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Conceiving Monsters: Women, Knowledge, and Anomalous Births in the Nineteenth-Century United States

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SUMMARY: This essay examines historical case literature on "monstrous births," revealing how childbearing women both participated in and were excluded from processes of medical knowledge-making. In the nineteenth-century United States, physicians studied newborns with major anatomical differences as "medical specimens of monstrosity," asserting a singular authority over knowledge of bodies and reproduction. However, this essay shows that in practice medical knowledge-making entailed an interactive, socially embedded process that intimately engaged laywomen's perceptions, ideas, and understanding. By narrating and interpreting their lived experiences of pregnancy, women participated in determining the causes and meanings of anomalous births—even as hierarchies of gender, race, class, and citizenship conditioned and constrained this participation. Through an imaginative reading of case reports, this essay foregrounds the significance of diverse laywomen's social, affective, and embodied lives in historical practices of medical meaning-making. At the same time, it offers insight into how predominantly white male medical professionals increasingly sought to establish authority over women's reproduction.

KEYWORDS: childbirth, monstrosity, United States, nineteenth century, knowledge-making, women, patients

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The pregnancy, as the woman would later recall it, was a strange one. It would be impossible, of course, to untangle her memories of this period—recorded only in retrospect—from her knowledge of its "monstrous" culmination. But, as transcribed by prominent Boston physician Charles Hildreth in an 1834 case report, the woman's sense of unease began long before the night of her disquieting delivery.[1]

Though Hildreth attributed to her a "delicate frame" and a "very excitable temperament," the woman's prior experience with pregnancy and childbearing gave her reason for nothing but confidence. She had two sons, two and four years old at the time of this third pregnancy, both "stout" and in good health.[2] She had never experienced an infant death, a stillbirth, or, to her knowledge, a miscarriage—a notable circumstance for a married thirty-five-year-old woman in early nineteenth-century New England. She and her family were longtime private patients of Hildreth, suggesting, along with other details of the case history, that they belonged to a social class in Boston of affluent, white, Anglo-American Protestants. She could expect to receive attentive care from her doctor and his assistants as well as from a robust cadre of relatives, friends, neighbors, and attendants.[3] Yet this third pregnancy had been marked by unsettling sensations and incidents that filled her with a nebulous sense of foreboding—a vague but insistent fear that the child would be an unhealthy one, fated to "die young."[4] These memories

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[1] Charles T. Hildreth, *Case of Notencephale* (Boston: Published for the Author, 1834).
[2] Ibid., 4.
[3] Ibid., 4–8.
[4] Ibid., 5.

now seemed to assume a certain premonitory significance, presaging the birth and death of the infant that Hildreth would go on to classify as a remarkable "case of monstrosity."[5]

Nineteenth-century practitioners employed the now-jarring term "monstrosity" to formally describe and classify infants born with major, and usually terminal, congenital conditions like anencephaly. American physicians like Hildreth drew on the transatlantic field of teratology, defined in 1832 as "the modern scientific study of monsters," to transform newborn bodies into medical specimens of monstrosity. They presented these specimens to professional societies, added them to the collections of medical museums and universities, and published on them in the burgeoning American medical press. For Hildreth and other elite practitioners, a group composed overwhelmingly of white Anglo-American men in this period, the "scientific mastery" of monstrosity underscored the rising authority of modern medicine.[6] In published rhetoric, they portrayed themselves as singular producers and authorizers of knowledge about bodies, reproduction, and human variation: men of science who calmly dispelled the ignorance of the laity, transforming a portent of "gravest fears" into a specimen for an anatomy professor "to imprison in one of his immortalizing jars of alcohol."[7]

However, a careful reading of the nineteenth-century medical literature on monstrous births exposes a dynamic negotiation of knowledge-making that was at once more collaborative

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[5] Ibid., 16.
[6] Miriam Rich, "Monstrosity in Medical Science: Race-Making and Teratology in the Nineteenth-Century United States," *Isis* 114, no. 3 (2023): 513–36.
[7] Oliver Wendell Holmes, *Medical Essays, 1842–1882* (Boston: Houghton, Mifflin, 1891), 279–80.

and more contested than these self-fashioned images of singular scientific authority would suggest. This reading brings childbearing women to the fore of this history, revealing their multifaceted involvement in processes of medical meaning-making—even as it also shows how the terms of this involvement were conditioned by hierarchies of gender, race, class, citizenship, and other social relations of power.

This article engages long-standing efforts by social, cultural, and feminist historians of medicine to examine the experiences of historical patients and laypeople.[8] While calls to center lay and patient perspective in the field date back to at least the late 1970s, scholars today continue to navigate the formidable methodological and epistemological challenges of this project, particularly in areas where marginalized groups were prevented from directly recording their experiences. Present-day historians of medicine emphasize the need for imaginative and interdisciplinary methods of interpretation, including creative approaches developed by historians of slavery and historians of emotion, to provide deeper insight into marginalized subjects' social and affective experiences of health, illness, and embodiment.[9]

This essay attends to and elaborates childbearing women's constricted presence in the case literature in order to reveal how they both participated in and were excluded from practices

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[8] Susan Reverby and David Rosner, "Beyond 'the Great Doctors,'" in *Health Care in America: Essays in Social History* (Philadelphia: Temple University Press, 1979); Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory Soc.* 14, no. 2 (1985): 175–98.

[9] Carolyn Roberts, "Pharmaceutical Captivity, Epistemological Rupture, and the Business Archive of the British Slave Trade," *Bus. Hist. Rev.* 97, no. 2 (2023): 283–305; Courtney Thompson, "Finding Deborah: Centering Patients and Placing Emotion in the History of Disease," *Isis* 111, no. 4 (2020): 826–29.

of medical meaning-making. It begins by renarrating two medical case reports from the 1830s, imaginatively reconstructed to center the experiences of each childbearing woman: one, a wealthy Anglo-American woman in Boston, Massachusetts; the other, an enslaved Black woman near Savannah, Georgia. It then analyzes the broader roles and involvement of nineteenth-century women in the medical investigation of monstrosity, showing how women produced knowledge about the causes and meanings of anomalous birth within gendered and racialized social imaginaries. This period's widely shared framework of "maternal impression" attributed anomalous births to mothers' experiences or emotions during pregnancy, establishing the relevance of women's subjective sensations, observations, and ideas to the medical study of monstrosity. By sharing their narratives of pregnancy, women participated not only in determining the proximate causes of anomalous birth but also in configuring and conveying the broader meanings of monstrous difference. Recurrent narrative themes and motifs variously situated the genesis of monstrosity in troubled contacts between humans and animals, in encounters with racial alterity, and in the upheavals of industrializing urban life in the mid-nineteenth-century United States. Distinctions of race, class, region, and familial status conditioned, but did not foreclose, this involvement in medical meaning-making.

Yet even as some women used the theory of maternal impression to derive sense and meaning from an otherwise inexplicable experience, the framework could also be mobilized to deploy blame and assert medical authority over pregnant women's bodies and behavior. The essay concludes by considering how late nineteenth-century trends, including the increasing

ascription of birth anomaly to a mother's constitutional or hereditary pathology, further constrained childbearing women's participation in processes of medical knowledge production.

In centering the experiences of childbearing women in U.S. history, this essay builds on foundational work by Judith Walzer Leavitt on the social history of childbirth, Leslie Reagan on the history of pregnancy and disability, and Deirdre Cooper Owens on formations of race and gender in the history of reproductive medicine.[10] It joins a profusion of recent scholarship that foregrounds the social and political significance of women's lived reproductive experiences in the history of the Americas.[11] The essay's methodological approach draws on a rich tradition of reading historical medical texts "against the grain" by feminist historians, who mine physician-authored sources for unintended insights into patients' experiences as well as broader structures

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[10] Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950*, 30th anniv. ed. (Oxford: Oxford University Press, 2016); Leslie Reagan, *Dangerous Pregnancies: Mothers, Disabilities, and Abortion in Modern America* (Berkeley: University of California Press, 2010); Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2017).

[11] See, e.g., Elizabeth O'Brien, *Surgery and Salvation: The Roots of Reproductive Injustice in Mexico, 1770–1940* (Chapel Hill: University of North Carolina Press, 2023); Jennifer Morgan, *Reckoning with Slavery: Gender, Kinship, and Capitalism in the Early Black Atlantic* (Durham, N.C.: Duke University Press, 2021); Cassia Roth, *A Miscarriage of Justice: Women's Reproductive Lives and the Law in Early Twentieth-Century Brazil* (Stanford, Calif.: Stanford University Press, 2020); Wangui Muigai, "'Something Wasn't Clean': Black Midwifery, Birth, and Postwar Medical Education in All My Babies," *Bull. Hist. Med.* 93, no. 1 (2019): 82–113; Brianna Theobald, *Reproduction on the Reservation: Pregnancy, Childbirth, and Colonialism in the Long Twentieth Century* (Chapel Hill: University of North Carolina Press, 2019); Nora Doyle, *Maternal Bodies: Redefining Motherhood in Early America* (Chapel Hill: University of North Carolina Press, 2018).

of social inequity.[12] It is also informed by methods developed by scholars of Atlantic World slavery to address archival silences and exclusions, including Marisa Fuentes's method of "reading along the bias grain."[13] Fuentes enjoins historians to search for and "stretch archival fragments," accentuating and expanding the "spectral" presence of those denied more explicit representation in archival records while still "retaining the historical integrity of the documents."[14]

By closely reading nineteenth-century case reports to locate and interpretively expand on fragmentary details about childbearing women's experiences, this essay situates the significance of diverse laywomen's social, affective, and embodied lives in historical processes of medical meaning-making. At the same time, it offers insight into how predominantly white male practitioners increasingly sought to assert and consolidate authority over women's reproductive bodies in the nineteenth-century United States. The essay highlights "medical meaning-making" as a densely interpersonal process that ineluctably engaged the knowledge, insights, and lived experiences of these women, even as they were formally marginalized within emerging institutions of professional medicine.

