“The Despair of the Physician”: Centering Patient Narrative through the Writings of
Charlotte Perkins Gilman

A thesis presented to
the faculty of
the College of Arts and Sciences of Ohio University

In partial fulfillment
of the requirements for the degree
Master of Arts

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May 2018
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This thesis titled
“The Despair of the Physician”: Centering Patient Narrative through the Writings of
Charlotte Perkins Gilman

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ABSTRACT

REEHER, JENNIFER M., M.A., May 2018, English

“The Despair of the Physician”: Centering Patient Narrative through the Writings of Charlotte Perkins Gilman

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Patient narrative is often an undervalued or dismissed genre of writing in the field of literary criticism, largely because the hermeneutics of suspicion leads critics to see these texts as “misery memoirs,” as Ann Jurecic suggests. In this thesis, I argue for a new approach to reading and to criticism that moves away from the hermeneutics of suspicion and instead seeks to find conversations between patient narratives, case narratives, and popular or dominant medical and scientific texts. This shift would have readers focusing not on the ways in which an author might manipulate a story but instead on what the reader might learn from intently examining the resulting conversations. In doing so, I do not argue for a switch in the hierarchy—from doctor-patient to patient-doctor—but instead argue that both patient and case narratives have value; without both texts, we cannot have a full picture of what it is like to live with illness.

Making my argument through historical examination, I prove that by examining Charlotte Perkins Gilman’s patient narratives—those found in her letters, her diaries, and her autobiography as well as in “The Yellow Wallpaper”—alongside medical and scientific texts from her time, we can not only deepen and nuance current interpretations of these texts but we can also uncover motivations that may not be immediately apparent. While “The Yellow Wallpaper,” for example, has been considered as a critique of
patriarchal medicine, a horror story, and a liberation text—among others—it has never been explicitly examined as a patient narrative. This focus allows us to delve deeper into the conversation created between “The Yellow Wallpaper” and Gilman’s nonfiction narratives; I focus particularly on how we can see the eugenic arguments within “The Yellow Wallpaper” and how these arguments are connected to Gilman’s anxieties about marriage, motherhood, and her usefulness in society.

While ignoring patient narratives makes literary critics and historians complicit in the history of silence that surrounds medical patients, I conclude that by instead recognizing the validity and the value of the patient narrative, literary critics and historians could (1) better contextualize some of the most popular and canonical texts, especially those in which illness is a significant driving factor, (2) develop a more complete understanding of what it is like to live with illness, and (3) create new frameworks through which to read patient narratives, as well as other autobiographical texts.
DEDICATION

To my parents, Matt and Sherry Reeher

Thank you for your constant and unwavering love and support.
ACKNOWLEDGMENTS

I would first like to express profound gratitude to my thesis director Dr. Scanlan, who provided me not only with helpful comments and feedback but also with support and encouragement throughout the process of crafting this master thesis. I would also like to thank Drs. Hurley and Sheldon, the second and third readers on my thesis committee, for their insightful and prompting comments and for their keen eyes for detail. Finally, I must thank my peers in the Ohio University Graduate English Program, particularly Jeffrey Mccambridge, Devan Murphy, Megan Griffith, and Regina Yoong, all of whom actively listened to me to talk out my ideas, asked me brilliant and prompting questions, and encouraged me through every step of the thesis-writing process. Thank you.
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INTRODUCTION: A CASE FOR THE PATIENT NARRATIVE GENRE IN LITERATURE

In 1892, Charlotte Perkins Gilman published her most well-known work, the short story “The Yellow Wallpaper.” This story draws on Gilman’s own personal experience with medicine, particularly her experience with Silas Weir Mitchell’s “Rest Cure” following her diagnoses of hysteria and neurasthenia in 1887. Since its publication, “The Yellow Wallpaper” has been interpreted as a horror story, a critique of male-dominated and sexist medicine, a liberation text, and a eugenic argument; however, this story has never been explicitly examined as a patient narrative, a text that weaves together the experiences of the individual as a patient but also as a person living a life beyond the clinically-defined boundaries of their illness. This is, in part, because the genre of patient narrative is largely underappreciated—or, at times, completely absent—in fields of literary study. By embarking on such an examination, however, we can see how Gilman’s experience—which she recorded in a variety of narratives including the fictionalized presentation in “The Yellow Wallpaper”—was influenced not only by her health but also by (1) her experiences with marriage and motherhood, (2) the changing state of specialization and the doctor-patient relationship in American medicine, and (3) her racial, gender, and class identities. Through this experience and the (re)telling of her narrative, we can not only begin to see Gilman’s complicated relationship with health and medicine but also her attempts to both make sense of her condition and to reclaim ownership of her own story, an ownership that was directly challenged not only by the wider field of medicine but also specifically by her doctor, Silas Weir Mitchell.
What Is a Patient Narrative?—Defining the Terminology

There are a number of fields and disciplines that are concerned with patients’ autobiographical accounts of disease, illness, and treatment; however, there are inconsistencies in the terms (and their exact definitions) used to refer to this body of work. As such, the establishment of terms and their corresponding definitions needs to be explicitly and clearly set forth before beginning to discuss this genre of writing in any detail.

The term “patient narrative” is used to define a genre of writing that is made up of autobiographical accounts of disease, illness, and/or medical treatment from the patient’s perspective. Whether or not autobiographically-inspired fiction should be included in this genre has been up for debate, particularly as competing terms such as “clinical realism” have separately defined “[f]ictional writing where health problems are systematically represented, not as a metaphor, not as a plot point, and not as the central topic of the writing, but as a part of a character’s personal identity and day to day experience” (McDonald et al. 3); however, for my purposes, I will be including autobiographical fiction as a type of patient narrative. Because patients may want to employ fictional elements in their writing as a way of, among other things, understanding trauma, I argue that it is important that fictionalized patient narratives not be removed from the larger study of these autobiographical accounts; however, it is important to recognize the fiction/nonfiction genre of a patient narrative when critiquing or analyzing the work as the conventions of these genres function very differently and make different demands of both the author and the reader.
“Illness narrative” is also a term that has been used to define the same body of work as “patient narrative”; for the purpose of this work, however, I will be using the term “patient narrative” because I feel that it is important to center the person rather than the illness, allowing us to understand the author as a person who is bigger than their medical condition and health concerns. However, in favoring this particular term, it is also important to recognize that some patient narratives may come from authors who were never formally diagnosed and/or treated for their illness and, therefore, were never actually patients. In this case, the actual status of patient is not a prerequisite for producing patient narrative literature.

Closely related to the patient narrative is the “case narrative,” a record of a patient’s (or a group of patients’) experiences—including their symptoms and the medical treatments applied to them—as recorded by a doctor, nurse, or other medical professional rather than by the patient themselves. I will also be using the term “form narrative” to refer to the record of a patient’s experience that exists in medical forms—a format that restricts what stories can be told by forcing varied and individual experiences into boxes, asking a limited number of uniform and often ambiguous questions, and leaving little to no truly narrative space for individual explanation. It is also important to note that these form narratives are often recorded by a medical professional rather than the patient, though this is a frequent trend rather than a universal truth.

I will also, when necessary, use the term “illness narrative” to refer to the collective genre of writing about illness that includes patient, case, and form narratives as subgenres. This differs from the typical use of “illness narrative” which, as stated above,
often shares a definition with “patient narrative.” Here, however, it will function as a collective term.

By making these distinctions between patient, case, form, and illness narratives, I will be able to more explicitly address these records of experiences of illness and disease while acknowledging differences in authorship, audience, form, and purpose, all of which are important to consider when evaluating the function and value of patient narratives across fields and disciplines as well as in different time periods and cultures.

**Patient Narrative in Medical Humanities**

The patient narrative has, since the advent of medical humanities, gained status as a useful tool for building empathy, appreciating patient voice, and bringing the individual back into a system that is oftentimes focused on the clinical categorization and diagnosis of patients rather than the emotional impact that illness has on people as individuals. This approach to the patient narrative in medical humanities is not new. In fact, in Arthur Kleinman’s foundational study *The Illness Narratives*, published in 1988, Kleinman focuses on the patient narrative as a way for individuals to make sense of their conditions:

The [patient] narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term source of suffering. The plot lines, core metaphors, and rhetorical devices that structure the [patient] narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings. (49)
Kleinman is particularly interested in the potential of these narratives to give voice to a patient’s actual lived and felt experience, an experience that he feels is not being addressed in the clinical field of medicine. He goes on to argue that these records are valuable in ways which require further study, building this genre into his larger argument for the importance of studying what would eventually be termed “medical humanities.”

Since medical humanities has been introduced as a field of study, doctors, researchers, and teachers have explored many avenues connecting literature and science, particularly in terms of the creation of narratives. In fact, as Paula McDonald et al. argue in “Clinical realism: a new literary genre and a potential tool for encouraging empathy in medical students” (2015), students could increase their empathy for patients not just by reading patient narrative literature but also by doing creative writing exercises themselves. McDonald et al. base this claim on an experimental course where the students each created a character with a chronic condition and then wrote personal (fictional) narratives on different prompts from the fictional character’s perspective.¹ The results of this experimental course show that students were better able to understand their characters as people—rather than just as patients with chronic conditions—as the course went on. One student noted, “Creative writing enabled me to access an otherwise alien experience and perspective and as a result feel genuine empathy and compassion towards someone I may otherwise have been quick to judge” (7).

¹ It is important to recognize that this example of writing, while obviously valuable in the field of medical humanities, does fall outside the definition of true patient narrative since this is not autobiographically-inspired fiction but is fiction created by the students about characters who might be potential patients.
Charles E. Rosenberg also addresses issues of disconnect between physicians and patients in his article “The Tyranny of Diagnosis,” published in 2002; according to Rosenberg, in the current system “slippage, frustration, communication failure, and unmet expectations are inevitable” between the patient and the physician, and he cites a system that emphasizes and treats patients based on narrow, specific disease categories as the cause of this divide (253-254). He critiques the bureaucratic nature of medicine, saying that “[i]n the act of diagnosis, the patient is necessarily objectified and recreated into a structure of linked pathological concepts and institutional social power” (257). As medicine becomes more and more specialized, the doctor-patient relationship changes and, as it does, so does the purpose and value of the patient narrative.

In their 2009 article “Narrative-Based Medicine: Potential, Pitfalls, and Practice,” Vera Kalitzkus and Peter F Matthiessen recognize additional useful medical approaches to patient narrative including the “healing effect” that creating and sharing a narrative can have, arguing that a doctor and a patient working together to create a patient narrative “ultimately helps all parties involved in developing their human potential” (83, 84). However, they do also offer a warning that physicians not get too deeply involved in narrative to the point that they risk seeing disease and death only as stories and not as facts:

Narrative is not the only thing that counts in medicine: by no means is it meant to devalue medical knowledge. Also there are patients who are not interested in telling their story or sharing their innermost feelings, and not every topic raised in consultation calls for detailed narrative exploration. (84)
Ultimately, they argue, it is important to be aware of narrative, to acknowledge and use narrative, but to do so carefully and purposefully while remaining focused on scientific facts, data, and treatments; engaging a patient in narrative discourse is but one tool in the doctor’s medicine bag.

Altogether, these studies and arguments favor the patient narrative and recognize its potential for positive implications in the field of medicine, particularly in terms of increasing empathy in medical professionals, helping to heal or soothe patients, and allowing a space for emotional expression in clinical spaces that may otherwise seem cold in their strict focus on measurable and diagnosable data.

Patient Narrative in Literature

While the field of medical humanities is embracing the patient narrative, this same genre is largely undervalued and underexplored in the field of literature; when discussed, this body of work is often referred to by dismissive and demeaning terms such as “misery memoirs” and “victim art” (Jurecic 10). Interestingly enough, it is the same characteristic of the patient narrative that gives it value in medical humanities but also causes it to be distrusted among literary critics; the personal, intimate quality of these writings not only causes many critics to become suspicious of the validity of the narrative, but critics are also often reluctant to review a work that “may seem to be self-indulgent manipulations of sentiment and goodwill” and complicates the traditional conventions of literary criticism that are based on the hermeneutics of suspicion (Jurecic 3-11).
According to this particular theory of criticism, the literary critic should begin each critique from a standpoint of suspicion—suspicion of both the author and their intentions—and the author has a burden to overcome that suspicion and convince the critic that they are trustworthy. I would argue, however, that instead of approaching patient narratives from a point of suspicion, we should be considering the specific conventions assigned to this genre—and to its subgenres and many varieties of forms. We must understand that different genres have different conventions which place different demands on the writer as well as on the reader; there are different ethics to reading and writing in different genres.

In relation to Gilman specifically, we must consider that her various patient narratives are written accounts of the same experience recorded at different times and in different genres. In order to examine these narratives, then, we need a way of reading that recognizes the demands of these different conventions on both Gilman (the writer) and on us (the readers). For example, Gilman (re)narrates her experience with marriage in her autobiography, the narrative with the most temporal distance between Gilman’s experience and the writing itself. The hermeneutics of suspicion would encourage a reader and critic to use the differences between this reflection on her marriage and the reflections present in her earlier writings (“The Yellow Wallpaper” as well as Gilman’s letters and diaries) to suggest that Gilman is either lying or otherwise altering her story for intentional and manipulative reasons. However, when considering the particular conventions of autobiography against, for example, fictional genres, we can see how the demands of this specific genre might dictate the changes to her presentation of that
relationship. In autobiographically-inspired fiction, for example, there is distance between the author and the narrative, a distance that only the author can truly gauge; this allows for a very different expression of the ties between marriage and health than the autobiography in which that distance between the author and the narrative is closed. By departing from the hermeneutics of suspicion, then, and instead focusing on narrative and genre comparisons, the reader can not only develop a wider picture of the author’s experience but can also examine genre conventions in comparison.

When it comes to reading patient narrative, then, the problems with the hermeneutics of suspicion are many. Beyond the importance of recognizing difference in genre-based conventions, it is also generally uncomfortable to approach an author’s personal account of illness—and oftentimes pain—from a place of skepticism; however, the recognition of this discomfort is typically accompanied by an unwillingness to forgo skepticism for fear of falling victim to an author’s oversentimentalization, a type of writing that, critics fear, emotionally manipulates the reader into accepting arguments and viewpoints that may not hold water if examined from an objective and logical (i.e., non-emotional) perspective (Jurecic 3-11). This clash of discomfort and unyielding skepticism often results, then, in this particular genre being pushed to the margins.

The challenge when approaching patient narrative as a literary genre, then, is in what exactly we do with these narratives. How do we read them? How do we critique

---

2 We can also see immediate genre-based differences in presentation and convention between autobiography (which is intended to be publically consumed) and more private forms of writing such as letters and diaries which, by all accounts, were never intended to be publically presented.
them? How do we teach them? With the hurdles of potential emotional manipulation, sentimentality, and other critical challenges in the way, we have to start with a new theoretical and analytical approach that, as Ann Jurecic argues in her *Illness as Narrative*, moves away from debunking these narratives and towards assembling and understanding personal experiences; she argues that we should adopt Latour’s notion that the critic should not position themselves against the author but should instead see themselves as a collector of individuals’ stories, providing these authors with “arenas in which to gather” (Latour qtd. in Jurecic 16). This allows the critic to maintain their distance from the author’s emotional appeal while not automatically assuming that the author is untrustworthy; instead, the critic can now observe these narratives in conversation within Latour’s “arena” and, from there, the critic can build criticism and analysis on these conversations. This format also allows us to see—when multiple narratives exist as in Gilman’s canon—how the narrative changes across genres and across time. By examining the conversation between those narratives, we can start to understand not only what the differences are between the presentations but also how those differences might be explained by differing conventions, the effect of time on memory, and a number of other factors that do not immediately assume that the author is untrustworthy by nature.

In this work, I will build on the recent scholarship of Jurecic and her *Illness as Narrative*; as Jurecic has already made the case for the study of recent and current patient narratives, however, I will argue for the importance of studying historical patient narratives and medical texts in the field of literature by looking at the works of Charlotte Perkins Gilman and her doctor, Silas Weir Mitchell. In order to make this argument, I
examine fictional, autobiographical, and medical literature in conjunction and, through this practice, develop the beginnings of a medical theoretical framework through which literary historians might approach other texts in future studies and research. This framework, I suggest, should build on Jurecic’s vision, looking at the conversations among patient narratives as well as the conversations between these narratives and other medical texts, but also examining contextual documents in politics, culture, and other sciences in order to recognize and contextualize the differences—and sometimes dissonance—that inevitably arise when reaching into the past. I argue that a historical-medical-theoretical lens might look something like a medically-focused version of New Historicism—borrowing and building, of course, from elements of critical studies of disability, race, and gender—that fights to bring the personal and individual stories back into a field that is frequently homogenized and regarded as scientific rather than literary. This lens would consider questions and implications of audience, purpose, and moment that recenter medicine and narrative on the author/patient and the author/patient’s experience rather than viewing both the patient and the author with distrust and suspicion and instead favoring the doctor by default.

Gilman, Mitchell, and American Medicine at the Turn of the 20th Century

In order to establish the importance of analyzing the patient narrative genre in literary history and, especially, as a piece of literature, I focus on the works of Charlotte Perkins Gilman and her doctor, Silas Weir Mitchell. There are a number of factors that make Gilman an ideal candidate for this research: (1) Gilman’s privilege has made her narratives available during her lifetime as well as in the modern-day, leading her writing
to be reviewed across varying time periods; (2) Gilman’s experience as a patient was recorded at different times in her life and in multiple forms that differ in genre, audience, and purpose (her autobiography, her letters, her diaries, and her fictionalized account in “The Yellow Wallpaper”); and (3) Gilman was publicly and vocally involved in scientific and medical discussions of her day, particularly in regards to the eugenics movement, so she was exposed to and aware of ideas coming out of popular medicine and science at the turn of the 20th century.

In presenting Gilman’s work as a collection of patient narratives, I compare (1) diaries that record her personal account of her conditions (neurasthenia or “nervous prostration” and hysteria) as she is experiencing it; (2) her correspondence with Mitchell, an account of her condition and history as written for her doctor; (3) “The Yellow Wallpaper,” a fictionalized account of her experience, along with “Why I Wrote ‘The Yellow Wallpaper,’” Gilman’s account, years later, of what motivated her to write the short story; and (4) Gilman’s autobiography, published in 1935, which is her public account of her experience written almost 50 years after her neurasthenic and hysterical diagnosis. I not only compare these varying accounts for similarities and differences in narrative, but I also consider Gilman’s portrayal of her symptoms, treatment, and responses alongside Mitchell’s medical texts which provide a professional and scientific account of neurasthenic and hysterical experiences. In considering how Gilman’s narratives relate to the state of medicine in a broader context, I also utilize additional research that addresses changes in medicine that were happening in the United States in the late 19th and early 20th centuries that directly affect doctors and patients alike.
Chapter Overview

In my first chapter, I establish the state of medicine in the United States during the late 19th- and early 20th-centuries, focusing particularly on the treatment of patients with nervous conditions such as hysteria and neurasthenia; these conditions represent both Gilman’s diagnosis and Mitchell’s specialty. Gilman’s conditions, and the practices developed to treat them, are tied to race, gender, class, ability, etc., and thus her experiences can’t be separated from her identity; in order to truly contextualize her experience with illness, we need to understand how that experience—including her diagnosis and treatment—are influenced by those identities, particularly in the ways that those characteristics were pathologized during this particular time period.

In my second chapter, I examine the complicated doctor-patient relationships that existed during this time period, the advancements in medicine that altered these relationships, and how these relationships in turn affected patient narratives. In doing so, I consider medical texts that deal with nervous conditions and patients in a more general sense as well as with specific case narratives. Because Gilman is in direct contention with Mitchell, in order to best understand her experience as his patient, we need to also understand the state of medicine and the specific concerns and anxieties affecting Mitchell and, in turn, affecting his patients. Thus, by examining the changing state of medicine, increasing specialization and technology, and the changing doctor-patient relationship, we can see that doctors such as Mitchell were frequently pitted against their patients—and, on more than one occasion, against other doctors—in order to maintain their authority and to project and protect their expertise. This leads not only to clinical but
also dismissive rhetoric in relation to the patient in Mitchell’s case narratives as well as a focus on himself—the physician—as the active agent in the patient’s medical experience.

The third chapter focuses on Gilman’s various accounts of her illness as visible patient narratives from this time period. In this chapter, I examine differences in Gilman’s patient narrative when presented for different audiences, in different forms, and at different times in her life. I also compare her collective narrative against Mitchell’s accounts of neurasthenia as a condition and of the behavior and experience of neurasthenic and hysterical patients. Gilman’s patient narratives—especially her combined patient narratives—allow us to best see her personal experience with illness in the wider, non-clinical world. Reading these narratives reveals anxieties not only about Gilman’s health but also about her “usefulness,” her marriage, and motherhood. These anxieties are all, in one way or another, tied to her health concerns, and yet such reflections on the patient’s personal feelings are largely absent from contemporary case narratives (such as Mitchell’s case narratives that are examined in Chapter 2).

In my fourth chapter, I explore the ways that responses to specific patient narratives can not only give us a window into the historical and cultural moment in which the narrative was written but can also allow us to examine the state of medicine, culture, and personal values in times when the narrative was reviewed and responded to by readers. In order to do this, I compare readers’ reactions to “The Yellow Wallpaper” both at the time of its publication and when it was “revived” in the 1970s and 1980s. Through this comparison, I aim to prove that by examining how “The Yellow Wallpaper” responds to and plays off not only the anxieties that Gilman felt but also the leading
scientific and medical beliefs of the day, we can either strengthen, negate, or complicate previous interpretations of this short story while also developing some entirely new readings of the text. In this section, I specifically argue that “The Yellow Wallpaper” is only narrowly a story of liberation; that the “horror” of “The Yellow Wallpaper” is rooted in eugenic fears; and that “The Yellow Wallpaper,” when read as a patient narrative, allows us to examine complicated anxieties about identity, marriage, and motherhood through the lens of science-and-literature.

In my concluding chapter, I argue for the importance of understanding and preserving the patient narrative as a literary genre and present the wider implications of my research for medical and literary history more generally. This includes arguing for the development of a healthy theoretical and literary framework for studying patient narratives that (1) moves beyond a hermeneutics of suspicion and instead focuses on implications of both genre-specific conventions and narrative differences, and (2) focuses on the intersection of “hard” or professional science, popular science, and literature; such a framework may open doors, not only for a new literary study, but also for disruptive and hysterical histories, to borrow a term from Victor Vitanza, that will help to challenge dominant and silencing historical, medical, and literary narratives.

