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Verbal and Visual Rhetorics of Cancer: Defying Silence in Margaret Edson, Audre Lorde and Jo Spence's Works

By Catalina Florina Florescu¹
In memoriam: R., T. & F.

Abstract

In this essay I offer some powerful verbal and visual examples of the rhetorics of cancer in an attempt to bring to our attention the experiences and reflections of those who felt more like medical cases than persons-patients while facing and eventually dying because of cancer. My essay is a critical "travelogue" through the pain of the other, more specifically as it is presented in Margaret Edson's play *Wit* (2000), Audre Lorde's memoir *The Cancer Journals* (1992), and Jo Spence verbal and visual memoirs *Putting Myself in the Picture: A Political, Personal, and Photographic Autobiography* (1988) and *Cultural Snipping: The Art of Transgression* (1995).

Keywords: Cancer, Embodiments, Power, Writing

Introduction

In her book, *The Body in Pain*, Elaine Scarry makes the following assertion: "Because the person in pain is ordinarily so bereft of the resources of speech, it is not surprising that the language for pain should sometimes be brought into being by those who are not themselves in pain but who speak *on behalf* of those who are."¹ Needless to say, there is a clear distinction between incipient pain and its last stages, where one's language as well as one's body's stamina are devoid of power and significance, rendered almost, if not completely, unspeakable. While Scarry's endeavor is to bring into discussion instances of those who are in pain either in torture or at war, my essay examines the fundamental *birth* into embodiment through the pain of cancer as experienced by three women: Vivian Bearing in Margaret Edson's play *Wit*, Audre Lorde, and Jo Spence.

While one may not be able to accurately verbalize one's pain *when* in pain, nonetheless one never forgets it. Paralleling the pain of the other, in this essay I analyze the depths and limitations of the emotional recall. In "Autoethnography, Personal Narrative, Reflexivity: Researcher as Subject," Carolyn Ellis notes that the emotional recall is used when we want to understand an event that has left serious marks on our identity.

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As she remarks,

The advantage of writing close to the time of the event is that it doesn't take much effort to access lived emotions—they're often there whether you want them to be or not. The disadvantage is that being so involved in the scene emotionally means that it's difficult to get outside of it to analyze from a cultural perspective.²

What Ellis describes above applies perfectly to my case. When my mother died because of cancer, I did not record her reactions--although some of her intense painful moments did leave an irremovable scratch on my life's "tape." Years after her death, I realized my double loss. Not only did I lose my mother because of breast cancer, but also—without keeping a rudimentary diary—I lost a record of her then reactions, as well as mine. Because of that, I felt I experienced a loss of a loss. Luckily, through the experiences of Bearing, Lorde, and Spence, I have been able to "reconstruct" some of my then feelings vis-à-vis my mother's suffering, and thus, once again stress to my readers the importance of recording what they feel. I believe it is important to record what we feel not only for our own sake, but also to let our feelings participate in a dialogic community of cancer survivors, cancer victims, and/or relatives of the two.

In this light, a question that needs to be raised is, what is the connection between medicine and art? As Thomas G. Couser asserts, "The word 'pathography' first caught my attention not in its clinical context, in which it simply refers to writing about illness, but in the context of 'autopathography,' i.e., autobiographical narratives of illness or disability."³ For Ellis, during the process of autoethnography, one reveals one's vulnerability, and that is a courageous act because, once we reveal our vulnerability, we cannot "[t]ake back what [we]'ve written," just as we cannot have "[a]ny control over how readers interpret it."⁴ Finally, since an autoethnography "[i]s an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural,"⁵ it helps me keep focused my primary motivations and concerns in writing this essay; in order to feel the other as being part of the community, we should listen to his/her story as experienced in a rather isolated environment, i.e., the hospital. If we do not listen to such stories, then we risk facing the consequences of what I call "cultural loss," which could be just as damagingly devastating as environmental pollution, abuse, crimes, lack of sharable intimacy, etc.

Preliminary Remarks: The Verbal Barrier

I started this essay with one of Scarry's ideas. As I was structuring my arguments, I could not help thinking: What exactly does Scarry mean by "*on behalf* of those who are [in pain]"? If she implies that the ones in terrible pain are inevitably bereft of logic, fluidity in talking/writing, then I could agree with her. Arguably, this is *not* an essay about my cancer, so how could I genuinely talk about mastectomy, hysterectomy, chemotherapy, if I have not experienced them for myself? How could I talk "on behalf" of someone in pain, if I have not been diagnosed with a terminal illness? Writing this essay, I have become more conscious of weighing the words I am using in daily conversations and writing. Think for a moment at a pharmacist's task who has to be careful when combining and measuring the substances that make a potion or drug. We

should follow this path, too, especially since we *cannot* talk on behalf of the ones in pain; instead we could listen to their stories, and thus somehow engross ourselves into their suffering.