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[12] Barbara Duden, *The Woman Beneath the Skin* (Cambridge, Mass.: Harvard University Press, 1991); Laura Briggs, "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology," *Amer. Q.* 52, no. 2 (2000): 246–73.
[13] Marisa Fuentes, *Dispossessed Lives: Enslaved Women, Violence, and the Archive* (Philadelphia: University of Pennsylvania Press, 2016).
[14] Ibid., 7, 78.

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Two Vignettes of Birth

The details of the unnamed woman's life, as presented in Hildreth's 1834 report, are patchy and unavoidably filtered through the physician's authorship. Yet, read carefully and imaginatively, her transcribed recollections of pregnancy offer a glimpse into an embodied world structured by manifold relations of care and affective ties. Throughout her pregnancy, the woman tended to an ailing elderly relative confined to an upper-level room of the house; against the strenuous objections of her friends, she often brought her youngest son with her on these visits, balancing the robust two-year-old child on her growing belly as she climbed up and down the stairs. Then, several months before her delivery, she and her husband were riding back to town when their horse startled and began to race away with them. Though they managed to halt and soothe the agitated animal, she remembered experiencing a brief but marked surge of fear.[15]

Hildreth's interest in recording the woman's narration of this incident stemmed from a widespread belief in "maternal impression": the concept that a woman's feelings, perceptions, and experiences during pregnancy could physically imprint themselves on her developing offspring.[16] In this case, the woman did not give any indication that she assigned causality, in retrospect, to a particular prenatal event. But her experience of this period had clearly been an uneasy one, haunted by discomforts and a recurrent feeling of dread. At no point, she said, did

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[15] Hildreth, *Case of Notencephale* (n. 1), 4.
[16] Sarah Richardson, *The Maternal Imprint: The Contested Science of Maternal-Fetal Effects* (Chicago: University of Chicago Press, 2021), 34–39; Marie Hélène Huet, *Monstrous Imagination* (Cambridge, Mass.: Harvard University Press, 1993).

she explicitly suspect a "malformation"; yet she did describe a despondent premonition that the child would be born "puny" and "delicate in health," destined to "soon die."[17]

The quality of the fetal movement concerned her the most. There was a delay in feeling the first "decided motion" inside her womb; by her attentive calculations, this moment of quickening came fully five months into the pregnancy, later than she was expecting. She felt some anxiousness at this, which soon turned to alarm at "the infrequency and imperfection, or rather singularity of the child's motions." She felt them only once or twice a week, and the internal sensation was odd and unsettling: in stark contrast to the sensation of her previous children's "rigorous movements in utero," this one seemed "more as if it fell, or impinged on some intervening substance between the child and the uterus, than as if it moved its limbs or body." Palpated from the outside, something likewise felt amiss: her distended belly was tense and uniformly rigid under her hand, with no suggestive gradations "either of surface or solidity" to suggest the shape of the fetus within.[18]

Toward the end of the seventh month, her uneasy experience intensified into acute misery. Her belly swelled to nearly double in size quite suddenly, overwhelming her with discomfort and pain. After rising one night in this state to attend to her youngest child, who had taken ill, she described "a very remarkable subsidence" of the mass in her womb; she told Hildreth that she "felt the child fall."[19] This sudden descent was marked by wracking spasms of

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[17] Hildreth, *Case of Notencephale* (n. 1), 5, 4.
[18] Ibid., 5.
[19] Ibid., 5.

pain that coursed through her left hip, suffusing the tense joining where her hipbone linked to the base of her spine, and persisting in acute form for nearly a week. She received a variety of medical treatments intended to relax her spasmed state, mainly by effecting the release of bodily fluids: bloodletting, blistering, laxatives, and enemas.[20] Nineteenth-century patients did often find subjective relief from such measures; for both patients and practitioners, they made sense in the context of a shared cosmology of health that centered flow and equilibrium, conceptualizing healing as a restoration of the body's balance of fluid exchange with its environment.[21]

In this case, however, comfort was elusive: the woman remained tense and wracked with nausea, her flesh tender to the touch, her pulse racing. Eventually the intensity of her discomfort diminished but did not resolve. Two weeks before the delivery, she finally got some respite in the form of a tremendous discharge of water, which ran "in a broad stream across the floor from her chair," overflowing the floor "to the amount of half a pailful" and leaving her clothes "completely drenched." She experienced an enormous feeling of relief after this immense release of fluid, grateful to be "relieved from the load which had oppressed her." This left her feeling "more light and comfortable than for a long time before," and for the first time in a while she was "rather disposed to be cheerful." The fetal motion remained weak and infrequent but could

[20] Ibid., 5–6.
[21] Charles E. Rosenberg, "The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America," *Perspect. Biol. Med.* 20, no. 4 (1977): 485–506.

still be felt every day or two leading up to the birth.[22] The labor began in the dead of night; two female friends came immediately to attend her, and Hildreth was summoned from a mile away.[23]

Calling a male physician to a birthing room in early nineteenth-century America was unusual, but certainly not unheard of. Across the course of the nineteenth century, the United States underwent a massive transition in customary practices of childbirth, from an earlier model of "social childbirth"—typically a home event attended by female relatives, friends, neighbors, and lay midwives—to one increasingly conceptualized and administered in medical terms. While most nineteenth-century women continued to give birth in homes rather than hospitals, it became more and more common for them to employ professional male physicians as attendants, often in addition to rather than instead of female midwives, relations, and friends.[24] In the early nineteenth century, those who employed physicians were most often wealthy Anglo-American women in the densely populated cities of the northeast, who paid men like Hildreth to attend them in their own homes.[25] Nineteenth-century physicians claimed that upper-class white women were in special need of medical aid to make it through the ordeals of childbirth, amplifying a

[22] Hildreth, *Case of Notencephale* (n. 1), 6.
[23] Ibid., 7.
[24] Leavitt, *Brought to Bed* (n. 10), 36–141; Charlotte Borst, *Catching Babies: The Professionalization of Childbirth, 1870–1920* (Cambridge, Mass.: Harvard University Press, 1995), 117–60.
[25] Leavitt, *Brought to Bed* (n. 10), 8, 36–50.

pervasive nineteenth-century theory that the "excesses and artifices of civilization" rendered these women fragile, nervous, and overly sensitive to pain.[26]

Later, the woman described to Hildreth "the conscious happiness she experienced on the birth of the child": she perceived a "sensation at that moment as if it were moving its arms and body in endeavoring to crawl," and rejoiced to know her child was alive.[27] But this happiness was bitterly short-lived. The child was born "en caul," still encased in the amniotic membranes, and seemed to have suffocated by the time Hildreth arrived some half an hour after the birth. Hildreth thought there might still be a chance of resuscitation; however, upon clearly viewing the infant for the first time, he summarily abandoned this idea.[28]

Drawing on the recently established field of teratology, Hildreth diagnosed a "case of *notencephale*": a major anomaly of head development, in which the cranial vault remains open and the brain forms outside the fetal skull.[29] After "discovering the monstrosity" and subsequently discarding their plans to "attempt the inflation of the lungs," Hildreth and his assistants turned their attention to extracting the placenta through manual techniques and the

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[26] Miriam Rich, "The Curse of Civilised Woman: Race, Gender and the Pain of Childbirth in Nineteenth-Century American Medicine," *Gender Hist.* 28 (2016): 57–76, quotation on 70; Briggs, "Race of Hysteria" (n. 12), 246–73.
[27] Hildreth, *Case of Notencephale* (n. 1), 16.
[28] Ibid., 7.
[29] Ibid., 12.

administration of ergot.[30] They attended the woman for two weeks after the birth, at one point providing ample opium to relieve a migraine-like headache, before she was "discharged cured."[31]

A commissioned medical illustration suggests that, at some point, the newborn's body was cleaned and nestled on a pile of bedding. Soon after, Hildreth removed the body for dissection, enlisting the aid of eminent colleagues including John Barnard Swett Jackson, later dean of Harvard Medical School, and Walter Channing, Harvard's first professor of obstetrics and a founder of the Boston Lying-In Hospital. The physicians transformed the body into a "dry" skeletal specimen as well as several "wet" specimens of organs suspended in preservative fluid, which they added to the "Monstrosities Division" of the anatomical collections of the Boston Society for Medical Improvement, a nineteenth-century professional association of elite physicians.[32] Hildreth went on to document the case in an extended published report, accompanied by a colored drawing, a lithograph, and several commissioned engravings depicting the infant. A leading Boston medical journal reprinted Hildreth's report, and the case was cited in the second volume of French scientist Isidore Geoffroy Saint-Hilaire's seminal treatise on teratology.[33]

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[30] Ibid., 7.
[31] Ibid., 8.
[32] J. B. S. Jackson, *A Descriptive Catalogue of the Monstrosities in the Cabinet of the Boston Society for Medical Improvement* (Boston: Freeman and Bolles, 1847), 27–30, accessions 05785, 05786, and 05787 (nonextant), Historical Collections of the Warren Anatomical Museum, Harvard Medical School, Boston.
[33] Isidore Geoffroy Saint-Hilaire, *Générale et Particulière des Anomalies, ou, Traité de Tératologie* II (Paris: J-B Baillière, 1836), 313.