3 “Hysterical histories,” as defined by Vitanza, are histories that disrupt dominant discourse and challenge traditional notions of authority, importance, and worthiness (Vitanza 311-316).
CHAPTER 1: TREATING NERVOUS CONDITIONS IN LATE 19TH- AND EARLY 20TH-CENTURY AMERICAN MEDICINE

According to her autobiography, Charlotte Perkins Gilman’s earliest experience with acute symptoms of “nervous prostration” coincide with the birth of her daughter on March 23, 1885. However, it wasn’t until the spring of 1887 that Dr. Silas Weir Mitchell diagnosed Gilman with a case of neurasthenia which had reached a hysterical level. Gilman continued to struggle with hysterical neurasthenia—in spite of, or perhaps because of, her medical treatment—up until she left her husband Walter Stetson and moved to Pasadena, CA, though she continued to deal with related concerns throughout the rest of her life (Gilman, Living 88-109). It was between the spring and the fall of 1887 that Gilman sought Mitchell’s advice and attempted to follow his prescription for improving her health and her life (Gilman, Living 95-96). During this time, “nervous prostration”—as neurasthenia was sometimes called—was a “new disease [that] had dawned on the horizon” (Gilman, Living 90). The newness of the condition created

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4 The process of separation/divorce, as well as Gilman’s process of healing, took place over a number of years. Gilman and Stetson first decided to divorce in the fall of 1887, though Stetson eventually followed Gilman to Pasadena in hopes that the change of environment might have improved her condition enough that the two could be reconciled; in January 1890, Stetson left Gilman after realizing that this would never happen (Gilman, Living 109). It wasn’t until 1890 that Gilman considered herself “finally free” and able to start writing again (Gilman, Living 98). However, she does reflect in her autobiography that her condition lasted beyond 1890 and that she was not immediately better upon being “finally free”:

I think that if I could have had a period of care and rest then, I might have made full recovery. But the ensuing four years in California were the hardest of my life. The result has been a lasting loss of power, total in some directions, partial in others; the necessity for a laboriously acquired laziness foreign to both temperament and conviction, a crippled life. (Living 98)

This passage shows not only the first concrete steps in Gilman’s recovery but also her concern with the lasting effects of her condition and the ways in which her condition restricted her far beyond this period of her life.
complications for physicians, patients, and the general public, as Gilman explains in her autobiography: “No one knew much about it, and there were many who openly scoffed, saying it was only a new name for laziness. To be recognizably ill one must be confined to one’s bed, and preferably in pain” (Living 90).

In order to best understand and contextualize Gilman’s condition, diagnosis, and treatment that she reflects on and portrays in her writing, then, we must establish a more general understanding of American medicine and nervous conditions during this time period, exploring the understanding of neurasthenia as it was introduced to American society and as it became enculturated in social, political, racial, classed, and gendered tensions.

What Is Neurasthenia?

While neurasthenia is now an outdated term no longer applied to patients with nervous conditions, in the late 1800s and early 1900s it became a rather common diagnosis in American medicine that indicated that a patient had depleted their nervous reserve. The term “neurasthenia” itself comes from a series of Greek roots that, when interpreted literally, means “lack of nerve strength,” and this same condition was also referred to by both patients and doctors as “nervous exhaustion,” “nervous prostration,” and “nervous debility” among other terms (Beard, Nervous Exhaustion v-vi). During this time period, people believed that individuals had a certain amount of nervous energy that they could spend, and when that energy ran out, the individual would exhibit a number of different physiological and psychological symptoms that would indicate that the patient was neurasthenic. Treatment, then, was often designed to help the patient regain some of
this energy so that they could go about their daily life as they had before their neurasthenic episode.

Medicine, however, is not separate from social and political influence, and a neurasthenic diagnosis indicated more than just a patient’s state of health. Neurasthenia was seen as an upper-class condition, often considered a sign of superiority. In the late 19th century, George M. Beard, an American neurologist who both pushed for and participated in more detailed studies of neurasthenia, published two medico-social treatises on this particular nervous condition that provide a direct and explicit window into the connections between neurasthenia, American nationalism and exceptionalism, class structures, and eugenics: (1) *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment* (hereafter referred to simply as *Nervous Exhaustion*) published in 1880 and (2) its supplemental text *American Nervousness: Its Causes and Consequences, A Supplement to Nervous Exhaustion (Neurasthenia)* (hereafter, *American Nervousness*) published a year later in 1881.

According to Beard, “Neurasthenia is an American disease in this, that it is very much more common here than in any other part of the civilized world, and here it first received its name and description; it could not be expected that European authorities would be the pioneers, either in the study of its nature or treatment” (*Nervous Exhaustion* 9, original emphasis). To Beard and to many other American doctors, the United States

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5 When considering Gilman’s connection to this condition, her class identity is reflective of this medical belief. Gilman’s family was affluent and well-respected, and Gilman herself occupied a middle-to-upper-class social status.
provided a very specific set of cultural and geographic factors that allowed for the prevalence of neurasthenia. These factors included (but were not limited to) the uniqueness of American liberty, the particular climate in the United States, and the advancements of modern civilization which Beard distinguishes from ancient civilizations by five characteristics: “steam power, the periodical press, the telegraph, the sciences, and the mental activity of women” (*American Nervousness* vi).

Beard also cites the lack of European precedent for the condition as one of the main reasons that the study of neurasthenia has been so neglected in the United States:

[…] we, in this country, where the disease most abounds, have depended so exclusively on European precedent and experience. […] In Europe, these functional nervous diseases, although they exist, yet are so rare that even specialists in diseases of the nervous system do not see them constantly, and when they see them, do not, with very few exceptions, recognize or treat them.

(*Nervous Exhaustion* 8-9)

Beard and his contemporaries, as this quote makes clear, were very invested in a split between the United States and Europe, arguing that the United States is superior to Europe by highlighting what Beard sees as European shortcomings. By pointing out the prevalence of neurasthenia in the United States and the lack of knowledge and precedent concerning this condition coming out of European medicine, Beard not only makes an argument about the shortcomings of European medicine but also presents a call-to-action for American doctors and scientists; this condition is something that only they can appropriately study, understand, and treat.
By establishing neurasthenia as the quintessential “American nervousness,” Beard and his contemporaries connect this condition to a sense of American nationalism, exceptionalism, and pride, suggesting that the American population is superior to the populations of other countries and that neurasthenia could prove this superiority. In one example, Beard argues that “higher culture and sensitive nerves react to slight irritation; while low culture and insensitive nerves require strong irritation” (American Nervousness 74). He uses this argument not only to show that American women, in this specific example, are superior to women from England, Germany, or Switzerland, but also to make class and racial distinctions within the American population itself.

Because it is “high culture” or elite nerves—nerves that reside in elite people and become “high culture” through biological or genetic inheritance, education, social exposure, and other upper-class activities—that were easily excitable, neurasthenia, became a strictly upper-class condition. In fact, Beard explicitly defines the organization of a person who could develop neurasthenia in American Nervousness:

It is the organization of the civilized, refined, and educated, rather than of the barbarous and low-born and untrained—of women more than of men. It is developed, fostered, and perpetuated with the progress of civilization, with the advance of culture and refinement, and the corresponding preponderance of labor of the brain over that of the muscles. (26)
While neurasthenia was a cause for concern that needed to be treated seriously, it was also a badge of honor and a sign of an individual’s class; it was more closely related to brain-work than muscle-work and was a mark of high civilization.6

This also meant, conversely, that people who were not of this “superior” class could not develop neurasthenia. In *American Nervousness*, Beard identifies these groups that he considers incapable of ever developing neurasthenia, largely because they do not, according to Beard, have the physical, mental, intellectual, or emotional makeup that would allow them to develop such a condition. Among these groups of “barbarian[s] and immature mind[s]” are:

the Indians of South America and Central America – the negroes of Africa and of our own country, young children everywhere, and adults who have never matured in the higher ranges of intellect [who are] in varying degrees – like the Indians of the Western plains, living not for science or ideas, but for the senses and emotions. (131)

In fact, Beard argues that “[i]n savagery, life is mostly sensual, with much mental force held in reserve, as with North American Indians, while the intellect has but slight strength” (*American Nervousness* 118). He contrasts this description of so-called “savage life” with that of “highly civilized people” by suggesting that in the process of becoming civilized, elite people’s nerves become quicker to excitement and must therefore be

6 When considering Gilman’s diagnosis, it is important to note that she is not only educated but also actively participates in “brain-work” such as writing and political and social activism. It is also important to note that Gilman’s gender identity, the fact that she is a woman, also plays a role in this diagnosis, though neurasthenia is not as much of a gendered diagnosis as hysteria is.
controlled; without this control, Beard argues, civilization would be impossible (*American Nervousness* 118). The more civilized a person is, the more elite a person is, the more easily excitable their nerves are; hence the neurasthenic connection with only a specific, narrow, upper-class group of people.\(^7\)

Together, these texts—*Nervous Exhaustion* and *American Nervousness*—represent not only American nationalism and exceptionalism and their connections to medicine during this time period but also the eugenic ideas of superiority based on race, class, intelligence, and other qualities deemed to be signs of “better breeding”; it is not surprising, then, that neurasthenia is frequently included in and inextricably connected to conversations about eugenics that are happening in the United States during this same time period. In fact, as the neurasthenic diagnosis became more and more popular, some physicians became concerned that a number of their colleagues were applying this diagnosis too liberally, particularly to people who fit the “inferior” classes. This concern was so pronounced that the 1889 edition of Beard’s *Nervous Exhaustion* included an editor’s preface by A. D. Rockwell, an American physician who worked with Beard, in which Rockwell criticized the liberal application of the neurasthenic diagnosis, arguing that “[t]he doctrine to be taught and strongly enforced is that many of these patients are not neurasthenic, and under hardly any conceivable circumstances could they become neurasthenic. They do not belong to the type out of which neurasthenia is born, either

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\(^7\) Here, it is obvious that the category of “civilized” is also a highly racialized category and, when considering Gilman as a potentially neurasthenic patient, her whiteness is a part of the identity that makes this diagnosis a possibility.
mentally or physically” (3). Rockwell is urging physicians to reserve this diagnosis only for the “type” that Beard describes.

Rockwell’s insistence on the “type” that are capable of becoming neurasthenic shows not just medical concerns with potential misdiagnosis but also the social anxieties related to issues of class and race that are disrupted if these lower-class or “unfit” patients are capable of developing this upper-class, elite, superior condition. Beard’s chapter in Nervous Exhaustion that is specifically dedicated to problems of misdiagnosing patients also plays a similar role in detailing the fears and anxieties associated with misdiagnosis across class lines; it was very important to Beard that doctors know how to distinguish between neurasthenia and other diseases that may have similar symptoms but which are associated with lower-class people (80-117). By defining neurasthenia as a definitively American condition, Beard is also arguing, by extension, that those people who are not of the “superior” class that can develop this particularly American nervousness are, in fact, not truly American. These texts inspire American nationalism and exceptionalism based on a very specific part of the American population that fits this “superior” model: white, upper-class, intelligent, healthy, etc. 

8 It is important to note that it is not only white, upper-class individuals who could exhibit the symptoms associated with neurasthenia. However, whenever a patient who was poor, working-class, unintelligent, and/or a person of color presented with these same symptoms, their condition was understood very differently and was therefore approached with a different diagnosis and different treatments than those that would be applied to neurasthenic patients. A prime example of this difference in treatment and diagnosis comes from Rockwell’s preface to the 1889 edition of Nervous Exhaustion:

Many of them [referring to non-neurasthenic patients who, because they present with neurasthenia-like symptoms, have been misdiagnosed with neurasthenia] are unintellectual, phlegmatic, and intolerably indolent, and are pleased at a diagnosis which touches the nerves rather than the stomach, bowels, and liver. Instead, therefore, of rest, quiet, and soothing draughts,
Causes of Neurasthenia

Because neurasthenia is a condition that affects the nerves of upper-class people, many of the causes of neurasthenia are specifically tied to an elite lifestyle. However, it is important to note that there are several different types of elitism that are connected to this diagnosis: (1) the elite status of being a person living in the United States, (2) the perceived superiority of civilization over savagery, and (3) elitism that is based on American notions of class and the American class system. It is also important to recognize the differences in gender roles and expectations and the ways that these social constructions also feed into the understanding of the causes of neurasthenia for male patients and for female patients differently.

The first type of neurasthenic causes that Beard addresses in *American Nervousness* are those that are distinctly American and that separate the United States from all other countries. Among these are the American climate, American liberties, and pursuits and ideals that would later be linked to the concept of “the American Dream.” The climate in the U.S., according to Beard, is particularly marked by changing seasons and the dryness of the air, two factors that distinguish the American climate from that of

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they need mental and physical activity, less rather than more food, depletion rather than repletion. (3)

This quote exemplifies the difference in treatment between the classes, their possible diagnoses, and the remedies used to treat these respective diagnoses. While the neurasthenic patient is encouraged to rest, vacation, or travel and to eat more food, the non-neurasthenic patient—who doctors diagnose with troubles of, among other organs and systems, the digestive tract rather than the nerves—requires more work and activity and less food; oftentimes, as this example shows, the treatments for these class-based conditions are opposites rather than similar or complementary.

9 Though the term “the American Dream” would not exist until later, the idea that certain pursuits, such as social and economic mobility, were uniquely American was already present during this time.
Europe (American Nervousness 142); this becomes a unique factor in neurasthenia, then, because dry air “excites nervousness by heightening the rapidity of the process of waste and repair in the organism, so that we live faster than in a moist atmosphere” (American Nervousness 149). The role of the climate then takes on interesting properties when the U.S. is considered nationally as the climate varies from state-to-state or region-to-region. In this case, Beard presents maps and data that show that nervousness is much more common in northeastern states than in other parts of the nation. He connects this to questions of climate and weather, but it is difficult to separate other issues such as the prevalence of cities and industrialization in the northeastern United States at the time as well as the class and race of people most commonly living in these states as well (157-161).

American liberties and the American Dream are also tied to neurasthenia as a presentation of American nationalism and pride. Beard argues that:

A factor in producing American nervousness is, beyond dispute, the liberty allowed, and the stimulus given, to Americans to rise out of the position in which they were born, whatever that may be, and to aspire to the highest possibilities of fortune and glory. (American Nervousness 122)

Beard believes that overcoming issues of poverty and class is more easily accomplished in the United States than in other countries, and this concept of class mobility and the nervous energy focused on this pursuit can also be attributed to the nervousness of the American population.
The second type of neurasthenic causes are based more generally on notions of civilization and what it means to be civilized, particularly when contrasted with societies and people that Beard and his contemporaries deemed to be “savage.” For example, Beard suggests that “[s]avages may go to the most furious excesses without developing any nervous disease” even providing a concrete example: “It would be impossible for an American Indian by any degree of recklessness or excess to make himself nervous” \cite{AmericanNervousness}. Beard goes on to argue that “Southern negroes” are just as uncivilized as “their distant relatives on the banks of the Congo,” saying that their “uncivilized” nature allows them to work for long periods of time without sleep \cite{AmericanNervousness}. This provides another example of the “savage’s” immunity to excess and, thus, to neurasthenia. Beard believes that “savage” or “barbaric” peoples\footnote{It is important to note, as I have mentioned earlier, that Beard’s classification of “savage” or “barbaric” peoples is comprised of broad categories including (among other people and populations) the native people of North, Central, and South America, the native people of Africa (specifying that they retain their “savagery” whether they currently reside in Africa or in the United States), children, the uneducated, the “insane,” etc.—as well as their descendants \cite{AmericanNervousness}.} have incredibly insensitive nerves; their nerves are so insensitive, in fact, that no excess of any kind will deplete those nervous.

Beard also suggests that one reason that “savages” cannot become nervous is because they do not have the same concerns as “civilized” people. While the civilized person may spend time worrying over domestic and financial troubles that are a direct result of civilization, Beard argues that the “savage” does not carry the same burden of being civilized: “The savage has no property and cannot fail; he has so little to win of wealth or possessions, that he has no need to be anxious. If his wife does not suit he
divorces or murders her; and if all things seem to go wrong he kills himself” (*American Nervousness* 121-122). Beard also quickly addresses the importance of not equating the nervous conditions that a “savage” can develop with the specific and upper-class condition of neurasthenia: “The nervous diseases from which savages suffer, and the lower orders of peasantry, are largely of a subjective, physical character, being caused by the emotions, and assume very different phases, whatever their names be, from those herein described” (*American Nervousness* 171).

These issues of savagery-versus-civilization are also tied to the causes of neurasthenia which Beard suggests are related to class. It is important to note that the concept of class in the United States cannot be separated from concerns of race, economy, inheritance, biology, and intelligence/education. In fact, when addressing the climate concerns that I detailed earlier, Beard suggests that race is a significant factor in which people will make up the dominant and most successful class: “[...] race is, in some sociological aspects, more potent than climate, since the strong races, like the Hebrews and Anglo-Saxons, succeed in nearly all climates, and are dominant wherever they ago” (*American Nervousness* 173). This belief in a naturally strong and dominant race is also apparent in Beard’s descriptions of the “savage” races.

When addressing the class-based nature of different nervous conditions—specifically considering classes capable of developing neurasthenia—Beard is explicit:

All that is said here of American nervousness refers only to a fraction of American society; for in America, as in all lands, the majority of the people are muscle-workers rather than brain-workers, have little education, and are not
striving for honor, or expecting eminence or wealth. All our civilization hangs by a thread; the activity and force of the very few make us what we are as a nation. [...] Of our fifty millions of population, but a few millions have reached that elevation where they are likely to be nervous. (American Nervousness 96-97)

Beard is also quick to note that, though neurasthenia is common only among the elite few, “insanity of the incurable kind is more common among the lower or the middle than in the very highest classes” (American Nervousness 98).

Beard explains this class divide by using advancements in technology—particularly, Edison’s electric light and the steam engine—as a metaphor for the workings of the human nervous system. According to Beard, there is a limited amount of power generated at the source (whether that is horsepower, steam power, or nervous power); this power output, then, is used to maintain the normal function of the device (a light, an engine, a person). Asking a person to perform more functions, particularly the “higher” functions of brain-work, without also providing them a way to increase their initial power potential ultimately leads that person to use up all of their power (their nervous reservoir), the depletion of which is the source of neurasthenia (American Nervousness 98-100).

Beard argues, then, that it is only the elite few who are asked to deal with the additional burden of added brain-work:

The invention of printing, the extension of steam power into manufacturing interests and into means of conveyance, the telegraph, the periodical press, the political machinery of free countries, the religious excitements that are the sequels
of Protestantism—the activities of philanthropy, made necessary by the increase of civilization, and of poverty, and certain forms of diseases—and, more than all, perhaps, the heightening and extending complexity of modern education in and out of schools and universities, the inevitable effect of the rise of modern science and the expansion of history in all its branches—all these are so many additional lamps interposed in the circuit, and are supplied at the expense of the nervous system, the dynamic power of which has not correspondingly increased.

(American Nervousness 99-100)

In Beard’s mind, these are issues that tax the well-educated and the upper-class almost exclusively; hence the quickness of the excitement of their nerves versus the relative insensitivity of the nerves of the classes not affected (at least in terms of brain-work) by these advancements in technology and science, changes in education, and morphing social structures.

In the study and treatment of neurasthenia, there is also an undeniably gendered approach in terms of the types of activities and experiences that deplete women’s nerves versus those that deplete men’s nerves. Beard focuses predominantly on the way that men’s nerves are taxed by increased philosophical debates, innovation and invention, and changes in business (American Nervousness 113-116). These signs of modern civilization meant that, to use Beard’s metaphor, men were adding more and more lamps to their circuits, specifically in terms of brain-work that affected their economic livelihood.

Because women of the potentially-neurasthenic classes may also take part in philosophical debates and enter—at least slightly—into the public sphere, they also felt
the effects of certain factors that affected men’s nerves as well. However, women also have particular concerns and causes that are directly linked to their sex: women’s nerves, Beard argues, are often affected by both education and concerns about maternity and motherhood.\(^1\) He states that “[i]n no other country are the daughters pushed forward so rapidly, so early sent to school, so quickly admitted into society” (American Nervousness 66); the increase in women’s educational opportunities as well as the age at which girls and women started attending school were then seen as a way of adding more lamps to the circuit, more areas of brain-work that these women were concerning themselves with.\(^2\)

Beard also argues that motherhood taxes a woman’s nerves, both in terms of being concerned about her family and in worrying about the painful and dangerous process of childbirth itself (American Nervousness 78, 121). In fact, Beard describes the disease-like nature of post-partum issues for women including both physical effects of labor (such as lacerations) as well as nervous effects such as the fatigue that can be caused by nursing a child (American Nervousness 77-78). Once again, Beard cites these

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\(^1\) Again we can see a direct connection between the forefront of medical thought during this time period and Gilman’s own experience leading up to her diagnosis. Gilman was well-known for taking part in philosophical, political, economic, and social debates; she was educated; and at the time that her symptoms began presenting most acutely, she had recently given birth to her first (and only) child.

\(^2\) Beard closely ties the standards for American women’s education to his perception of American women’s beauty, saying that this early exposure causes them to develop more aesthetically appealing characteristics such as expressive features (American Nervousness 66). He also extends his argument about American women’s beauty and nervousness to areas of fashion:

The American girl of the higher order is exquisitely susceptible, is impressed by mild irritation acting upon any of the senses; she dresses in taste, and, where the means are at hand, with elegance, in colors that are quite subdued, and noticeable only at a short distance. […] Bright-colored scarlet and red, so common in Switzerland and in certain parts of Germany, are never seen in America in any class. (American Nervousness 73-74)
issues—even the concerns of motherhood—as being particularly relevant to upper-class women.¹³

Treatments for Neurasthenic Patients

With neurasthenic patients potentially presenting with symptoms such as mental irritability, hopelessness, morbid fears, insomnia, bad dreams, muscle spasms, temporary paralysis, and temperature sensitivity, several treatments were developed and recommended for the treatment of neurasthenia that focused on these symptoms (Beard, *Nervous Exhaustion* 11-83). As the symptoms were often numerous and varied, so were the treatments recommended, and Beard specifies that “[d]ependence should not be placed on any one exclusive mode of treatment, but rather on a combination of various methods”; he also advocates for changing methods or modifying a method as needed by each individual patient (*Nervous Exhaustion* 133). Some treatment methods Beard specifically details in *Nervous Exhaustion* include digestive hygiene (which looks to adjust the diet of the patient to achieve a healthier body), rest and isolation (this treatment may be particularly effective when considering the quality and character of the friends and family from which the patient might be isolated), and the appropriate application of different medicines including arsenic, cannabis, and caffeine (these drugs in particular

¹³ It should be noted that, as Beard is the American expert on neurasthenia during this time, I have relied almost entirely on his published works for the causes of this condition; these causes, however, are supported and reflected in other publications by other physicians during this time period as well, so Beard does not stand alone in this analysis. For example, Mitchell also recognizes gendered causes for neurasthenia in *Fat and Blood* when he distinguishes between “[t]he man harassed by business anxieties” and “the woman with morbidly-developed or ungoverned maternal instincts” (64).
work to alleviate a variety of the symptoms associated with neurasthenia) (135, 141, 147-149).

