative was a wet nurse’s emotional expression and countenance. Though relatively minimal in explicit criticisms towards mothers who used wet nurses, Mauriceau warned that a child “by means of the nourishment which it draweth from her; and in sucking her, it will draw in both the vices of her Body and Mind.” Not only would the experience of certain passions negatively alter the nurses milk, but they could also be passed to the infant to become a permanent part of their internal makeup. This meant that emotional regulation was critically important. Guillemeau warned that in addition to “good behaviour,” the management of passions like anger and fear was vital, as “there is nothing that sooner corrupts the bloud, of which the milke is made.” Raynalde recommended that she should not be hasty in words, overly sad, too fearful or too timid because “these affections and qualities be pernitious and hurtfull to the milke, corrupting it, and pass forth through the milke into the child, making the child of like condition.” Likewise, Mauriceau warned that a quarrelsome wet nurse was especially dangerous because “it may make bad impressions on the Child, as because this passion doth extraordinarily heat the Milk.” Mauriceau also warned against passions like melancholy, and instead urged women to choose a nurse whose disposition was “merry and cheerful, smiling often” to distract a distressed child. She should further “shun all disquietness of mind” and be “neyther vesing, nor grieving, nor too cholerick,” all of which could impact the quality of milk. Similarly, Culpeper found that Erysipelas (essentially a red rash or bump), was caused by a fright or by anger, while “sadness, fear and the like, may hinder blood from flowing to the Breasts.”

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266 Guillemeau, The Happy Delieverie of Women, 10.
267 Rösslin, The Birth of Man-Kinde, 153.
269 Mauriceau, The Diseases of Women, 436.
270 Guillemeau, The Happy Delieverie of Women, 10.
271 Culpeper, A Directory for Midwives, 219.
the inability to produce milk was a very serious problem with life-threatening consequences for suckling infants. Women’s failure, whether mother or wet nurse, to properly nourish their infants could be a personal failing of emotional self-control. The emotional causes attributed to the cause are, in addition to their Hippocratic roots, reflective of moral behaviors women were urged to exhibit elsewhere.

All authors warned against venery because they believed it would diminish milk supply or ruin it, but French surgeon Ambroise Paré added lust, which should be avoided because both “the milk that it sucketh will be worse and more depraved than otherwise would be.” Aristotle’s Masterpiece agreed, arguing that “above all that she be not too desirous of carnal copulation, by which means the Milk will be rendered unwholesome.” The use of “unwholesome” here had dual meaning, both suggesting immoral behavior contagion via breastmilk, as well as diminished nutrition. Without doubt, the qualities practitioners shunned in bad wet nurses were the same negative qualities for which moralists critiqued aristocratic mothers. The difference for these authors was that aristocratic mothers were supposedly better equipped to overcome these faults, in part because of the love they by nature felt towards their own children. These attachments were either characterized as impossible for wet nurses to achieve, or as the downfall of the family for those who could.

Less direct, but equally important, references to wealth and class were embedded in these works. For example, Culpeper urged wet nurses be located near “Pure and cleer Air” because it made for healthy bodies through the engendering of the animal spirit. According to Hippocratic-Galenic models, the movement of the animal spirit through the body caused what modern observers would call emotional expression. In this case, the quality of air mattered because good air could bring forth joy, trust, humanity, and mercy just as easily as bad air could “Fear, Sadness, Despair, Envy, Hatred, [and] Malice.” Hippocratic tradition dictated that “concepts of pollution and impurity” could explain the cause of disease or trigger an imbalance

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274 Aristotle’s Masterpiece, 164.
276 Culpeper, A Directory for Midwives, 210-1.
The discrepancies in quality of living standards between the wealthy and the poor in early modern England are well documented, suggesting that the targeted, if not explicitly stated, group to avoid was poor women. Paré similarly noted that a wet nurse should speak “distinctly and plainely, for she is the onely mistrisse to teach the childe to speake,” perhaps a reference to accent variations associated with classes and locales. Guillemeau likewise warned that children would learn to speak by listening to their nurses. While a child may be born of good parents, the “bad nurture of a wicked Nurse, will make the child vicious and wicked.” Though this seems like an attack on individual wet nurses, it assumed that only under very narrow circumstances would it be safe to hire a wet nurse. Guillemeau pointed out that “the Manners and conditions of the mind, do follow the temperament of the bodie, and the temperament ariseth out of the nourishment.” These supposed inferiorities were used as justifications for the argument that children were “better bred and fashioned by the Mother, than by the Nurse.”