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Many of the "monstrous specimens" produced and circulated through nineteenth-century medical practices were birthed by women like Hildreth's patient. The contingent history of U.S. physicians' involvement in childbearing tended to facilitate collection of infant bodies birthed by white, Protestant, U.S.-born women, who were far likelier in the nineteenth century to be attended by professional physicians during childbearing. However, systems of racial violence and economic inequity also directly shaped the contours of collection. In addition to attending the births of wealthy private patients, nineteenth-century physicians also sometimes interacted with childbearing women in much more vulnerable social positions, including enslaved, immigrant, and impoverished women. These women were exploited as sources of clinical training experience and "experimental 'material'" in the expansion of obstetrics and, later, gynecology as fields of professional American medicine.[34] In populous cities, women who did not have the social and material resources to give birth at home—often impoverished and unmarried women, or immigrants without local family ties—might give birth in maternity wards, dispensaries, and "lying-in hospitals" designed to serve the poor and friendless.[35] In the antebellum South, physicians also encountered and exercised authority over childbearing women within the institution of racial slavery—as occurred in another account of "monstrous" birth published in the medical press just a few years after Hildreth's.[36]

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[34] Briggs, "Race of Hysteria" (n. 12), 246–73; Owens, *Medical Bondage* (n. 10).
[35] Leavitt, *Brought to Bed* (n. 10), 64–86.
[36] Marie Jenkins Schwartz, *Birthing a Slave: Motherhood and Medicine in the Antebellum South* (Cambridge, Mass.: Harvard University Press, 2010).

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Details of this case report indicate that the woman, who gave birth near Savannah, Georgia, in 1837, was an enslaved Black laborer. Aged around thirty, she had given birth eight times before—never, it was reported, with any significant trouble. Initially, this time seemed no different. The pregnancy had been "nothing peculiar." Indeed, the woman had felt her child move "sensibly" inside the womb up until the birth. Labor began early, in the eighth month; however, she recalled that two of her other children had also been born before full term, and at first nothing seemed awry with the delivery. The attendants noticed a greater quantity of amniotic fluid than expected, but "nothing to lead to a suspicion of anything unusual"—that is, until the stillborn infant was "fairly exposed to the light."[37] To someone familiar with the condition, the newborn showed a classical presentation of anencephaly: the prominent round eyes atop the upturned face; the steeply angled head, sloping down past the absent portions of the infant's brain; and the open lesion at the back of the skull, where the scalp had never formed or closed.[38]

In stark contrast to Hildreth's upper-class Anglo-American patient, whose matronly "respectability" was emphasized against any judgments that might arise from the appearance of her offspring, the birth of this child immediately raised suspicions. Were the missing skull and scalp evidence of violent mutilation? Was the open lesion at the back of the head an inflicted wound? Eventually, unspecified birth attendants summoned local physicians Alexander Nicoll and Richard Arnold to render a professional medical judgment on "whether violence had been

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[37] Alexander Nicoll and Richard Arnold, "Account of an Anencephalus, or Human Monstrosity without a Brain and Spinal Marrow," *South. Med. Surg. J.* 2, no. 1 (1837): 10–18, quotation on 18.
[38] Ibid., 12–13.

used or not, which in consequence of the singular appearance [the child] presented, was supposed by those who attended at the delivery."[39] An incident rendered as personal tragedy in the case of Hildreth's patient was readily interpreted here as grounds for probable wrongdoing. Nicoll and Arnold encountered the mother not as patient to be treated, but as a potential criminal to be investigated—evocative of the classed and racial divisions that structured physicians' relationship to childbearing women in the nineteenth-century United States more broadly.

This woman's disparate treatment was contextualized most immediately by the imperatives of racial slavery, an institution sustained by the violent requisition of Black women's reproductive labor for white men's financial gain. Within the brutal racial, gendered, and capitalist logics of this system, an enslaved woman's failure to produce a healthy child constituted a direct affront to the enslaver who claimed her as property, preventing him from "realizing a profit on the birth" by increasing the amount of capital he owned.[40] Further, the moral tenability of chattel slavery rested on the vicious fiction that enslaved parents birthed and reared offspring without forming bonds of kinship with them—the forced reproduction of what Hortense Spillers terms "kinlessness."[41] In addition to their dependence on Black women's childbearing and the negation of Black kinship bonds, white plantation authorities were eager to

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[39] Ibid., 10.
[40] Deborah Gray White, *Ar'n't I a Woman? Female Slaves in the Plantation South* (New York: Norton, 1999), 86; Jennifer Morgan, *Laboring Women: Reproduction and Gender in New World Slavery* (Philadelphia: University of Pennsylvania Press, 2004); Sasha Turner, *Contested Bodies: Pregnancy, Childrearing, and Slavery in Jamaica* (Philadelphia: University of Pennsylvania Press, 2017).
[41] Hortense J. Spillers, "Mama's Baby, Papa's Maybe: An American Grammar Book," *Diacritics* 17, no. 2 (1987): 65–81, quotation on 74.

displace blame for high infant mortality rates onto enslaved mothers rather than themselves.[42] In cases of infant death, then, they were quick to accuse Black mothers of guilt.

In this instance, the accusations were dismissed after the summoned physicians recognized the striking visual signs of anencephaly. Nicoll and Arnold concluded that "no violence had been used to destroy the child, but that it was a monster of an interesting character."[43] They asserted that "the history of the mother affords no clue" to the origin of the monstrosity, deeming her not salient to the field of inquiry—a stark departure from the comparatively extensive details of prenatal experiences, emotions, and internal sensations documented in Hildreth's report.[44] This may have reflected Nicoll and Arnold's disinterest in or inability to contemplate the subjective experiences and complex interior world of an enslaved Black woman, consistent with a pervasive nineteenth-century discourse that cast racially marginalized bodies as "insensate" and unfeeling, lacking refined capacities to process and be affected by emotional and sensory impressions.[45] It also seems likely that the woman's position of extreme vulnerability throughout this encounter, and her awareness of the explicit power these white physicians held over her life, left her distinctly disinclined to share intimate information about her embodied, social, and affective worlds in the kind of granular detail that Hildreth's patient provided. Beyond noting that the woman was cleared of the suspected infanticide, the

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[42] White, *Ar'n't I a Woman?* (n. 40), 86–90.
[43] Nicoll and Arnold, "Account of an Anencephalus" (n. 37), 10.
[44] Ibid., 18.
[45] Kyla Schuller, *The Biopolitics of Feeling: Race, Sex, and Science in the Nineteenth Century* (Durham, N.C.: Duke University Press, 2018), 8, 10–15.

physicians recorded no further details about her health, experience, or life following the delivery. After dissecting the infant's body and presenting their findings to a professional association, they published a case report in the *Southern Medical and Surgical Journal*, later reprinted in the *American Journal of the Medical Sciences* and the British medical journal the *Lancet*.[46]

From one perspective, these two birth stories constitute similar cases in the history of nineteenth-century medical practice: each concluded with a formal diagnosis of teratological monstrosity, anatomical dissection and presentation, and publications in a national (and international) medical press. Yet as these contrasting narratives show, diverse social contexts deeply informed and distinguished women's lived experiences of monstrous birth. These contexts—related to gender, race, region, kinship configurations, economic systems, and legal subjecthood—differentially shaped the care each woman received, her relationship to the physician, and the way she was located more broadly in relation to the developing field of reproductive medicine. Such contexts also conditioned the terms of women's involvement in the formal narration and interpretation of their experiences. This constrained and obscured, but never fully eliminated, women's participation in medical knowledge-making surrounding monstrosity.

[46] Alexander Nicoll and Richard Arnold, "Account of an Anencephalus, or Human Monstrosity," *Amer. J. Med. Sci.* 22, no. 43 (1838): 253–57; Nicoll and Arnold, "Account of a Human Monstrosity," *Lancet* 29 (1837): 202–4.