However, because the causes of neurasthenia were often understood to be gendered causes, the treatments for this condition were often gendered as well, designed to treat neurasthenia with its specific causes in mind. Silas Weir Mitchell, American physician and doctor to Charlotte Perkins Gilman, specifically applies two different treatments to neurasthenic patients that were largely based on gendered understandings of the causes of the condition: the Rest Cure and the West Cure.14

The Rest Cure, which is explained in detail in Mitchell’s Fat and Blood: An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria, could be effectively used on both neurasthenic and hysterical patients. This treatment relies on “a combination of entire rest and of excessive feeding” (7) that is supplemented with massage and electricity. While Mitchell argues that this treatment may be beneficial to any neurasthenic or hysterical patient, he does specify that “[t]he cases thus treated have been chiefly women of a class well known to every physician,—nervous women, who, as a rule, are thin and lack blood” and that “for some reason, the ennui of rest and seclusion is far better borne by women than by the other sex” (7, 48); while male patients might be encouraged to take some amount of Rest Cure, this treatment is primarily designed for and applied to female patients.

14 The “West Cure” is a term later assigned to what Mitchell calls the “Camp Cure”; I will be using the term “West Cure” to be in conversation with other recent scholarship. The term “West Cure”—in addition to making a rhyming pair with the “Rest Cure”—refers not only to the camping that Mitchell recommends but the specific location where many patients were able to pursue their return to nature: the frontier of the American West.
The Rest Cure, then, is a response to the commonly-understood causes of neurasthenia in female patients: overexcitement of the nerves that was often associated with intellectual pursuits and public life—deviations from normal gender roles that restricted women to the private and domestic sphere. As such, the Rest Cure includes restrictions against reading, writing, and any other activity that might require mental stimulation while at the same time requiring an effective doctor to employ “moral medication” by reminding his patient of her “lapse from duties to others,” particularly those domestic duties that make her a model mother and/or wife (Fat and Blood 57-58, 62).

The West Cure, in many ways, presents the exact opposite treatment and is favored for male neurasthenic patients. The West Cure, or the “Camp Cure” as Mitchell calls it in his published works, focuses on a return to nature as the way of replenishing a person’s nervous reservoir. This treatment does not simply replenish the nerves by reducing mental activity and requirements, but specifically replenishes them by placing the male patient in very “manly” situations that combat some of the “effeminizing” effects of civilization: “The surest remedy for the ills of civilized life is to be found in some form of return to barbarism” (Camp Cure 45). In fact, Mitchell sees a “return to barbarism” as having a healing effect both in terms of mental capacity and in terms of physical strength:

Civilization has hurt—barbarism shall heal. In a word, my tired man who cannot sleep, or who dreams stocks and dividends and awakens leg-heavy, and who has fifty other nameless symptoms shall try a while the hospital of the stone-carver.
He shall reverse the conditions of his life. [...] The sleep that is dreamless, the keen senses, the Arab vigor that makes exercise a jest and the mindless work of the camp a simple pleasure,—all these are the reward which comes to a man who is living the out-door life of the camp. (Camp Cure 46-47)

Here, it is obvious that Mitchell is considering a combination of the symptoms of neurasthenia (sleeplessness and bad dreams, for example) and the causes of the condition (in this case, excessive concern about business). Based on this analysis of a hypothetical male patient’s condition, Mitchell recommends that he return to nature to reap the benefits of—what is, in Mitchell’s mind—a barbarous life.

There is also an important homosocial element to the West Cure, in which Mitchell acknowledges that much of the enjoyment of the West Cure “comes of the contact with guides, woodmen and trappers, and the simple-minded, manly folk who live on the outposts of civilization” (Camp Cure 57). Mitchell recommends not only living in nature but also interacting with the men who live in nature (rather than in cities and in “civilization”), drawing from his personal experience:

Amidst all the social pleasures of such a life I remember with most distinct gratification the social life of the camp, the evening chats about the camp-fire, the jest and story, the trappers’ tales, the laugh over improvised dishes, the ghostly splendor of light and shadow made by the fires, on which vast tree-trunks were piled to warm and cheer us. I recall too, most gratefully, how near this close intercourse has brought me to many good and kindly men, when the punch was brewed and the cheerful pipes glowed and faded by turns, like the gleam of
revolving lights on some distant shore, seen and lost, as it were, now and again.

(Camp Cure 61)

Between the recommendations Mitchell makes to male patients and the account he provides of his own experience, it seems obvious that these homosocial relationships between manly men living off nature are just as important to the healing process as nature itself—if not more so.\textsuperscript{15}

It is also worth noting that, while the Rest Cure and the West Cure are gendered treatments designed to encourage a return to traditional gender roles with more domestic women and more outdoorsy, “manly” men, the gendered application of these treatments was not entirely rigid.\textsuperscript{16} Men could be—and often were—prescribed some version of the Rest Cure; however, the Rest Cure was often not as strictly enforced for male patients, allowing them more time each day to engage in some kind of work or mental stimulation.

Similarly, the West Cure was not only for men. In fact, Mitchell dedicates an entire chapter of his text \textit{Doctor and Patient} to the potential benefits of outdoor and camp-life for women; however, as with men taking the Rest Cure, the West Cure looked

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\textsuperscript{15} Mitchell also maintains that a return to nature is not just beneficial on an individual level but that it can have positive effects on the (white) race as a whole: “Some such return to the earth for the means of life is what gives vigor and developing power to the colonists of an older race cast on a land like ours” (\textit{Wear and Tear} 5-6). This focus on racial superiority and concerns about racial health presents many of the same concerns that Beard addresses when examining the causes of American nervousness. Finding a way to treat and cure neurasthenia is not just an individual health concern that can be addressed patient-by-patient; there are larger social and political concerns at play here that, among other things, have ties to race and class anxieties.

\textsuperscript{16} It is also worth noting that, in \textit{Doctor and Patient}, Mitchell argues that the West Cure would also be beneficial to people who don’t come from wealthy families; he recognizes a lack of wealth as a barrier to pursuing a true, long-term West Cure, but says that even taking a weekend in the mountains may be beneficial to the health of an entire family (158-160).
\end{flushleft}
very different for female patients. A woman who desired to take the West Cure, then, must be accompanied by male companions and guides to provide her with protection and to teach her how to observe nature. According to Mitchell, even a “reasonably educated” woman will make only superficial observations about nature that are not enough to allow her to benefit fully from the West Cure; it is her male companion’s job to teach this “nice young girl” how to make deeper, more meaningful, and more specific observations about nature so that she can obtain that full benefit (Doctor and Patient 165-168). Another striking difference between the West Cure for men and for women is the goals of these treatments. When the patient is male, the goal is to replete his nerves so that he can become more “manly” and can return to his normal work in a healthier condition; when the patient is female, however, the goal of this treatment is to return her to health so that she can be a more “wholesome and vigorous wife and mother” (Doctor and Patient 158).

Even when the same treatment is applied to male and female patients, the desired results of that treatment are distinctly gendered. Whether a male patient is prescribed the Rest Cure or the West Cure, the goal is to make him healthy enough to return to work; whether a female patient is prescribed the Rest Cure or the West Cure, the goal is to make her a better wife and mother. Ultimately, the gendered application of these treatments is obvious, through both (1) the prevalence of female patients given the Rest Cure and male patients given the West Cure and (2) the rhetoric surrounding the need for better/healthy female mothers and better/healthy male workers.
Connecting (and Separating) Neurasthenia and Hysteria

Another common nervous condition during this time—particularly for women—was hysteria. While hysteria was not considered a class-based condition in the United States in the late 1800s in the way that neurasthenia was, hysteria instead comes with a complicated set of gendered baggage. As Beard notes, there is a strong gendered divide in hysterical patients that does not exist—at least to such an extreme extent—with neurasthenic patients:

Hysteria is found usually in those whose emotional natures greatly predominate. Hence, relatively to neurasthenia, it is far more common in females than in males. Indeed, hysteria was once supposed to be exclusively a disease of women; hence its name. Neurasthenia, on the other hand, although more frequent in women, is yet found in great abundance in both sexes, and in both men and women of intellect, education, and well-balanced mental organizations. (*Nervous Exhaustion* 103)

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17 Hysteria was, at this time, considered a legitimate medical and technical diagnosis, though the history and application of this diagnosis is rife with complications and criticisms. Most of these concerns stem from the “catch-all” nature of the diagnosis, as hysteria was a chameleon-condition and could mimic other diseases and ailments in its symptoms and presentation. Hysteria did, however, maintain its own common set of symptoms beyond medical mimicry, often focused on sexuality and social behaviors. These symptoms included screaming, silence, laughter, tears, the use of coarse or vulgar language, irritability, erotic fantasies, and masturbation—among others (Scull 50, 108, 150). Perhaps the most notable symptom or presentation of hysteria was in the hysterical paroxysms; these were convulsions that hysterical patients would have that were often both violent and emotional. These paroxysms could be both unsolicited symptoms as well as responses to different treatments and therapies. Based on the clinical descriptions provided of these reactions, “hysterical paroxysm” is understood now as a clinical term that further medicalized the female orgasm and masked both the sexual nature of the condition and of the many therapies used to treat it (Maines 3). Beard specifically cites these paroxysms as one distinguishing feature separating hysteria from neurasthenia (*Nervous Exhaustion* 103-104).
In fact, Beard goes on to state that hysteria is particularly common in “the undisciplined and weak-minded of all races and classes and ages” (Nervous Exhaustion 103). Ultimately, this means that elite people—especially elite women—could be hysterical but that hysteria is not, by its own virtue, an “elite condition” the way neurasthenia is; instead, hysteria could develop in a person—especially a woman—of any class.\(^\text{18}\) It is in hysteria, then, that we see a more thorough connection to Gilman’s gender identity; on the other hand, the neurasthenic diagnosis, while not ungendered, is more closely related to Gilman’s racial and class identities.

While it is important to understand neurasthenia and hysteria as separate conditions, Beard also suggests an evolution of nervousness\(^\text{19}\) that could potentially connect neurasthenia to hysteria as a patient’s condition progresses: “Neurasthenia, like anaemia, may, it is true, lead to hysteria as it may lead to insanity” (Nervous Exhaustion 103). However, it is also important to note that (1) this was not the only way to become hysterical and that (2) this pathway to hysteria was not considered to be common. In fact, Beard asserts that it is only a minority of hysterical cases that can be traced back to an earlier bout of neurasthenia (Nervous Exhaustion 122). Beard also argues that many of the well-known cases of hysteria that had been treated in famous hospitals—especially

\(^{18}\) It is worth noting that this not true of all time periods and all locations. A thorough history of hysteria would show that in different cultures and at different times, hysteria is associated with either the upper or lower class. It just so happens that the American view of hysteria at the turn of the 20th century sees this condition as separate from distinctions of class, race, and age.

\(^{19}\) This evolution is presented in American Nervousness both in the front matter which includes a map of nervous evolution and in the “Evolution of Nervousness—Nervous Exhaustion (Neurasthenia)” subsection that covers pages 55-59.
those treated by Jean Martin Charcot at the Salpêtrière—were not descended from neurasthenia; instead, Beard says that the young women Charcot experimented on “are not, usually or always, of a neurasthenic type; they are simply weak-minded, mentally untrained girls, who can usually be affected either way” (Nervous Exhaustion 122). In this case, Beard is explicitly making comments about the class identity of Charcot’s patients and concluding that this particular identity—lower-class and uneducated—would disqualify them for a neurasthenic diagnosis.

Mitchell also acknowledges the need to understand the separate-but-connected qualities of neurasthenia and hysteria: “I see every week—almost every day—women who when asked what is the matter reply, ‘Oh, I have nervous exhaustion.’ When further questioned, they answer that everything tires them. Now, it is vain to speak of all of these cases as hysterical, or as merely mimetic” (Fat and Blood 37). Not all neurasthenic patients were also hysterical or would become hysterical; similarly, not all hysterical patients were previously or simultaneously neurasthenic.

This struggle to understand the difference between neurasthenia and hysteria is not new to medical historians. As David G. Schuster points out in his 2011 book Neurasthenic Nation, “[s]ome doctors [at the turn of the 20th century] believed hysteria developed out of severe neurasthenia. Others claimed that neurasthenia represented a variety of hysteria. Still more argued that neurasthenia and hysteria represented two
independent conditions” (5). Even for Beard and Mitchell, this distinction is not always clear as they present their readers with multiple interpretations of the connections between the two conditions and, as explicitly revealed in Mitchell’s *Fat and Blood*, often treat these conditions with the same cures/methods. This struggle and conflict gives us a window into the anxieties and uncertainties that these conditions represented for physicians during this time period as well as into the experience Gilman had as a patient ultimately diagnosed with both conditions.

The Challenges Presented by Hysterical Patients

Because hysteria itself is such a complicated and sometimes contradictory condition, it also presents a unique and trying set of problems for the physician who treats hysterical patients. Because it was such a varied condition, it was also notoriously difficult to treat, and this resistance to treatment often became a point of annoyance for the physicians who saw hysterical patients; this was in part because hysterical patients, who found themselves repeatedly unsatisfied and uncured by their treatments, were often vocal about their discontent with such therapies and could threaten a doctor’s career by holding him responsible for their continued suffering (Scull 65). As such, some of these doctors began to see their most vocal and discontented patients as actresses who were faking symptoms rather than as patients who were in need of a different treatment (Scull 66-67).

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20 In fact, it is also not uncommon for historians to conflate the two conditions. For example, in Andrew Scull’s *Hysteria: A Disturbing History*, he claims that George Beard described *hysteria* as “American nervousness” when Beard actually assigned this title to neurasthenia (Scull 95).
This concern is prevalent in Mitchell’s writing as he accounts for drastic practices in the application of the Rest Cure to separate the fakers\textsuperscript{21} from the true hysterics. Not only does he refer to hysterical patients as “the despair of the physician,” but he also suggests that physicians prescribe a harsh and militant version of rest and seclusion as a way of weeding out patients who are faking their symptoms or simply looking for attention (\textit{Fat and Blood} 36). According to Mitchell, “there are women who mimic fatigue, who indulge themselves in rest on the least pretence [sic], who have no symptoms so truly honest that we need care to regard them” (\textit{Fat and Blood} 54). By prescribing long and unexciting rest which is coupled with total isolation (except for occasional visits from a doctor or nurse), Mitchell argues, a doctor can tell if a woman actually requires the Rest Cure. Women who are not sick and do not need rest will not take this kind of treatment; according to Mitchell, they want to take the kind of rest where they are visited and doted on by family and friends:

[...] the rest I like for them is not at all their notion of rest. To lie abed half the day, and sew and little and read a little, and be interesting as invalids and excite sympathy, is all very well, but when they are bidden to stay in bed a month, and neither to read, write, nor sew, and to have one nurse,—who is not a relative,—

\textsuperscript{21} This concept of “faking” or twisting a story for the purpose of gaining sympathy, attention, or other manipulatively-gained emotional responses is also tied to the hermeneutics of suspicion. We might understand the doctor as the analyst/critic and the patient as the author; patient narratives have been discounted (by the doctor and the critic alike) because of the suspicious (in)accuracy of the account. In this case, the “master narrative” is the diagnosis, the account put forward by the physician, even when a patient isn’t faking their symptoms/condition.
then repose becomes for some women a rather bitter medicine [...] (Fat and Blood 57-58).

If a doctor suspects that a patient does not actually require treatment but is still insisting on having bedrest, Mitchell recommends this severe application of the Rest Cure to test the doctor’s suspicions; he says that only a woman truly in need of the healing powers of total rest would accept this extreme treatment while any potential fakers would quit the doctor’s care (Fat and Blood 58).

The fact that Mitchell feels the need to so explicitly address concerns about patients who might be faking hysterical symptoms in the hopes of being ordered to bed for a short period of time proves the seriousness of physicians’ concerns about hysterical patients who may or may not be taking advantage of the medical system and skewing the physician’s own understanding of the condition and related treatments, as well as wasting the physician’s time.

Many physicians were also concerned about the spread of hysteria and believed that there were two different ways that this condition could be transmitted: hereditarily and socially. First, hysteria was a condition that a person would be more likely to develop if there was a history of the condition in her family. Not only could she have inherited a weak or excitable nervous system and heightened emotions, but she also may have inherited the propensity for deviant sexual and social behaviors which were often seen as signs of hysteria. It is important to note that, during this time period, the common scientific belief was that inheritable traits were not limited to physical characteristics such as eye color and height but that non-physical elements of a person’s behavior and
personality could likewise be inherited. Laziness, morality, and promiscuity are all examples of such behavioral characteristics that were attributed to a person’s biological inheritance (Davenport 18-19).

There was also a concern, which Mitchell makes explicit in *Fat and Blood*, that a single hysterical woman would inspire the other women around her to also become hysterical if the appropriate protective and isolating measures were not taken: “An hysterical girl is, as Wendell Holmes has said in his decisive phrase, a vampire who sucks the blood of the healthy people about her; and I may add that pretty surely where there is one hysterical girl there will be soon or late two sick women” (*Fat and Blood* 49).

Mitchell says that when a close friend or family member acts as a nurse for the hysterical patient, this untrained nurse or assistant is likely to indulge the patient in her desire for sympathies to such a point that the nurse finds her emotions high and her nerves excited, inducing a hysterical condition and making the former nurse a new patient herself. According to Mitchell, the nurse—“the healthy life”—is actually “absorbed by the sick life, in a manner more or less injurious to both, until, sometimes too late for remedy, the growth of the evil is seen by others” (*Fat and Blood* 40). Because of this, Mitchell insists that anyone acting as nurse to a hysterical patient—whether they are familiar to the patient or a stranger—should be prepared to act with firmness and in the best interest of the patient’s health (as defined by the doctor) not the patient’s own desires (*Fat and Blood* 39-42).
Neurasthenia, Hysteria, and American Anxieties

Neurasthenia and hysteria provide a window not only into the state of medicine in the United States at the turn of the 20th century but also into the most prevalent American anxieties held at this time. Perhaps the most obvious anxiety brought to the forefront by a discussion of these conditions and their treatments is the concern with the health of the American population. In many ways, it is not surprising that issues of neurasthenia, hysteria, and class-based medicine are a part of the larger conversation of eugenics happening in the United States at this time. When many people looked at the American population, they had the same fear present in Beard’s *American Nervousness*: “All our civilization hangs by a thread; the activity and force of the very few make us what we are as a nation” (96). This is matched with a concern that the “unfit” populations (in Beard, these are the people he lists as “savages” and “barbarians”) are reproducing faster and in higher numbers than the “fit” population; people feared that “defective conditions […] are apparently being reproduced faster than the more normal characteristics” (Davenport 17).

The stereotypical hysterical woman, then, represents just one portion of this “unfit” population. She is often promiscuous and is always unfit or unhealthy in one way or another. In fact, the emotional and nervous state of women more generally presents a pressing problem for people concerned with breeding the American population for the purpose of racial conservation and improvement. Building on ideas that can be traced back several decades earlier, there is a concern about the fitness of American mothers, a concern that is directly tied to the health of American children and, therefore, the future
population of the United States. As Edward M. Dixon, an American physician, argues in his 1847 text *Woman and Her Diseases: From the Cradle to the Grave*, mothers who are uneducated, unhealthy, and nervous are a threat to the future of the United States (v-vi).

This concern with motherhood continues through the turn of the 20th century and becomes a central part of debates about American health, eugenics, and feminism.

As science and medicine progress, American understandings of biological inheritance also become a central part of this debate. By focusing on the inheritability of non-physical traits such as morality and laziness, a scientifically-backed understanding of the passing on of “bad blood” becomes a part of this argument as well. Because of the introduction and growing popularity of Mendelian genetics, scientists, doctors, and social reformers during this time period are particularly invested in the *nature* portion of the nature/nurture debate, and almost all traits and characteristics were seen as inheritable through germ plasm.22 This also meant that if a person had an ancestor who was an imbecile,23 then they could perhaps have an offspring that turned out to be imbecilic—even if both of that offspring’s parents were intelligent. The idea of “undesirable” traits still existing in the blood, even if those traits did not present outwardly, fed American anxieties about race and class superiority and biological inheritance (Davenport 16-21). The fear of these “hidden”—but still present—inheritable traits quickly became a part of the conversation about reproductive rights, motherhood, and eugenics.

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22 Germ plasm may be best understood through a comparison to modern-day DNA and genes; germ plasm is, at the risk of oversimplifying later scientific advancements and understandings, the turn-of-the-20th-century equivalent of what we understand today as DNA and genes.

23 At the turn of the 20th century, “imbecile” was a technical medical term; I use it here in that regard.
The newest and most advanced science of the day was then put to use in remedying what were seen as “social issues” that were often linked to race, class, and gender. Through this application, the United States heard eugenic arguments in favor of birth control, women’s liberation, medicine, science, and environmental and conversation efforts; many of these debates in turn begot other scientific and medical advancements, political policies, and social change.

Gilman and Mitchell: In Context

If we are to understand Gilman’s patient narratives, then, in their medical and scientific context, it is important that we consider her not only as a patient but also a feminist and a eugenicist; these are aspects of her life that cannot be separated from her ideas about gender, health, and motherhood. It is also important to understand the common and popular treatments for neurasthenia and hysteria during this time period so that we can consider Gilman’s treatment through the wider lens of American medicine and American nervous conditions.

In particular, it will be beneficial to remember the ties between medicine and class as we progress in our examination of Gilman’s narratives as well as the connections between health, motherhood, and arguments for racial superiority. It is worth noting that Gilman fits the “type” or class of person who could potentially develop neurasthenia as well as the fact that Mitchell originally did not want to treat her because of the likelihood.

24 As an active participant in the Woman’s Movement and a person in favor of progressive social reform, Gilman was directly interested in these ideas, often putting forward her own eugenic arguments in texts and lectures such as “Our Place Today” (1891), Women and Economics (1898), “A Suggestion on the Negro Problem” (1908), and “Sex and Race Progress” (1929).
that she inherited the same nervous qualities as other members of her family that he had previously treated (Gilman, *Living* 95). It is also worth mentioning that Mitchell identifies the cause of Gilman’s condition in line with gendered notions of nervous conditions at the time (too much public exposure, not enough time in the domestic sphere, etc.) and then prescribes treatment for the condition that is in line with the common and recommended treatments at the time.  

