

**Medical Narratives/Cultural Stories:
Tales of Breast Cancer in the 20th Century**

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In “The Yellow Wallpaper,” Charlotte Perkins Gilman writes of a woman in the 1890’s who is suffering from postpartum depression and psychosis. As the writing cure was not considered a legitimate healing practice then, especially for women, the woman is realistically forbidden to write and placed in a children’s nursery to rest. Her husband and doctor explain to her that absolute rest is necessary for a complete recovery, but their restrictions on her writing practices actually cause her psychosis to rapidly advance. In this novella, Gilman straightforwardly describes this one woman’s thwarted attempts to heal through writing, but more importantly, she addresses a society’s ability to oppress its inhabitants through widely accepted healing practices.

Today, doctors do not monitor many patients’ literary habits, and there has been a notable increase in the amount of writing by patients in the United States: patients suffering from cancer, depression, addiction, migraine headaches, and other ailments. Many of the autobiographies that I have examined have been written, filmed, and created by women living with breast cancer, and they include stories and images that, along with Gilman, have criticized the dominant discourse of cancer in the United States. They have confronted issues of normalization as an oppressive component of healing

practices, and they have worked to form the foundation for a new type of autobiographical narrative that could, with proper exposure, challenge the parameters and definitions of categories such as science, narrative, autobiography, identity, and health.

Autobiography, noticeably, comes from three separate words -- auto for self, bio for life, and graphe for writing, as a unit meaning, "writing the life of the self". The three parts of the word are equally important, but Julia Watson, a contemporary cultural analyst, points out in her article, "Towards an Anti-Metaphysics of Autobiography," that there is such a thing as a bios-bias. She writes that the life (bios) often takes precedence over the self and the writing. In other words, autobiographies seem to be read for the quality of the life rather than the quality of the self and writing. Perhaps because of this bios-bias, there is little innovation in popular autobiographical writing. In many autobiographies, there is no attempt to structure the material beyond chronology, and the writing often remains transparent. The most common autobiographical structure seems to follow chronological events, weaving in lessons learned from those events, with every scene adding to the culmination of who the writer "is" at the end of the book. This can be achieved through a "rags-to-riches" story or an equally recognizable return narrative. The return narrative presents the writer as part of a group, familial, religious, or cultural; he or she breaks free of that group usually through selfish or ignorant acts and then returns to that group or a different group, changed, but back within the realm of normality. "I was lost but now am found."

Medical autobiographies utilize this return narrative with alarming consistency. The patient is healthy and happy in the background of the story; in

the schism, he or she discovers the disease and battles it heroically, and the reintegration involves the patient's quickly beaten path back to normal. It is a narrative structure that we are all comfortable with, but with the subject of healing narratives on the table, I'd like to call into question the inevitability of this structure and point out that the return to normalcy is often a moral lesson as well as a good story structure. It helps keep folks within the fold, as Gilman's character was supposed to remain, and often, the patient who returns, returns with a fervor, becoming more normal than he or she was in the past.

Kathlyn Conway writes in her breast cancer autobiography, *Ordinary Life: A Memoir of Illness*, that this structure is expected of her, and she writes feverishly because, "[T]he ability to tell a story would...be a way to make sense, at least within my narrative, of another chaotic episode in my life. Although the story would not redeem the experience," she writes, "...it would help to restore me to myself" (Conway 5). She desires the restoration of 'me to myself,' wonders when the feeling of normalcy will return, and continually compares her new identity to her pre-cancer identity to see if she has yet become "normal" again. At the end of her story, Conway admits that the experience of having breast cancer has changed her forever, but she still desires the appearance of normality for her friends and family. Because they were waiting for the end of the story, each procedure, each surgery, each stage of the illness was a deferral that they were willing to endure in order to reach the conclusion of her story. However, much like the audience reaction to a typical plot of a movie or film, the viewer is only willing to sustain a certain number of deferrals. At a party celebrating her survival, Conway looks over at her husband and friend

who, she writes, "...are obviously commenting on [her] to each other." She writes, "I know they are saying "Doesn't she look great?" and we exchange a laugh across the room. I know that they really mean, thank God she's back. Thank God she is her old self" (Conway 238). This is a poignant moment in Conway's narrative, and her husband's joy is certainly the joy that, in practice, most people would strive to fulfill, the joy not to think about illness anymore, a chance to enjoy life again, a chance to return to normal. In theory, however, this return to normalcy is disturbing. "Thank God she is her old self," they think, proving that the conclusion of Conway's story for them is not just a return to health but a return to her self prior to disease, and if this change in self is not addressed, and if the structure of the story doesn't allow for the indefinite deferrals, then the autobiography is not attempting to achieve anything beyond normalcy.