Women's Knowledge-Making and the Question of Causality

Practitioners like Hildreth, Nicoll, and Arnold sought to establish their authority over the knowledge of monstrous birth at a time when physicians' rising authority over childbearing was neither self-evident nor secured. Physicians attended around a fifth of births in the United States at the start of the nineteenth century and around half of U.S. births at the century's close, though this number remained significantly lower among many lower-class, immigrant, Black, and Indigenous communities.[47] Only a small fraction of physician-attended births took place in hospitals and medical institutions, locations where physicians could expect to exercise a far more unilateral form of authority. Instead, for the nineteenth-century women who paid physicians to attend them in their homes, inviting an obstetric practitioner into the birthing room generally did not mean relinquishing control to him; a physician was usually one attendant among many, often working alongside a midwife, female relatives and female friends, and older women from the community. This female-dominated set of attendants, as well as the birthing woman herself, negotiated with the physician about interventions and interpretations rather than automatically deferring to his obstetric expertise.[48] While physicians took formal credit for the knowledge published in medical case histories of births, the embodied processes that produced that knowledge engaged these multiple kinds of actors.

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[47] Leavitt, *Brought to Bed* (n. 10), 12 (graph); Borst, *Catching Babies* (n. 24), 1–11; Gertrude Jacinta Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge, Mass.: Harvard University Press, 1998), 139–237; Theobald, *Reproduction on the Reservation* (n. 11), 29–36.

[48] Leavitt, *Brought to Bed* (n. 10), 87–115.

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To analyze these processes, this essay draws evidence from a review of several hundred medical case reports on the birth of "monsters" in the nineteenth-century United States, which appeared in national and local medical journals, medical museum catalogues, and medical society reports from at least thirty-five states. These reports involved childbearing women from heterogeneous racial, ethnic, and socioeconomic backgrounds. Private patients of physicians—typically white, Protestant, U.S.-born, middle- and upper-class, married women—were particularly well-represented in this set of case histories, though childbearing Black, immigrant, working-class, unmarried, and rural women also appeared. In age, the women ranged from their teens to their mid-forties.

While formally authored by physicians, some of these case reports included explicit acknowledgment of childbearing women or lay female attendants as agents of credible and creditable knowledge production. Generally, white upper-class private patients—especially older married women with long-standing relationships to their attending physicians, like Hildreth's patient—were likeliest to be quoted at length in the case reports, and their knowledge claims about pregnancy and birth were likeliest to be explicitly treated as authoritative. By contrast, recorded contributions from many women in more marginalized social positions, like the enslaved woman near Savannah, were often comparatively minimal in scope. In this way, the attribution of epistemological authority, even in this already circumscribed capacity, was markedly racialized and classed as well as gendered.

Women's capacities of observational and quantitative knowledge-making were acknowledged in matters such as assessment of gestational age, which was directly calculated by

the pregnant woman, and the timing and qualia of sensations of movement in utero. Women provided granular observations of internally perceived fetal motions: one described "an intermittent, spasmodic and strange jerking movement, increased or prolonged by exercise or by jarring"; another "perceived most violent motion of the child, which she said felt '*as if it would break through her*.'"[49] Women also explicitly interpreted the observational knowledge they produced; for instance, one mother was able to "foretell" the condition of her offspring based on "unusual and anomalous symptoms" she experienced during pregnancy.[50]

Some case histories also specifically recognized the knowledge and expertise of female attendants or relatives. For instance, in an 1838 case involving the birth of twins, one born without any organs of the upper body, elite Boston physician J. B. S. Jackson recorded the observations of a patient's mother who "took charge" of her daughter's placenta after the delivery. The woman, he wrote, "observed that [the placenta] was small and divided into two portions; this last circumstance was noticed, as she herself once had twins, when, as she remembers, the after-birth formed one continuous mass." Noting that this woman "has frequently been with women during labour, and knows the appearance of a placenta," Jackson opined that her statement "certainly seems to deserve some credit."[51] Drawing on her observational skills

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[49] W. W. Pennell, "A Pseudocephaloid Infant," *Med. Surg. Report.* 62 (1890): 81; Samuel Purple, "A Literary, Historical, and Practical Sketch of Acrania, 'Brainless' or Pseudencephalus Monsters," *N.Y. J. Med. Collat. Sci.* 5 (1850): 40–58, quotation on 45.
[50] S. B. Cunningham, "A Case of Monstrosity," *South. Med. Surg. J.* 1, no. 3 (1845): 120–21, quotation on 121.
[51] J. B. S. Jackson, "Case of Monstrosity," *Amer. J. Med. Sci.* 21, no. 42 (1838): 362.

and experience, this laywoman produced the type of empirical knowledge—derived from and verified through direct observation—that elite American physicians like Jackson were claiming in this period as a foundation of scientific medicine.[52]

Childbearing women's participation in medical knowledge-making notably extended into one of the central questions of scientific teratology: determining the cause of monstrosity. This was a question that deeply concerned laywomen and physicians alike, for both divergent and overlapping reasons. For physicians, understanding the cause of monstrosity was part of a larger project of asserting their scientific authority over the interpretation and management of human bodies. More concretely, the study and collection of monstrosity could be a pathway for professional advancement and recognition: presenting a teratological specimen offered an individual physician an opportunity for national or even international publication, and submitting specimens to prominent medical collections promised to "provide for the perpetuation of his name as that of a physician interested in the progress of the profession."[53] Anatomical collections with robust holdings of monstrous specimens were framed as points of pride for prominent medical schools, or even for the "national prestige" of American medicine as a whole.[54]

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[52] On "the American preoccupation with empiricism" in the first half of the nineteenth century, see John Harley Warner, *Against the Spirit of System: The French Impulse in Nineteenth-Century American Medicine* (Princeton, N.J.: Princeton University Press, 1998), 3–16, 8.
[53] John S. Billings, "On Medical Museums, with Special Reference to the Army Medical Museum at Washington," *Boston Med. Surg. J.* 119, no. 12 (1888): 265–73, quotation on 272.
[54] Ibid., 273.

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The study of monstrosity was of particular interest within the growing subfield of obstetrics, where it helped establish the scientific legitimacy of obstetrics by linking it to the laboratory sciences of experimental embryology and teratology.[55] In the later nineteenth century, medical interest in monstrosity overlapped with rising ambitions toward the scientific management of pregnancy and motherhood.[56] The medical investigation of monstrosity was situated within an increasing assertion of reproduction as a proper area of interest and intervention for medical practitioners, and specific aspirations to establish the prenatal period as an object of medical supervision and regulation.[57]

Yet, across the course of the nineteenth century, physicians remained acutely aware of a critical limitation when it came to their authority over monstrosity. While they could confidently explain the genesis of monstrosity in an arrest or deviation of embryological development, they still could not explain what caused these deviations to occur and, relatedly, could offer no way to prevent them. Physician John Barry lamented in 1894 that "the etiology of monstrosities is as

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[55] For discussions of experimental teratology in obstetric case literature, see, e.g., Frank Stahl, "Maternal Impressions and Their Significance," *Amer. J. Obstet. Dis. Women Child.* 33, no. 4 (1896): 501–16; Henry Lewis, "Iniencephalus," *Amer. J. Obstet. Dis. Women Child.* 34, no. 1 (1897): 11–39. On nineteenth-century medical engagement with embryology, see Shannon Withycombe, "From Women's Expectations to Scientific Specimens: The Fate of Miscarriage Materials in Nineteenth-Century America," *Soc. Hist. Med.* 28, no. 2 (2015): 245–62.

[56] Rima D. Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick, N.J.: Rutgers University Press, 2006), 11–33.

[57] Felicity Turner, *Proving Pregnancy: Gender, Law, and Medical Knowledge in Nineteenth-Century America* (Chapel Hill: University of North Carolina Press, 2022); Shannon Withycombe, *Lost: Miscarriage in Nineteenth-Century America* (New Brunswick, N.J.: Rutgers University Press, 2018), 125–61; Judith Walzer Leavitt, "The Growth of Medical Authority: Technology and Morals in Turn-of-the-Century Obstetrics," *Med. Anthropol. Q.* 1, no. 3 (1987): 230–55.

vague as ever, and medical pride bows in abject submission when confronted with the task of averting the misfortune, or even comforting the pangs of sorrow and distress incident upon a. monstrous conception."[58]

Leading nineteenth-century physicians publicly sought to cultivate an image of aloof neutrality for the profession, contrasting their impartial scientific regard with the public's "emotional" reactions to monstrous births.[59] But individual case reports suggest a clear affective component to physicians' interest in resolving the question of monstrosity's cause: physicians described feeling unsettled, fearful, horrified, repulsed, and "shocked, as well as astonished" by the material realities of monstrous birth, particularly aspects that appeared to them "unnatural" or beyond explanation.[60] The elusive ability to explain the etiology of monstrosity (and, perhaps, advise on its prevention) could appeal to physicians as a way to soothe not only their patients' emotions but also their own.