While researching and then writing *The Culture in Pain*, David B. Morris was asked an invariable question: “Are you writing about physical or mental pain?”⁶ But what would be the difference between these two pains, and, even more importantly, why would we continue to divide the two? As the author reminds us, “[d]octors may find it convenient, even indispensable, to prescribe one drug for physical pain and a second drug for mental suffering. [...] Pain, unfortunately, is not a subject we can master through a knowledge of drugs alone.”⁷ That is to say, despite our obsessive desire to divide the two, thus continuing to operate within a Cartesian paradigm of thinking, pain *is* concomitantly physical and mental.

However, there is still a category of people whose minds operate not only from a Cartesian perspective, but whose religious beliefs make them conceive of illnesses as being inflicted on our bodies as a result of an immoral life. According to Elizabeth Grosz, “Within the Christian tradition, the separation of mind and body was correlated with the distinction between what is immortal and what is mortal. [...] Christ was a man whose soul, whose immortality, is derived from God, but whose body and mortality is human.”⁸ In addition to the distinction between immortal and mortal, the Christian tradition made another drastic division, between moral and immoral. In this light, illnesses were thought to be divine punitive inscriptions onto the bodies of those who had sinned. Christianity also implied a split between mind and body, immortal and mortal, immoral and moral, thus creating a *cult* for thinking religiously. I think it would not be wrong to suggest that if for Plato men felt that they were trapped in their bodies “as in a dungeon,”⁹ with the institutionalizing of Christianity, human beings felt trapped in their minds, i.e., not thinking for themselves, not using their mental capacities, but following rules and commandments which never fit carnally into their understanding of life. Let us break these rules. Let us not become anarchic either, but let us realize that being vulnerable is not a sign of being weak; it is rather a sign of being frail and human. Let us stop covering our so-called flaws, and let us reveal what, where, and how deep pain shakes our foundations; how much the death of our beloved ones opens a hole in our soul never to be fully healed. Ellis remarks that it is about time social scientist (and literary critics for that matter) wrote about personal disasters, thereby not keeping them isolated anymore. As she argues,

Although social scientists have written about disasters, their emphasis tends to be on the destruction of community, community behavior during disasters, community social order, and community mental health crisis intervention.

But in airplane crashes, unlike most natural disasters, there is no community for survivors or families of victims. Passengers are strangers who have come from many regions, and survivors disperse quickly after accidents.¹⁰

Ellis wrote that article in the aftermath of her brother's sudden death in an airplane crash. I think patients who are in hospitals, patients who can barely speak and/or walk, are in a frustratingly similar situation. Although there are numerous international and national cancer-related organizations, I think the vast industry of mass-media should involve itself

more passionately in this subject, broadcasting more detailed interviews on the disaster that is cancer (which, still with no sure remedy, could be rightly referred to as an “ongoing disaster”).

Margaret Edson’s *Wit*

In *The Body in Pain: The Making and Unmaking of the World*, Elaine Scarry argues, “[w]ork and its artifacts are names that are given to the phenomena of pain and the imagination as they begin to move from being a self-contained loop within the body to becoming the equivalent loop now projected into the external world.”¹¹ In Margaret Edson’s play *Wit*, the stage is empty, bare. Vivian Bearing--the protagonist--has advanced ovarian cancer. The emptiness of the stage parallels the baldness of the patient, as well as the simplicity of her hospital gowns. They are now parts of who she has become: a stranger to/in her own body. Vivian is completely dependent on the machines (IV poles and others), and on chemically induced treatments. These are the outside markers of her new identity. Her inside identity is challenged, too. According to Sontag, “In cancer, non-intelligent cells are multiplying, and you are being replaced by the non you.”¹² Can these “non-intelligent cell” completely replace/erase one person’s/patient’s identity?

The first part of this essay puts into spotlight the last days of a woman whose former individuality comes to her and us through flashbacks, and the protagonist’s reactions to her cancer, hospitalization, and the loss of contact with the outside world. Tom Chambers writes that “Ellipses usually occur [...] between periods of entrance into the medical setting. [...] The farther the character goes from the medical world, the greater the chance of ellipses.”¹³ In Vivian’s case, the protagonist is not going to get out of the hospital. Her ellipses occur only at the level of her mind when she recollects fragments of her former identity.