Musa Mayer, a breast cancer survivor, writes that some women who opt for reconstructive surgery are seeking "...not only the appearance of normalcy but normalcy itself" (Mayer *Examining* 110). And interestingly, the scientific discourse encourages the same rhetorical emphasis on normality. For example, the Plastic and Reconstructive Surgery chairman at Columbia Presbyterian Medical Center admitted that the hospital's "...basic philosophy is that [after a mastectomy] you don't leave the hospital without a breast" (Hugo 54). More tellingly, breast cancer specialist, Darcy Spicer, writes that researchers are working on a preventative cure for breast cancer that "will make people feel not just normal but *better than normal*" (Mestel 76, my emphasis). I believe that it is within this rubric of "better than normal" that many of our cultural expectations are allowed to flourish within the medical field.

In her book, *Altered Conditions: Disease, Medicine, and Storytelling*, Julia Epstein writes that traditional narratives told about the human body, in disease or in health, are saturated with cultural expectations. Her goal in *Altered Conditions* is “to make clear...how cultural ideas saturate medical language,...and how much we take for granted the idea that we can establish an objectively defined delineation of the ‘normal’ with respect to the human body” (Epstein 6). She points out that we medicalize homosexuality, diagnose “temporary insanity” in courtrooms, and medicalize social enigmas. The most striking medical enigma that she points out is the medical illness of drapetomania, which was the nineteenth century disease designation for runaway slaves. Our culture uses medical terminology to reinforce cultural ideas of normalcy, and the return to normalcy, in all of these cases, is a return to culturally designated positioning, in one case even a return to slavery.

But, as we all have asked at one point or another, what is normal? Who’s defining the term? In medical circumstances, the same questions should apply. For example, in discussing an amputee who is re-learning how to walk, Epstein quotes medical literature that argues over whether the amputee should learn how to walk like a “normal” person or like an amputee. What exactly is normal, and how much is the patient giving up in order to appear normal? Epstein understands the medical establishment’s dilemma over how to teach an amputee how to walk because the price of appearing “abnormal” in our culture is a high price to pay even for increased mobility and comfort. “Nevertheless,” Epstein writes, “in an ideal world, the gait that achieves optimal function without pain or instability for that reason alone should earn the status of being normal for that individual” (16). Normalcy in

this context is fluid, not fixed. It is never an equilibrium to be reached at the end of a narrative because it is always already a continuum. It is never the same from person to person, saying that everyone should leave the hospital with a breast is as shocking as to say that no one should leave the hospital with a breast. There is no universal normality; therefore, the return to normalcy in the typical medical autobiography is a flawed conclusion at best. At worst, it is creating false expectations for other patients and allowing other cultural normalcies to cement their seeming inevitability.

However, not all autobiographies have succumbed to this narrative structure. Not all have ignored the writing or the self in favor of the life, and not all of the autobiographies have encouraged a patient's passivity and politeness. Two autobiographical portraits, Deena Metzger's *Tree* and Sandra Butler and Barbara Rosenblum's *Cancer in Two Voices*, are able to use the content of their stories to challenge the status quo of the treatment of women with breast cancer in the United States, and they are also able to challenge the traditional narrative structure and the normalization tactics that traditional narratives impose upon their users.

A Los Angeles poet and writer Deena Metzger, in her autobiographical piece *Tree* from 1981, is able to paint an autobiographical portrait that includes herself, her friends, and also the characters of the dominant scientific/political discourse. Already, she has dismantled the traditional notion of autobiography because hers is not just a story of self. With several narrative innovations, she includes even the possibility of readers' voices entering the text. She literally leaves blank spaces in *Tree* for her readers to write, allowing her readers active participation in Metzger's own life story. In the first section, she asks her

readers to tell her what they are afraid of, and then anticipating that perhaps they have not yet done so, she reminds them: “I asked you to tell me what you are afraid of. I’ll leave a space – you fill it in – whisper it – don’t be afraid – you can shut the book again and no one will ever know. Not even ----- you” (Metzger 141). Metzger explores selfhood (her own and that of her readers) with the understanding that the self is able to keep secrets from itself and that identity is not something that can be held up and contemplated but rather something that is continuously being recreated. Because Metzger assumes that her readers can shut the book after writing their fears and not any longer “know” what they had written, then she is also assuming that the self is a much more fluid and complicated creature than Descartes’ “I” in “I think; therefore, I am,” a much more complicated creature than that found in the typical return narrative. This process requires her readers to confront their fears in order to confirm their selves, and in order to synthesize these selves and fears, Metzger later gives an opportunity for her readers to identify themselves. After setting up her own fears of a publicized identity by invoking conspiracy theories about the Defense Department, the FBI and Big Brother, she writes: “I leave a space here. Write your name in. _____” (206). Readers are put on the spot, implicated either by writing their names in the blank spaces of Metzger’s life story or leaving them as blank spaces. These are narrative gaps that will never be reconciled with Metzger’s self, and the plot can never return to a predictable equilibrium because this information is not controllable.