Though childbearing laywomen did not have the same opportunities as elite physicians to directly describe their interest in knowing more about monstrosity, many of them also appeared highly driven to understand the cause of their offspring's condition. An attentive reading of case

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[58] John Barry, "Cases of Monstrosities, with Special Reference to the Theory of Maternal Impressions," *Med. Rec.* 46, no. 26 (1894): 811–13, quotation on 811.
[59] Billings, "On Medical Museums" (n. 53), 271.
[60] J. W. B. Garrett, "Singular Case of Monstrosity," *West. J. Med. Surg.* 6 (1850): 1–5, quotation on 2; Charles Hasbrouck, "Notes of Country Obstetric Practice," *Trans. N.J. Med. Soc.* (1871): 189–219, 208; John Fraser, "A Sternopagous Monster," *Amer. J. Obstet. Dis. Women Child.* 23 (1890): 840–44, 841; Mark Knapp, "The Clinical History of an Anencephalous Monster," *Med. Rec.* 51, no. 15 (1897): 530–31, 530; I. M. Shrader, "Some Incidents in the Practice of Obstetrics," *West. Med. Reformer* 57 (1897): 138–41, 138.

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histories yields a portrait of women who were motivated and engaged participants in determining the origin of monstrosity: offering their own causal theories, expressing doubts and certainties, sharing and seeking knowledge that could help them interpret and make sense of an unexpected and often deeply troubling experience. For such women, the stakes of this search were singularly heightened: they intimately experienced the impact of monstrous birth on their own bodies and health, on their hopes and aspirations for a projected future, and on their role and relational standing in their respective social and familial worlds.

While a woman could draw on a variety of nineteenth-century religious, popular, and legal discourses to try to make sense of her monstrous birth, existing schematics of interpretation could sometimes be inadequate to fully reconcile her particular embodied experience, to fully satisfy her and her loved ones' desire to understand what had happened and why and what they were to make of it in the context of their own lives and relations. If so, an encounter with a medical practitioner who also aspired to know more about monstrosity could represent an opportunity to collaborate in a shared search for deeper context, meaning, and understanding—even as the premises, goals, and conclusions of that search did not always align among the participants. The case histories reveal women's extensive involvement in attempts to determine the origins of monstrosity, showing that physicians consulted and often affirmed childbearing women's epistemological authority regarding questions of causality. Cases regularly detailed the

"cause assigned by the mother"; even in instances where the woman provided no theory, case histories noted that her input had been solicited.[61]

Recognizing this engaged, interpersonal dynamic complicates traditional narratives of this history, which portray lay and medical explanations of monstrosity as opposed forces and depict nineteenth-century medical experts sweeping in to replace women's folk beliefs in "maternal impression" with an improved scientific understanding of monstrosity's embryological origins.[62] However, on the evidence of hundreds of case histories published throughout the nineteenth century, "maternal impression" frequently served as a shared belief system for both physicians and childbearing women. Certainly some physicians rejected the notion that a mother's mental and sensory experiences during pregnancy could shape the form of her developing offspring, as did some laywomen. But at midcentury the idea garnered support within even the most elite American medical circles, defended by leading Harvard physicians like J. B. S. Jackson and David Humphreys Storer.[63] In 1889, a Philadelphia physician described belief in maternal impressions as "almost universal with the laity" and "also shared to a large

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[61] Purple, "Pseudencephalous Monsters" (n. 49), 47; F. H. Getchell, "Case of Monstrosity," *Amer. J. Med. Sci.* no. 106 (1867): 418.

[62] On the persistence of maternal impressions theories in nineteenth-century science and medicine, see Richardson*, Maternal Imprint* (n. 16), 34–39.

[63] William Morland, "Extracts from the Records of the Boston Society for Medical Improvement," *Amer. J. Med. Sci.* no. 50 (1853): 356–61.

extent by the members of our own profession," while a Chicago physician in 1896 likewise identified a widespread belief in maternal impression among American physicians.[64]

Indeed, many nineteenth-century physicians found maternal impression to be perfectly compatible with newer embryological explanations of monstrosity. While scientific consensus now attributed monstrosity to arrests or deviations in embryological development, it remained to be determined what mechanism produced these arrests and deviations—and here, maternal impression was entertained as readily as any of the other major candidates (which included mechanical accidents, nutritional deficiencies, embryological disease, or hereditary pathology of the parental "germ"). Physicians seamlessly integrated theories of maternal influence within embryological frameworks of monstrous production, even proposing specific physiological mechanisms by which strong maternal emotions could materially disrupt development: one suggested that anencephaly could arise when a woman's experience of intense emotional shock early in pregnancy elicited a physiological impulse "to contract and gather" the uterine walls, inadvertently damaging the cells "at the superior pole of the developing embryo."[65]

Embraced by large numbers of nineteenth-century physicians and laypeople alike, the shared explanatory framework of maternal impression particularly facilitated the involvement of laywomen in the production of knowledge about monstrosity's etiology, establishing the relevance of mothers' subjective sensations, observations, and thoughts. In some cases,

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[64] J. Richards, "Maternal Impressions," *Phila. Med. Times* 19, no. 8 (1889): 340; Stahl, "Maternal Impressions" (n. 55), 501–16, quotation on 511.
[65] Stahl, "Maternal Impressions" (n. 55), 509.

physicians reported soliciting this information directly, urging their patients to recall any events or experiences during early pregnancy that had elicited feelings of fear, shock, disgust, or grief.[66] In other cases, physicians recorded recollections that were offered by women unsolicited. Either way, the medical reporting of monstrous births became an occasion for gathering and recording information both about childbearing women's theories of monstrous production, and about their subjective experiences and moments of deepest emotional significance during pregnancy.

Hierarchies of race, class, and social position shaped the way that physicians solicited and recorded women's contributions; they influenced which women were more readily imagined as creditable reporters of subjective experience or even imagined to be possessed of a complex subjective interiority at all. In a suggestive pair of cases, a South Carolina physician, Dr. A. A. Moore, published two reports of monstrous birth, one involving a woman described as "blonde," and the other involving a woman described as "colored." In the first case, Moore asked the patient to recount any memorable emotions or experiences during pregnancy; in the second, he did not.[67] Jenifer Barclay argues that nineteenth-century physicians particularly associated the phenomenon of maternal impression with white women, constituting "a racialized attempt to understand and explain disability among newborns"; Marli Weiner likewise avers that antebellum "physicians who debated prenatal influences did so almost exclusively in terms of

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[66] See, e.g., G. Garland, "Acephalous Monster," *West. J. Med. Surg.* 7, no. 3 (1851): 212–14, 213; A. W. Lueck, "Acephalic Babe," *Med. Surg. Report.* 22, no. 8 (1870): 150; J. S. Haldemann, "Gleanings from Exchanges: Maternal Impressions and Acephalous Foetus," *Phila. Med. Times* 12, no. 22 (1882): 763.
[67] A. A. Moore, "Anencephalic Monster," *Amer. J. Med. Sci.* 54 (1867): 281–82, 281; Moore, "Anencephalic Monster," *Med. Surg. Report.* 47, no. 17 (1882): 461.

white women's bodies."[68] Indeed, across nineteenth-century case literature, especially detailed descriptions of maternal impression events often involved "refined" upper-class white women. Prevailing nineteenth-century medical discourse attributed to these women a heightened emotional and physiological sensitivity, positioning them as uniquely capacitated to receive and be affected by mental and sensory impressions.[69]

Yet, notably, the case literature also shows that physicians did solicit and record information on maternal impressions from childbearing women in more racially marginalized positions as well, including women described as "negro," "colored," and "mulatto."[70] In a few rare cases, nineteenth-century physicians even speculated on how social and economic conditions of marginality might systematically expose women to distressing experiences during pregnancy—for instance, a Wisconsin physician testified that the "nervous shock caused by her arrest and incarceration" could leave a woman in jail "liable to give birth to a monstrosity," while

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[68] Jenifer Barclay, "Bad Breeders and Monstrosities: Racializing Childlessness and Congenital Disabilities in Slavery and Freedom," *Slavery Abol.* 38, no. 2 (2017): 287–302, 294–95; Marli Weiner with Mayzie Hough, *Sex, Sickness, and Slavery: Illness in the Antebellum South* (Champaign: University of Illinois Press, 2012), 114.

[69] On nineteenth-century discourses of "impressibility" and racialization, see Schuller, *Biopolitics of Feelings* (n. 45).

[70] Garrett, "Singular Case of Monstrosity" (n. 60), 1–6; George Badger, "A Rare Case of Monstrosity," *Med. Rec.* (1869): 166; E. J. Overend, "Maternal Impressions," *Pac. Med. J.* 33 (1890): 70–77; T. W. Burton, "Iniencephalic Monster," *West. Med. Reformer* 57, no. 4 (1897): 209–13; William Hestle, "Obstetrics," *Amer. Gynaecol. Obstet. J.* 15 (1899): 386–93.

a New York physician named a woman's "great privations" and "condition of poverty" during pregnancy as possibly relevant factors.[71]

Because they were the ones best positioned to observe events and sensations during their pregnancies, childbearing women were recognized to have access to privileged forms of relevant knowledge within the framework of maternal impression. Some case reports indicated that a woman's knowledge of her offspring's condition preceded anyone else's, confirmed when she gazed for the first time on an infant whose condition she had known to expect prior to delivery. Following an 1841 birth, "after a few moments of recovery, the mother wished to know if it was a perfect child, for, said she, 'I did not expect it would be.'" Asked to elaborate, she explained, "'I thought there would be something the matter with its head, for I dressed the head of a calf last June, and when I took the axe to cut it open, I felt dreadfully, and thought I should faint or die for the next two or three hours.'"[72] Sometimes, this premonitory knowledge foiled physicians' attempts to paternalistically shield the "delicate" sensibilities of patients—typically coded as upper-class white women in these cases—from the sight of their own offspring. In an 1842 birth of an infant with anencephaly, the woman's "first enquiry was, is not something the matter with the head? Being answered negatively, she asked to see it, which, it was thought, prudent to

[71] Henry A. Riley, "Medical Cases in the Courts," *Med. Rec.* 32 (1887): 452–53, 452; Egbert Grandin, "Transactions of the State Medical Society" (1893), *Amer. Gynaecol. Obstet. J.* 3, no. 7 (1893): 633–42, 639–40.