The Emotional & Physical Labor of Childrearing

Practitioners and moralists were well aware of the exhaustive work of infant care and enumerated the numerous duties wet nurses were required to perform. Women’s labor combined the physical, like frequent changes of soiled clothes, rocking a child to sleep in their cradle, sleep training and of course breastfeeding itself with the emotional work of ensuring that she “present to his sight things that rejoyce him, and to remove what may affright, or grieve him.” Guillemeau urged women to learn their babies’ cries, and to meet their associated needs. His methods included playing, kissing, singing, and gently dancing in addition to ensuring a clean and dry bottom. Culpeper offered similar advice, wanting wet nurses to be “always playing and singing, she delights in the children, and therefore is the fittest Nurse for one.” Culpeper was

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284 Guillemeau, *The Happy Delieverie of Women,* 5.
the only author to suggest selecting a wet nurse who preferred the company of others and despised being alone. His suggestion here seems rather obvious: choose an individual who enjoyed being around children, because the labor of infant care was continuous and her temperament by both proximity and through breastmilk could impact the child’s development.

The management of an infant’s emotional well-being, especially regarding crying, by nurse or by mother had lasting physical consequences for infants. The emotional-physical connection between infant and nurse/mother through breastfeeding itself was also reinforced by the physical labor of caregiving this required. Culpeper’s advice on the basic care of newborns was to allow them frequent sleep and for them to be “carried in the arms often, and [to] give it the dug” on demand. Infant’s emotional regulation was equally important, allowing only small amounts of crying. Crying in the seventeenth century was understood as harmful to infant health and symptomatic of many ailments including gripe and worms. Guillemeau demanded that if a child were to “cry and weep,” the nurse shall “endeavour by all meanes to still him.” Paré noted that a certain kind of tumor grew in children that could “growth greater when it [the tumor] ariseth on children that are wayward and crying.” He explained that choler and anger could cause the same ailment in adult men, and only cured “[w]hen they have done crying, or ceased their anger.”

Later in the century, the author of Aristotle’s Masterpiece warned that if, immediately following birth, an infant had “extreme throws,” it must be treated with common foodstuffs administered in various fashions, like topical ointments or clysters. The risks then, of hiring a working-class wet nurse who was “forced to let the childe lie and crie” were very pressing for early modern commentators.

The processes of breastfeeding and childrearing required a mutually reinforcing management of emotional and bodily needs. The handling of infant emotional distress, especially fear and sadness, was central to infant’s overall health. Jane Sharp advised nursing women to avoid frightening a child because it risked causing them to fear sleeping alone. Guillemeau warned that being frightened or startled too intensely could cause epilepsy and the falling

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286 Culpeper, A Directory for Midwives, 229.
288 Parey, The Workes of that Famous Chirurgion, 905.
289 Parey, The Workes of that Famous Chirurgion, 906.
290 Aristotle’s Masterpiece, 161.
291 Gouge, Of Domestical Duties, 512.
sickness in some children. He likewise believed that bad dreams and night terrors in children were caused by overconsumption, causing harmful vapors to rise to the child’s brain as they slept. His cure was two-fold. First, to avoid certain meats and other harmful foods like peas and leeks that could produce destructive vapors and “sadde and Melancholike dreames.” The second, more heavily stressed approach was to “let the Nurse…embolden him: taking heed that they put him not in feare of anything, by shewing him any picture or beast, or other thing, which may breed any feare, or terror.” He also urged a more careful approach to handling bed-wetting which he felt was sometimes caused by unpleasant dreams, and disapproved of harsh punishments because of the fear it instilled in children. This could force children to hold their urination with even worse physiological (gangrene) and emotional (shame) consequences. Guillemeau’s language assumed that it was wet nurses rather than mothers who would perform this work, which also exposes the roots of his fear that the bonds of love, crafted by this labor, would be constructed between infant and nurse rather than infant and mother.