But who is Vivian? She is a professor specialized in the 17th century poetry, particularly in John Donne’s metaphysical poems. Because of her cancer, she is now a student in illness. Furthermore, because her ovarian cancer is in an advanced stage, the doctors propose to her a very drastic treatment (someone might want to add inhuman), of which they do not know much, if anything at all. As Vivian sadly admits, “Shrinking in metastatic tumors has not been documented.”¹⁴ Therefore, incapable to still have control over her body, unable to teach her students the beauty and difficulty of Donne’s poems, Vivian performs one final role: that of a patient who has been isolated in a cold and mechanized environment, practically forgotten by everybody.

Then, if defined, what would be the pedagogy of medicine? How is it performed onto our bodies? In order to assume possible answers, it is worth noting the relationship between patients and doctors. Ronald A. Carson suggests that “The hyphen is a key to understand the relationship between patients and doctors. The hyphen simultaneously signifies separation and synergy, disjunction and conjunction.”¹⁵ Thus, “The hyphenated space in the doctor-patient relationship is a liminal place of ethical encounter, alternating voices and actions—back and forth, address and response.”¹⁶ However, in Edson’s play, whenever doctors explain something to Vivian, her reactions are written side by side, an evocative case of the gap and/or miscommunication between her and doctor Kelekian and his staff.

DR. KELEKIAN.

VIVIAN.

The antineoplastic will affect some healthy cells. Antineoplastic. Anti: against
Neo: new
Plastic: to mold. Shaping.

Antineoplastic. Against new
Shaping.¹⁷

A diligent, passionate scholar, all her life Vivian has tried to understand the meaning of words. This play offers significant flashbacks, for example, the recollection of the encounter between Vivian and her teacher, E.M. Ashford. Debating over one of John Donne's poems, the two have the following set of retorts:

E.M. ASHFORD. Nothing but a breath—a comma—separates life from life everlasting
[...] Life, death. Soul, God. Past, present.

VIVIAN. Life, death ... I see. It is a metaphysical conceit. It is wit!

E.M. ASHFORD. It is *not wit*, Miss Bearing. It is truth.

VIVIAN. The insuperable barrier between one thing and another is ... just a comma?¹⁸

Life, death, and, like Vivian, we do not realize that between the two there is *just a comma*, an instant of breathing, an infinitesimal moment that potentially could transform life into death, existence into nonexistence. As Vivian painfully admits, "We are discussing life and death, and not in the abstract, either. We are discussing *my* life and *my* death [...] Now there is not time for metaphysical conceit, for wit... Now is a time for simplicity."¹⁹ Thus, as she is approaching death slowly but inexorably, Vivian, the professor-scholar-mentor, seems to have lost any interest in sophisticated notions and ideas. Like the cancer which now has spread all over her body, Vivian's language has hardened in itself by being devoid of its former fluidity. As Scarry argues,

To assent to words that through the thick agony of the body can be only dimly heard [...] is a way of saying [...] there is almost nothing left now, even this voice [i.e., of the one in abominable pain], the sounds I am making no longer form my words but the words of another.²⁰

This moment could be understood as if the one who has been in pain has finally surrendered, not wanting anything anymore, not being capable of thinking beyond pain. It is as if Vivian has been expelled from her own locus of becoming, as if time stopped and now it pours itself violently, backward, inward, and centripetally toward a immobile center.

On her deathbed, Vivian says, "I am like a student and this is the final exam and I don't know what to put down because I don't understand the question and I am *running out of time*."²¹ The unwritten, unspoken, yet understood meanings of Vivian's degenerating body, raise the following questions: What is cancer? Does cancer have a meaning? Could we understand cancer other than through the physicality of the one in pain? According to Barbara Rosenblum,

When you have cancer, you are bombarded by sensations from within that are not anchored in meaning. They float in a world without words, without meanings.

You do not know from moment to moment whether to call a particular sensation a 'symptom' or 'side effect' or a 'sign.' [...] Words and their referents are uncoupled, uncongealed, no longer connected.²²

Cancer almost makes language meaningless. Words--like cancerous cells that spread all over one's body--are eaten up by silences, interrupted by short sentences, and then continued by some more unbearable silences. I read Vivian's pain and her inevitable

death through the signs inscribed on her body: she is bald, “has a central-venous-access catheter over her left breast, so that the IV tubing goes there, not in her arm,”²³ vomits constantly, and has lost considerable weight.

VIVIAN. In everything I have done, I have been steadfast, resolute—some would say in the extreme. Now, as you can see, I am distinguishing myself in illness.