[72] L. P. S., "Influence of Maternal Feelings—Acephalous Child, &c.," *Boston Med. Surg. J.* 24, no. 5 (1841): 72–73, quotation on 73.

refuse." The woman was not fooled: "She replied, despondingly, that she always knew something was the matter, and our refusal to let her see it confirmed her belief."[73]

Women's Narratives and the Meanings of Monstrous Birth

The narratives of pregnancy recorded in these case histories reflect women's participation not only in determining proximate causes of anomalous birth, but also in configuring and conveying the broader meanings of monstrosity in nineteenth-century medical literature. In descriptions of their prenatal experiences, women often described monstrosity as being presaged by a disruption of social, affective, and bodily boundaries. The themes and motifs that arose in their narratives tended to locate monsters within relational orders of kin and strangers, situating the genesis of monstrosity in troubled contacts between humans and animals; encounters with racial alterity, particularly white women's encounters with Blackness and Indigeneity; and physical dangers posed by the reformation of urban life in the mid-nineteenth-century United States. Some of these motifs bore continuities with classical, medieval, and early modern attributions of monstrosity—particularly the association of monsters with transgressed human-animal boundaries—but they were given new form and specificity in the context of nineteenth-century

[73] J. Manlove, "Remarks on a Case of an Acephalous Monster, Read before the Medical Society of Tennessee," *West. J. Med. Surg.* 4, no. 5 (1845): 401–5, quotation on 403.

clinical encounters and the embodied interpersonal worlds of nineteenth-century American women.[74]

A motif running through many different women's narratives involved distressing encounters with animals during pregnancy. More than any other, these narratives of prenatal animal encounters cut across stratifications of race, class, and region. An enslaved Black woman in Tennessee was "much frightened by seeing for the first time, and very unexpectedly, an *elephant* belonging to a traveling menagerie" in 1850, while an upper-class Anglo-American patient of an elite Boston physician was "much frightened" by unexpectedly seeing a "serpent" in 1849.[75] Women reported fear and shock at the general sights and sounds of bellowing bulls, shrieking screech owls, and drowning hogs.[76] One woman approached a "good sized dry log" on the Florida coast and was "in the act of seating herself" on it when she realized, with sudden terror, that the log was in fact an alligator.[77]

Several narratives described male relatives using animals to intentionally inflict distress. The husband of a white woman in New York "amused himself by walking around her" and

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[74] On monstrous births in earlier periods, see Lorraine Daston and Katharine Park, *Wonders and the Order of Nature, 1150–1750* (New York: Zone Books, 1998), 173–214; and Huet, *Monstrous Imagination* (n. 16).
[75] Garrett, "Singular Case of Monstrosity" (n. 60), 6; Warren Anatomical Museum, *A Descriptive Catalogue of the Warren Anatomical Museum* (Boston: A. Williams and Company, 1870), 90.
[76] S. S. Oslin, "A Monstrosity," *Med. Rev.* 3 (1875): 197–200, 199; Flint L. Keyes, "Two Cases of Monstrosity," *Med. Surg. Report.* 12 (1865): 501; Drs. Lucas and Pankake, "Anencephalous Monster," *Med. Surg. Report.* 63, no. 25 (1890): 716–17, 717.
[77] O. P. Baer, "First Causes of Structure and Character of the Embryo in Utero," *U.S. Med. Investig.* 7 (1878): 151–58, quotation on 157.

dangling crabs in front of her, knowing "she was afraid of them," while the brother of a multiracial woman in Virginia "entered her room about midnight and threw a living opossum on the bed, frightening her much."[78] Some encounters involved multiple animal kinds. A Black woman in South Carolina was shocked by a sudden encounter with a buzzard devouring a pig, and afterward felt "attacked with 'uneasy sensations'" in the pit of her stomach.[79] A Methodist woman in Ohio tried to flee from agitated horses after being "badly frightened" at a camp meeting, only to be chased and jumped on by a large dog; another woman was "out with a friend gathering some whortle berries" when they came across a "huge rattle-snake, which first bit their dog and then made battle with them."[80]

A less ubiquitous but still recurring narrative in the case histories, more narrowly tied to a specific class and racial demographic, featured a married upper-class white woman's overly intimate attachment to a companion animal during pregnancy. In one 1840 case, a pregnant woman doted on a dog "which had been used to draw her breasts" after an earlier miscarriage. She sent for her private physician "in consequence of her anxiety" from the critiques of her friends, who believed her inordinate fondness for the animal would mark her developing child.[81]

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[78] George Peck, "Bureau of Obstetrics: Abstract of Discussion," *Med. Advance* 17, no. 2 (1886): 117–23, quotation on 123; Hestle, "Obstetrics" (n. 70), 386.
[79] Overend, "Maternal Impressions" (n. 70), 74.
[80] Dr. Hadlock, "Cincinnati Academy of Medicine: Acephalous Foetus," *Med. Surg. Report.* 21, no. 19 (1869): 280–81, quotation on 280; D. M. Hudson, "Case of Monstrosity," *Med. Examiner* 114 (1854): 326.
[81] J. B. S. Jackson, *A Descriptive Catalogue of the Anatomical Museum of the Boston Society for Medical Improvement* (Boston: William D. Ticknor, 1847), 256–57.

Similarly, a later 1894 case involved an affluent woman who was described as having "distinct predilection for lower animal tastes," being "much devoted during her pregnancy to the care of a dog and a pet rabbit, the latter of which was to be frequently seen nestled in her lap or poised on her shoulders." Her friends "repeatedly discouraged these attentions on her part, but to no purpose."[82] These narratives encoded general anxieties about the transgression of affective and bodily separations between humans and animals, as well as more specific anxieties about excesses in the sentimental attachment to animals that was associated with nineteenth-century constructions of genteel, civilized white femininity.[83]

Taken together, the frequency with which animals appeared in these accounts suggests the ways in which monstrosity implicated anxieties over interspecies boundaries and, particularly, the stability of the kinship boundary between humans and beasts—as in the case of the woman in 1840, whose friends disparaged her attachment to a dog she had suckled in place of a human child.[84] Recalling earlier classical and medieval notions of monsters as the promiscuous mingling of animal species, these associations of monstrosity took new shape in the contexts of nineteenth-century women's daily activities, relationships, and social imaginaries.

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[82] Barry, "Cases of Monstrosities" (n. 58), 813.

[83] On the significance of animals in sentimental culture, see Karen Halttunen, "Humanitarianism and the Pornography of Pain in Anglo-American Culture," *Amer. Hist. Rev.* 100 (1995): 303–34; Jennifer Mason, *Civilized Creatures: Urban Animals, Sentimental Culture, and American Literature, 1850–1900* (Baltimore: Johns Hopkins University Press, 2005).

[84] On the iconography of "suckling as a point of intimate connection between human and beasts," see Londa Schiebinger, *Nature's Body: Gender in the Making of Modern Science* (Boston: Beacon, 1993), 53–59.

In another recurrent narrative, a monstrous birth was attributed to a woman's encounter with a figure of racial alterity during pregnancy. Typically, this involved a white Christian woman's encounter with a deviant racialized figure, inscribing racist tropes that conflated Blackness and Indigeneity with monstrosity. A birth attended by a Pennsylvania physician in 1865 involved a married mother of five described as "of delicate organization" and "exceedingly nervous"—words typically associated with white, Protestant, middle- or upper-class femininity. Prior to delivery, she informed the physician "that her babe would be deformed," citing an incident that had occurred about nine weeks into her pregnancy: her husband had left her home alone in the evening with their children, when "about dusk a large negro man, in soldiers' clothes, came to the door and asked for an axe; he was the worst featured and most disgusting human being she had ever beheld." The woman "was so alarmed as to faint; and lay upon the floor unconscious until her husband returned and lifted her to bed, where she remained much agitated and very feeble for several days."[85] In a similar narrative from an 1871 birth history, a "Christian lady" of "excitable, nervous temperament" reported to her physician that "a colored woman, with large protruding eyes and singular expression, suddenly approached her whilst in her ninth pregnancy, giving her a fright, to which cause she attributed this malformation of the foetus."[86] An 1886 case history described a pregnant woman's trip to New York City to see "the Aztec children," referring to a popular circus or "freak show" exhibition in which individuals

[85] J. M. Stevenson, "Case of Monstrosity," *Med. Surg. Report.* 12 (1865): 223–24, 223.
[86] J. N. Snively, "Remarkable Case of Monstrosity," *Med. Surg. Report.* 24 (1871): 383.