**Infant Illness & Breastmilk**

As workers hired to perform tasks vital to the development of infants born to aristocratic parents, wet nurses bodies were conceived of as open for inspection in ways that resembled bodily interrogations in criminal cases like infanticide. Many authors suggested a close inspection of her milk and breasts to check for signs of sickness, disease, or some other harmful corruption. Paré warned that a problem with breastmilk signaled a larger problem with a woman’s entire body, an idea that reflects chapter one’s argument that the womb was central to women’s whole-body health. To ensure quality, breastmilk should be inspected by all the senses. One should feel the nurse’s breasts to ensure that “the flesh bee solid and firme.” By sight good milk was a bright white, rather than black, red or blue. It should smell sweet and pleasant, “which is a testimony of a good temperament” and should taste “sugared, without any

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295 Guillemeau, 76.
acrimony or other strange taste.”#299 Most medical authors assumed this inspection should be performed as part of the selection process, though Culpeper found this unnecessary and urged examination only when there was evidence of illness in the child and even then, only by sight.#300 Guillemeau even suggested careful observation of the potential wet nurses infant when they were around 7 or 8 months old to look for signs of good health, which he believed would reflect the quality of milk the mother produced.#301

Likewise, wet nurses bodies were, at least in theory, under regulation in cases of infant illness, reflecting how the incorporeal and physical work of infant care could blur lines between the infant’s body and its nurse. Based on the perceived threat of infant illness, the invasiveness of interventions escalated. If a child seemed feeble, or unable to move Raynalde’s advice suggested no small amount of labor for their nurse. Raynalde would have the “nurse be comforted and strengthened with such things the which have virtue to heat and to dry.”#302 In case of fever, rather than treating the infant, it was “the Nurses part to eate and use such things the which coole and moysten.”#303 Similarly, the cause and cure for an infant who refused sleep was the quality of breastmilk.##304 For “hyckot” or the hiccups caused by a choler, grief, or anger, a wet nurses’ milk applied to the infants belly worked as a cure.##305 Even incidents as everyday as rashes and cradle cap were cause enough for a wet nurse to alter her diet, in this example to one that was cooling and drying.”#306

The restrictions on wet nurses’ bodies went beyond inspection and diet modifications and could include more invasive procedures like purging and bleeding when the infant suffered from illnesses like thrush.##307 Similarly, if a young toddler suffered from convulsions, it was thought to be less taxing on the infant to instead alter the makeup of the nurses’ milk through various interventions. Guillemeau’s solution was to have the nurse eat less, hoping for it would balance out her milk. If the child needed to be purged, Guillemeau also thought that “it will be fitter to

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#299 Mauriceau, The Diseases of Women with Child, 435.
#300 Culpeper, A Directory for Midwives, 207.
#301 Guillemeau, The Happy Delieverie of Women, 7.
#302 Rösslin, The Birth of Man-Kinde, 182.
#304 Rösslin, The Birth of Man-Kinde, 172-3.
#307 Mauriceau, The Diseases of Women with Child, 398.
give the Nurse a purgation than the child.”308 The same went for the cure for bedwetting.309 In the case of the French Pox in an infant or toddler, Guillemeau also recommended that the nurses’ blood be let, her diet monitored and recommended she consume a certain opiate that would turn her milk medicinal for her nursling.310

Emotional regulation was equally important and was performed not only by others, but by the wet nurse herself. Culpeper counselled wet nurses to avoid “Disquietness of the Mind” like anger, grief or frustration because these altered her facial expression to such a degree that if a woman saw her own reflection, “she would hire a Man to throw stones at it,” and could temporarily alter the quality of her milk.311 Jane Sharp warned that “great Anger” could cause what was probably mastitis in breastfeeding women.312 Similarly, “[s]trong passions of anger, or fear will cause chollerick and melancholy milk, which makes the child lean, that it cannot thrive.”313 In her work, Sharp then offered a long list of ailments these passions caused, suggesting that the infant’s life literally depended on the ability of its nurse to regulate their passions. This practice of treating and monitoring wet nurses to impact infant health suggests a connection between infant and caretaker that mirrored the mother-child connection envisioned in utero, where the food mothers consumed and the emotions they experienced were all thought to leave an impact on their growing child.

The Construction of Love & Loyalty

Throughout the seventeenth century, authors who aimed at convincing wealthy mothers to nurse their children often attempted to convince readers that the bonds of love and loyalty were constructed through the act of breastfeeding. Sending their children away to be nursed then risked severing these bonds and signified a failed performance of motherhood. The mechanisms that shaped the bond between infant and caretaker relied on widespread understandings of the mutually reinforcing connections between the mind and body. A nurse’s temperament was passed to her nurslings through the breastmilk they ingested. Their character traits were refined by how their nurse managed their emotional expression and how she met their physical needs.