I contextualize this not only to preview the in-depth analysis in the following chapters but also to remind us that nothing about Gilman’s condition or her treatment suggests that it falls outside of the social or medical norm of her time. As we delve further into the connections between the social, the political, and the medical that Gilman’s patient narratives offer, this point is worth remembering. While her experiences may feel out-of-place or abnormal to the modern-day reader, they were fairly typical in her own time period.

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25 While Mitchell prescribed the Rest Cure for Gilman, Jennifer S. Tuttle argues in her article “Rewriting the West Cure: Charlotte Perkins Gilman, Owen Wister, and the Sexual Politics of Neurasthenia” that Gilman also pursued her own version of the West Cure—though not through a medical prescription—whenever she moved to California and began writing again. For more on this argument and Gilman’s reclaiming and reframing of the West Cure, see Tuttle’s “Rewriting the West Cure.”
CHAPTER 2: THE CHANGING DOCTOR-PATIENT RELATIONSHIP AND TENSION IN CASE AND PATIENT NARRATIVES

As Paul Starr details in his book *The Social Transformation of American Medicine*, the turn of the 20th century represents significant changes in the field of American medicine. These changes, inspired and made possible by advancements in science and technology, not only affect the status and authority of the American physician but also have a direct and lasting impact on the quality of the doctor-patient relationship. In this chapter, I examine the how these transformations affect illness narratives; I argue that we can see these changes in the field of medicine through written case narratives as recorded by the physician. As discussed in Chapter 1, Mitchell felt that hysterical patients were the “despair of the physician” and an increasing distance between physician and patient was growing during this time period (Mitchell 36, Starr 86-87). I argue that these changing relationships along with increasing medical specialization and authority give rise to a particular need for patient narratives such as Gilman’s. In making this argument, I look at Mitchell’s accounts of several case narratives to identify common elements, rank the characteristics and experiences of illness that he finds most valuable and relevant to these records, and examine the absences—the experiences of illness that are not the focus of this particular type of record.

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26 I use the term “illness narrative,” again, as a collective term encompassing patient, case, and form narratives.
While Gilman records personal and emotional details and the experience of illness beyond the clinical perspective, the desire to establish medical authority and professional audience keeps Mitchell’s narratives empirical and impersonal. Mitchell was initially reluctant to treat Gilman and was dismissive of her own account of her condition, both facts that tie back to this same desire to maintain distance as well as authority between the physician and the patient. As I show in this chapter, developing this authority was of paramount importance to a physician during this time period, as was distancing themselves from their patients; these tactics were specifically designed to protect an individual physician’s livelihood. Without a claim to authority, a physician’s practice was likely to fail.

In the particular case of Gilman and Mitchell, this meant that Mitchell initially did not want to treat Gilman because he had treated other women in her family and, after he did decide to treat her, he dismissed her own account of her condition in favor of his belief about what would be best for her. This history is what makes Gilman’s narratives so important to study; they give us a direct lens for studying these tensions between physicians and their patients, tensions that we can see in the comparison of patient and case narratives from this time period. In fact, in medical and scientific historical context, Mitchell’s reluctance to treat Gilman and subsequent dismissal of her narrative fit into a broader history and do not stand out as being uncommon or unique. Instead, this relationship between Gilman and Mitchell fits the trend of the changing doctor-patient relationship that we see during this time, largely due to advances in science, technology, and medical specialization.
The Changing Field of Medicine: Scientific Discoveries, Advancing Technologies, and Specialized Medicine

Because of the discovery (and rediscovery) of Mendelian inheritance in the late 19th and early 20th centuries, there was a particular focus on the inheritability of qualities that could be passed from parents to offspring; as such, nature was given much more credit than nurture for who a person was or who a child might become. In fact, as Peter J. Bowler points out in his book *The Mendelian Revolution: The Emergence of Hereditarian Concepts in Modern Science and Society*, “From the start there were American geneticists willing to develop the theme that the transmission of defective characters in the human population could be explained in terms of harmful mutations perpetuated according to Mendel’s laws” (167). It was not only physical traits that were seen as inheritable qualities, but also characteristics such as temperament, intelligence, and morality. Charles Davenport, a prominent American biologist and eugenicist at the turn of the 20th century, explicitly shows these concerns with inheritable traits in his article “Influence of Heredity on Human Society,” saying that “[d]oubtless many, if not all, of the elementary, physical, intellectual and moral characters are thus inherited,” using examples of laziness and “feeble-mindedness” to illustrate his point (19).

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27 Gregor Mendel initially published his work on pea plants in 1866 and his work was rediscovered and brought to the scientific forefront in 1900 by Hugo de Vries, Carl Correns, and Erich von Tschermak. Throughout the early 20th century, then, the ideas of Mendelian genetics and Mendelian inheritance were applied to a number of different characteristics and organisms as the scientific community attempted to understand the process of inheritance in reproduction (Bowler 1-3).

28 It is important to note that these qualities were also frequently linked with specific races, classes, and/or genders.
This understanding of the extremes of inheritability was also coupled with advancing technologies such as the advent of surgical anesthesia.\textsuperscript{29} With this advancement, surgeons could now perform operations more slowly and more carefully whereas prior to anesthesia it was of the utmost importance that surgeons perform their work as quickly as possible (Starr 156). Anesthesia also opened up new doors for treatment methods; as Starr puts it, “[s]urgeons began to operate earlier and more often for a variety of ills, many of them […] previously considered medical rather than surgical cases” (156). It is important to note, though, that operations still remained fairly infrequent after the advent of anesthesia, largely because of other dangers (especially fatal infections) that were associated with these procedures.\textsuperscript{30} Surgery did not actually

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  \item Anesthesia was first publicly demonstrated in a surgical capacity on October 16, 1846, by Dr. J. C. Warren as he operated on Gilbert Abbott to remove a growth from his neck; the anesthetic used in this first case was a compound of sulfuric ether and oil of orange developed by a dentist named William T. G. Morton, who administered the anesthetic prior to Abbott’s operation. Morton had previously used this compound on his dental patients but saw the opportunity for a wider use of this development in surgical settings. The most popular anesthetics that developed after this initial operation were a variety of ethers, chloroform, and nitrous oxide, which early anesthesiologists used to make good on Morton’s initial promise of “painless surgery” (Fenster 5-6, 240). Anesthesia, however, was not immediately and widely used on all patients; surgeons would pick and choose which patients “deserved” anesthesia based off their impression of how much pain a patient could feel. Again, this history brings us back to the issues of racism in medicine. Because surgeons believed that black patients could not feel pain (or, in some cases, as much pain), they did not believe that these patients would require anesthesia for surgery. In this way, anesthesia became a privilege predominantly reserved for white patients. J. Marion Sims, often known as the Father of Gynecology, experimented on slaves without consent and without anesthetic, believing that “Blacks did not have morals or perceive pain as Whites did” (Byrd and Clayton). As W. Michael Byrd and Linda A. Clayton note in their book \textit{An American Health Dilemma: A Medical History of African Americans and the Problem of Race: Beginnings to 1900}, “[m]edical exploitation of the Black slaves was accepted without comment. This would not have been accepted medical ethical practice on upper-class white women” (Byrd and Clayton). The advent of anesthesia does not change this racial and racist dynamic; physicians and surgeons still assert that the feeling of pain is different in bodies that are assigned different races, and people of color were often denied anesthetic (or given a small dose) based on this perceived “lack” of morals; this ties back to the neurasthenic belief that “savage nerves” cannot be drained or hurt by excess (even an excess of pain) as discussed in Chapter 1.

\item For example, in the years directly following the advent of surgical anesthesia, about 40% of amputations still ended in death (Starr 156).
\end{itemize}
become a common procedure until the 1890s and early 1900s with the further improvement of diagnostic tools and medical and technological advancements, such as the development of x-rays in 1895 (Starr 156).

These advances in science and technology directly translated to changing approaches, possibilities, and structures within the medical profession; particularly with the advent of anesthesia and the popularization of surgery came significant changes in the hospital system. Not only did the number of general hospitals increase significantly, but there was also a spike in “particularistic” hospitals that were “primarily religious or ethnic institutions and specialized hospitals for certain diseases or categories of patients, such as children and women” (Starr 170). There was also a focus, especially in “elite voluntary hospitals,” on two types of patients: (1) the poorest and lowest-class patients who were used primarily for teaching purposes and experimentation and (2) the wealthiest and highest-class patients who were used to increase the hospitals revenue (Starr 171).

However, while the number of general hospitals grew, mental hospitals and asylums experienced a different type of expansion. Starr notes this discrepancy: “By 1920, when there were some 4,013 general hospitals with an average size, in beds, of 78, there were 521 mental hospitals with an average size of 567” (169). While general hospitals grew in number with each hospital maintaining a smaller number of beds (which translates to a smaller number of patients in a single hospital), mental hospitals grew internally, increasing the number of beds (and therefore patients) per institution rather than the number of institutions themselves. According to Starr, this can be
attributed to the general social prejudice against patients seeking medical attention for mental conditions: “While communities wanted to have general hospitals readily accessible, they were quite prepared to have the mentally ill removed to a distance” (169).  

In the late 1800s and early 1900s, we also see increased specialization and increased authority in the field of medicine, though doctor’s anxieties about lacking authority and status were still very prevalent as this transition is taking place. As Starr points out, prior to this time period, most doctors were “independent general practitioners”; the ability to specialize grew largely out of increasing understandings of the human body and the ways that the human body and its many conditions could be treated (Starr 86). This specialization and increased cohesion within the profession

31 This acute fear and prejudice against “mentally ill” patients is also why people hoped to avoid being assigned a mentally ill diagnosis. While today we might see conditions such as Gilman’s as falling under the umbrella of mental health, during her time doctors and patients both often understood that these conditions were directly related to some kind of imbalance in the body, often in nerves and energy. This is why Gilman is relieved to hear that Mitchell believes that her condition is hysterical but not yet dementia, a diagnosis which would indicate an issue of mental health (Gilman, Living 95); this is also why we see John, the husband and physician character in “The Yellow Wallpaper,” react the way he does when the speaker suggests that she might be healed in body but not in mind (Gilman, “Yellow Wallpaper” 652). As such, even specialists who were treating patients that would likely have a mental health diagnosis today were not necessarily mental health specialists; instead, they were often specialists, as Mitchell was, on nervous conditions.

32 It is important to note that specialization does not happen all at once; it is a gradual process, and the turn of the 20th century features both the advancements that come along with specialization as well as the lingering anxieties about a lack of authority held by the medical profession. As George Weisz points out in his article “The History of Medicine: Early Specialization in America,” less than 20% of the practitioners profiled in William Atkinson’s 1878 essays were focusing on a specific and specialized area of medicine. As Weisz points out, “Atkinson’s essays suggest clearly that certain forms of specialization had become widespread by the 1870s, but they also confirm that this was new” (Weisz).

33 Another significant factor in the specialization of medicine—which Starr focuses on more heavily in his book—is the development of cohesion within the field itself; as medical professionals worked to develop common ground and common understandings, they were able to present themselves as a cohesive profession rather than individual doctors with separate practices and separate beliefs (Starr 79-81).
brought with it two significant changes that were developing throughout the turn of the 20th century: (1) physicians gained more status and authority and (2) emotional and social distance increased between the physician and their patients.

This increase in specialization creates tension not only between doctors and patients but also between specialized physicians and general practitioners (Starr 223). This conflict may also contribute to the amount of push back against other physicians that we see in Mitchell’s work, particularly against physicians who don’t focus predominantly on nervous conditions. We see an explicit example of this in Mitchell’s 1904 article “The Evolution of the Rest Treatment.” In describing the case of a “Mrs. G,” Mitchell describes her diagnosis from a previous doctor:

Naturally enough, her case had been pronounced to be hysteria, but calling names may relieve a doctor and comfort him in failure, but does not always assist the patient, and to my mind there was more of a general condition of nervous excitability due to the extreme of weakness than I should have been satisfied to label with the apologetic label hysteria. (369-370)

These suggestions that inept or unspecialized physicians might use a diagnosis of hysteria to hide and excuse their own failures show Mitchell’s assertion not only of his own authority on the matter but also of his skepticism at another physician’s ability to properly diagnose their shared patient. The authority Mitchell builds up against Mrs. G’s

34 This tension comes prior to the unity that later comes out of increased specialization. Before specialization helps to solidify the concept of general medical authority, however, physicians attempting to establish themselves in their field—and, especially, in their specialization—add to these increased tensions as every doctor is trying to prove their own authority, often at the expense of other physicians.
prior physician in this publication, as with specialization more generally, also increases the distance between Mitchell and his patient; while there was a certain distance between Mrs. G and her prior physician based on their doctor-patient relationship, that distance would be increased between Mrs. G and Mitchell because Mitchell has proven more authority than her previous doctor. This works to prove Mitchell’s advanced specialized knowledge about Mrs. G’s condition, putting Mitchell and Mrs. G on very different social and intellectual platforms.\textsuperscript{35}

Changing Doctor-Patient Relationships

These advancements in science, technology, and medical specialization all have a significant effect on the state of the doctor-patient relationship, both through authority and distance as well as through the physician’s ability (and encouragement) to dismiss the patient’s personal feelings and knowledge as being insignificant or ignorant in the face of the physician’s own medical and scientific knowledge.\textsuperscript{36}

With the focus on Mendelian inheritance and the ways in which patients could inherit not only physical characteristics but also behavioral and moral characteristics as well, patients were often blamed for their own conditions and “bad behavior” (a distinction that is often tied to a society’s belief in morality) was linked to blood. Rather

\textsuperscript{35} Here, it is important to note that medical specialization is implicated in class and gender narratives. Not only is Mitchell’s account of Mrs. G’s condition privileged based on his position in the doctor-patient hierarchy, but he also benefits from his position as an upper-class man. Further, medical and, more broadly, scientific knowledge itself is seen as a kind of upper-class, masculine knowledge.

\textsuperscript{36} There are also gendered implications of the value of “knowledge” in the context of a patient’s personal history. Personal history is \textit{domestic} as the experience of sickness happens in the home and in the private sphere; as such, this is categorized as “feminine” knowledge. Specialized medical knowledge, then, is classified as “masculine” as it relies on logic and science.
than seeing a patient as someone who was suffering from a condition that might be remedied, this focus on the inherent and inherited nature of many characteristics meant that some patients were incurable. Their condition might be, quite literally, in their germ cells. Gilman ran into this issue with Mitchell, who was initially reluctant to treat her because of his past experience with women in her family: “He had a prejudice against the Beechers. ‘I’ve had two women of your blood here already,’ he told me scornfully” (Gilman, *Living* 95).

Even with these scientific advancements and new approaches to medical diagnosis and treatment, however, physicians in general lacked the authority and status that we associate with them today. As such, it was crucial that each individual doctor protect their reputation and their practice. This may be, at least in part, why hysterical and other difficult patients were “the despair of the physician” (Mitchell 36); patients that were difficult to treat and would not get better were a severe detriment to a physician’s reputation and, at a time when medical authority was increasing but was still relatively low and individualized, that detriment could be a direct threat to the physician’s career and livelihood. As such, it was particularly important to physicians to maintain a barrier

37 In this case, Mitchell is not only referencing a familial tie but also playing into this belief that behavioral traits could actually be passed along in a person’s “blood” through heredity. Here, Mitchell is not simply stating that there may be a common process of nurturing in Gilman’s family that would lead her to share certain behavioral traits with her relatives but that there is something irreversible in her behavior that she—and her relatives—inherited.

38 As Starr notes, physicians today are often treated with significant respect and authority following the extensive training it takes to become a doctor. Because extensive training was not necessarily required to be a physician in late-19th-century America, there was not the same assumption of medical authority and expertise during this time period. Instead, physicians had to prove to both their patients and their colleagues that they were fit for their position; hence the ever-present anxiety associated with proving authority and knowledge and competency in their position (Starr 79-92).
between themselves and their patients. As Starr notes, not only could physicians in this time period “not allow people to get overly familiar with them,” but they also had to ensure that they retained their authority by keeping medical knowledge a privilege of the physician (86). As Starr says, quoting from D.W. Cathell’s *The Physician Himself* (originally published in 1881), “The physician ought to do tests at his office, not at patients’ homes, lest they ‘begin to do tests for themselves—think they know more than they really do, and give you trouble’” (Starr 87). We can also see elements of this medical anxiety in Gilman’s narrative when she recalls that Mitchell dismissed her “long letter giving ‘the history of the case’ in a way a modern psychologist would have appreciated” as a sign of “self-conceit” (Gilman, *Living* 95).39

This focus on keeping medicine out of individual homes and instead solely in physicians’ offices or other clinical spaces would put physicians in direct conflict with mothers in particular; because mothers often were—and, in fact, often still are—held accountable for the family’s health, mothers were most often the administrators of medicine within the home. We can see this tension, particularly in medicosocial texts such as Edward H. Dixon’s *Woman, and Her Diseases, from the Cradle to the Grave* (1847) in which he makes this point explicitly:

> The domestic administration of physic we abhor; and it is doubtful if a much greater evil exists in society, if we except the constant errors of youthful training,

39 We can also tie this to Mitchell’s dismissal of other physicians’ diagnoses, as we have seen in the example of Mrs. G. Mitchell must simultaneously protect and build his authority both in the face of other medical professionals and in the face of his patients themselves.
than the dosing of affectionate mothers and aunties;—next to which comes that of a mere physic-giving doctor; one who sees no evil in a complete disregard of every law of nature—bad food, want of exercise, ill made and insufficient clothing, ant of personal cleanliness, ill ventilated chambers, etc., etc.—but is ever ready with some paltry drug, that is to restore his patient in a day, and face the consequences of years of error, and total prostration of bodily power. (x)

According to Dixon, mothers and aunties—those women who would be responsible for caring for their families and ensuring their health—who give medicine/treatment to their families are the utmost evil (excepting “errors of youthful training”) that exists not only in terms of medicine but in society overall. This quote is not only designed to scare women into not treating their families but also to shame those that do.

Technological increases also left their mark on the doctor-patient relationship, primarily through their connection to medical professional specialization. As we’ve already seen, that specialization is coupled with increasing authority and distance between the physician and the patient; not only was Mitchell dismissive of Gilman because of her “blood” and her other family members that he had treated, but he also dismissed her personal account of her medical history and current condition. There was also, however, the distance created by specialists rather than general practitioners. The general practitioner that a patient would usually see for their medical concerns would likely be familiar with the patient and the patient’s history and family—perhaps even on a personal level as general physicians were often an active part of their communities (Starr 83).
I would argue that, with a specialized physician—particularly one that a patient might travel great distances to see, as Gilman did with Mitchell—the doctor is less likely to have as thorough a knowledge of the patient themselves, even if they have a better understanding of the particular type of condition that the patient has. In a way, the patient trades a specialization in their personal history for a specialization in a particular medical condition when moving from a general practitioner to a specialized physician. With the increasing number of specialists during this time period, specialized options become increasingly available the patients as well.

Because increased specialization also leads to a decrease in the physician’s (especially the specialized physician’s) “free” time due to the increased demands of the profession, physicians—both general and specialized—also tend to be less involved in non-medical pursuits. Prior to specialization, many physicians also held secondary positions or followed secondary (or in some cases, supplementary) pursuits. For example, as the medical profession became more and more specialized, fewer physicians were pursuing additional positions in legal and political fields, a common pursuit of physicians prior to this period. This is due in part to the extended training required of physicians and also in part to the increased authority and economic stability that came to the profession as a result of specialization. Doctors, in part, did not have time for the same pursuits but simultaneously also needed fewer supplementary positions to boost their status and wealth; in many ways, being a physician was now enough to support a life of respect and influence (Starr 83).
This, coupled with the desire to increase the distance between patient and physician as a way of building physicians’ authority and job security, meant a significant, growing disconnect between the patient and the medical professional. Because doctors now spent less time with each individual patient and were now almost solely focused on the scientific and empirical experiences of illness, there was less of a focus on the emotional, personal experiences that a patient had beyond their status as a patient. This limited focus is obvious in the existing record of case narratives that physicians published about their patients and their patients’ conditions.

Case Narratives: Patient Experience in the Doctor’s Hand

In contextualizing Gilman’s patient narratives, then, it is beneficial to understand what an illness narrative looks like when written by a doctor rather than a patient. In order to examine the structures and focuses of these case narratives, I turn to Mitchell’s publications. It is important to note that case narratives are, in a way, more difficult to access than patient narratives are as maintaining medical privacy was considered tactful—if not actually legally required—even before laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA); since the implementation of HIPAA and similar laws/regulations, however, many of these historical records are also protected. As such, I focus on the largely anonymous and anecdotal accounts of patients’ experiences that Mitchell records in Fat and Blood, published in 1884. These records

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40 HIPAA is also not the first law in place protecting patient confidentiality; in the U.S., laws and regulations preventing the sharing and distribution of certain health-related information come from as early as 1974.
show the influence of the doctor’s priorities as well as the differences in structure and focus when the illness narrative is written by a doctor instead of a patient.

When considering the purpose of case narratives, Mitchell includes his records of patients’ experiences in *Fat and Blood* to support his argument in favor of the Rest Cure and as a way of presenting the results of its implementation. This text is also written for other physicians as instructions for implementing Mitchell’s Rest Cure. As such, Mitchell’s priorities—not unlike other doctors in his time—are focused on proving the validity of his medical practice. This means that Mitchell often positions himself as the active party in the relationship; while the patient remains in a passive position, Mitchell—as the doctor—takes action that will return the patient’s health (in his rendition of these narratives). As such, his emphasis is on empirical evidence and case studies that are concerned with the patient as a *patient*—a subject who can be acted upon—rather than as a *person* with their own agency. This includes a focus on the changes in symptoms, the physiological and psychological reactions to treatments, and the general state of health; what is largely absent, then, is any consideration of what it is actually like to live with the conditions that Mitchell writes about outside of a clinical setting.

For example, *Fat and Blood* includes Mitchell’s account of the experience “Mrs. C”\(^{41}\) has with her failing health, particularly after her pregnancies. Mitchell begins by

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\(^{41}\) I have chosen Mrs. C’s case narrative to include here because (1) it is one of the most detailed patient narratives available in *Fat and Blood* and it includes a detailed record of the patient’s history, treatment, and response to treatment, and (2) her case narrative shares several key elements with Gilman’s patient narratives: pregnancy prior to developing the condition, an emotional element to the diagnosis, and the implementation of the Rest Cure as a treatment for her condition. Mrs. C’s case narrative is also reflective of the other case narratives published by Mitchell and many of his contemporaries (Beard among them) in its structure and focus.
providing his reader with some pertinent background information on Mrs. C and her condition: she is a 33-year-old woman who “at the age of sixteen [had] a severe course of mental labor, and within two years completed the whole range of studies which, at the school she went to, were usually spread over four years” (120); Mitchell also records that she has “[a]n early marriage, three pregnancies, the last two of which broke in upon the years of nursing” (120). It was after this particular experience that Mrs. C’s health began to suffer:

[She] at last gave way quite abruptly, ceased to menstruate five years before I saw her, grew pale and feeble, and dropped in weight in six months from one hundred and twenty-five pounds to ninety-five. Nature had at last its revenge. Everything wearied her,—to eat, to drive, to read, to sew. Walking became impossible, and, tied to her couch, she grew dyspeptic and constipated. […] so at last, despite unusual vigor of character, she gave way to utter despair, and became at times emotional and morbid in her views of life. (121)

This background constitutes Mrs. C’s history—according to Mitchell—prior to her becoming his patient.