with microcephaly were presented as descendants of an ancient Central American race.[87] In all these cases, a narrative of maternal impression located the genesis of monstrosity in a white woman's encounter with racial alterity—part of a broader racialization of monstrosity that configured cultural meanings of monstrous difference in nineteenth-century medical literature.[88]

Finally, a number of narratives attributed monstrous births to women's experiences of physical dangers and maladies associated with industrialization and expanding urban populations in the mid- to late nineteenth-century United States. Some involved violent traumas related to new technologies of economic production and transportation: these included a woman attending a brother whose hand had been "torn off by machinery," witnessing a child run over by a street car, or seeing the disfigured face of a family member killed in a railroad accident.[89] In another instance, a woman suffered "fatigue and seasickness" while traveling "in cars and steamboat."[90] Other narratives implicated the emergence of new carceral systems in increasingly densely populated cities. During one pregnant woman's visit to her incarcerated brother, "a prisoner was brought in shackled, and she repeatedly spoke of the sight, and hoped her brother would not be treated in that manner"; throughout her pregnancy, she was haunted by dreams of "her brother in

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[87] Peck, "Bureau of Obstetrics" (n. 78), 119–20.
[88] Rich, "Monstrosity in Medical Science" (n. 6).
[89] Morland, "Extracts from the Records" (n. 63), 358; Stahl, "Maternal Impressions" (n. 55), 506; Haldemann, "Gleanings from Exchanges" (n. 66), 763.
[90] Francis Minot, "Reports of Medical Societies," *Boston Med. Surg. J.* 62 (1860): 160–66, quotation on 160.

irons."[91] Here, women's narratives associated monstrosity with anxieties over the social, technological, and institutional upheavals of nineteenth-century industrial capitalism, and the new risks to life introduced by mechanization and urbanization in this period.

Medical Authority and the Facilitation of Blame

While some women used the shared framework of maternal impression to voice and theorize their lived experiences within a medical literature that frequently sought to exclude them, this same framework could also be a source of distress for nineteenth-century mothers. Some women recalled how the entirety of their pregnancies had been subsumed by a sense of dread and foreboding after experiencing a fright early on, tormented by the recurrent thought that their developing child had been harmed by the incident. One woman was "exceedingly troubled" at seeing a boy injure a hen with a stone, and "as her pregnancy advanced, continually dwelt upon the subject, insisting that her child when born would be found to be deformed."[92] Another, upon visiting an ailing friend and watching her suffer a hemorrhage, "was greatly shocked, so much so as to faint; and she subsequently thought frequently of the occurrence, fearing its effects upon the child she carried."[93] A third woman was frightened by a snake during her pregnancy and "felt at once that the child would be 'marked'"; she "tried to forget it, but could not, and 'often' spoke of

[91] J. W. Underhill, "Transactions of the Obstetrical Society of Cincinnati: Maternal Impressions Affecting the Fetus in Utero," *Amer. J. Obstet. Dis. Women Child.* 11 (1878): 626–40, quotation on 634–35.
[92] Morland, "Extracts from the Records" (n. 63), 356.
[93] Ibid., 361.

it to her friends in a nervous state."[94] In these instances, a shared belief in maternal impression clearly exacerbated the fear and anxiety that women experienced during pregnancy.

Popular medical advice manuals on childbearing and motherhood, written by credentialed practitioners for an assumed readership of white middle-class women in the mid- to late nineteenth century, also conveyed elaborate warnings about the dangers of maternal impression.[95] These manuals cautioned women about the perils of harming their developing offspring through their thoughts, behavior, and emotions during pregnancy, in language that seemed likely to heighten feelings of anxiety. The physician author of one manual warned that "during pregnancy there is unusual susceptibility to mental impressions" liable to "operate on the fragile structure of the unborn being," and enjoined pregnant women to remember that "the child, though unborn, lives within her; its life is a part of her own, and so frail, that any indiscretion on her part may destroy it."[96] Women sometimes heard similar advice from their own physicians. One physician wrote in to the *Medical and Surgical Reporter* in 1883 to decry colleagues who warned patients about the dangers of maternal impressions during pregnancy, lamenting that "I have had women to become frightened at a fish, and worry and fret because they were sure, from what they had been told by doctors, that the child would have scales."[97]

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[94] Warren Anatomical Museum, *Descriptive Catalogue* (n. 75), 93.
[95] On nineteenth-century medical advice literature for women, see Apple, *Perfect Motherhood* (n. 56), 11–33.
[96] George Napheys, *The Physical Life of Woman: Advice to the Maiden, Wife and Mother* (Philadelphia: George MacLean, 1870), 158, quotation on 173.
[97] S. R. Millen, "Effects of Maternal Impressions on the Foetus," *Med. Surg. Report.* 49, no. 11 (1883): 305.

In addition to heightening fear and anxiety, the framework of maternal marking could also facilitate the assignation of blame—used to suggest that a mother was at fault for recklessly exposing herself to upsetting sights and situations while pregnant or to exert control over pregnant women's behaviors in mandating they avoid such exposures. At a time when the medical oversight of pregnancy was not yet routine, the framework of maternal impression could be invoked to advance a rising medical interest in asserting authority over the prenatal period.[98]

This mobilization of medical authority involved not a direct assertion of physician control over gravid bodies but rather the inculcation of orderly norms at microsites of everyday living, through self-administered changes of habit and practices of personal care. As part of their injunction for the reformation of daily habit, manuals still urged reliance on the oversight of an authoritative physician: as Elisabeth Robinson Scovil, superintendent of the Newport Hospital in Rhode Island, advised in *Preparation for Motherhood*, "The function of a medical man ought to be not so much to cure his patients of disorders as to keep them in order."[99]

To keep pregnant women in order, manuals freighted imperatives around maternal impression with an expansive moral weight, configuring women as responsible not only for the quality of their own offspring but also for society and humanity writ large. One explained that "the mother's influence upon her unborn child, and through it upon society, church, and state, is immeasurably great," while another averred that a pregnant woman's conduct during pregnancy mattered "not only for the sake of herself and her husband, but also for the sake of her forming

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[98] Charles Green, "The Care of Women in Pregnancy," *Boston Med. Surg. J.* 126, no. 8 (1892): 186–90.
[99] Elisabeth Robinson Scovil, *Preparation for Motherhood* (Philadelphia: H Altemus, 1896), 50.

child and for the welfare of the human race."[100] Authors explicitly moralized pregnant women's behavior through the invocation of Christian Providence and sin, warning that "Providence does not design monstrosities," or decrying the birth of "deformed" infants resulting from "a sinful neglect of those special measures imperatively demanded in the ordering of the daily life . . . upon pregnancy."[101]

The potential to "mark" a developing fetus was extrapolated to specific directives for maternal conduct, environment, affect, perception, and thought; authors advised that "during pregnancy, the minds of mothers should be watched, as well as their bodies, with the greatest care."[102] Manuals stipulated that "all the surroundings and employments of the pregnant woman should be such as conduce to cheerfulness and equanimity"; she should "cultivate grace and beauty in herself at such a time" and "maintain serenity and calmness."[103] Conversely, a pregnant woman must guard against "violent and sudden emotion"; she should avoid "ungraceful positions and awkward attitudes" as well as "all causes of excitement."[104] She should remove "disagreeable and unsightly objects" from her environment and refrain from "looking at, or thinking of ugly people, or those marked with disfiguring diseases."[105]

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[100] E. G. Cook, *Mothers and Daughters: A Manual of Hygiene for Women and the Household* (New York: Arcade, Fowler & Wells, 1884), 213–14; Seth Pancoast, *The Ladies' New Medical Guide* (Philadelphia: JE Potter, 1890), 585.
[101] Cook, *Mothers and Daughters* (n. 100), 213; Napheys, *Physical Life of Woman* (n. 96), 173.
[102] Cook, *Mothers and Daughters* (n. 100), 167.
[103] Napheys, *Physical Life of Woman* (n. 96), 159, 115–16.
[104] Horace Conger and Caroline Crane, *Obstetrics and Womanly Beauty* (Chicago: American Publishing House, 1900), 283–84; Napheys, *Physical Life of Woman* (n. 96), 115, 159.
[105] Napheys, *Physical Life of Woman* (n. 96), 159, 115.

