

October 2019

## “Failure of Will”?: TB Patient Narratives and Susan Sontag’s Illness as Metaphor

Bryon Dickon

*The University of Akron*, bjd33@zips.uakron.edu

Ashley Gonzalez

*The University of Akron*, arg109@zips.uakron.edu

Please take a moment to share how this work helps you [through this survey](#). Your feedback will be important as we plan further development of our repository.

Follow this and additional works at: <https://ideaexchange.uakron.edu/spa>

 Part of the [Archival Science Commons](#), [Digital Humanities Commons](#), and the [Public History Commons](#)

---

### Recommended Citation

Dickon, Bryon and Gonzalez, Ashley (2019) "“Failure of Will”?: TB Patient Narratives and Susan Sontag’s Illness as Metaphor," *Student Projects from the Archives*: Vol. 2 , Article 5.

Available at: <https://ideaexchange.uakron.edu/spa/vol2/iss1/5>

This Article is brought to you for free and open access by IdeaExchange@UAkron, the institutional repository of The University of Akron in Akron, Ohio, USA. It has been accepted for inclusion in Student Projects from the Archives by an authorized administrator of IdeaExchange@UAkron. For more information, please contact [mjon@uakron.edu](mailto:mjon@uakron.edu), [uapress@uakron.edu](mailto:uapress@uakron.edu).

## **“Failure of Will”?: TB Patient Narratives and Susan Sontag’s *Illness as Metaphor***

Bryon Dickon, *University of Akron, Department of English* and  
Ashley Gonzalez, *University of Akron, Department of English*

Susan Sontag outlines in *Illness as Metaphor* the romantic narratives of what she called a “tubercular personality.” Sontag writes the following in doing so, describing one key aspect of romantic tuberculosis: “TB was understood, like insanity, to a kind of one-sidedness; a failure of will or an overintensity...the tubercular was considered to be someone quintessentially vulnerable, and full of self-destructive whims” (63-64). “A failure of will” and “quintessential vulnerability” form a set of characteristics through which a narrative of the “tubercular personality” is constructed. The tubercular narrative Sontag describes is based on a wide variety of stereotypes. This creates a paradox in which the metaphorical trappings of the tubercular disposition are simultaneously correct and incorrect as persons with TB adhere to the narrative in some ways and deviate from it in others.

One aspect of this narrative touches on a “failure of will” regarding individuals living with TB. Sontag describes this part of the metaphor in detail in *Illness as Metaphor*:

While syphilis was thought to be passively incurred, an entirely involuntary disaster, TB was once...thought to be a pathology of energy, a disease of the will... Getting TB was thought to signify a defective vitality, or vitality misspent. (61-62).

This paradox is particularly apparent in a collection of case files from a psychiatric study conducted by Daniel Harris at the Saranac Lake Study and Craft Guild in the 1950s. Results from these case files culminate into a narrative in which patients conform in some ways to the “quintessentially vulnerable” patient while simultaneously diverging from such stereotypes significantly. The aim of this paper is to examine a sample of these case files (patients 210, 293, and 241). Primary focus will be placed on questionnaires and interview responses which reveal the patients’ personalities, and plans made during and after their treatments. The narratives created by these responses will also be supplemented by forms filled out by the interviewers themselves. The paper will then compare these

narratives to the tubercular profile found in Sontag's *Illness as Metaphor* and account for the paradoxes they present.

Sontag writes, "For more than a century and a half, tuberculosis provided a metaphoric equivalent for delicacy, sensitivity, sadness, [and] powerlessness" (61). Viewing tuberculosis stereotypes as a "pathology of energy" is beneficial for understanding how narratives of tuberculosis are formed. It is also important to bear in mind that many participants in Daniel Harris' study had been hospitalized for extended periods of time, which may account for some cases of reduced energy recorded in the files. The narrative of TB studied by Sontag paints a picture of lethargy and vulnerability which may have persisted in the subconscious of patients participating in the study. As such, patient answers found in the interview questions may unconsciously conform to tubercular narratives. Patients may also actively rebel against such narratives if they are consciously aware of them. The result is the culmination of a new narrative that is simultaneously a continuation and a divergence from previous ones.

The patients participating in Daniel Harris' study were anonymous apart from an assigned patient number. This protected the identities of the patients but also had a depersonalizing effect on their narratives. We are nevertheless able to speculate about their personalities by analyzing their answers on extensive examinations and questionnaires that were part of the study.