Throughout the rest of Mitchell’s case narrative for Mrs. C, he provides direct empirical data related to her condition including a specific and detailed list of her diet during the time that he treated her (122-123). He also records specific observations of her physiological state (“Her morning temperature was 97.5° F., and her white corpuscles were perhaps a third too numerous”), the different steps of the treatment he employed (“At the sixth week of treatment the soup was dropped, wine abandoned, the iron
lessoned one-half, the massage and electricity used on alternate days, and the limbs exercised as I have described”), and her response to that treatment (“The cure was complete and permanent; and its character may be tested by the fact that at the thirtieth day of rest in bed, and after five years of failure to menstruate, to her surprise she had a normal monthly flow. This continued with regularity until eighteen months later, when she became pregnant”) (121, 124).

This narrative is not unique; the case narratives in *Fat and Blood* (as well as those in other medical publications during this time such as Beard’s *American Nervousness*) follow a similar format. The most personal information revealed about the patient comes from the history and provides clues as to the cause of the condition that the patient has developed by the time they seek medical attention and advice. The rest of the account of the illness is a narrativized version of empirical data: accounts of symptoms; records of temperatures and weight throughout the sickness; explanations of treatments used; and the results of that treatment (again, often including measurable data such as resulting temperature, weight, and regularity of menstruation). In the case of Mrs. C, Mitchell is also able to boast an additional success as a result of his treatment: Mrs. C is able to become pregnant. This is especially significant considering the cultural focus on women as mothers, suggesting that a successful woman is a wife and mother who is both healthy and fertile.

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42 It is important to note that not all of these case narratives include a history. In some cases, the history is absent and the case narrative begins with an account of the patient’s symptoms and the treatments used to relieve those symptoms.
In these narratives, it is obvious that the physician is focused on the empirical and clinical side of the illness experience rather than the personal or emotional experience of the patient. The effects that living with illness have on other areas of a patient’s life are noticeably absent from these case narratives; there is little to no consideration of how the patient processes their diagnosis or how the patient’s relationships are affected by their condition, except in cases where the patient is (1) a wife who is not performing her wifely duties, (2) a mother who is not performing her motherly duties, or (3) a contagious or infectious patient who passes her condition to a close friend or family member. In all three of these cases, the health of the patient is directly tied to the health of another person.\footnote{The omission of a patient’s personal relationships from case narratives (except in these particular cases) should not come as a surprise; while this is obviously an absence in these records, the physician was concerned only with the health of the patient; beyond the patient’s clinical existence, the physician no longer had authority and expertise. Instead, physicians focus on the areas in which they do have expertise: the patient’s direct and acutely observed state of health.

In focusing only on the physician as the expert, however, we (as literary historians) tend to dismiss patient narrative as, as Jurecic explains, “victim art” and “misery memoirs” (10). These patient narratives are often dismissed because of their perceived sentimentality; however, in identifying these absences in the case narrative, it becomes obvious that without patient narrative, we cannot have a true understanding of what it means to be ill in society or of what it means to actually live with an illness.}

The case narrative of “Miss P” as recorded by Mitchell in *Fat and Blood* provides us with an example of such a case:

Miss P., æt 29, weight one hundred and eleven pounds, height five feet four inches, dark-skinned, sallow, and covered with the acne of bromidism, consulted me last year. She had had one attack which was considered to have been epileptic, and which was probably hysterical, but on this matter she dwelt with incessant
terror, which was fostered by the tender care of a near relative, who left her neither by night nor day. Vague neuralgic aches in the limbs, with constant weariness, asthenopia, anæmia, loss of appetite, and loss of flesh, followed. Then came spinal pain and irregular menstruation, a long course of local cauterizations of the womb, spinal braces, and endless tonics and narcotics. [...] I broke up the association which had nearly been fatal to both women, and, confidently promising a cure, carried out my treatment in full. In three months she went home well and happy, greatly improved in looks, her skin clear, her functions regular, and weighing one hundred and thirty-six pounds. (156)

In this example, as with Mrs. C, we can see both the empirical focus on the recording of measurements and data as well as an account for the changes in and, ultimately, suspension of symptoms; we can also see the lack of personal information and consideration beyond Miss P’s connection to her “near relative” who also began experiencing hysterical and nervous symptoms because of her close association with Miss P. The arc of the case narrative covers only relevant history (as defined and perceived by Mitchell, not as defined and perceived by the patient), time spent experiencing symptoms and/or sickness, and time spent in treatment and recovery; this type of narrative does not consider the wider implications of what it means to be a sick person in society or what it means to live a life with illness, particularly a life where illness is not the only factor in a person’s experience or identity.44

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44 Many form narratives, often recorded by physicians or other medical professionals, are similarly restrictive. While the purpose of these forms is often to learn and record patient history, the spaces provided for personal expression and experience are minimal and are often combined with restrictive one-size-fits-all
Keeping empirical and impersonal records of patients’ illnesses and conditions, however, seems to have been a privilege for the physician. According to Gilman’s autobiography, when she sent Mitchell a letter detailing her current condition and her personal and family history (a document that I will examine closely in the next chapter), Mitchell dismissed her letter as a sign of “self-conceit” (Gilman, Living 95). However, in looking at the letter itself, it is Gilman’s patient narrative that most closely follows the case narrative structure: she begins with a description of her parents and grandparents, focusing predominantly on their health and their professions; she then moves into her

questions. For example, one of the intake forms for new patients at the Ridges Asylum in Athens, OH, in 1874 asks physicians to record (1) whether or not they deem the patient to be insane, (2) the patient’s age and a brief history of the patient’s case (two lines are provided), (3) the duration of the patient’s disease “dating from the first symptoms,” (4) whether or not the patient has “any infectious diseases or vermin,” (5) the cause of the disease and whether or not it is hereditary, (6) whether or not the patient is epileptic, (7) whether or not the patient has ever been violent against themselves or others, and (8) what treatments have been pursued thus far in the patient’s case (Hart).

These particular examples have been taken from one specific intake form used in 1874; other forms and certifications used during the same time period focus on similar questions, and different physicians fill the forms out to varying degrees of completion and detail. In this specific example, Seth Hart, M.D., lists patient Mary Jane Weaver’s previously pursued medical treatment as “the same as common in cases of such irregularities,” providing a vague connection but no specific details as to her previous treatment (Hart).

What narrative elements are present in these forms, as few and limited as they are, are often focused on empirical and clinical representations of the patient’s particular case; as with case narratives, this limits the patient’s experience to only the elements of their condition or illness and, when recorded with vague descriptions such as “the same as common,” create a uniform description of illness and treatment rather than a unique and personal account of the patient’s experience.

This approach to recording patient experience, both in terms of the restrictive form and in terms of uniform and generic physician-supplied responses, is reductive and creates a uniform description of illness. However, illness is not uniform and even two patients who are diagnosed with the same condition and who undergo the same treatments cannot be adequately fit into the same box. This approach denies patients individuality and personal experience, suggesting instead that all patients who are able to check the same boxes on the form are having (and, in many ways, will have) the same, overall, uniform experience.

45 Gilman’s diaries, her autobiography, and her fictionalized narrative in “The Yellow Wallpaper” do not include the same empirical focus on history and symptoms that her letter to Mitchell does.
own case including what she feels are the relevant details about her upbringing and mental history through childhood and adolescence; then she moves from this point into the relevant details of her marriage and her emotional state and physical health up through the birth of her daughter and her current health concern (Gilman, *Selected Letters* 45-49). It is at this point where she breaks from the clinical and objective history to beg Mitchell “not to laugh at me as every one else does, not to say it is ‘almost as bad as a disease’ as one of my friends does, no to turn me off” (Gilman, *Selected Letters* 49). This moment marks a shift at the end of the letter where Gilman becomes more reflective and emotional.

Mitchell’s active dismissal of this letter⁴⁶ might suggest several different complications in his relationship with Gilman. First, it is possible Mitchell dismissed Gilman’s empirical and clinical account of her own condition as a way of protecting the physician’s authority and (supposedly) unique power to diagnose and record patient experience. This would help him to create distance between himself and his patient as he was developing and proving that authority. In Mitchell’s dismissal of Gilman, he tells her what is wrong rather than asking her. It is also possible, however, that Mitchell felt that Gilman was incapable of providing an unbiased and accurate account of her condition and/or that he needed to belittle her so that he could position himself as someone who needed to be obeyed.⁴⁷ Because creating obedient patients is crucial to his cure, ⁴⁶ As Gilman records in *Living*, Mitchell calls this letter a sign of “self-conceit” (Gilman, *Living* 95).

⁴⁷ Mitchell’s insistence on the importance of creating obedient patients is one that he focuses solely on *female* patients. When he writes about how to treat male patients, this same focus on obedience is largely absent. This is a sign of sexism and patriarchy in medicine, suggesting that an adherence to socially constructed gender roles (particularly, the role of the submissive and obedience woman) is medically
establishing not just authority but also dominance over the patient is essential to
Mitchell’s methods, and we can see that establishment actively at work in his dismissal of
Gilman’s objective patient narrative and history.48

While this dismissal of a patient’s emotional history may be seen as beneficial, or
in some ways necessary, in terms of allowing a physician to then construct an objective
history, that dismissal is a sign of larger problems including the growing disconnect
between a physician and their patient. Also, while this argument for the benefits of
dismissing a patient’s own history may be made (though problematically) in medicine,
the same argument does not stand for literary history. As historians, we do not need to—
nor should we—approach the patient narrative with this same suspicion; when we do, we
are participating in this history of dismissing and silencing the patient in favor of the
physician’s “expert” perspective, a perspective which is, as we have seen, too often
tainted with racist and sexist ideologies, which are often supported by the science of their
day.

By approaching patient narrative not as a genre which needs to be treated with
suspicion, disproven, or critiqued but instead as the necessary and valuable partner to
case narrative, we can begin to uncover these voices—of which Gilman is only one
example—that are often dismissed as emotional, sentimental, and untrustworthy; this is a

48 We can also see this need for obedience come through in Mitchell’s case narratives in which he is the
agent acting on the patients, who are passive parties; through this construction, he subjugates his patients
and presents himself as the active, authoritative agent who is owed obedience if patients are serious about
getting better.
dismissal that is often a response to the genre and content of patient narrative, but which is also indicative of a social and intellectual distrust of their authors. I argue, instead, that we shouldn’t think about these different narratives in hierarchical terms; rather, we must understand that patient and case narratives are different—though not in a way that marks one as superior and the other as inferior—because the demands of these different genres create different documents. While the demands of case narratives necessitate a focus on predominantly quantifiable data and a narrative of the treatment applied to a particular patient or group of patients, the patient narrative extends beyond that clinical, quantifiable space and, as such, demands a wider, more emotional lens to encompass the full experience of living with illness. As we see with Gilman in particular, the demands of patient narrative are not always easily met and may, for some individuals, require multiple (re)tellings—at different times, in different genres, etc.—in an attempt to fully, accurately, and satisfactorily account for, make sense of, and take ownership of such an experience.
CHAPTER 3: GILMAN’S PATIENT NARRATIVES

Gilman wrote multiple accounts of her experience with illness, four of which I focus on in this chapter: (1) her letter to Mitchell detailing her condition; (2) her diary entries that record her day-to-day symptoms, emotions, and concerns; (3) her autobiography which, years later, reflects on her condition and the ways in which it affected her life;49 and (4) her fictionalized account in “The Yellow Wallpaper,” which was written three years after her experience with the Rest Cure.50 It is important to note that Gilman had experiences with different illnesses and conditions throughout out her life; however, in the interest of comparing the Gilman and Mitchell narratives, I focus on her experiences with hysteria and neurasthenia, particularly around the time that she was treated by Mitchell.

In these narratives, we see a focus not just on the clinical experience of illness but on the wider implications of living with illness; we see how Gilman’s conditions affect her romantic, family, social, and public lives as well as the private, emotional toll that it takes on her personally and the lasting ramifications of her conditions, all focuses that reach far beyond Mitchell’s clinical and empirical accounts of illness as recorded in his medical publications.

49 The Living of Charlotte Perkins Gilman: An Autobiography was originally published in 1935, shortly after Gilman’s death. Gilman worked on revisions and the selection of images for the text up until she ended her own life on August 17, 1935; the autobiography was published October 4 of the same year (Lane xix). As such, this particular text reflects Gilman’s understanding of her condition and its effects on her life at the very end of her life, the largest temporal gap between her treatment with Mitchell and a narrative of her experience with illness.

50 “The Yellow Wallpaper” was written in 1890 and published in 1892; Gilman was treated by Mitchell in the spring/summer of 1887.
Gilman’s Letter to Mitchell

As discussed in Chapter 2, Gilman’s letter to Mitchell detailing the history of her condition, dated April 19, 1887, is perhaps the most closely related to the case narrative in its predominant focus on an objective and empirical account of patient history and condition. Gilman opens this letter by explaining her purposes for writing to Mitchell prior to her trip to Philadelphia for treatment:

I write this for you, fearing that I shall soon be unable to remember even this much. I am coming to Philadelphia next week, to see you, but a week does a great deal now. Excuse me if I write unnessary [sic] facts, it is through ignorance. My desire is to make you acquainted with all the facts of the case, that you may form a deeper judgement than from mere casual examination. (45)

She then provides family history, writing about the health of her maternal grandfather, her maternal grandmother, her mother, her paternal grandfather, her paternal grandmother, and her father.

These histories are succinct but include the details that Gilman feels are relevant to her parents’ and grandparents’ health and living such as the cause of death, other instances of “nervous prostration” and related nervous conditions in the family, and the age of marriage and childbirth. Gilman’s history of her mother is particularly telling: “A deep thinker, but absolutely illogical. Is in every way an exaggerated type of the so called ‘feminine’ qualities, love of husband home and children being almost manias” (46, original emphasis). This, coupled with a description of her paternal grandmother’s children, shows the history of women with nervous conditions in Gilman’s family: “One
of her [Gilman’s paternal grandmother’s] daughters has had nervous prostration. The other under pressure of great trouble lost her reason for a time, recovered, was ill again, and was out of her mind when she died I believe” (46). It is important to note that these histories combine elements of health and behavior, as Mitchell’s case narratives do. The focus on inheritable behavioral traits, as discussed in Chapter 2, makes these behavioral qualities a necessary part of the biological and medical history of an individual.

Gilman then moves into her personal history, still focusing objectively on health concerns and life changes that she believes are relevant to her current condition, beginning with her childhood. She asserts that she “reached womanhood in perfect health” and “became impressed with the truths of physiology and hygiene,” maintaining that she was “perfectly well [physically] up to my marriage at twenty-three—four” (47). She then moves into a mental history, informing Mitchell that she always had an active imagination, so much so that “at thirteen it was a large part of my life, and so real that I actually believed it” (47). In thinking about her imagination and mental work, Gilman also provides a brief history of her student and intellectual interests, saying that she began an individual life at fifteen which included “drawing help and companionship from books, scientific and philosophical” (48). Throughout this history, she talks about the added strain her mother introduces to her life, being a burden on her nerves.

Gilman then reaches the point in her history where she recounts her marriage and the birth of her daughter:

51 These descriptions are of the Beechers, the family that Mitchell treated prior to treating Gilman and that caused his initial reluctance to treat Gilman.
Was not specially sick in carrying her; and had an easy time enough at birth. Had terrible fits of remorse and depression all through the time, but thought nothing of them as I had had the same in the two years torture called courtship. Began to show “nervousness” in the months confinement. Had wild and dreadful ideas which I was powerless to check, times of excitement and times of fear. No one thought there was anything the matter. (48)

Gilman says not only that she has been sick since this point until the time of her writing, but also that prior to her marriage she had a “very cheerful disposition” but since her marriage she has “scarce known a happy moment,” positioning her marriage (and the subsequent birth of her daughter) as the turning point in her emotional state (48). She describes her experience since her condition developed: “All that summer I did nothing but cry, save for times when the pain was unbearable and I grew wild, hysterical, almost imbecile at times” (49). Since that time, she had a short lapse in her feelings of depression, despair, and hysteria; she traveled to California for the winter of 1885, felt “perfectly well,” but relapsed upon returning home the following March. She also informs Mitchell that she began taking “Dr. Bucklands Essence of Oats” in August 1886, further detailing her experience with attempts to treat her condition and return to health.

The detailed history up through this point of the letter follows much of the same arc as many of Mitchell’s narratives. Similar to the narrative of Mrs. C (recorded in Fat and Blood and examined more closely in Chapter 2), Gilman focuses on her marriage and pregnancy, her schooling and history of work and thinking, and the change in her demeanor as well as other symptoms brought on by her condition; she also details the
different actions she has taken in an attempt to relieve herself of this condition: the
vacation to California and taking a remedy designed to treat nervous conditions (among
other ailments). As Gilman recounts these symptoms and the changes in her health,
however, one obvious difference between her account and Mitchell’s case narratives is
the lack of statistical data: while Mitchell provides measurements to indicate changes in a
patient’s state (such as temperature and weight), Gilman relies solely on a description of
the conditions without empirical data to back her narrative.

After this history is completed, the tone and focus of Gilman’s letter changes
significantly as she moves away from objective histories and treatment accounts and into
her call for assistance; Gilman makes an emotional, desperate, and heart-wrenching
appeal to Mitchell:

There is more physical prostration than ever before. And there are mental
symptoms which alarm me seriously. These I can tell you better. But I beg of you
not to laugh at me as every one else does, not to say it is “almost as bad as a
disease” as one of my friends does, not to turn me off. (49)

After begging Mitchell to take her seriously, Gilman writes about her commitment to her
work, insisting that “I want to work, to help people, to do good,” adding that “[s]urely it
is worth while to save a good worker, one who asks little and longs to give much” (49,
original emphasis). Gilman also recognizes that Mitchell is “the first authority on nervous
diseases,” an assertion of his authority and her desire to be treated by him (49). In this
appeal, Gilman finds it necessary to both recognize Mitchell’s authority and to prove her
worth, a worth that she defines in terms of work, presenting the prospect of curing her as a beneficial economic exchange: she wants to take little but wants to give much.52

The desperation of Gilman’s request comes through in this final portion of the letter, a quality that is not immediately evident in the history she provides before this transition. This letter, written while Gilman is experiencing her condition but before she undergoes Mitchell’s treatment, gives us a clear view of her emotional state, even as she tries to remain logical and objective. Her audience for this letter, a medical professional, also has an effect on her tone and approach to her narrative; she wants to provide Mitchell with the information that he will need to make an accurate and expert diagnosis, an intention that she makes clear in her opening paragraph.

Even in Gilman’s most clinical and intentionally objective account of her experience with this particular condition, though, we see the qualities of the patient narrative: the questions and anxieties of how to deal with illness in day-to-day life, the effect of illness on personal relationships, and the dual desires to get answers and to be taken seriously.

Gilman’s Diaries

Gilman’s diaries provide us with another window into her experience with hysteria and neurasthenia. These entries, recorded on a day-to-day basis, allow us to see

52 It is worth noting, as was discussed in Chapter 1, that the general goal of treating women with nervous conditions was not to make them better workers but instead was focused on improving their ability to be effective wives and mothers; men, on the other hand, were treated with the goal of making them healthy and effective workers and thinkers. In this sense, Gilman’s appeal to Mitchell based on her potential and worth as a worker is outside the commonly accepted and highly gendered reasons for treating female nervous patients.
what her life was like while living with this condition and her perception of her health in the moment. This narrative is a valuable resource as it shows us how Gilman records these experiences not when thinking of herself as a potential patient (as she is when writing her letter to Mitchell) but when thinking of herself as a human being. Also, because her diaries were personal and Gilman, by all accounts, never intended to publish them on her own, keeping these diaries was a record and an activity meant only for Gilman herself; there isn’t the outside influence of an audience dictating—at least, intentionally—how Gilman’s experience should be presented.53

As one might expect when reading a person’s diary, not all entries deal with Gilman’s health; as such, I will be referring to excerpts that give us a clear idea of her health concerns as related to Gilman’s experiences with these nervous conditions leading up to Mitchell’s treatment.

In these entries, we are able to see a part of the patient that is largely absent from case narratives: emotional concerns. While we see some of these concerns present themselves explicitly at the end of Gilman’s letter to Mitchell, her diary goes into more emotional detail and also records her often conflicting and changing emotions and experiences in a form that we can (largely) trust to be genuine. For example, in her final diary entry of 1886, Gilman asserts that she feels in some ways “lowered—degraded—traitor to my cause. But I am not sure, it may be a lingering trace of the disordered period

53 Gilman’s diaries remained unpublished until Denise D. Knight’s 1994 edition; prior to this, excerpts from Gilman’s diaries had been quoted in various biographies but the full collection had never been published in its entirety.
just passed” (Diaries 364). While Gilman recognizes that she is having these intense feelings, she also records that she cannot necessarily trust those feelings—those feelings may just be the product of her nervous conditions. This emotional uncertainty—or, perhaps more aptly described, this awareness of a potential disconnect between emotion and logic caused by these nervous conditions—is no small factor for the patient to contend with. However, the awareness of potentially manipulated or overexcited emotions is not addressed in case narratives or other medical literature at the time. These texts only go so far as to say that the emotions may be manipulated; they don’t tell the patient how to deal with that in day-to-day life. Managing or handling this distrust of the self was left for the patient to navigate outside of a clinical setting.

In Gilman’s entries, we can also see connections between symptoms and behaviors. For example, she writes on March 15, 1887, “Put K[atharine] to sleep and sleep in the rocking chair myself. Get chilly and have a crying fit. Sleep ill, and am utterly useless the next day” (Diaries 379). In this entry, we can see a lack of sleep and a “crying fit” (both symptoms of hysteria and neurasthenia) and their connections to emotional outbursts and feelings of “uselessness.” Here, we have not just a description of symptoms but also of how Gilman lived her life with this feeling as she writes about her “useless” day:

Call on Mrs. Buffum and stay to dinner, getting much help. A Mrs. Batty there, a Friend, nice woman. Then I go to see Miss Pease, long talk, then meet Walter on Angell St; and go to the Slicer’s to tea. Pleasant evening. Home by 10.30 to lonesome Walter. (379)
This seemingly perfectly ordinary day gives us some insight into how Gilman navigated a social life and social obligations while living with her conditions. While she was feeling “utterly useless,” as this entry states, Gilman was also forcing herself to participate in social activities and found that such activities gave her “much help” (379).