309 Guillemeau, The Nursing of Children, 76
311 Culpeper, A Directory for Midwives, 211.
Commentators argued that it was the combination of the emotional and physical labor that infancy required that helped to establish these bonds. Their tendency to use the image of the wet nurse, defined by the breastmilk she provided, to mark the qualities of a ‘true’ mother underscores the importance in the connections between the mind and body to early modern the development of infants temperaments.

Though historians have suggested that it was predominately in the eighteenth century that social and medical commentary vilified wet nursing and wet nurses themselves, seventeenth-century predecessors frequently targeted the women who engaged in the practice. Wet nurses could be indifferent at best and nefarious at worst, and the mothers who hired them guilty of abandonment, murder, or both. Conversely, wet nurses could usurp the love due to ‘natural’ parents. In describing wealthy mothers who sent their children to wet nurses, Sharp suggested that “multitudes pretend weakness [inability to provide milk] when they have no cause for it, because they have not so much love for their own, as Dumb creatures have.” She indeed even questioned whether such a mother could “ever love it so well as she doth that proves the nurse to it as well as Mother.” Indeed, Guillemeau declared that breastfeeding created a reciprocal bond of love between mother and child that could be constructed in no other way, saying “natural affection…cannot bee so earnest, either from the Mother toward the child, or from the child toward the Mother; if shee have not nursed him and given him suck.” William Gouge argued in his popular Of Domestical Duties that the biblical commandment that mothers love their children referred especially to maternal breastfeeding, as “a meanes of preserving and increasing love.” When nursed by an affectionate and skillful wet nurse, the love a child should have developed for their mother was instead shifted to the wet nurse. Children put out to nurse tended to “love those nurses all the daies of their life.” That this relationship between nurse and nursling could form also suggests that the bonds between nurse, who provided nourishment as well as emotional and physical care, and infant the social constructions of love and loyalty were understood as stronger than biological ties.

317 Guillemeau, The Happy Delieverie of Women, Preface.
318 Gouge, Of Domestical Duties, 509.
319 Gouge, Of Domestical Duties, 512.
The physical work of infant care helped create the bonds of love between nurse, whether mother or hired worker, and infant. Gouge noted that the love a mother bore a child who she nursed herself surpassed that of others she did not.\textsuperscript{320} The concept of love forged through the consumption of breastmilk also reflected the same sentiments found in medical manuals, which argued that along with milk, infants also took in “some smacke of the affection and disposition of the mother: which maketh mothers to love such children best as they have given sucke unto.”\textsuperscript{321} And the feeling went both ways, with children who were suckled by their mothers preferring her above all others. Sharp clarified that “without doubt the child will be much alienated in his affections by sucking of strange Milk and that may be one great cause of Childrens proving so undutiful to their Parents.”\textsuperscript{322} In this construction, strange meant both that the milk came from an outside figure and that the milk foreign to the infant’s body, making it more difficult to digest. Not only then did mothers supposed love their children less by virtue of failing to breastfeed, the reciprocal love would be equally diminished in their offspring, resulting in disloyal and disobedient children.

Breastmilk then played an important role in the formation of family units, which many argued could be disruptive to biological parents. Distance, according to nonconformist commentator Henry Newcome, caused mother’s “warmth of love” to “[cool] by degrees,” until eventually “Foster-Children are more dear to their Nurses than their mothers.”\textsuperscript{323} Newcome’s concerns were not over love per se, but its use in protecting family ties and bloodlines. Those bonds were built in the rearing of children, where a mother may “in placing her Breast so conveniently for the embracing of her little Nursery, that she…receive fresh Endearments every Moment from those intimate Embraces.”\textsuperscript{324} The emotional and physical in this example work together to create the image of what authors call a “mothers love.” Without a nursing mother, their child can only receive but “half of that Love.”\textsuperscript{325} This love was not only created between infant and mother/nurse, but between others (siblings or unrelated children) who consumed the same milk.\textsuperscript{326} Ingesting breastmilk from the same woman forged a bond between siblings,
creating a more cohesive and loyal family unit important to aristocratic families. Newcome was explicit in the risks of wet nursing, urging mothers to “prevent all Opportunities of wronging their own Heir.”