I have survived eight treatments of Hexamethosphacil and Vinplain at the *full* dose... I have broken the record. I think Kelekian and Jason [his intern] foresee celebrity status for themselves upon the appearance of the journal article they will no doubt write about me. But I flatter myself. The article will not be about *me*, it will be about my ovaries.²⁴

What we could infer from this passage is that the one in pain not only succumbs to pain itself eventually (when the body does not have resources to fight against the illness anymore), but also that the body of the ill person is unjustly claimed by the medical staff. After all, Kelekian and his interns will most likely write an article about Vivian’s ovaries. Consequently, Vivian is not treated as a whole body. The focus of the doctors’ research has switched to her ovaries, thus treating Vivian metonymically.

I think that while medicine tries to find a norm for our bodies, ironically or not, our bodies constantly prove the endeavor futile. We are bodies within bodies. Not one body, but multiple embodiments that change their morphology constantly accompanied by multifarious sensations and myriad of reactions. To diagnose someone means to put that person’s/patient’s illness in one category. However, to treat one him/her means to find a cure for his/her special case of illness. The role of the doctor is to attentively collect and interpret the information received about his/her person/patient. (This information comes to him/her through routine and/or sophisticated clinical tests, dialogues with the persons/patients, and collaborations between a doctor and his/her staff) As it has often been argued, doctors play the role of historians. But, when the events did not happen in the more or less remote past, but are present, then, in a shift of reflexivity, the person/patient becomes a historian. Narrating his/her “present-past,” the person/patient may be willing to do it succinctly or with abundant details, may be able to recollect in depth the events “as they happened,” or may not be willing to share too much of his/her sudden invaded intimacy. From history textbooks, we have learned that, if an event has at least two interpretations, then each one claims supremacy over the other. Put differently, when one’s body is analyzed by the doctor-as-historian and by oneself-as-historian, then inevitably there occurs conflicts in interpreting the events “as they happened.”

I believe that these conflicts are a pertinent example to show that there are limitations in medicine and the way it views its patients, just as there are limitations in any other science of the humanities. In Edson’s Vivian’s case, having been diagnosed late in her life, the doctors knew that they would not be able to save her life. Their mistake, however, was to treat Vivian just as a case, and not as a human being. As Leonardo Cassuto points out, “The case study relies on this continuing tension between the abstract (and general) and the concrete (and individual).”²⁵ But Vivian sadly admits, “Medical terms are less evocative [i.e., than John Donne’s metaphysical conceits]. Still, I want to know what the doctors mean when they ... anatomize me. [...] My only defense is the acquisition of vocabulary.”²⁶ Unlike her former fascinating acquisition of Donne’s terms such as “ratiocination,” “concatenation,” “coruscation” which have taken her a lifetime to

taste the flavor of their multiple connotations, now Vivian feels not only is she running out of time, but also she is refused a genuine dialogue with her doctors. As she says, “In isolation, I am isolated. For once I can use a term literally.”²⁷ Instead, she regrets the fact of not having been given the opportunity to communicate effectively with the medical staff, and, thus, to understand more things about her cancer. She realizes that there is a more perverse dimension to isolation. She is isolated because her immune system is so low, defenseless, that it may actually attack her body. When she is put in that isolated room, she is literally left alone with her body, which she finally sees more clearly. It is not her body anymore, but something accompanied, surrounded and sustained by an orchestrated set of machines. Ironically, *she* justifies the existence and meaning of those machines. In other words, the machines could function without Vivian; they could be plugged and unplugged effortlessly, with a simple touch of a button. Sadly, it is Vivian who cannot function without them. This is the ultimate definition of isolation which comes as a shock to her.

Only Susan, her primary nurse, is there to support and comfort Vivian. The close relationship somehow resembles that of a midwife to a pregnant woman. The *only* difference is that Vivian is pregnant with death, and, in her role of “midwife,” Susan teaches Vivian how to less painfully step on the liminal threshold between being and non-being, life and death. According to Carson, “The concept of liminality (from Latin *limen*, for ‘threshold’) refers to the ritual ‘space’ in which one is suspended between two worlds, neither here nor there, betwixt and between settled states of self, as in rites of passage, or, by extension, when experiencing illness.”²⁸ The hyphenated relationship between doctors and patients is often replaced by the hyphenated relationship between nurses and patients, who approach them as persons/patients candidly by assisting them more effectively in their needs.