As we can see in the end of this entry, one common theme in Gilman’s entries about her health is her relationship with her husband at the time, Walter Stetson. While Mitchell’s accounts of patient narrative often do not greatly consider marital relationships—at least in the ways that they might be affecting women—Gilman does not hesitate to link some of her symptoms to the way that she is treated by Stetson: “Begin to give Kate her bath before breakfast,” Gilman writes on February 7, 1887, “but get discouraged by Walter, who thinks eating directly afterward is injudicious. Accomplish little all day, but have a very jolly time at the gym. in the evening” (Diaries 373). Gilman pinpoints her marriage as a significant turning point in her personal health; this is something that we have also seen in her letter to Mitchell. On February 15 of the same year, Gilman also notes the couple’s financial struggles: “A Financial Crisis. No coal, no money. I tell Walter he must get it, or I will; and he does” (Diaries 374, original emphasis). It is obvious that there is tension in their marriage, both emotionally and financially, and each of these factors is contributing to Gilman’s failing health.54

54 At the same time, however, the narrative of Gilman and Stetson’s relationship is not as straightforward and consistently unhealthy as these passages (and her letter to Mitchell) make it sound. There are also a number of diary entries in which Gilman expresses love for Stetson and thanks for his attentive care when she is unwell. For example, when Gilman is “pretty well used up by loss of sleep[,] Walter stays at home in the morning” so that she can nap (Diaries 327); “Walter sends me one of the new Postal Sheets, just to show it me and say ‘I love you’. Dear tender heart!” (Diaries 343); in one particular instance of Gilman getting “real nervous and shaky,” Stetson “gives me a warm bath and puts me to bed” (Diaries 369); and in one instance when Gilman is “[f]eel[ing] very tired[,] [Stetson] reads to me, ‘Women of the 19th Century,’
As Gilman also states in her letter to Mitchell, caring for her daughter is another point of anxiety and concern for her. On January 9, 1887, Gilman writes, “Fall with K[atharine] in my arms; bumping her head and lamming my knees. Then she tires me out in the sleepgoing; and I get real nervous and shaky” (Diaries 369). On March 9, 1887, after Katharine catches a bad cold, Gilman writes, “I give out completely in the morning, crying with weariness” after a night of taking care of her sick daughter (Diaries 378). On March 13, 1887, Gilman writes, “A very hard day. I have a crying fit while trying to make Kate go to sleep, and am all used up” (Diaries 378). These are only a few examples of many. Gilman is quickly wearied and brought to tears by the process of caring for her daughter, suggesting more than once that her daughter has no special connection with her. This feeling of disconnect and the constant demands of caring for another person are, along with her marriage to Stetson, major reasons that Gilman cites as the causes and catalysts of her nervous conditions.

In these entries, we not only see accounts of how caring for Katharine affects Gilman’s health, but we also see how Gilman’s concerns about motherhood—especially concerns about whether or not she is a good mother—are affected by her health. For

55 by Margaret Fuller” (Diaries 370). These passages show that, while Gilman very much believes that her relationship with Stetson is responsible for her health conditions, understanding their relationship requires more than seeing the connection between their marriage and Gilman’s health; the patient narrative gives us this access, a chance to understand the bigger, more intricate picture.

55 There is also an additional value in terms of patient narrative in Gilman’s diary entries from February 27 through March 11, 1887; in these entries, not only does Gilman write about catching a bad cold herself, but also writes about giving the cold to her daughter and then having to care for her daughter. Her daughter’s treatment for this cold includes having a doctor come to the house and trying a change in the medicine used to treat Katharine’s cold. Though this cold is not the same health concern that Gilman brings to Mitchell, it provides us with another window into what it’s like to live with illness and care for someone with an illness, especially as a mother.
example, on September 19, 1886, Gilman writes, “Get hysterical in the evening while putting K[atharine] to sleep. Walter finishes the undertaking, and sleeps with her. When I am nervous she never does sleep easily—what wonder” (Diaries 344). She believes that her child is suffering because of Gilman’s health and emotional state, a belief that causes Gilman to see herself as a subpar mother—especially when coupled with her belief that Katharine does not feel a connection with her.

The effects that these conditions have on mothers and children are something that Gilman also perceives outside of her own personal experience. We can see this in her February 20, 1887, entry:

[…] feed K[atharine], dress, read some poetry, cry some over our incompatibility. Mr. & Mrs. Smythe call, and we get them to stay to some dinner. Have a good talk with Mrs. S. She is “another victim”. Young, girlish, inexperienced, sickly; with a sickly child, and no servant; and now very sick herself. Ignorant both, and he using his “marital rights” at her vital expense. Ah well! (Diaries 375)

This particular entry shows not only anxiety over Gilman’s “incompatibility” with her own daughter, but also records Gilman’s perception of Mrs. Smythe’s health and the connection of her state of health to both her child and her husband. To Gilman, this is not a unique experience but something far more common. She is concerned that it is not only her marriage and her child that has made her sick but that women in general are made
sick by marital and social systems that privilege a man’s “marital rights” over a woman’s health and autonomy.\textsuperscript{56}

However, all is not despair in Gilman’s life, even in these entries where she is struggling with her health; her diaries give us a window into Gilman’s hopefulness as well. For example, on December 31, 1886, Gilman writes, “I leave behind me tonight a year of much happiness, growth, and progress; also of great misery. But the happiness and progress are real and well founded; and the misery was owing mainly to a diseased condition of the nervous system. It is past, I hope forever” (Diaries 364). While this entry may be bittersweet—especially since in hindsight we know that her nervous conditions were not in her past but would continue, in some degree, throughout her life—it also shows us an important part of Gilman’s patient narrative: the preservation of hope, the optimism, the willingness and the desire to feel better.

In her diaries, Gilman very often strongly associates health with work. When she is feeling healthy, she is able to do more work, and when she is feeling unhealthy, sometimes doing a little work can improve her condition. Gilman’s entry for March 20, 1887, is a particularly poignant example of this connection: “Bathe. Bad day. Getting back to the edge of insanity again. Anna and Aunt C. call. Put K[atharine] to sleep and feel desperate. Write my ‘column’ though” (Diaries 380). This entry shows that, even when faced with a day so bad that Gilman describes herself as being at “the edge of

\textsuperscript{56} With Gilman’s focus on the need for white women’s equality with white men (a core part of Gilman’s eugenic beliefs), we can also understand this argument as being one strictly for other white women in positions similar to Gilman’s.
insanity,” she is able to make herself work. This work is a repeated comfort that we can see in many of her entries, such as the February 11, 1887, entry which begins with Gilman’s assertion that it was a “[v]ery poor day. accomplish [sic] very little” but ends with Gilman saying that she read Ruskin in Walter’s studio and “[f]eel[s] much better for it” (Diaries 374).57 This focus on the apparently healing powers of her work gives us a better sense of her pleading conclusion to her letter to Mitchell. When Gilman says that she wants to work and she wants to be productive, she is also building on all of these experiences that she has prior to writing that letter; when nothing else seems to make her feel better, working provides a relief (though sometimes just a small and temporary relief) of Gilman’s symptoms.

Gilman’s diaries also provide us with a window into her reactions and responses to different treatments. Her first entry that suggests she felt she was hysterical is from August 28, 1885. This is also the first entry where Gilman interacts with Dr. Edward Balch Knight:

I am having a doctor. Dr. Knight. He came first I think on Fri. the 14th. Again, having considered the case on Sun. 16th. I had had one of my bad times when he

57 Similarly, Gilman writes about her days when she is too ill to work, often combining elements of illness with a feeling of a lack of accomplishment in a given day. From her August 30, 1886, entry: “Don’t feel very brilliant. Wash dishes. Wash baby, put her to sleep and set her porridge boiling. Read and loaf and accomplish little” (Diaries 341). Other examples of this come from Gilman’s September 7, 1886, entry (“A poor day. Accomplish nothing to speak of; only read a little in the geology book”), October 3, 1886, entry, (“Do not feel very well and accomplish little”), and January 16, 1887, entry (“Very tired and miserable. Do nothing to speak of”) (Diaries 342, 347, 370). This is also important when considering this repetition in the diary narrative in conjunction with Gilman’s assertion of her worth at the end of her letter to Mitchell. In her letter, she makes it clear that she feels that her worth is tied to her ability to work; an inability to work is then, for Gilman, the equivalent of worthlessness—a feeling that we see in these repeated accounts of exhaustion, illness, and a lack of accomplishment in her day-to-day diaries entries.
was first sent for. The next day was bad too; highly excited; hysterical; seeming to myself wellnigh insane. (*Diaries* 331)

Knight continues to treat Gilman, not just for her hysteria and potential insanity but also for more short-term concerns such as colds. Through these interactions with Knight, we can see that Gilman was not seeing Knight just as a specialist but as a general practitioner who was concerned with her overall health.

Though Gilman goes through ups and downs while seeing Knight, she is not cured; when she becomes hysterical again following a winter spent vacationing in California, Gilman tries again to get adequate treatment for her nervous conditions. The entries from April 9 and 10, 1887, describe one of Gilman’s visits to Dr. Knight and the prescription of medication to treat her condition:

*Sat. April 9th. 1887.*

Worse. Take Kate over to mothers [*sic*] and leave her there, while I go see Dr. Knight. Explain my condition and he gives me two medicines. Wearily return, bring Kate back, and lie down. More physical exhaustion than I’ve felt yet.

*Sun. April 10th. 1887.*

Don’t feel so much active misery, but am in a pitiful condition nervously. The least irritation upsets me quite. Walter takes baby out. I call on Mrs. Diman. Have some dinner there. She and E. walk down with me. Then I take the “tiddly” for a little walk. Lie down a little. Walter, baby, mother, supper. bed [*sic*] finally.

(*Diaries* 383)
Following these entries, Gilman writes that Mrs. Diman offers her one hundred dollars that “is to send me away to get well” which Gilman follows with another visit to Dr. Knight “to inquire about sanitarium, sea voyages etc.” (Diaries 383-384). The initial medical treatment, though not given a significant amount of time to take effect, was not producing the results Gilman wanted as quickly as she wanted; as such, she resolves to seek further treatment, a decision which leads her to Mitchell.

Gilman’s April 18, 1887, entry is the culmination of many of these themes and significant factors that can be found throughout her diaries: (1) concern for her health, (2) the general helpfulness of writing, (3) the pain she has suffered as a result of her symptoms, (4) a need for relief, and (5) a certainty that her relationship with Stetson is largely responsible for her state of ill health:


I have kept a journal since I was fifteen, the only blanks being in these last years of sickness and pain. I have done it because it was useful. Now I am to go away for my health, and shall not try to take any responsibilites [sic] with me, even this old friend.

I am very sick with nervous prostration, and I think with some brain disease as well. No one can ever know what I have suffered in these last five years. Pain pain pain, till my mind has given way.

O blind and cruel! Can Love hurt like this?
You found me—you remember what.

I leave you—O remember what, and learn to doubt your judgement before it seeks to mould another life as it has mine.

I asked you a few days only before our marriage if you would take the responsibility entirely on yourself. You said yes. Bear it then. (Diaries 385)

Gilman not only believes that her relationship with Stetson is the cause of her condition but also that he should be held responsible for it. She follows this entry with only one more, the final line of which records that she is beginning to write “an account of myself for the doctor” (Diaries 385). This brings her experience full circle, as her letter to Mitchell picks up where this diary leaves off. Gilman did not keep a diary again until 1890, after she had been treated by Mitchell.

Gilman’s Autobiography

Gilman’s autobiography, then, moves us away from the actual time of her hysterical and neurasthenic diagnosis; The Living of Charlotte Perkins Gilman: An Autobiography was published in 1935, allowing Gilman 45 years of hindsight through which to record her experience with hysteria, neurasthenia, and Mitchell’s Rest Cure. It also differs from Gilman’s letter to Mitchell and her diaries in terms of audience. While the letter was intended strictly for Mitchell and the diaries were for personal use, Gilman

58 This is the same year that Gilman wrote “The Yellow Wallpaper.”

59 When Gilman returns to diary-writing in 1890, she does not directly reflect on Mitchell or the Rest Cure. She is also no longer burdened by her relationship with Stetson since she has, in the time between the end of the previous diary and the beginning of the new one, left him and moved to California. While Gilman continues to include details about her health, direct references to the intersections between her health and Mitchell’s treatment are absent from these later entries, so I haven’t presented them in detail here.
fully intended for her autobiography to be published and thus records her experience in this text for public consumption. The temporal distance between her treatment and her writing as well as the influence of a general audience should both be taken into account when examining this particular patient narrative. As discussed in the introduction, it is also important to consider the specific conventions of autobiography when examining this particular narrative. In comparison to “The Yellow Wallpaper”—Gilman’s other patient narrative intended for public consumption—*Living* does not afford Gilman the same distance from the narrative; while the fictional account of living with illness gives the author more creative freedom, the importance of accuracy in autobiography requires different tactics and a different approach to the narrative.

As with Gilman’s diaries, *Living* is about Gilman’s life as a person—not just a patient—and as such includes many details beyond her clinical experience with hysteria and neurasthenia. Again, as with her diaries, I examine excerpts that are most relevant to this particular part of her life.

In *Living*, Gilman explicit addresses her conflicting feelings about her relationship with Stetson, even before the two were married. While feeling both intellectual and sexual attraction to Stetson, Gilman felt conflicted about the prospects of marriage:

> On one hand, I knew it was normal and right in general, and held that a woman should be able to have marriage and motherhood, and do her work in the world also. On the other, I felt strongly that for me it was not right, that the nature of the life before me forbade it, that I ought to forego the more intimate personal happiness for complete devotion to my work. (83)
In spite of these conflicting feelings which never abated, Gilman married Stetson in May 1884 (Living 84). In fact, the first consideration that Gilman gives her nervous conditions in conjunction with her marriage paints a rather different picture than the connection presented in her earlier narratives of her condition:

We were really very happy together. There was nothing to prevent it but that increasing depression of mine. My diary is full of thankfulness for happiness and prayers for deserving it, full of Walter’s constant kindness and helpfulness in the work when I was not well—the not-wellness coming oftener and oftener. (Living 87)

While in earlier narratives, Gilman had painted Stetson and their relationship as being the reason for her nervous conditions, in the narrative recorded in her autobiography, the cause-and-effect relationship is flipped. Instead, Gilman suggests that she should have been perfectly happy in her relationship with Stetson had she not developed these nervous conditions.

Gilman also considers the connection between her condition, her pregnancy, and the subsequent experience of motherhood. After the birth of her daughter on March 23, 1885, Gilman expected some relief from her condition because “[w]e had attributed all my increasing weakness and depression to pregnancy”; as such, after giving birth, there was an expectation of recovery (Living 88-89). That recovery, however, did not come:

After [the nurse’s] month was up and I was left alone with the child, I broke so fast that we sent for my mother, who had been visiting Thomas in Utah, and that baby-worshipping grandmother came to take care of the darling, I being incapable
of doing that—or anything else, a mental wreck. [...] Here was a charming home; a loving and devoted husband; an exquisite baby, healthy intelligent and good; a highly competent mother to run things; a wholly satisfactory servant—and I lay all day on the lounge and cried. (Living 89).

As with earlier narratives, Gilman’s autobiography gives us a chance to see how Gilman lived with her condition. This includes the ways that she made provisions not only for her own health but also for the health and safety of her family, especially at times when this health and safety were affected by Gilman’s inability to perform what she saw as her wifely and motherly duties; Gilman procuring her mother’s assistance when she was unable to care for the family is one such example. Still, Gilman desired not to simply manage her condition but to actually get better. As a part of this recovery, Gilman wanted to feel a connection to her baby, the lack of which—as we have seen in other narratives as well—was an emotional and trying element for Gilman: “I would hold her close—that lovely child!—and instead of love and happiness, feel only pain. [...] Nothing was more bitter than this, that even motherhood brought no joy” (Living 92-93).

In this narrative, perhaps even more so than in her letter to Mitchell and in her diaries, Gilman identifies her condition and both the symptoms and the attempted remedies that she experienced. She explicitly names her condition: “In those days a new disease had dawned on the medical horizon. It was called ‘nervous prostration’” which she describes as a disorder that “involved a growing melancholia, and that, as those know who have tasted it, consists of every painful mental sensation, shame, fear, remorse, a blind oppressive confusion, utter weakness, a steady brainache that fills the conscious
mind with crowding images of distress” (Living 90). She also distinguishes between 

exhaustion—a term used to describe “the idea of being tired” and a kind of “physical weariness”—and nervous exhaustion, which Gilman describes in detail:

There is no “appetite” in the mind, no interest in anything. To see, to hear, to think, to remember, to do anything, is incredible effort, as if trying to rise and walk under a prostrate circus tent, or wade in glue. It brings a heavy darkness, every idea presenting itself as a misfortune; an irritable unease which finds no rest, and an incapacity of decision which is fairly laughable. (Living 102)

These descriptions of both the symptoms of nervous exhaustion and the distinction between nervous exhaustion and exhaustion are in line with George Beard’s description of the symptoms of neurasthenia given in Nervous Exhaustion. Gilman also describes the tonics and sedatives that she took to try to help her condition as well as her trip west in which she visited her brother in Utah and friends in California (Living 92-93).

Gilman goes beyond giving a clinical description of her condition and the remedies she attempted, however. She also writes about what it was like to actually live with this condition, outside of the clinical, medical setting. In writing about “nervous prostration,” Gilman informs her reader that “No one knew much about it, and there were many who openly scoffed, saying it was only a new name for laziness. To be recognizably ill one must be confined to one’s bed, and preferably in pain” (Living 90). She also notes that “the doctors examined me and found nothing the matter” and that this lead her to chastise herself:
Prominent among the tumbling suggestions of a suffering brain was the thought, “You did it yourself! You did it yourself! You had health and strength and hope and glorious work before you—and you threw it all away. You were called to serve humanity, and you cannot serve yourself. No good as a wife, no good as a mother, no good at anything. And you did it yourself!” (Living 91)

In these portions of Gilman’s narrative, we see her not only struggling with her condition but also with the complications of that condition, particularly in terms of the condition being considered “real” and trying to find a reason for the condition. Not only is Gilman struggling with a condition that is new and not yet understood, but she is also dealing with the added burden of skepticism from other people who would believe that she is not ill but just lazy; together, this leads her to wonder if—or, at times, even truly believe that—she is responsible for her condition and that her symptoms are the result of something that she has done to herself.

When considering this skepticism and the social problems she faces with her condition, Gilman focuses particularly on the apparent invisibility of her condition:

But since my public activities do not show weakness, nor my writings, and since brain and nerve disorder is not visible, short of lunacy or literal “prostration,” this lifetime of limitation and wretchedness, when I mention it, is flatly disbelieved.

(Living 98).

She also makes an apt comparison between other visible medical concerns and her particular condition:
An orthodox visible disease that sends one to bed, as scarlet fever or mumps, is met by prompt sympathy. A broken arm, a sprained ankle, any physical mutilation, is a recognized misfortune. But the humiliating loss of a large part of one’s brain power, of more than half one’s working life, accompanied with deep misery and anguish of mind—this when complained of is met with amiable laughter and flat disbelief. (*Living* 104).

While Gilman, in her letter to Mitchell, does previously mention the problem of not being taken seriously, the narrative recorded in her autobiography is the first time that Gilman directly and thoroughly unpacks the connection between the way she is treated with her condition—especially when speaking out about her condition—and the invisibility of her condition in a published work.

The version of Gilman’s narrative that she presents in her autobiography is also unique because it is the only nonfictional recording of her experience with Mitchell that goes into depth about her treatment with the Rest Cure and her response to that treatment. She first introduces Mitchell with a description of his response to her letter:

At the time the greatest nerve specialist in the country was Dr. S. W. Mitchell of Philadelphia. Through the kindness of a friend of Mr. Stetson’s living in that city, I went to him and took “the rest cure”; went with the utmost confidence, prefacing the visit with a long letter giving “the history of the case” in a way a modern psychologist would have appreciated. Dr. Mitchell thought it only self-conceit. (*Living* 95)
In Chapter 2, I considered why Mitchell may have dismissed Gilman’s letter this way, but in this chapter, focused on the patient, I would like to consider instead how this would affect Gilman. She mentions his “prejudice against the Beechers” as one possible reason that he may have dismissed her account and takes a jab at his lack of understanding of her specific condition: “The eminent physician was well versed in two kinds of nervous prostration; that of the business man exhausted from too much work, and the society woman exhausted from too much play. The kind I had was evidently beyond him” (Living 95). However, she does concede that “he did reassure me on one point—there was no dementia, he said, only hysteria” (Living 95).

Gilman also describes her specific treatment while taking the Rest Cure: “I was put to bed and kept there. I was fed, bathed, rubbed, and responded with the vigorous body of twenty-six” (Living 96). This corresponds to what Mitchell recorded as his recommendations for applying the Rest Cure to a patient in Fat and Blood. Gilman goes on to note that “[a]s far as he could see, there was nothing the matter with me, so after a month of this agreeable treatment he sent me home” (Living 96). However, the recommendations that Mitchell made for how Gilman should live her life directly conflict with her account of what causes her to become nervous. As Gilman recalls, Mitchell left her with this advice:

“Live as domestic a life as possible. Have your child with you all the time.” (Be it remarked that if I did but dress the baby it left me shaking and crying—certainly far from a healthy companionship for her, to say nothing of the effect on me.)
“Lie down an hour after each meal. Have but two hours’ intellectual life a day. And never touch pen, brush or pencil as long as you live.” (Gilman, Living 96)

While Mitchell’s prescription in this passage corresponds with the advice he presents in Fat and Blood, it is Gilman’s interjection that I find most interesting. She reminds her readers of her experience with nervousness and its relation to her position as a mother; through this reminder, she also shows us that Mitchell is not considering this a serious or valid cause of her condition. Instead, he believes that Gilman needs to focus on traditional female gender roles. Mitchell’s beliefs about Gilman’s health overshadow Gilman’s own concerns, concerns which are based on her actual lived experience.

Trusting in Mitchell’s authority, however, Gilman does her best to follow these instructions, recording in Living that she did so “rigidly for months, and came perilously near to losing my mind” (Living 96). Gilman’s descriptions of her experience of approaching insanity are raw and painful. She describes living with a pain that is not physical but is instead “just mental torment, and so heavy in its nightmare gloom that it seemed real enough to dodge”; she also describes her increasingly erratic behavior as a result of this mental torment: “I made a rag baby, hung it on a doorknob and played with it. I would crawl into remote closets and under beds—to hide from the grinding pressure of that profound distress” (Living 96). It was at this point that Gilman and Stetson decided to divorce.