### **The Patients**

We will begin by considering patient 210 who was a twenty-five-year-old woman and whose husband was also diagnosed with tuberculosis. This is the only significant illness that was mentioned in a listing of her family medical history. On August 6, 1949, she had begun working with doctors on her treatment prior to her participation in the study (April 6, 1951). She had been hospitalized since May 4, 1950 which may account for any indications of lethargy or vulnerability in her answers. Prior to her hospitalization, the patient worked as a stenographer, and had completed six months of college.

This patient adhered to the TB narrative in multiple regards. When prompted on how she was working to facilitate her treatment, she responded, "I don't know what I'll do—I want to be with my husband and still do something" (210, A-3). Additionally, when asked questions about her occupation (stenographer) she writes in the margins that she was "never happy at it" (210, A-3). Despite her unhappiness with her line of work, she expresses little interest in finding other forms of employment, even saying "if I don't go to school, I'll go

back to stenography” (210, A-3). Such responses could be interpreted as moments of vulnerability. Her professed inability to make quick decisions could indicate a “tubercular” failure of will or what Sontag described as “passionate resignation” (12).

Conversely, patient 210 also indicates critical points of departure from the tubercular narrative of the “quintessentially vulnerable.” The answers on her Cornell Index construct a narrative of a strong-will, particularly in the patient’s emotions. As Sontag writes, “The myth of TB constitutes the next-to-last episode in the long career of the ancient idea of melancholy” (32). However, the supposed connection between TB and melancholic emotions is challenged by the patient’s Cornell Index, on which she repeatedly checks “No” on questions inquiring about negative emotions such as “miserable and blue” and “entirely hopeless” (210, Cornell Index Form N2). Additionally, the patient scored exceptionally high on social interests in a Study of Values Test. These values combined with interview responses indicating her enjoyment of “dancing” and “traveling” do not agree with the narratives of “lethargy” or “a failure of will.”

The interviewers also provide insight into patient 210’s will. Following patient interviews, the interviewer assessed certain aspects of the patient’s demeanor and appearance. Within this list of ratings, the interviewer indicates under the assessment of “verbal fluency” that the patient “must be prompted” for answers to their questions (210, J-1). When asked if the patient “seems to think and act for self, or to follow and depend on others” the interviewer indicated that she was “fairly independent” (210, J-1). These answers indicate that the patient exhibits at least an averagely strong-will. She is independent and somewhat guarded in a way that suggests an attempt to maintain an air of control, to exert her will over the study and control her narrative. However, there are also indications that the patient simultaneously adheres to stereotypes associated with the “quintessentially vulnerable” patient. It is worth noting that several answers on her Cornell Index Form were clearly changed from “Yes” to “No.” This occurred frequently on questions which gauged the patient’s moods and vulnerability such as “Do you have very disturbing or frightening thoughts” or “Are you extremely shy or sensitive” (210, Cornell Index Form N2). Although these answers may indicate some vulnerability in the patient, the fact that they were changed indicates a willfulness on the part of the patient to take charge of her own narrative.

Our next case study is patient 241, a twenty-two year old man who began his present treatment on March 21, 1949. A review of his medical history revealed a previous diagnosis of epilepsy, though the patient had not had an epileptic seizure

for seven years. His sister is noted to have possibly had tuberculosis, though her diagnosis was uncertain. At the time of the study the patient was married with a previous marriage having been annulled. One year of college, with a major in accounting, had been completed. The date of his participation in the study was December 20, 1950.

There were multiple instances in which the patient's narrative conformed to that of the typical romanticizing of TB. The patient scored above the 92nd percentile in the "social service" category of the Kuder Preference Record. In addition to this remarkably high score, the patient's social score in the Profile of Values was also relatively high. Despite these strong values, a look into the patient's relationship with his family—particularly his spouse—suggests that he may have had some degree of a "failure of will" in implementing these values into his social interactions. When questioned about his relationships, the patient wrote "conflict" regarding both his step-mother and his spouse. This is indicative of a strong will that is often at odds with others, which the interviewer bluntly notes: "[the patient has a] history of conflict, chiefly revolving about [the] wife's lack of adherence to [the patient's] 'compulsive' standards in terms of economic striving—and [the patient's] lack of 'compulsive' standards in terms of his own social functioning (she was extremely jealous)" (241, B-3). He conforms to the romantic idea of TB patient being simultaneously "passionate and repressed" (Sontag 39), though he himself seems to be repressing the implementation of his passionate social values.