Mothers who chose to hire a wet nurse were described as “Cruel to their infants,” and murders of their children. On the other hand, wet nurses were seen as a threat to aristocratic families by either siphoning off children’s love and loyalty or by harming the child under their care. Wet nurses were frequently described as “Negligent” and “Dirty” and Paré’s exact example of smallpox spreading from nurse to infant a century before was often reused to threaten that with the use of a wet nurse, the spread of disease was probable. At the same time that practitioners circulated the threats that children and their wet nurses would forge more powerful bonds than child and mother, Newcome and other moralists argued that wet nurses would do a poorer job than an inherently more patient, modest, loving, and watchful mother.

**Class Made Visible**

Every aspect of wet nursing in the seventeenth century was tinged with elements of class tension. Medical manuals were formally addressed to various audiences, but like with conception and pregnancy, the advice contained within was clearly aimed at a wealthy patient. That there are sections on guidance aimed at choosing a wet nurse and how to manage her rather than how one ought to best perform the work assumed a wealthy reader. Sharp even observed that it was the “usual way, for rich people” to “put forth their children to nurse,” though she felt that it was a “remedy that needs a remedy.”

Many of the concerns over wet nursing, both from practitioners and from moralists, reveal concerns over class mingling and that the lower orders would have a negative impact on the elite. Clinton’s 1622 *The Countesse of Lincolnes Nurserie* urged elite women to set a proper godly example for their social inferiors by nursing their own children. She noted with concern that the practice of wet nursing was spreading as wealthy merchant’s wives sought to hire out this labor. Clinton viewed these women as pretenders, as “lower ones” who paid for a service

their husbands could not afford and who linked the ability to pay for wet nursing as a status symbol that they too wanted to acquire. Whether these were really the motivations of those who Clinton described as inferior is unclear, but it does suggest that from her perspective, the ability to have a wet nurse was linked with status. Clinton linked this class dynamic to the costs paid by poor women as well, observing that hiring a wet nurse would require “a poorer woman to banish her owne infant, for the entertaining of a richer womans child…bidding her unlove her owne to love yours.” Clinton was referring to the necessity that a wet nurse to stop breastfeeding her own child earlier than suggested so that she could provide milk enough for the nursing she was paid for.

Authors were, at the core of their writings, concerned with who nursed the next generation of ruling elites. Many were troubled that these women were of a lower economic class. A later 1672 edition and much-altered printing of Culpeper’s Directory advised particularly against a wet nurse who was too poor, because “if she want, so must the Child.” This assumed that while wet nursing may have provided important income, it was not typically enough to change the station of those performing the work. It was, however, necessary for sustaining a household. Gouge points out that one objection to the discontinuation of the custom was that “poore women maintaine their house” through wet nursing wealthy women’s children. Gouge showed little sympathy for this protestation, dismissively suggesting that women should simply find other means of providing for their families. Even more revealing, Sharp proposed that some women who produced an overabundance of milk could be permitted to “suckle another for a friend…if they be poor, for it will help them with food, and not hurt their own child.” Sharps suggestion indicated a difference between working as a hire for a wealthy family and trading nursing services for food or other stuffs and it urges women to avoid allowing their children to be influenced by those of England’s lower orders. Sharp deemed class to same class milk-sharing appropriate, while discouraging the practice in other configurations.

More than simply innate intellectual inferiority, practitioners gave specific reasons to avoid wet nurses entirely. At a fundamental level, elite mothers were conceptualized as better

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equipped to monitor their emotions and more invested in the upbringing of their children. Neglect at the hands of a wet nurse was supposedly common, since lower class women often had to allow children to cry while they worked, having come from the lower echelons of society and therefore needing to perform more basic household duties as well. Clinton warned that the deceptive lies of wet nurses caused the death of at least one or two of her infants. Guillemeau argued that more nurses than not were “polluted and infected with the French Poxes, and other diseases.” These illnesses could be passed through milk to their nurslings, and then by proximity children could infect their parents.