SUSAN. Well, they [Kelekian and his staff] thought that drugs would make the tumor get smaller, and it has gotten a lot smaller. But the problem is that it started in new places too. They have learned a lot for their research [...] There just is not good treatment for what you have yet, for advanced ovarian. I am sorry. They should have explained this.²⁹

They should have, but they did not. Consequently, it is Susan who admits the plain truth to Vivian, and who also explains the latter’s choice of being resuscitated or not when her heart will stop. Being so focused on Vivian as a case, and not a person, the doctors forgot to explain this very important option to Vivian. When her heart stops, Jason claims her body, and he calls for a code blue intervention by saying angrily to Susan, “She’s Research!,” to which Susan replies: “She’s NO CODE!”³⁰ Ignoring Susan’s intervention, Jason does call for a code blue team to resuscitate Vivian. Thus, the end of the play parallels, on the one hand, the agitation, confusion, and lack of ethics on the part of the medical staff (with the exception of Susan) and, on the other hand, Vivian’s entering into death with dignity, thus “claiming” her own body.

CODE BLUE TEAM.

(Reading) Do not resuscitate. Kelekian. Shit.
(the Code Team stops working)

JASON. Oh, God.

CODE TEAM.

- It is a doctor fuck-up.

AUTHOR.

She [Vivian] walks away from the scene, toward a little light.
[...] The instant she is naked and beautiful, she reaches for the light ...

- What is he [i.e., Jason], a resident?
- Got us here, called a code on a no-code.

JASON. Oh, God.³¹

Through Vivian's nakedness, Edson may propose a way in which persons/patients could reclaim their personhood. Vivian enters, if not becomes, the invisible yet pervasive light. I could be totally wrong, but for me Vivian's tearing of her hospital gown at the end of the play has positive meanings. Only when she tears them apart, only when she is naked again, can she finally break off the cocoon of her hospitalized identity.

[III]

Audre Lorde's *The Cancer Journals*

If Margaret Edson introduced a fictitious character diagnosed with cancer to us, as an example of the enactment of cancer, Audre Lorde's *The Cancer Journals* documents this woman's struggle with cancer. Moreover, if having ovarian cancer is biased on the implication of a total internal affliction, and consequently it is less "effective" for the public eye, breast cancer raises all sorts of questions. The fetishism of the female breast has been construed socio-culturally, and should definitely be scrutinized and reflected upon.

In the 1970s, when Lorde was diagnosed with cancer, there were erroneous trends that attributed the illness to the patient/person him/herself. As Diane Price Herndl asserts, "Cancer in the late 1970s was being attributed to a particular—and bad—personality type. Depression, repressed emotions, and succumbing to stress were designed as causes of cancer; therefore the patient was blamed for her illness."³²

Having one breast surgically removed, Lorde finds herself lost, but, at the same time, tries to find persuasive means to communicate her most intimate feelings: "I want to write rage, but all that come is sadness. [...] I am not supposed to exist. I carry death around in my body like a condemnation. But I do live. There must be some way to integrate death into living, neither ignoring it nor giving in to it."³³ Losing a breast to mastectomy provides an opportunity to demystify the myth that a woman is whole only if she is *symmetrical*, narrowly understood as having two breasts. As Lorde recollects,

In September 1978, I went into the hospital for a breast biopsy for the second time. [...] I knew it was malignant. [...] The gong in my brain of 'malignant,' 'malignant,' and the icy sensations of that frigid room, cut through the remnants of anesthesia like a fine hose trained on my brain.³⁴

Prior to finding out whether or not her tumor was malignant, Lorde sensed fear all over her body. Actually, the adjective malignant seems to have spread all over her being, obsessively adding a psychological pain to a physical one. According to Scarry, "[t]o have pain is to have certainty; to hear that another person has pain is to have doubt."³⁵ Could we honestly agree with Scarry's point of view? Doesn't it deny our capacity to empathize with the other? All her life, and particularly after discovering her cancer, Lorde tried to express her anxieties and stop these "tyrannies of silence."³⁶ As she writes reflecting upon her cancer,

What I most regretted were my silences. [...] Death is the final silence. And that might be coming quickly, now, without regard whether I had ever spoken what I needed to be said, or had only betrayed myself into small silences, while I planned someday to speak, or waited for someone else to say the words for me.³⁷

Her life took a dramatic turn when she discovered that it could have been saved only if her breast was to be surgically removed. After the surgery, she remembers, “My breast which was no longer there would hurt as if it were squeezed in a vise. [...] The euphoria and the numbing effects of the anesthesia were beginning to subside.”³⁸