However, the interviewer's opinionated commentary changes the perspective one may have about the patient. The interviewer further comments on the patient's social skills, noting how he "cannot relate to people. He is not seclusive, he has charm, is likable, and wants to relate; it is just that he doesn't understand people or himself" (241, J-3). With this additional interpretation of him in mind, the patient seems less like one who conveys a "failure of will" in applying his values to his actions. He is portrayed more as someone who wishes to improve, though he doesn't understand or quite know how to go about doing so. The question of how one learns to "understand people" or "relate" is one that reveals a social vulnerability in the patient, likening him to the stereotypical romanticized TB patient who exhibits pointedly vulnerable characteristics.

Though several of the interviewer's notes are a matter of personal opinion (the patient's likability, charm, etc.), other notes are more factual. The interviewer records the patient's progress in adhering to his treatment regime in the sanatorium, observing how the patient would frequently "leave bed against orders"

(241, C-1). It is additionally noted that the patient had difficulty adjusting to “following out his treatment regime” and “in planning or carrying out rehabilitation procedures” (241, C-6). This suggests a hyperactivity present in the patient, resulting in the simultaneous manifestation of a strong will to pursue his own personal desires, and a weak will to follow the desires of others.

Patient 241 showed a remarkably strong will at times. The interviewer writes of how the patient “had a very far advanced case.” His health was in such a critical condition that a doctor informed his wife that he had “very little hope” of recovery. The patient’s reaction when confronted with such morbid news was one of a strong rebuke, as the interviewer writes down his verbal response word-for-word: “I ain’t gonna die—But I was mad ‘cause they told my people they were worried—I don’t see how a Dr. can say people are going to die when he don’t know” (241, B-5). Rather than fall into a depression, or be overtaken by fear of his death, the patient’s response is one of anger, of indignation upon hearing the doctor’s words. Herein lies an intriguing paradox: while the patient may be considered strong-willed by his refusal to dwell on the negativity connected with the possibility of his death, it may also be argued that the patient exhibits a “failure of will” by sternly refusing to consider his own death—perhaps showing tell-tale traits of denial, the first stage of grief. It may be a mix of both possibilities.

Our last case study is patient 293, a thirty-year old man who began his treatment on October 16, 1950. His family history reveals a significant presence of illness among family members. A wife is listed but no information is noted regarding her state of health. The date of his participation in the Daniel Harris study was May 17, 1951.

Patient 293 deviated from the typical narrative of the “quintessentially vulnerable” patient, at times exhibiting an exceptionally strong will that bordered on the performative. He indicates solid plans for working through his treatment and beyond. When prompted on what he planned to do during his treatment he indicated an interest in “work[ing] toward becoming a lawyer” (293, A-3). Previous employment for this patient includes being a “truck driver” and a “clerk.” The patient’s apparent interest in upward mobility is indicative of a strong personality, uncharacteristic of Sontag’s account of the tubercular narrative. Interests in upward mobility are confirmed by the results of this patient’s Study of Value tests which indicate strong economic and political interests.

This patient also indicated that before his present illness, typical activities included “swimming”, “fishing”, and “spectator sports” (293, A-4). Interests such as these contrast with “languidness” which is part of the tubercular narrative as

well (Sontag 12). This patient's performative rebellion against the narrative of tuberculosis may be accounted for by narratives of gender. As written by Sontag, "twentieth-century women's fashions...are the last stronghold of the metaphors associated with the romanticizing of TB in the late eighteenth and early nineteenth centuries" (29). The resulting connection to be made from this observation is that as the patient performs his masculinity, he is also performing a narrative which deviates from TB--which is viewed as both feminine and vulnerable.

When asked about the patient's "poise during [the] interview" the interviewer indicates that he was "quite poised, self-possessed" (293, J-1). When asked about the patient's "characteristic output of energy", the interviewer marked him down as tending toward "lively" (293, J-1). This is vastly uncharacteristic from the tubercular narrative, what Sontag would have called a "defective vitality." However, it is also worth noting that the tubercular narrative was always one of contrasts and extremes, "hyperactivity alternating with languidness", "white pallor and red flush" (Sontag 11). Therefore, even as the patient attempts to perform against one stereotype of TB, he invariably alternates to another by characterizing himself in the opposite extreme.