When reflecting on her divorce in her autobiography, Gilman then considers the possible connection between her marriage and her condition. She points out that her condition grew steadily worse from the time of her courtship with Stetson through their
marriage up to the point of their divorce, citing as further evidence the fact that she felt better when she was not home—particularly when she took her vacation to visit her brother and her friends. However, she also believes that, in the case of their marriage, both the mistake of the marriage and the suffering in the marriage were mutual and shared by both Stetson and herself. However, she also points out that it would have been better for her health if the two had separated earlier:

If this decision [to separate and divorce] could have been reached sooner it would have been much better for me, the lasting mental injury would have been less. Such recovery as I have made in forty years, and the work accomplished, seem to show that the fear of insanity was not fulfilled, but the effects of nerve bankruptcy remain to this day. So much of my many failures, of misplay and misunderstanding and “queerness” is due to this lasting weakness, and kind friends so unfailingly refuse to allow for it, to believe it, that I am now going to some length in stating the case. (Living 97)

Not only does this passage show the detriment that Gilman believes her marriage had on her health, it also shows us the lasting effect of this condition on Gilman’s health throughout her life. While I am only closely examining the time in Gilman’s life when she was taking the Rest Cure, the implications and effects of her condition stretch far beyond this period of time—and, as this passage along with those quoted early make clear, so does the state of skepticism that accompanies this condition.
“The Yellow Wallpaper”

The fourth and final recording of Gilman’s patient narrative that I examine here comes in her short story “The Yellow Wallpaper.” As I discussed in the introduction to this project, whether or not fictional works should be included in the genre of patient narrative is up for debate; however, I have included this text here as it gives us further insight into Gilman’s condition. Not only does she draw heavily on autobiographical experience when constructing this story, but “The Yellow Wallpaper” is also the first account of Gilman’s experience that she intentionally wrote to be consumed by a public audience.60 “The Yellow Wallpaper” is also the most well-known of the four narratives that I examine in this chapter. This provides us with a patient-subject with whom many literary historians are already familiar; additionally, we also have the opportunity to trace the history of the public reception of “The Yellow Wallpaper” to see how that reception has changed over time.

However, if we are going to include “The Yellow Wallpaper” in this collection of Gilman’s patient narratives, we also need to make the distinction between this short story and the other narratives explored earlier in this chapter. Because “The Yellow Wallpaper” is autobiographically-inspired fiction—but still very much fiction—we must recognize that not all elements of “The Yellow Wallpaper” correspond with Gilman’s own experience. Instead, “The Yellow Wallpaper” is exaggerated and supernatural and horrific. However, these details also provide us with a window into Gilman’s mental and

60 Gilman sought treatment from Mitchell in the spring of 1887. “The Yellow Wallpaper” was written in 1890 after Gilman moved to California and was then published in 1892.
emotional state. For her, these events were horrific, and we can see that just as explicitly in her nonfiction narratives as well. In this way, emotion and experience influence choices of genre and style. I also present “The Yellow Wallpaper” as the last in this collection of Gilman’s patient narratives because, after examining her nonfiction narratives of this same experience, we are better poised to determine what is a direct reflection of Gilman’s experience and what is exaggeration, fictionalized, or otherwise altered.

One significant parallel between Gilman’s experience and the experience of the speaker in “The Yellow Wallpaper” is their diagnoses; the speaker says that she has “temporary nervous depression—a slight hysterical tendency” (648). John, the speaker’s husband and doctor, does not want her to write, though the speaker herself feels some relief in writing. The speaker also has a complicated relationship with her newborn child. She wants to be able to care for him, but she “cannot be with him, it makes me so nervous” (“The Yellow Wallpaper” 649, original emphasis). The speaker also goes into details of her treatment that are reminiscent of elements of Mitchell’s Rest Cure. She has a specific diet, must not work, lays in bed, and is told to avoid “stimulating people” (“The Yellow Wallpaper” 649).

Gilman also shares certain concerns and conflicts with the speaker in her short story. Both, for example, are concerned about their ability to be mothers. Though the speaker’s child is only mentioned directly twice in the story itself, it is obvious that the speaker has conflicting feelings about motherhood and the ways that her condition might affect her child. She remarks that “[i]t is fortunate Mary is so good with the baby” since
the speaker herself gets too nervous around him, but she also expresses a willingness to sacrifice herself to the unhealthy environment of the nursery so that the baby does not have to live there: “If we had not used it, that blessed child would have! What a fortunate escape! Why, I wouldn’t have a child of mine, an impressionable little thing, live in such a room for worlds” (“The Yellow Wallpaper” 649, 652). The speaker, looking for a silver lining in her situation, notes that she can “stand [the nursery’s environment] so much easier than a baby” (“The Yellow Wallpaper” 652).

Gilman and the speaker both also struggle with doctors who do not believe that there is anything “wrong” with them: “[John] knows that there is no reason to suffer, and that satisfies him” (“The Yellow Wallpaper” 649, original emphasis). The speaker also struggles with John over their differing accounts of her health: “[B]ut you really are better, dear, whether you can see it or not,” John says to the speaker. “I am a doctor, dear, and I know. You are gaining flesh and color, your appetite is better, I feel really much easier about you” (“The Yellow Wallpaper” 652). According to the speaker, however, she does not weigh more; in fact, she asserts that she is actually losing weight and that her appetite is only better in the evenings when John is around. At this assertion, John chides her and mocking tells her that “she shall be as sick as she pleases,” suggesting that her health concerns are not legitimate but are instead pleas for attention (“The Yellow Wallpaper” 652). Here, we also see a parallel to Mitchell’s concerns about patients who fake their symptoms in hopes of getting sympathy from family and friends.
Narrative as a Window into Medical Practice and Patient Experience

Through these four different narratives of Gilman’s experience with illness, we can see several common themes that are always present: (1) a desire to be taken seriously, (2) an assertion of worth—often coupled with a lament of lost purpose without her work, (3) concerns about motherhood—both in the ways that motherhood affects her condition and in the ways that her condition might affect her child, (4) the relationship between her marriage and her illness, and (5) attempts to maintain a social and public life while living with her condition. Each of these themes focuses on Gilman’s personal and lived experience with this illness. While we also see descriptions of her symptoms and the treatments and remedies that she tries to use for relief, the true markers of patient narratives are these personal considerations, these questions of how life can be lived with illness and how to carry on in the face of a diagnosis.

Through this collection of narratives, we can view medical practice in Gilman’s time—at least in the way that it was applied to Gilman—from the patient’s viewpoint. We can begin to see what it is like to not be taken seriously by the people who have the authority and knowledge to treat you. We can begin to understand the way that concerns about personal health do not end with the patient themselves; instead, there are constant concerns about how an individual’s personal health is both affecting and affected by other members of the patient’s family or social circle. These narratives also present an emotional appeal to the audience to see Gilman as an individual person—not just as a patient—who lives a life outside of the medical sphere. When she goes home following Mitchell’s treatment with the prescription to live a domestic life, it is Gilman who has to
put that prescription and advice into practice and try to make that work within the scope of her life. Mitchell’s assessment of her needs and her health end with the prescription, but Gilman must live with her condition and her treatment.

In the absence of these narratives, we might struggle to see the person in medicine, we might focus on the patient solely as that: a patient, a mind and body that a doctor works to heal. In focusing on the doctor as the acting agent in the doctor-patient relationship, we miss the complications and intricacies of the patient’s life and the ways that patients themselves have to be acting agents, making tough calls and difficult decisions about how to proceed with the information that medical professionals can provide for them. This value in the patient narrative is recognized by medical humanities for just these reasons: it works to keep the focus on the patient as a person as well as to keep the focus on the patient’s experience.
CHAPTER 4: ADDING PATIENT NARRATIVE TO THE CRITICAL CONVERSATION ABOUT GILMAN

As long as literary historians remain skeptical of the patient narrative genre, it is not enough to suggest that the combination of these four texts—Gilman’s letter to Mitchell, her diaries, *The Living of Charlotte Perkins Gilman*, and “The Yellow Wallpaper”—presents us with a better understanding of Gilman’s experience with illness. As such, I intend to also show how this reading of Gilman’s works fits into larger critical conversations already happening around Gilman’s canon—and, in particular, around “The Yellow Wallpaper”—to further the argument for the importance of a careful rereading through the framework of the medical and scientific history that informs Gilman’s experience.

In her article “‘But One Expects That’: Charlotte Perkins Gilman’s ‘The Yellow Wallpaper’ and the Shifting Light of Scholarship,” Julie Bates Dock points out the problematizing factor of omission, purposeful construction, and bias in Gilman’s autobiography building on the works of Beate Schöpp-Schilling, Juliann E. Fleenor, and Ann J. Lane. All of these critics are concerned about the reliance on Gilman’s own account of her life and the fact that all of Gilman’s nonfiction accounts—her diaries, her letters, and her autobiography—are intentionally designed to shape Gilman’s personal narrative for her own purposes. This is true of all diaries, letters, and autobiographies; it is not unique to Gilman (Dock, “‘But One Expects That’” 58). These constructions, these critics argue, present the reader with a dilemma as “there is much in *The Living,*] as in all autobiographies, of fiction, of self-deception, of purposeful misleading, of a
refashioned and recrafted life, of a persona created for the occasion” (Lane qtd. in Bates, “‘But One Expects That’” 58). These are many of the same reasons why literary historians and critics are skeptical of the patient narrative genre; it is an autobiographical account of a person’s experience with illness and is thus likely rife with omission, bias, and perhaps even self-deceit.

My response to this concern relies on studies not only of autobiography and self-presentation but on the practice of historiography as a whole. As James Neel argues through his examination of Plato and Derrida, all histories—and, in fact, all writings—include omissions; it is impossible to include every detail. This is why, as Neel explains, we cannot equate writing with truth; truth is infinite while writing is limited and restricted (Neel 89). Neel argues not only that the author is singularly aware of what is left out of their text but also that writing itself “exists at least as much by what it excludes, suppresses, and leaves blank as by what it includes, represents, and fills in”61 (Neel 86, 120). I would also argue that this is also true of writing that is often viewed as being more critical and unbiased; even scientific writing is informed and influenced by the biases held by the scientist as well as by the larger society in which the scientist is writing.62 We might specifically consider the ways that social and personal biases led to racist, sexist, classist, ableist, and heteronormative implications in the work of medical professionals such as Beard and Mitchell as well as the ways that anxieties about personal and

61 Neel argues that this theory is demonstrated in Derrida’s La carte postale.

62 This is something that I explored in Chapters 1 and 2.
professional authority are presented in Mitchell’s medical writings and in his medical practice.

It should perhaps be surprising, then, that we are willing to accept—or, perhaps, to remain willfully ignorant of—these omissions and biases in the fields of history-writing and science-writing but not when the author is writing about their experience of self. Whenever the writing might be considered autobiographical, literary historians tend to be most critical of the author’s motives and their intentions to “lie” to their reader or even to themselves. However, the hermeneutics of suspicion are not productive in examinations of Gilman’s patient narratives because examining such narratives requires the reader to leave suspicion behind and instead view these texts as valid sources. Additionally, suspicion is also unnecessary when we can see clear motives—especially genre-based motives—for the differences in the texts. I would argue, as Jurecic does, that the best way to approach these autobiographical writings—and, more specifically, autobiographical accounts of illness—is not for the purpose of discrediting the author but for the purpose of examining the experiences the author presents and the conversations that they are participating in when sharing their stories (Jurecic 16). If we consider Neel’s argument as well, that writing is just as much absence as it is presence, then we may also be able to examine significant absences in patients’ narratives without resorting to accusations of untruthfulness. This is especially true since, after all, a limited number of words could never adequately or fully convey an infinite truth.

In examining the varied interpretations of “The Yellow Wallpaper,” I will not only be looking at different readings and critiques of “The Yellow Wallpaper” but I will
also be looking at this text’s reception history. I will be considering what is valuable about this text or what we might learn about the author and the society in which she wrote through each different interpretation. I will also be considering how the society in which the critique itself was written may influence the interpretation, though as Dock argues, to suggest that there has been a clear and obvious progression from one interpretation to another is to overlook many earlier critiques (Dock, “‘But One Expects That’” 59-60). While, as Dock suggests, “[t]he textual history of ‘The Yellow Wallpaper’ since 1973 illustrates changing critical priorities in the academy,” because those priorities are not a strict progression and because they focus on changing elements of criticism, I look at the reception of “The Yellow Wallpaper” thematically rather than through a progressive and linear timeline (Dock, “‘But One Expects That’” 53).

“The Yellow Wallpaper” as a Horror Story

One common interpretation of “The Yellow Wallpaper” that was especially prominent at the time of its publication was that it is a horror story that represents one woman’s descent into madness following the progression of her mental breakdown. In fact, one anonymous review published in Literature in July 1899 comments on the construction of such a gruesome and original story that is “worthy of a place beside some of the weird and uncanny masterpieces of Hawthorne and Poe” (qtd. in Dock, History 111). This focus on “The Yellow Wallpaper” as a tale of supernatural horror is one that has always been present, in varying degrees and accompanied by various supplemental interpretations, since the original publication of the short story.
Supernatural writing, as a genre, also opens interesting doors to Gilman as a writer that, I would argue, allow her to explore and explain an experience with illness that is difficult to contextualize in other formats. The creeping woman/women behind the wallpaper and the darting figures that the speaker sees outside of her window manifest fears, anxieties, frustrations, and hopes in a way that would be difficult to articulate in a nonfiction or even non-supernatural context. We can see Gilman struggle with explanations of these feelings in her autobiography later when she cannot rely on these symbols; though she attempts to explain her mental and emotional state, the people around her either do not believe her or do not understand the extent of her pain because they see a façade—or, at least, an incomplete version of her experience. From the outside looking in, the people around her cannot reconcile the two apparent realities that Gilman lives.

This focus on “The Yellow Wallpaper” as a horror story, however, often requires the reader to construct the tale as a single character’s unique story; many critiques of these interpretations focus on the failure to see the bigger picture. For example, Conrad Shumaker (building on the work of Jean F. Kennard) suggests that feminist scholarship opens the door to see “The Yellow Wallpaper” as “an exploration of women’s role instead of the tale of horror or depiction of mental breakdown its original audience found” (589). As Dock points out, however, this distinction between “the late nineteenth-century audience [that] read it as horror” and “the enlightened readers of a century later [that] see it accurately” is neither fair nor accurate; instead, she argues that the early reviews show the same realization of the critique of marriage and the treatment of
women, “although these discussions do not use modern terminology” (Dock, “But One Expects That” 59-60).

For example, in a review from June 1899, Henry Blackwell describes the tale saying that “Nothing more graphic and suggestive has ever been written to show why so many women go crazy, especially farmers’ wives, who live lonely, monotonous lives” (qtd. in Dock, History 107). In other reviews, John is described as “singularly blind to the persistent and harrowing distress caused by [the speaker’s] confinement” and whose “stupid devotion” drives his wife insane (qtd. in Dock, History 100, 106). Even so, many of these reviews see these qualities in the treatment of women and the confines of marriage and/or society as being a part of the element of horror, suggesting as Anne Montgomery does that what “seems at first to be only a skit—a gentle, mildly amusing joke […] grows and increases with a perfect crescendo of horror” or that, as an April 1892 review printed in the Boston Evening Transcript suggests, the story is so vivid and “graphically told” that it “contains deadly peril” to readers, especially those “whose lives have become a struggle against an heredity of mental derangement” (qtd. in Dock, History 104, 103).

These combined reviews show that while Shumaker’s assertion that the original audience saw “The Yellow Wallpaper” as a horror story is not untrue, the original audience did not see it simply as a horror story; instead, the original audience was concerned both about (1) how the ways that women were treated made for a very realistic horror story and (2) the ways in which the description of the insanity the speaker suffers is so vivid that it may actually transfer onto the audience itself.
Another common focus of interpretations of “The Yellow Wallpaper” is the role that medicine plays in a person’s life. As such, there is a wide body of scholarship (including articles by Ann Oakley and Jane F. Thrailkill) that examines the ways that “The Yellow Wallpaper” is a direct critique of Mitchell and his Rest Cure. These interpretations often rely on both Mitchell’s and Gilman’s biographies as sources for connecting John’s treatment of the speaker in “The Yellow Wallpaper” to Gilman’s own experience as Mitchell’s patient.

This interpretation is also supported by Gilman herself; “The Yellow Wallpaper” is unique in that we have access to Gilman’s later article “Why I Wrote ‘The Yellow Wallpaper’” (published in the Forerunner in 1913) in which Gilman reveals her intentions with this work of autobiographical fiction. Having “Why I Wrote” presents us with both insight and complications that are created not only by that article but also by “The Yellow Wallpaper” itself. In examining these insights and complications, it is important to note the temporal space between the publication of “The Yellow Wallpaper” (1892) and the publication of “Why I Wrote” (1913). These 21 years give Gilman the advantage of hindsight, but also allow us to see Gilman’s continued push for her own agenda, showing us a world that Gilman wanted but maybe did not totally achieve. We can see this, for example, when Gilman claims that Mitchell changed the way he approached hysterical and neurasthenic patients after reading her work (“Why I Wrote”
But, as Dock points out, an examination of Mitchell’s own career does not support this claim; Mitchell continued writing about and lecturing on his Rest Cure until his death (History 25-26).

One of the perhaps most frustrating complications of “Why I Wrote” is the way that this assertion that Mitchell changed his practice because of Gilman’s story becomes a part of wider research and arguments, even though, as Dock points out, this is not supported in his own work. For example, Oakley’s article “Beyond The Yellow Wallpaper” sites “Why I Wrote” as evidence of the importance of sharing personal experience:

[ Gilman] sent a copy of “The Yellow Wallpaper” to the specialist in question, and, although he did not acknowledge receipt of it at the time, she learnt many years later that he had publicly said that not only had he read the story, but he had also altered his treatment of nervous depression in women after reading it. I think we may be justified in concluding that there is something intrinsically valid about personal experience and that, in coming clean about their own perspectives on health and illness, women may actually bring about the beginning of a change in those who hold powerful alternative views. (32)

While I would agree that personal experience is both valid and powerful, this particular argument is built only on Gilman’s account of Mitchell’s supposed change and does not...

63 Gilman makes this same claim again in her autobiography.
cite anything in Mitchell’s own canon to show that the supposed change in his approach actually happened, let alone what that change might be.

Even if “The Yellow Wallpaper” did not cause Mitchell to change his practice, however, it is still a powerful critique of the Rest Cure; interpretations of “The Yellow Wallpaper” that do not rely on “Why I Wrote” as evidence of the story’s power prove this point. For example, in Thrailkill’s article “Doctoring ‘The Yellow Wallpaper,’” she argues that “The Yellow Wallpaper” is a critique of the Rest Cure but that it “does not document the difference between a feminine and a masculine epistemology”; instead, she argues that “the text makes an appeal for a sex-neutral medical model” (529). Thrailkill then puts “The Yellow Wallpaper” in conversation with not only Mitchell but also Freud, seeing the text as a way to bridge the gap between somatic medical concerns (such as Mitchell’s focus on neurology) and psychosomatic concerns (such as Freud’s focus on psychology). Ultimately, this conversation leads Thrailkill to conclude that “[t]he ‘story’ the narrator tells in appropriately literal (or really, corporeal) form, then, is the story of textualization of nervous disease, of the advent of a new epistemology that would raise ‘sign-reading’ to a medical art” (551).

Because Thrailkill believes that Gilman’s intentions with her story were not to create a firm distinction between masculine and feminine discourse but to disrupt the gendered distinctions of social, academic, and intellectual fields, she considers Gilman’s possible reaction to the number of interpretations that come particularly from feminist scholars:
Though Gilman may have puzzled over the meanings that twentieth-century scholars discerned in “The Yellow Wallpaper,” and certainly would have disapproved of its being used to establish a textual paradigm for gender difference, she would, I think, be enthusiastic about its effects: the founding of a vibrant, contentious field of study and myriad institutional venues that have helped propel women into the academy in startlingly numbers since the 1970s. (553, original emphasis)

If we agree with Thrailkill’s assessment of Gilman’s intentions and the way that she would react to the plethora of scholarship surrounding her short story, we can see that Gilman may have helped to create the type of change that she wanted to see after all—even if that change did not take effect with Mitchell directly.

Interpretations of “The Yellow Wallpaper” as a critique of sexist medicine, however, do not go so far as to assign “The Yellow Wallpaper” to the genre of patient narrative or to examine the ways that health concerns in turn affect other areas of a person’s life. What is largely absent from these considerations, then, are the ways that the narrator’s condition affect her feelings of “usefulness” (an anxiety shared by Gilman) in economic, intellectual, and political contexts—and in domestic and maternal ones—as well as the effects that her condition and, even more directly, her treatment have on her social life. Part of John’s attempt to keep the narrator isolated is removing people that are stimulating and exciting; this is done under the guise of pursuing healing, but also has an effect on the narrator’s life that extends beyond the clinical consideration of health.
“The Yellow Wallpaper” as a Liberation Text

As we have already seen—especially through Dock’s assertion that audiences have always been aware of Gilman’s critique of sexist social and medical systems—the idea that “The Yellow Wallpaper” is a story about women’s liberation is not unique to its revival period in the 1970s and 1980s. However, during this time we see the rhetoric of liberation used more frequently in critiques and interpretations of the text. It is also interesting to note that these interpretations of “The Yellow Wallpaper” as an explicit liberation text coincide with the women’s health movement’s utilization of similar rhetoric. In her account of changes in medical history, Jurecic describes this time period, building on the work of Lisa Dierich:

Beginning with the women’s health movement of the 1970s, Dierich observes, patients and writers began to “challenge the structures and structuring of illness from the patient’s side of the doctor patient binary” and to “present affective histories that are attentive to the rhetoric and practices of politics.” Women’s health activists called for women to liberate themselves from the masculine medical establishment by becoming knowledgeable about their own bodies, particularly with regard to reproductive health. (8)

Given this context, I would argue that the focus on “The Yellow Wallpaper” as a call for women’s liberation—socially but also specifically in the male-dominated field of medicine—is also a product of this same movement focused on the role of women—and, more specifically, of women as patients. While similar interpretations of “The Yellow Wallpaper” were made prior to the “revival” of the short story after the 1973 Feminist
Press edition, it is through the 1970s and 1980s that the rhetoric of liberation and freedom come into the criticism explicitly.64

One such interpretation comes from Conrad Shumaker who, in conversation with Paula Triechler, argues that “[a]s Triechler suggests, ‘her triumph is to have sharpened and articulated the nature of women’s condition,’ but she is free only from the need to deceive herself and others about the true nature of her role” (598). In this case, Shumaker believes that the narrator is liberated, but not entirely; instead, she is only liberated from the need to “deceive herself.” As such, the narrator is able to critique the society in which she lives and the ways that this society devalues women, but she is not able to change or escape that society.