Guillemeau ends his preface with what nearly all parents wish they had-a parenting hack and guarantee that if his advice was thoughtfully followed, “your children will be healthfull.” Part of these instructions were to choose a good wet nurse, if unable to rise to the task through true illness. In doing so, the first quality he names to look for is her birth and parentage, desiring wet nurses from “good stocke” without stain in “bodie or mind.” I contend that Guillemeau and others like him were revealing concerns over class contamination, against wet nurses who were unsuited because of their nature, their temperaments, their speech, and their living conditions to properly care for the children of the aristocracy.

**Conclusion**

Medical manuals and moral commentaries which addressed the topic of wet nursing illustrate the ways in which the connections of the mind and body worked through wet nurses and nursing mothers to impact the long-term temperament of the infants in their care. Practitioners and moralists argued that breastfeeding, especially when performed by hired outside help, needed to be monitored. The debate over the proper source of nutrition for infants was especially heated because all believed women’s comportment and emotional expression impacted the quality of breastmilk she produced and passed onto the child. Not only that, but practitioners often pinpointed breastmilk as the cause of and, in other cases, the cure for many infant illnesses. Practitioners’ descriptions of a wet nurses’ proper role and the standard of care she should provide for her nurslings served as the basis to highlight what could go wrong in the

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performance of motherhood and demonstrate the very different kinds of horrors when done right. These commentaries, although sometimes subtle, reveal concerns over the class from which these workers originated.

What mattered to commentators was not so much why women chose to not to breastfeed, but what they were denying their children. Put simply, fewer infants and children were thought to die in the care of their mothers than in the care of a wet nurse. Many of the poor children nursed by wet nurses hired by the community did tend to die young, but so did wealthy children. While some may be attributed to carelessness, it seems more likely that wet nurses were themselves often poor and could have taken on more children than she had milk.\textsuperscript{342} But it was more than the physical outcomes that commentators fretted over. For Brathwaite and others, it was “the milke of morality,” that a wet nurse was unlikely to offer, but that aristocratic mothers produced.\textsuperscript{343} Implied in these passages as well was that an avoidance of breastfeeding was accompanied by mother’s unwillingness to raise and tutor their children. Brathwaite described a mother’s duty in stages that lasted her lifetime, “the office of a Nurse in her childrens infancy, of a Guardian in their minority, of a Sage Counsellour in their maturity.”\textsuperscript{344} This, the successful nursing and raising of their children, rather than what were considered vain pursuits, was where women should find their glory.

\textsuperscript{342} Wiesner-Hanks, 92.
\textsuperscript{343} Brathwaite, \textit{The English Gentlewoman}, 108.
\textsuperscript{344} Brathwaite, \textit{The English Gentlewoman}, 108.
Epilogue

That the beliefs in the connections between the mind and the body weathered seventeenth-century turmoil that in many instances reconfigured the relationships between people and traditional forms of authority does not mean that childbirth practices remained unchanged throughout the period or that debates over these configurations failed to make an impact. Instead, the following two centuries witnessed the rise of man-midwifery in Europe and North America and the parallel increase in the popularity of breastfeeding among aristocratic women. These shifts did not suddenly occur, as some studies on the topic have suggested. Neither was it solely the result of a change in female culture and labor practices that broke up bonds between women that transcended social classes. Rather, the emergences of these seemingly different trends were far more connected than previous scholarship has allowed. Widely circulating seventeenth-century medical manuals were responsible for disseminating arguments about medical theory, the roles of practitioners and the evils of wet nursing, all of which asserted male authority in childbirth and all of which were instrumental in laying the ground work to eighteenth- and nineteenth-century shifts in the gender dynamics of childbirth and childrearing. At least as early as the seventeenth century, there were unsteady and contested shifts, but shifts nonetheless, which saw an increased presence of male practitioners in childbirth and increased value and volume in male-produced knowledge concerning women’s reproductive bodies in general and childbirth in particular.

Assumptions that lie at the heart of narratives asserting an abrupt presence of man-midwives also tend to characterize childbirth in the medieval and early modern world as an exclusively female affair, which is just as misleading as accounts that depict a strict gender divide in practitioner/patient constructions in other aspects of healing. Male practitioners have always been involved and interested in childbirth in some manner, just as women have always treated men for various ailments. Seventeenth-century manuals suggest that, especially in France, more and more male specialists were attending typical births that midwives had traditionally directed. The aristocracy, and royalty in particular, were the first to hire men rather

than women to attend the birth of their children. The ultimate sign of status, elite families eventually viewed men as better qualified and more skillful at assisting women in childbirth. Fears of indecency, that male sight of the female body would cause unspeakable harm to birthing women, diminished with belief in man-midwives or accoucheurs abilities to produce better outcomes for childbearing women and their infants. I suggest that the authority and clout which male practitioners eventually garnered was in part thanks to the flood of birthing manuals and medical treatises printed in the preceding century. In these works, male practitioners not only categorized the many supposed failings of midwives, but enumerated stories of their own successes often in response to a midwife’s mistakes.