By opening up her narrative and her voice to the voices of so many others, Metzger cannot follow the traditional plot structure. With the focus on the writing and the self rather than on the life, she even allows herself to enter

moments of narrative incomprehensibility. She opens her first journal entry with a stream of consciousness section drawing on different ideas and images in her mind and allowing them to flow onto the page without structure or sense: “Looking for the moon,” she writes, “light falling, falling, light breaking time falling. Moon sway, moon break, ice heart breaking, night cry breaking down, down. Moon fall singing, light falling, break break,... night singing, hold hold, break break, light light...” (135). Metzger’s prose in this section is littered with repetition, alliteration, and seemingly nonsensical combinations of words such as “Moon fall singing” and “...night cry breaking down, down.” This is the language of song, children, and madness. Metzger also utilizes the language of her dreams and song to access parts of her brain that are not strictly controlled by consciousness, those parts of her brain not tightly tied to public discourses and the urge to communicate.

By engaging in nonsensical grammatical patterns and incantations of song, Metzger accessed what is known as the semiotic chora, described in Julia Kristeva’s work *Revolution in Poetic Language*. Kristeva defines the semiotic chora as the poetic aspect of language that most closely resembles our pre-linguistic experience. Semiotic “communication,” for Kristeva, refers to the music of nonsensical language and the ravings of hysterical women who step outside recognizable languages to moan, shriek, and babble. Kristeva sees this form of communication as subversive and as a tool that the French avant-garde could use in their poetry to attack traditional notions of communication and constructions of identity. Instead of using coherent thoughts to reinforce the existence of the self, Kristeva points out that artists can use narrativized nonsense to remove themselves from the constraints of

that discourse (Kristeva 31).

Metzger writes, “But first I would like to sing a little song, because not knowing how to sing, I have always maintained a silence here. So I think we shall have a little ritual silence-breaking. And I will do what is difficult to do – and you can hum along if you like” (Metzger 139). Metzger opens up a space for women to enter the public discourse without taking on the narrative structures of that discourse. They don’t need to know the terms of breast cancer, the statistics and diagnoses and treatment options. They don’t have to sound like the doctor in order to converse with the public about breast cancer. The important thing to Metzger is that they put their voices out there, suggesting that a collective hum can be powerful even if the words aren’t understood. Metzger seems to argue that anything is better than being the polite, silent patient who waits for the doctor to speak. Metzger writes, “If I am going to come out of silence – and I am determined – then it will be with a big noise. A woman’s noise” (Metzger 138). She writes that breaking silence is as an important a ritual as breaking bread, going along with Audre Lorde’s idea that silences need to be broken on every level of our society. Lorde also suffered from breast cancer and wrote two autobiographical works about it, *The Cancer Journals* and *A Burst of Light*. One of her arguments was that women needed to be able to see each other on the street as fellow cancer survivors and that reconstructive surgery took away the power of recognition and thereby the power of collectivity. Breaking silence verbally or physically does not allow the patient to return to normal, but it does have the power to undo the expectations for patients to silently endure.

Another medical autobiography that plays with the parameters of

narrative and normalized individual identities is the 1991 portrait written by Barbara Rosenblum and Sandra Butler, *Cancer in Two Voices: Living in My Changing Body*. The “two voices” in the title refer to the two authors, but like Metzger’s autobiography, there are many other voices in the text including the voices of the authors at different times in their lives, the voices of their friends and families, the voices of medicine, law and anthropology, and the heteroglossia of voices from the many intersections of culture that meet within their relationship. Rosenblum and Butler are lovers and partners and writers, and when Rosenblum is diagnosed with breast cancer, they both face the prospect of her death and decide to write their story in order to hold themselves together during the process of Rosenblum’s dying (the cancer had already metastasized). They decide to set an example for other women with breast cancer and also to face life and death with open eyes and honesty. They write about the medical and economic decisions they make, the late night discussions they have about life and death, and the role of their friends in maintaining Rosenblum’s quality of life. They also write about the anguish that they feel when they cannot express themselves. Their portrait, in fact, becomes, in its writing, a celebration of a language that is created at the margins of accepted discourses. There is no normal story here; there is no chance for a return to normalcy, and instead of closing themselves away or shrouding themselves in silence, they work to find ways to make the narrative structure fit their own needs, rather than tailoring their own story to fit the normal narrative.