Although after the mastectomy Lorde tried to lift her spirits by making the rather unusual comparison between her situation and that of the Amazons—those famous mythological female archers whose one breast was cut to allegedly make them more combative/precise in fights—nevertheless she knew she was more than an Amazon. She was a carnal, vibrant, real woman, and not a mythological creature. Furthermore, to her bitter disappointment, she found out that there were few documents related to other women who had lost a breast because of cancer. What happens when women are convinced to wear a prosthesis, and thus fit into a “norm”? In this instance of “normalization,” does the hyphenated space of doctor-person/patient bear the marks of *scarification* and pressure of those aberrant rules that say a woman is a woman only if she has two breasts? As Lorde admits, “To imply to a woman that yes, she can be the ‘same’ as before surgery, with the skillful application of a little puff of lambswool, and/or silicone gel, is to place an emphasis upon prosthesis which encourages her not to deal with herself as physically and emotionally real, even though altered and traumatized.”³⁹ In addition, “[a]rtificial limbs perform specific tasks, allowing us to manipulate or to walk. Dentures allow us to chew our food. Only false breasts are designed for appearance only.”⁴⁰ Furthermore, according to Thatcher Carter, “Normalization is the key component in prosthetic breast sales; there is no medical reason to have a prosthetic breast, and the breast is shaped to fit the norms of our society.”⁴¹ There are two key words in this succinct, yet powerful passage: “(breast) sales” and “to fit.” When women are convinced, after mastectomy, that they should return to “normal,” this normality implies not only an integration into consumer society, but also an artificial reconstruction performed on the site of a female body. But how could such a “breast” be considered healthy, when it is artificial?

In my view, Elise Siegel’s *Portrait # 3* speaks about feelings of entrapment, not only in a gown (i.e., bra), but also in the strictures of the ideological discourses. Combining wire mesh and modeling paste, by remodeling, Siegel challenges one of the standardized views of a very fetishized item: the female bra. The wire mesh is representative of how we are enmeshed in situations, and above all in ourselves, as we move too close or too far away from ourselves, our spaces of love, hate, ignorance, forgetfulness, and passion.

There is something else about this wire mesh: its filigree-like quality is effectively contrasted by a rigid, black frame. Furthermore, because a bra is a garment worn underneath other layers of clothing, it inevitably provokes me to raise this question: What type of image is constructed in a mirror when a woman with a prosthetic breast sees herself?

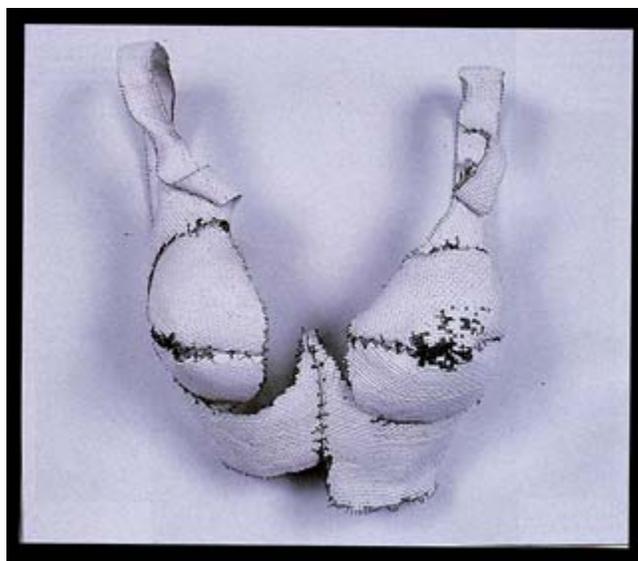


Figure One: Elise Siegel. Portrait # 3. Breast Cancer Answers, New York, 1992.

During the mirror stage,⁴² first there is the realization that we have different embodiments than our mothers'. Later, when we look at ourselves in a mirror, hoping to find an evocative image of ourselves, how many times do we reject what is projected onto the surface of the mirror? Those are also the moments when we realize that our bodily contours are as protean as is our uttering of words. Put differently, what is missing when we see ourselves in a mirror is what lies hidden inside ourselves, what cannot be properly put into words, what is deeply buried into the sites of our using of language. Thus, the mirror stage is *staged*, since in front of a mirror we see the (speculative) reflection of our bodily contours. That which is *us* refuses to be present in front of a mirror since we constantly stage, pose, and act in front of it. Of course this play on words (mirror staged) is effective only in English, since in its original, French, there is image spéculaire. However, spéculaire comes from the Latin noun speculum [i.e., mirror] which gives in English the verb “to speculate.” Therefore, to make our bodies matter is to permanently speculate about their meanings, to constantly provoke new readings for our never-fully-developed, always-in-motion-and-becoming bodies. But how could we possibly control our bodies whose shapes are not controllable, but elusive in their nature?