Similar prescriptions appeared in formal medical literature and case reports. In an 1853 case report, a physician suggested that women should be "cautious of needless exposure to unpleasant sights in the early months of pregnancy."[106] Another, in 1894, wrote that "it seems to be the concensus of opinion that one cannot go far wrong by assuming it to be his duty to discourage morbid reflection, worriment, or apprehension of defective progeny in the minds of nervous, impressionable, pregnant women." He added, "If the minds of our pregnant patients are schooled in the aversion of voluntary, catastrophal sightseeing . . . it is just possible that monstrous conceptions might be a less frequent misfortune."[107]

These invocations mobilized a discourse of maternal impression to shape and assert an intimate form of control over the lives and habits of pregnant women, in ways that seemed likely to direct blame and guilt at women who "failed" to avoid monstrous impressions during pregnancy. Friends as well as physicians could be the source of such shaming: one case reported that "Mrs. A–," after ignoring her friends' warnings that her excessively intimate attachments to companion animals would mark her developing child, was "constantly upbraided with her misfortune" after the birth.[108]

Yet, this does not mean that a belief in maternal impression had a singularly negative impact on pregnant women's lives and autonomy. For one, it seems that many women engaged the theory of maternal influence not as a way to assign blame to themselves but as a way to

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[106] Morland, "Extracts from the Records" (n. 63), 357.
[107] Barry, "Cases of Monstrosities" (n. 58), 813.
[108] Ibid., 813.

derive sense and meaning out of a distressing and seemingly inexplicable experience—and sometimes as a way to explicitly direct blame toward circumstances or actions outside of their control. The shared framework of maternal marking could afford a site where a woman might actively participate with her physician in the medical narration of her experience and the production of medical knowledge about her body and offspring, a site where she could contribute her concerns, ideas, and narratives of subjective experiences in a shared search to more deeply understand the causes, meanings, and contexts of monstrous childbirth. This was especially significant during a period of rising medical authority over the interpretation of bodies and reproduction, and a widening cleavage between medical and lay knowledge—at a time when women were often excluded from becoming formally authorized producers of medical knowledge within the developing profession of obstetrics.

Further, though the theory of maternal impression could be mobilized to blame women for undesired birth outcomes, it could also be invoked to shield individual women from a more totalizing form of blame and stigma. In some case reports of monstrous birth, usually involving married white Anglo-American women, physicians took pains to distinguish an instance of maternal impression from a larger indictment of constitution or character: they invoked the theory of maternal impression to underscore that a monstrous birth had simply been caused by an isolated, onetime incident and that its occurrence should not be taken as a broader reflection on the moral or social standing of the mother, who was emphasized to be "a highly respectable and

intelligent lady of my neighborhood" or "the wife of one of our most respectable citizens."[109] Indeed, in the nineteenth-century literature, the framework of maternal impression was often deployed in a less overtly stigmatizing way than a theory that increasingly also appeared toward the end of the century, which posited a parent's constitutional or hereditary pathology as a potential cause of monstrous births.

Stigma and Epistemological Exclusion in the Late Nineteenth Century

While a substantial number of late nineteenth-century case histories continued to invoke theories of maternal impression, reports also began to more frequently take note of mothers' and fathers' "constitutional" and "hereditary" conditions as possible causal factors, locating potential origins of monstrosity in a sustained pathology of the parental body or family line.[110] In an explicitly stigmatizing formulation, late nineteenth-century case reports often discussed these potential conditions as "taints," a word that appeared most frequently in cases concerning working-class or racially marginalized parents. One physician recorded that the mother, "a farmer's wife" in Michigan, had "a specific taint"—in this case, a venereal disease.[111] In another case, involving a

[109] Manlove, "Acephalous Monster" (n. 73), 401; Charles Meigs, "Case of a Monstrous Birth," *Amer. J. Med. Sci.* 30 (1855): 13–21, quotation on 13.
[110] R. U. Moffat, "Medical Progress: Teratology," *Missouri Med. Surg. J.* 75 (1898): 326–27, 327; J. Edwards, "Case of Acephalous Monster," *Nashv. J. Med. Surg.* 45, no. 6 (1890): 227–28, 228.
[111] Richard Wood, "An Anencephalous Monster," *Med. Rec.* 48, no. 25 (1895): 893.

multiracial mother in Missouri, the physician assessed the presence of "hereditary taint in the family."[112]

Late nineteenth-century authors cast "hereditary taints" as a form of generationally transmitted "degeneracy" that corrupted both parent and child.[113] In a period of rising cultural anxieties around venereal disease, the category of "hereditary taints" could also encompass syphilitic infections. Presented as a threat to the middle-class familial and social order, syphilis was discussed in stridently moralized terms: not just as an infection, but as a transmissible "taint" that contaminated a person's whole being and lineage.[114] (In the coming decade, physicians would make explicit the eugenic implications of this framing of venereal disease.)[115]

A notation of the parents' venereal disease status became a frequent inclusion in late nineteenth-century reports of monstrous birth, with some physicians directly naming syphilis as the likely cause of the infant's condition.[116] Notably, case reports that assessed and recorded parents' syphilitic status (whether positive or negative) often involved patients of lower social or racial status. An 1886 report "ascribed the cause to syphilis" when discussing an infant born to a

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[112] "Remarkable Monstrosity," *Med. Surg. Report.* 46 (1882): 350–51, quotation on 350.
[113] Eugene S. Talbot, "Degeneracy and Marriage," *Alien. Neurol.* 20 (1899): 45–54.
[114] Allan Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880*, 35th anniv. ed. (New York: Oxford University Press, 2020), 6–57.
[115] Ibid., 20–25.
[116] See, e.g., Knapp, "Anencephalous Monster" (n. 60), 530; Burton, "Iniencephalic Monster" (n. 70), 213.

patient "at the dispensary," an institution that primarily served "the urban poor" in this period.[117] An 1888 report noted that "the mother was unmarried" and that she "denied syphilis"; another, from 1899, noted that the mother, "a colored woman," had "no evidence of syphilis."[118] In an 1898 report involving an upper-class married woman in New York, the physician felt the need to defend the classed respectability of his patient, the married Mrs. M, by clarifying that her venereal infection was "believed to have been contracted from a water-closet seat used by a servant who was later found to be suffering from syphilis."[119] Physicians proposed a variety of mechanisms to account for how a "syphilitic taint in the mother" might beget monstrosity.[120] Theresa Bannan, one of about seven thousand female physicians in the predominantly male American medical profession at this time, suggested in 1894 that both mothers and fathers with "syphilis, chronic alcoholism, and other constitutional affections" were liable to conceive monstrosities due to their faulty "ovum and spermatozoon"—showing how concepts of moral, constitutional, and hereditary pathology could merge in causal narratives of "defective" parental bodies.[121]

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[117] Peck, "Bureau of Obstetrics" (n. 78), 126; Charles Rosenberg, "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary," *J. Hist. Med. Allied Sci.* 29, no. 1 (1974): 32–54.
[118] Charles Dana, "Report of a Case of Anencephaly, with a Microscopical Study Bearing on Its Relation to the Sensory and Motor Tracts," *J. Nerv. Ment. Dis.* 13, no. 1 (1888): 21–32, quotation on 22; H. S. Crossen, "Transactions of the St. Louis Obstetrical and Gynecological Society," *Amer. J. Obstet. Dis. Women Child.* 39, no. 2 (1899): 208–15, quotation on 214–15.
[119] L. Duncan Bulkley, "Society Proceedings: Northwestern Medical and Surgical Society of New York," *Med. News* 73, no. 5 (1898): 155–59, quotation on 158.
[120] Ibid., 159.
[121] Theresa Bannan, "A Case of Monstrosity," *Med. Rec.* 45, no. 25 (1894): 788–89, quotation on 789.

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Unlike information related to maternal emotion and experience, which was communicated by the patient, knowledge about "constitutional taint" was to be gleaned by the physician through expert assessment of the body.[122] In the case of venereal disease, a New York physician avowed in 1898 that it was "absolutely necessary" for physicians to learn "the signs by which we can determine the existence of syphilis," explaining, "It is proverbial that persons with syphilis or gonorrhea are liars. It is useless to question the father or mother in these cases for they will only mislead one."[123] The trained discernment of the physician, then, and not the subjective input of the patient, was configured as the epistemological basis for such knowledge—shutting out childbearing women from what had formerly been, for some, spaces of interactive knowledge production.

The later nineteenth-century shift to harden and consolidate physicians' authority over their childbearing patients was reflected in other aspects of the case reports as well. Physicians in this period attended a larger proportion of deliveries, particularly among white middle-class women, and they assumed an increasingly interventionist role during the process when present. Late nineteenth-century physicians established authoritative knowledge of monstrosity in part through their ability to recognize and clinically diagnose it prior to delivery, usually through the performance of increasingly common and extensive prebirth digital exams (and, in subsequent decades, through the advent of medical imaging technology). Through this avenue, physicians gained access to knowledge that they could then disclose to or conceal from the patient as they

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[122] Moffat, "Medical Progress" (n. 110), 327.
[123] Bulkley, "Society Proceedings" (n. 119), 157.

determined fit. The physician's rising authority in the birthing room was underscored by these kinds of shifts in the structure of access to knowledge, accentuating an ever-widening asymmetry of power and epistemological authority between physicians and patients in this period.[124]

While these late nineteenth-century changes in obstetric practice further constrained women's involvement in medical meaning-making, they never fully foreclosed that involvement. Despite physicians' increasingly adamant claims to unilateral epistemological authority, laywomen continued to shape the formation of medical knowledge on monstrous birth. Their experiences, insights, and ideas remained entangled in the interpersonal processes of producing knowledge about biological bodies and reproduction, even as they were largely excluded from formal recognition within ascendant institutions of medical science. Their often-obscured yet insistent presence in the case literature sheds light on medical meaning-making as a densely embodied, relational, and socially embedded historical practice.

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[124] Norman Jewson, "The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870," *Sociology* 10 (1976): 225–44.

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