In their Introduction, they describe themselves as writers who have based their relationship on words. They talk through everything, and after Rosenblum’s diagnosis, they try to trust and interpret the doctors’ “guarded

language of diagnosis.” They want to believe in the power of accepted narratives to make sense of their lives and aid them in the communication of their feelings and ideas. However, early on in their experience, Rosenblum writes about the non-narratibility of medical disclosure. She notes that she does not have the proper channels to tell her story, and because of this, she sometimes floods the channels she does have. She writes, “Under what conditions does disclosure become relevant?...Give it language, it becomes exposed to air. It breathes, it’s alive: to tell is to make real. I must. I am impelled to reach out” (39). She believes in the power of language to make her cancer diagnosis real to herself, and she feeds on the power that this destruction of silence provides for her:

Disclosure begins as desperation, a frothing at the mouth, a constant foaming of anxiety. The anxiety is pervasive. So is my disclosure.

Everyone has to know. I have no boundaries, no ability to differentiate among levels of friendship, levels of intimacy. (39)

Already at this point, readers can see that language is changing; it becomes a “frothing at the mouth” rather than a polite mode of communication. And healing narratives are normally asked to be polite communications; in fact, most of the popular medical autobiographies are written only after the patient has been healed, only after he or she has returned to normal. One author, after writing about her illness during her illness, asked her publisher repeatedly if she could just go back and change the tone of the book or make apologies for it. It seemed too raw for her and not polite enough; she didn’t see herself in the person she had been, and she was embarrassed by her anger. Luckily for us, the publisher wouldn’t let her change a word.

Rosenblum and Butler also begin to distrust their own instincts and uses of language. They begin to talk about words as “clumsy instruments for communication” (22), and they eventually write, “Cancer doesn’t respond to words” (38). They cannot find answers to the questions that cancer raises. Rosenblum wishes at one point that she could communicate through the moaning and wailing of animals, the same language of the hysteric woman from Kristeva’s study. Through much of her illness, Rosenblum is surrounded by family and friends, but one weekend, her partner leaves for a conference on the same day that her parents return home, and she can’t express her feelings of loss in human words. “When we are all together,” Rosenblum writes, “I am relaxed, part of a system. But when first Sandy and then my parents left, I had tremendous separation anxiety. I felt like a seal or baboon that’s been separated from its mother. If I could, I would make those heartbreaking animal sounds that reach the deepest places of the soul to express my longing” (43). Rosenblum and Butler both also have dreams that they cannot put into words in the morning. Trying to write down her dreams, Rosenblum finds that it is impossible, that her thoughts are beyond words, and instead of capturing the images of her dreams, she writes down in the middle of the night “I long. I long.” Finally, at Rosenblum’s funeral, Rosenblum’s mother also finds the limitations of normal communication:

The words ‘Yit-ga-dal ve-yit-ka-dash she-mei ra-ba’ filled the sanctuary and with them grew the sound of a shriek, sustained for a heartbeat and becoming a wail, grew higher and louder as Barbara’s mother ...began to
move toward the coffin containing the body of her first-born...As her

throat pushed forth these primitive sounds, I remembered the sounds of labor and birth, the elemental sounds the body makes when it is beyond its capacity to tolerate pain. (172)

Rosenblum's mother taps into the "primitive sounds" of the semiotic chora precisely at the moment when her body can no longer tolerate the pain of loss. She responds in a language that is incomprehensible yet completely understandable to everyone present. Later at the mourning, a friend comments that Rosenblum's mother "remembers how to mourn, how to make the sound we have all forgotten and needed to hear. She is a woman who is not muted and well-behaved in her grief as we have learned to be" (172).

The medical stories that are told about our bodies can be overwhelming and normalizing, but there is space at the margins of language and in the larger notions of narrative to find the power to break the patient's silence and to participate in the dominant discourse of illness autobiography without succumbing to its agenda of normalization. Whether these artists have made their work in order to heal themselves or in order to fulfill a lack in our public discourse is inconsequential. The point is that they do both, and we should respond accordingly by listening carefully to a patient's narrative, especially when it doesn't follow the traditional plot structure. Kept to themselves, their narratives would only heal their scars and not our own.

Now, when we read again "The Yellow Wallpaper," we recognize that it is not a failure that the woman is left at the end of the story slinking around the room tearing at the wallpaper and speaking in nonsensical terms. She never reaches the happy ending of her story where she is reintegrated into the

surrounding culture, better than ever, back to normal, but certainly it is the nonsensical semiotic chora that gives her a release from the traditional narrative, traditional notion of selfhood, and the traditional role of patient as a self without autonomy. We also should remember that it is the doctor/husband in "The Yellow Wallpaper" who faints after seeing his deranged wife, and while he lies on the floor unconscious, she actively slinks over him to continue on her journey around the perimeter of the room.