Even more importantly, when bodies are seriously affected by cancer, and when a cancerous tumor is surgically removed (sometimes by removing the neighboring area, i.e., breast, uterus, etc.), and, finally, when persons/patients are pressured to return into a “normality” imposed by socio-cultural and political discourses, we realize that between perceiving the body qua object and the body-*abject* there is a very thin line. Allison Kimmich points out that “*Abject* comes from the Latin *ab*, from, and *iacere*, to throw. Literally, then *abject* means outcast.”⁴³ In this light, she infers that “The prosthesis would allow the women and the culture at large to deny the possibility of *abjection*.”⁴⁴ But are ill women the ones who seize this transformation: from object of desire into *abject* site of repulsion? Or is it a subversive socio-political discourse underneath the surface of this aberrant, illogical transformation? As Lorde writes,

In the cause of silence, each one of us draws the face of her own fear—fear of contempt, of censure, or some judgment, or recognition, of challenge, of

annihilation. But most of all, I think, we fear the very visibility without which we also cannot truly live.⁴⁵

Therefore, by choosing to alternate two persons in her writings, “I” and “We,” Lorde understood that there is no subject in itself but there are subjects affecting each other permanently, zigzagging and thus leaving *visible marks* on the parchment of the official discourses. Moreover, if Judith Butler is right when she “[c]onceives of language as a process of reiteration carried forward by the (re)citations of subjects,”⁴⁶ then when we first see ourselves, and, more poignantly, when we first speak and perform ourselves there is always a chorus of hidden, sedimented, other voices within ourselves.

[IV]

Domestic versus Public Photography—Jo Spence’s Contribution to Making Breast Cancer Visible

If Audre Lorde opted for mastectomy, Jo Spence chose a different treatment for her breast cancer, by combining traditional Chinese medicine with phototherapy. In her works, Spence tried to juxtapose words and images, or, as she writes, “[w]e need to use our cameras, tape recorders, diaries, poems, videos—whatever cultural resources we have—to witness our own histories, to learn to protest and share, and to learn to nurture ourselves.”⁴⁷ Based on her philosophy that domestic photography, staged as it is, conceals rather than reveals our most intimate fears, Spence used her camera as a visual diary, accompanying her through the ordeal of cancer. As she remembers, “When I learned that I had breast cancer, [...] I used my camera as a third eye, almost as a separate part of me which was ever watchful: analytical and critical, yet remaining attached to the emotional and frightening experiences I was undergoing.”⁴⁸

Could a body be placed in front of a camera to faithfully record its ordeal of cancer? When Spence heard about her breast cancer, she did not know how to make it visible and meaningful to herself and others. Her task was probably even more challenging, since it questioned her own profession (i.e., photographer). As she writes, “Family photographs hide any evidence of illness or ageing, since photographic conventions encourage us to ‘smile for the camera’ and the lack of clarity in small images prevents us seeing fine detail.”⁴⁹ How many of us could identify ourselves with the photographs as taken in a studio, at a party, social event, or banal gathering? These photographs are not accurate for they are staged, controlled, and fixed. We manipulate the very instant of our visual recording in order to enhance our appearance. In his book, *Image, Music, Text*, Roland Barthes affirms,

The type of consciousness the photograph involves is indeed truly unprecedented, since it establishes not a consciousness of the *being-there* of the thing but an awareness of its *having-been-there*; [...] its reality that of the *having-been-there*, for in every photograph there is the always stupefying evidence of *this is how it was*, giving us [...] a reality from which we are sheltered.⁵⁰

Nonetheless, while a photograph may testify for our “being there,” the time represented counterfeits our seeing, and, even more significantly, our memory of the moment. Therefore, understanding this clear distinction between photographs as staging an identity and photographs reflecting an identity, Spence realized that her body could never be something other than a transitory site, onto which its fleeting signs are exchanging their attributes constantly: inside/outside, personal/social, and meaningful/meaningless.

Drawing on Scarry’s idea that pain cannot be verbalized, could it at least be shown? When diagnosed with cancer, although fully aware that neither words nor photographs (or any other media for that matter) could accurately testify for the body in pain, Spence nevertheless exposed her body in its partial or full nudity, thus sculpting out of her body many slices of fear and suffering. Entitling her project *Narratives of*

Dis-ease: Ritualized Procedures, Spence voices its manifesto as following,

In these photographs is the beginning of a ‘subject’ language, one which allows me to start the painful process of expressing my own feelings and perceptions, of challenging the ‘ugliness’ of being seen as Other. In so doing, I cease to be a victim, becoming again an active participant in life [...] If I don’t find a language to express and share my subjectivity, I am in danger of forgetting what I already know.⁵¹



Figure Two. Jo Spence—*Narratives of Dis-ease*. 1989.