Triechler’s larger argument in her article “Escaping the Sentence: Diagnosis and Discourse in ‘The Yellow Wallpaper’” falls along similar lines of partial and/or qualified liberation, but focuses more explicitly on the wallpaper not as a metaphor for a medical treatment or for sexism in medicine but as a metaphor for women’s discourse: “I interpret the wallpaper to be women’s writing or women’s discourse, and the woman in the wallpaper to be the representation of women that becomes possible only after women obtain the right to speak” (64). In this article, Triechler sees the wallpaper as a “first step towards freedom,” but ultimately concludes that:

64 This is an example of a complication of historical critique that Jessica Enoch writes about in “Releasing Hold: Feminist Historiography Without the Tradition,” building on the work of Kristy Maddux. As Enoch and Maddux argue, it is important that we recognize that “understandings of the present shape understandings of the past,” but that in order to appropriately interrogate this complication of present and past understandings—specifically, of feminist scholarship and movements—we must also interrogate not only the present and the past but also the actual process of memory making (Enoch 63).
The narrator of “The Yellow Wallpaper” is not free at the end of the story because she has temporarily escaped her sentence: though she has “got out at last,” her triumph is to have sharpened and articulated the nature of women’s condition; she remains physically bound by a rope and locked in a room. The condition she has diagnosed must change before she and other women will be free. (74)

In this way, removing the wallpaper makes the problem visible and starts the process of liberation, but further change is needed before freedom is a reality for the women trapped in and restricted by this system.65

Triechler’s argument does not totally discount the medical aspect of the story, however; instead, Triechler reflects on how the problems of privileging of medical and scientific knowledge over personal experience and emotion provide us with a specific window through which to view the bigger problem of privileging “masculine” discourse over “feminine” discourse. She points out that John “credits only what is observable, scientific, or demonstrable through facts and figures” (Triechler 63). The narrator’s language, on the other hand, “includes a number of stereotypical features of ‘women’s language’: not only are topics limited, it is marked formally by exclamation marks, italics, intensifiers, and repetition of the impotent refrain, ‘What is one to do?’” (Triechler 66). Through this binary, Triechler uses the metaphor of diagnosis to show the power of “the voice of medicine or science that speaks to define women’s condition” (65). For

65 Karen Ford later responds to this article reaching a similar conclusion but arguing that the wallpaper is not a representation of women’s discourse but is instead a representation of the patriarchal and masculine systems that repress women’s discourse; it must be systematically torn apart to release the women who are trapped behind it (309-312).
Triechler, the privileging of the logical, scientific voice over the emotional voice is a
gendered distinction that points to an issue that reaches far beyond the field of medicine.
“The Yellow Wallpaper,” then, challenges the authoritative practice and discourse of
medical diagnosis through the voice and experience of the narrator (Triechler 69).

I would argue, however, that the liberation here, particularly when considering
“The Yellow Wallpaper” as a patient narrative, is a patient-based liberation; this short
story is Gilman’s attempt to break the hold that medical rhetoric has on her condition and
on her narrative. Considered in this light, “The Yellow Wallpaper” is an attempt to claim
authority over her own experience; Gilman is liberating—or at least attempting to
liberate—herself from the restrictions of a clinical imposition on her narrative, an
imposition that insists that the “master narrative” is her diagnosis. Not only is her
diagnosis externally and clinically applied, but it is also applied by a person who is both a
physician and a man. This application and privileging of the diagnosis takes the
ownership of Gilman’s experience away from her, and “The Yellow Wallpaper”—
through the use of medical rhetoric, gendered discourse, and symbolism—represents one
of Gilman’s attempts to take that ownership back.

“The Yellow Wallpaper” as a Eugenic Argument

What many interpretations of “The Yellow Wallpaper” overlook, however, is the
way that the speaker’s diagnosis (and the way that Gilman’s diagnosis) fits into a larger
social system of understanding. As such, many critics point out that the narrator—like
Gilman—is neurasthenic.\textsuperscript{66} However, while these sources exhaust critiques of the sexism in medicine, without a wider focus on the scientific and social history that informed this medicine, critics miss—perhaps unintentionally but perhaps not—the eugenic argument that is also present in “The Yellow Wallpaper.”\textsuperscript{67}

As discussed in Chapters 1 and 2, Gilman was a eugenicist who believed in the importance of moral white motherhood to create a better race. This argument is present in many of her nonfiction tracts (such as \textit{Women and Economics} and “Sex and Race Progress”) and has also been explored in her other works of fiction (such as \textit{The Crux} and \textit{Herland}). However, examinations of the eugenic argument in “The Yellow Wallpaper” often slip through the cracks.\textsuperscript{68} Notable exceptions to this silence include the works of Susan Lanser and of Dana Seitler. In, Lanser’s article “Feminist Criticism, ‘The Yellow Wallpaper,’ and the Politics of Color in America,” Lanser exposes some of the racist elements of Gilman’s short story but doesn’t go so far as to link that racism to motherhood and to eugenics. Seitler’s article “Unnatural Selection: Mothers, Eugenic Feminism, and Charlotte Perkins Gilman’s Regeneration Narratives,” on the other hand, explores the eugenic implications of “The Yellow Wallpaper” (as well as other texts by

\textsuperscript{66} For example, see Triechler’s “Escaping the Sentence: Diagnosis and Discourse in ‘The Yellow Wallpaper.’”

\textsuperscript{67} There is no shortage of research and scholarship on the connection between Mitchell’s Rest Cure and Gilman’s “The Yellow Wallpaper”; however, this is frequently where the connection between medicine, science, and literature stops when examining this particular text. However, connections between neurasthenia, eugenics, and Gilman deserve further examination and consideration in order to understand the many different ways that “The Yellow Wallpaper” interacts with and responds to the medicine and science of its day.

\textsuperscript{68} Whether this is done out of ignorance or done with explicit intentions may be debated; either way, it is an absence and silence that must be remedied.
Gilman), especially considering the underlying argument that white women cannot be fit mothers if they are not healthy and that they cannot be healthy if they are kept in subservient positions; Seitler’s particular article, though, is more strongly focused on Gilman’s novel *The Crux* than on “The Yellow Wallpaper.”

We are missing an important part of Gilman’s patient narrative if we don’t see this bigger picture. Gilman was a eugenicist and one of her conditions (neurasthenia) was explicitly linked with eugenic ideas of race- and class-based superiority. As such, overlooking or omitting this connection is not only participating in a long history of silencing, it is also affecting our interpretations of all four of the narratives explored in this thesis. If we consider, then, Gilman’s position as a eugenicist and the ties between eugenics, “feeblemindedness,” motherhood, and heredity, we can see “The Yellow Wallpaper” as a story that is both (1) about a woman who is concerned about her viability as a mother and the ways that her child might suffer because of her, and (2) a horror story about the dangers of unhealthy white motherhood.

As Seitler explains in her article, “The Yellow Wallpaper” (among other texts in Gilman’s canon) is built on “a paradigm of white, middle-class motherhood as a model of social progress” (66). As such, anything that disrupts the paradigm of white, middle-class motherhood is then a threat to social progress. The narrator’s health, then, is one such disruption that, as Seitler points out, makes it “impossible to be a mother”; instead, she becomes “a creeping hybrid child-woman-animal” (70). This paradigm is central to Gilman’s feminist and eugenic arguments:
Gilman dramatizes feminist concerns over female agency and eugenic concerns over the social body simultaneously. In “Yellow,” in fact, feminism and eugenics appear structurally integral to each other—it argues, without sexual equality, that the woman’s body (and therefore her reproductive function) degenerates, and thus disables her role as a healthy reproducer of the social world. (Seitler 70-71)

By arguing that white women are central to cultural evolution and racial progress—an idea that is also present in a number of Gilman’s nonfiction texts such as “Sex and Race Progress” and *Women and Economics*—Gilman constructs a world in which the future of the white race is dependent on white mothers.

I would add to Seitler’s argument that this is a part of what makes “The Yellow Wallpaper” effective as a horror story within its time. The sick, white, middle- to upper-class mother is not only a danger to herself and to her family; she is also dangerous on a larger cultural scale in a society that accepts eugenic beliefs—particularly the belief that if white mothers are unhealthy, then white children are more likely to be unhealthy, and that means an unhealthy white race overall. Gilman argues, then, that keeping women in subservient positions—as demonstrated by the narrator’s relationship with John—keeps them unhealthy; the narrator’s illness marks the start of a cycle of unhealthy white motherhood that will never end until social, economic, and political gender inequalities are addressed.

I would also add that a close reading of “The Yellow Wallpaper,” especially considered in conjunction with Gilman’s other (nonfiction) patient narratives, might allow us to see motives for several of the details in “The Yellow Wallpaper” that differ
from Gilman’s personal experience. Perhaps the most glaring change in terms of concerns about motherhood is the gender-identity of the infant; while Gilman’s child is a daughter, the speaker in “The Yellow Wallpaper” has a son. The son is only directly mentioned twice in the short story, and yet this difference feels significant.

If it is Gilman’s goal to convince an audience of predominantly white, upper-class men—the people who have the power to affect social change—that white women need to be given respect and autonomy, then making the infant a male infant directly puts the future of white, upper-class manhood in danger. Based on the widely-held social and medical beliefs about unhealthy mothers at the time, the reader could assume that the speaker’s child likely does not fare well after the ending of “The Yellow Wallpaper”; however, prior to his mother’s hysterical and neurasthenic episode and subsequent degradation into madness, this child was very likely to live an affluent and prominent life (based on his race- and class-identities in this society). When his mother becomes unhealthy and the treatment she receives only makes her worse, the possibility of this male child’s affluent future is taken away. Therefore, by intentionally writing a male child rather than a female child as the infant in “The Yellow Wallpaper,” Gilman directly appeals to her white, male audience’s selfish (and classist and racist and ableist) concerns.

“The Yellow Wallpaper” as a Patient Narrative

Adding the interpretation of “The Yellow Wallpaper” that I have presented in this thesis to this history of varying interpretations and readings, and considering it alongside these interpretations and readings, we can perhaps more adequately understand some of
the most intriguing elements of Gilman’s patient narratives—in particular, her concerns about living with illness and being a mother.

Considering “The Yellow Wallpaper” as a patient narrative in conjunction with interpretations of this text as a horror story show the internal feelings that can accompany illness; as I argued earlier, for Gilman being ill is a horrific experience in which she cannot even trust her own interpretation of the world around her. “The Yellow Wallpaper” allows Gilman to experiment with that uncertainty, considering what the world might look like if her perception of the world from a sick person’s point of view was accurate. She uses elements of what some critics have called supernatural horror and other critics have called psychological realism\textsuperscript{69} to address and reproduce this fear for her readers.

Considering “The Yellow Wallpaper” as a patient narrative in conjunction with interpretations of this story as a critique of the Rest Cure, we can examine the feelings of the patient in relation to the authority of the doctor. We can see the ways that the doctor’s assertion of diagnosis and treatment, while socially and rhetorically privileged, is not always accurate; we can also see the ways that a patient must translate a diagnosis and prescription into a life beyond the clinical environment. Further, we can see the value in patient narratives that is already recognized in the field of medical humanities. If we only privilege the doctor’s view, we only have half the story; similarly, if we only privilege the doctor’s view, the patient is often reduced to their diagnosis and not fully seen as a

\textsuperscript{69} For example, see Beate Schöpp-Schilling.
person. Instead, as we see with the narrator in “The Yellow Wallpaper,” the patient is often reduced to a child-like state and treated as generally inferior, a treatment and dynamic that can worsen a condition rather than alleviate it.

Considering “The Yellow Wallpaper” as a patient narrative in conjunction with interpretations of this story as a liberation text, we can consider the ways that hierarchies such as doctor-patient are also reflective of other restrictive hierarchies and systems that the patient experiences; in Gilman’s case, we might consider her position as a patient in the doctor-patient hierarchy in conjunction with her position as a wife in the husband-wife hierarchy and her position as a woman in the man-woman hierarchy. Through these simultaneous considerations, we can start to see how Gilman’s patient narrative is influenced by multiple subservient and unprivileged positions, positions in which she is forced or expected to be passive (patient, wife, woman), all of which she connects to her health concerns.

Considering “The Yellow Wallpaper” as a patient narrative in conjunction with interpretations of this story as a eugenic argument, however, we also see the ways that the narrator in the story has privilege in social, political, and economic hierarchies of class and race. As we have seen in the medical texts of Mitchell and Beard, these positions of privilege are also directly linked to patient health, especially in ways that neurasthenia was seen as a white, upper-class condition. Considering this, we not only see how the

70 These hierarchies are not only problematic in their assertion of power but also in their position as binaries that support heteronormativity and binary gender assignments/cisnormativity; however, because these are the hierarchies and binaries that were presented in Gilman’s time, I have reproduced them the same way here.
narrator in “The Yellow Wallpaper” is a representative of the dangers of unhealthy white motherhood but also the ways that Gilman may have feared that she would pass her condition and her behavior to her child. The pressures and expectations of motherhood—especially in terms of protecting her child’s health, in part by protecting her own health—are other factors that Gilman repeatedly returns to when expressing her concerns with her mental and physical state.

Each of these separate considerations allow us not only to see more in the patient narrative but also to dig deeper into existing interpretations and analyses of “The Yellow Wallpaper” that don’t explicitly consider it as a patient narrative. Similarly, reading “The Yellow Wallpaper” as a patient narrative also allows and encourages us to explore further implications of the text, particularly in considering how illness affects a person’s life beyond their direct health concerns. As we can see in “The Yellow Wallpaper”—and as is supported in Gilman’s other narratives—living with illness is not as straightforward as receiving a diagnosis and following a treatment. There are direct economic, familial, social, and personal aspects of life that are also affected.

Isolation, for example, is a key component of the Rest Cure; however, what is not directly considered outside of the patient narrative reading of Gilman’s narratives is the way that the isolation that Gilman and the narrator experience also affects their feelings of social, economic, and intellectual worth. They share added anxieties of being non-producers when confined to quiet and domestic lives without access to writing and other forms of expression; they also share anxieties about the effects that their health has on their social lives, especially in terms of not being able to be as socially active because of
the illness and/or the treatment. Perhaps most predominantly they both share anxieties about motherhood not only in terms of the potential inheritability of their conditions but also in terms of the ways that their children will be affected by their actions (or, in some cases, inactions) as mothers. For Gilman, this concern about her actions as a mother are also directly tied to familial and generational concerns as Gilman feels that her relationship with her own mother is also partially responsible for her mental and emotional state and, thus, her health concerns (Selected Letters 45). The different genders of the children—Gilman’s daughter and the speaker’s son—are also significant to understanding Gilman’s experience as a patient and as a person. Though her own child is a daughter, Gilman sees an opportunity to appeal to a more socially and politically powerful audience by writing the speaker’s child in “The Yellow Wallpaper” as a son. This intentional deviation from her personal experience shows not only that she was aware of how to reach her most powerful audience but also who that audience was (white, upper-class men) and what Gilman wanted from them (liberation for women in positions similar to her own).

In order to tease out these nuances and subtly-presented concerns in “The Yellow Wallpaper,” however, the reader must suspend the hermeneutics of suspicion and instead trust that the author is attempting to convey, explore, and own an experience within the conventions and demands of genres of fiction, horror, and the supernatural; similarly, in order to truly examine Gilman’s other narratives, the reader must also be willing to accept that the author is making a similar attempt using the conventions of the other genres in which she presents her patient narratives.
CONCLUSION: THE VALUE OF THE PATIENT NARRATIVE

In *Negation, Subjectivity, and the History of Rhetoric*, Victor J. Vitanza urges us to write hysterical histories, histories that disrupt dominant discourse and challenge traditional notions of authority, importance, and worthiness. According to Vitanza, hystery-writing gives us a way to look past traditional and patriarchal histories:

Traditional *history-writing* works with, or suffers from the nostalgia of, an original that can be recovered; *hystery-writing*, however, paratestifies to the impossibility of an original of the real (which is the intractable, the impossible) and how it must be a-voided (denegated). *History-writing* presumes the ideal or actual whereas *hystery-writing* can assume impossibility, therefore, perpetual possibility. (316, original emphasis)

Vitanza wants readers who will take on the tasks of cutting up, rewriting, and reinscribing histories; challenging the accepted norm; and looking for who has been left out and how they have been used when included (311-312). By searching for these stories and exploring these undervalued, silenced, and ignored experiences, we can recover and bring attention to “the hysteries that have been denied legitimacy, locked up, and systematically oppressed” (Vitanza 329).

If we apply Vitanza’s notion of a hysterical history to the doctor-patient relationship and to the history of writing about illness, we can easily see the importance of valuing patient narrative as a literary genre. By privileging only what is provable and scientific, we are only seeing one side of a much broader story; case narrative doesn’t give us a picture of what it’s like to actually live with illness, to exist in society as a sick
person. Instead, case narrative restricts our understanding of illness to the doctor’s office, to the hospital, to the clinical setting that is sterilized and meticulously measured. While this understanding of illness is, undoubtedly, an important part of the puzzle, it does not tell us how people make sense of a diagnosis, what encourages them to pursue treatments, or how living with illness affects their lives as people. If we, as literary historians, dismiss patient narrative as mere “victim art,” as Jurecic has suggested, we are silencing these stories of navigating social experience and, in many cases, stigma and discrimination when living with illness.

In fact, if we remove or neglect the patient narrative, we are not only devaluing the patient and the patient’s experience but we are also removing the patient’s agency and humanity; we are participating in the history of silence and authority that has regarded the physician as the only party who is able to “accurately” describe a condition, an illness, and an experience. What many physicians present, however, is a biased and limited view of what living with a particular medical condition might entail and frequently does not include the emotional aspect of being a sick person. If we treat this story—the case narrative—as the only story of illness, we are complicit in creating a significant absence in our understanding of illness, literature, and history. We need to consider this absence—this missing literature, these missing stories—when we think about our understanding of 19th-century medicine, particularly when considering female patients, mental/nervous patients, lower-class patients, and patients of color. Similarly, this absence also affects our understanding of literature that is about or includes experiences of illness.
Accepting patient narrative as both valid and valuable also allows us to see further implications of even the most familiar texts—a case I have made in this thesis through my examination of “The Yellow Wallpaper.” By pursuing this further avenue of interpretation and analysis through a departure from the hermeneutics of suspicion, we can continue to add to the critical conversation. In fact, by ignoring wider scientific and medical history, we miss (perhaps purposefully) the eugenic message of “The Yellow Wallpaper.” While the implications of medical history surrounding the Rest Cure have been extensively explored—as shown in Chapter 4—the eugenic elements of Gilman’s message are frequently overlooked. By looking at the ways the eugenic science of the late 19th century influenced medicine of the same time—particularly in relation to reproduction, heredity, and women’s health—we can begin to uncover these implications and the complications that they create for our understanding of “The Yellow Wallpaper.”

When considering the hysterical histories that need to be written, we should consider not only the role that silencing has played within dominant culture but also the roles that silencing plays within specific subcultures and movements. Gilman’s connection to eugenics and the horrors of unhealthy white motherhood presented in “The Yellow Wallpaper” are just several examples of what we might find in those silent and silenced spaces.

As Kleinman argues in *The Illness Narratives*, only a balance between case and patient narratives helps us understand the larger meaning of illness and the ways that concerns about health radiate out into other areas of life:
Illness has meaning [...] in several distinctive senses. Each type of meaning is worth examining. From an anthropological perspective and also a clinical one, illness is polysemic or multivocal; illness experiences and events usually radiate (or conceal) more than one meaning. Some meanings remain more potential than actual. [...] Yet others change as changes occur in situations and relations. As in so many areas of life, their very ambiguity often supplies illness meanings with relevance, inasmuch as they can be applied now this way, now that way to the problem at hand. (8)

Kleinman further argues that our priority when inquiring about the meanings of medicine and illness are focused on a “radically materialistic pursuit of the biological mechanism of diseases” rather than an inquiring into the social reality and experience of illness (9). Without the patient narrative, then, we stay focused singularly on the biology of medicine and illness and do not consider social and personal experiences. This argument is foundational in the medical humanities’ approach to patient narratives.

As Jurecic has pointed out, however, this is a far step away from the opinion of patient narrative held by many literary critics who have termed these stories “victim art” and “misery memoirs” (10). Yet, an examination of the different meanings of illness in “The Yellow Wallpaper” reveals not only tension between a patient and her physician—in particular, regarding the narrator’s aversion to the Rest Cure—but also gender-based tensions that come out in medical diagnoses as well—in particular, related to the stigmas around hysteria. Further still, we can see the tension between the narrator’s emotional and mental health and her perception of herself as a mother; these concerns with motherhood
and the effect that her illness will have on her child opens the door, then, for further considerations of eugenics in Gilman’s story. This concept ties the medicine and illness in “The Yellow Wallpaper” and in Gilman’s nonfiction narratives not only to gender-based tensions but also to tensions and prejudices based on class, race, and ability as well. By teasing out these different meanings of illness for both Gilman and the narrator of “The Yellow Wallpaper,” we can see that living with illness is not a singular, compartmentalized experience but is also inextricably connected to the state of medicine, science, politics, and society.

Once we accept patient narrative as a valuable and important literary genre, we will also be able to develop theories and frameworks through which we can approach these accounts, creating a subgenre of narrative theory that combines elements of critical disability studies and a wider scientific framework as well. Such a framework could help us appreciate the patient narrative, both despite and because of its absences, its emotion and sentimentality, and its autobiographical bias. With such a framework, we will be prepared not only to account for these “shortcomings” but also to interpret them and use them to glean further meaning and value from these narratives.

Such a framework will also be helpful to historians who intend to write hysterical histories of patients, of illness, and of medicine. By having a method for not only recovering patient narratives but also interpreting them in a way that emphasizes their value rather than invalidating their stories, historians can challenge dominant discourses and established, patriarchal views of social and scientific authority. Such a framework will also benefit the field of medicine; if the field of medical humanities is going to use
literature, narrative, and literary theories to increase empathy and understanding in doctors and doctors-in-training, then this work done in the field of literature could also translate into similar expanding approaches and tools for medical humanities as well.


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71 This source is a scan of the original publication of “The Yellow Wallpaper.” At the time that this source 
was published, the title of the story was “The Yellow Wall-Paper” and the author is published under the 
name Charlotte Perkins Stetson. In order to be in conversation with current scholarship, I have updated the 
title and author names to “The Yellow Wallpaper” and Charlotte Perkins Gilman.