To be sure though, the majority of women in the seventeenth and well into the eighteenth century labored with a midwife attending. Still, eventually male-dominated obstetrics took hold, along with the foundation of lying-in hospitals, sometimes referred to as “gateways of death” because of the rapid spread of disease they saw. My contention is that, in addition to the cropping of these sorts of institutions, the venom with which midwifery and wet nursing were attacked, combined with the new widespread availability of English language medical texts made the position of man-midwife seem logical and nursing children as the proper choice for aristocratic mothers. Despite his popularity, Nicholas Culpeper’s complaints against London’s Royal College of Physicians, that “They mistook PRIVATE, for PUBLICK Good; and that’s the bane of a Common-wealth, and the only way to make you and yours, first Fools, secondly Slaves” seemed outmatched, while his defense of wet nursing disappeared from following editions.

Wet nursing in the eighteenth and nineteenth centuries diminished dramatically, and England’s landed classes took up the ideal of breastfeeding as a signifier of true motherhood. In the West, the practice has all but disappeared. Certainly, some of this is due to the fact that infants, at least in the medieval period, did seem to die more frequently in the care of a wet nurse and the eighteenth-century characterization of wet nurses as “angel-killers,” though it is difficult to tell if the numbers were indeed higher. Just why this happened remains unclear, though it is doubtful that wet nurses murdered their charges in attempts to place their own children in

wealthy homes. Another piece to this puzzle lies in constant medical denunciations that were reinforced by moralist literature concerned with breastfeeding.

Despite these changes and challenges, one element that did not disappear was belief that the experience of strong emotions directly impacted physical health. Ultimately, the dominance of Cartesian divides between the mind and body and medical discoveries that focused on physical phenomena diminished the prominence of the emotional in institutionalized medical care in the west. Yet early modern beliefs in the mind-body connection have not left us entirely. In a 2017 interview with Australia’s Studio 10 actress Fran Drescher, famous for her iconic role in the CBS sitcom The Nanny, discussed the impact of the emotional trauma of a decades’ old brutal rape on her physical health. She explained that even though she had achieved success in her career, she remained unhappy saying, "I really didn't deal with my pain for many, many, many years - with the rape. So, when you don't do that... I mean, I ended up with a cancer."351 The suppressed pain Drescher referred to was emotional not physical, and she conceptualized this negative emotional stress as being transformed into a form of gynecologic cancer. Perhaps even more illustrative of the longevity of these beliefs is the oft repeated testimony of Maria Elena Holly, the widow of the tragic musician Buddy Holly. When Holly died suddenly in a plane crash in February 1959, a pregnant Maria Elena blamed her miscarriage a few days later on receiving the news abruptly and unceremoniously.352 Much like Anne Boleyn’s claims in 1534, it was emotional trauma and insensitive delivery that triggered a miscarriage. Modern testimonies to the mind-body connection like Dresher’s are so ubiquitous that they often pass by unnoticed. The idea that the mind exercises power over physical health is obviously nothing new, not part of a passing fad. Rather, our modern mind-body talk is a surviving trace of medical beliefs that dominated early modern European thought on health and illness.

For Guillemeau, Mauriceau and others who tackled the task of writing about pregnancy and childbearing, the boundaries between the emotional and the corporeal were poorly defined, and yet vital to understanding health and wellness for both women with child and their infants. Although some scholars argue that this corpus had fallen out of favor by the nineteenth century, and while it no longer held the same authoritative weight, its remnants still influence the way we

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understand and discuss health and illness today. This lasting influence is in part thanks to the theory’s “great explanatory power” capable of “almost infinite variation.” Despite the more than 500-year span between the publication of the first birthing manual examined here and our own day, the idea that strong emotional responses have the potential wreak havoc on the body remains embedded in our nomenclature and medical practices.

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