### **The Paradox**

A pattern emerges from the case files we have examined from the Daniel Harris study. While the patients adhere to tubercular narratives in some ways, they diverge from them in others. The tubercular narrative is characterized by a myriad of paradoxes and binaries such as this one from *Illness as Metaphor*: "TB was an ambivalent metaphor, both a scourge and an emblem of refinement" (Sontag 61). By the Romantic and Victorian literary eras Sontag survey's, TB had already taken on a virtual mythology of meanings. Some of these mythological meanings had persisted nearly a century and a half after the eras described in Sontag's work. In *Illness as Metaphor*, Sontag addresses the persistence of these metaphors:

In 1881, a year before Robert Koch published his paper announcing the discovery of the tubercle bacillus...a standard medical textbook gave as the causes of tuberculosis: hereditary disposition, unfavorable climate, sedentary indoor life, defective ventilation, deficiency of light, and "depressing emotions." Though the entry had to be changed for the next edition, it took a long time for these notions to lose credibility. (54)

It is credible to assume that some aspects of the tubercular narrative had persisted even into the middle twentieth century when Daniel Harris' study was conducted. It could also be conjectured that some aspects of Daniel Harris' study were designed to study the possibility of a tubercular personality, putting the tubercular narrative under due scrutiny. It was difficult to discredit, nevertheless, because of the strength it accumulated over time. TB's wealth of contrasting meanings also made it laborious to unravel. Attempts to perform against one aspect of the tubercular narrative would typically result in conforming to another aspect of it on the opposite extreme. TB was "hyperactivity alternating with languidness"; it's both "white pallor and red flush" (Sontag 11). Through the accumulation of these extremes, the tubercular narrative becomes a kind of catch all, so that anyone would sometimes adhere to it, even if not perfectly. The implication is that the paradox is in fact a logical continuation of the tubercular narrative, which had become a broad metaphor covering wide spectrums of behavior and characteristics.

Perceived causes of TB have also been surprisingly resilient. Robert Koch had published his papers identifying the tubercle bacillus more than fifty years before the Harris studies were conducted. Questions in the Harris study gauged activity and moods of the patients before their "current illness" suggesting an interest in studying the veracity of these narrative causes. Sontag was critical of these narrative causes in *Illness as Metaphor*:

Needless to say, the hypothesis that distress can affect immunological responsiveness...is hardly the same as--or constitutes evidence for the view that emotions cause disease, much less for the belief that specific emotions can produce specific diseases. (53-54).

It is likely that Harris was also skeptical of the metaphorical causes of TB. Sontag believed that disease metaphors would become obsolete if the disease was studied under heavy scrutiny until it was no longer mysterious--such as what has happened with TB with gratitude to studies such as that conducted by Daniel Harris. Sontag writes the following about metaphors surrounding another disease, that of cancer: "perhaps nobody will want any longer to compare anything awful to cancer, since the interest of the metaphor is precisely that it refers to a disease so overlaid with mystification, so charged with the fantasy of inescapable fatality" (87).

## Conclusion

What Sontag hopes will happen to metaphors of cancer has presumably already happened to TB. The tubercle bacillus has been established as the culprit for causing TB rather than “depressing emotions” and “light deficiency.” Still the tubercular narrative persisted in the collective unconscious of populations after the Romantic and Victorian eras. A partial cause for the survival of TB narratives may be the political metaphors that were used into the twentieth century. Sontag illustrates a paradox present in such metaphors: “Modern disease metaphors specify an ideal of society’s well-being, analogized to physical health, that is as frequently anti-political as it is a call for a new political order” (76). Not unlike TB’s conflicting romanticizations, the duality of the political metaphors perhaps contributed to its enduring survival. And the enduring survival of the TB metaphor allowed it to accumulate many more metaphorical trappings until almost anyone seemed to adhere to at least one of its stereotypes.

Therefore, the paradox of patients both adhering to and departing from the tubercular narrative is not illogical. In fact, it is a logical continuation of what became a broad metaphor which began to accumulate entire spectrums of behavior. This is not to say that Tuberculosis both is and is not a “failure of will.” It is much more likely that the disease never was caused by a failure of will. Like many diseases, TB was prone to metaphorical narratives when it was still mystical and largely misunderstood. As written by Sontag, “it is diseases thought to be multi-determined (that is, mysterious) that have the widest possibilities as metaphors” (61).

## Works Cited

- Harris, Daniel. "Patient 210." 1951, Archives of the Center for the History of Psychology, Akron, OH, M3639 Folder 1. Pdf file. Accessed October 12, 2018.
- . "Patient 241." 1950, Archives of the Center for the History of Psychology, Akron, OH, M3639 Folder 3. Pdf file. Accessed October 12, 2018.
- . "Patient 293." 1951, Archives of the Center for the History of Psychology, Akron, OH, M3638 Folder 5. Pdf file. Accessed October 12, 2018.
- Sontag, Susan. *Illness as Metaphor and AIDS and Its Metaphors*. Picador, 1989.