The human body of any ill person is a powerful, evocative site and case in point for all the transformations a body experiences. As shown in the image above, Spence’s body acquires that feeling of monstrosity: what used to be healthy is now transformed into the unrecognizable Other. The question that Spence might ask is: What has happened to my body? Have I become overnight (here time is instantaneously contracted!) a stranger captive in an altered narrative and bodily image? Because of her deformed left breast as well as of the half mask she wears on her face, Spence speaks about her real “monstrosity.” It is not her sentient body that has become monstrous, it is society’s

refusal to acknowledge her suffering. In a desperate attempt to be seen, onto this woman's body is written "monster" (an explosive example for the dichotomy between visuality and textuality, as well as body as seen, read, perceived and interpreted). Moreover, although it is considered taboo not only the act of speaking about a terminal illness, but also the act of looking at one's deformed body, photographs finally permit us to analyze and construct different discourses for the body in pain.



Figure Three. Jo Spence—Narratives of Dis-ease. 1989.

In the above image, Spence inscribes on her cancer-affected breast "Property of Jo Spence!" What could be the meaning of this very unusual, yet powerful inscription? On the one hand, Spence testifies that her body, despite having been recently diagnosed with cancer, is still her own, her belonging, her property. But on the other hand, this image could also function as archival memory for the body that could lose a breast to mastectomy, or could even die because of cancer. As Spence recounts, "Before I went into hospital in 1982 I decided I wanted a talisman to remind myself that I had some rights over my own body. This is the one I took with me. I felt I was entering unknown territory and wanted to create my own magic fetish to take with me."⁵² Thus, by exposing her body, Spence wants not only to make it visible to others, but also to overcome those trends according to which it is shameful to show publicly the transformations of the body in pain. As she writes, "A lot of my work is about overcoming shame, about speaking what people feel has no validity, no right to be heard. [...] Shame is a cultural construct: one is not born ashamed, one is made so."⁵³ Like Lorde, Spence asserts over and over again that just as there are sanitized photographs so there are sanitized discourses, which, ironically or not, more profoundly harm a person, and, by extension, a society. Sontag rightly points out that "[i]f it is plausible to compare the polis to an organism, then it is plausible to compare civil disorder to an illness. [...] Society, by definition, never catches a fatal disease."⁵⁴ By her act of refusal to have a mastectomy, Spence undermines not only the socio-political discourses of women with breast cancer, but she also shows that medicine is not ready to embrace and/or combine other methods of treatments. As she sadly admits, "I do not think I have been so lonely in my entire life as I was after I'd refuse traditional allopathic treatment for breast cancer—the mastectomy and radiotherapy."⁵⁵

The act of speaking is/should be a moment of enchantment; understood as drugs, words are healing or harming, revealing or camouflaging, constantly taking us by surprise as long as they request us to participate. While we speak with a certain choice of words and tone, it seems to me that medicine is still in its incipient, prelinguistic stage. Medicine does not treat us as persons but as “cases,” not individually but collectively. The discourse of medicine is schematized, fleshless. If a word may have a certain impact on one person, but none on another, medicine uses the same discourses over and over again. Thus, its discourses are out of context, misplaced, and impersonal, and its signifiers are disembodied, floating aimlessly.

Consequently, pain insulates us. If we are more or less concerned about our bodies when they are healthy, we are definitely shattered when the moment of becoming ill furtively approaches us, and, when voicing pain from inside out, our bodies roar with anger. Moreover, the drama of an ill person has to be staged outside, inscribed onto the volatile surface of one’s body, in order to *contaminate* and catch the others’ perception/attention. We are an amphitheater of malleable embodiments, polyphonically arranged, constantly drawing the *blueprint* of our bodies, not knowing if our bodies will obey or disobey our needs. But the moment of becoming ill should not correspond with the moment of remaining silent. In addition, becoming patient has a double meaning. “Patient” could be understood either as a noun or as an adjective. Either way, or as I would like to suggest both ways simultaneously, becoming patient is a rhetoric of a body *about or attempting to be known*. As Spence writes,

In order to understand we first of all have to feel safe enough to deconstruct. We then have to put the pieces together again and again, continually montaging until we make new connections which will enable us to break out of the psychic bonds which hold us. Out of the broken pieces of the self will come a subjectivity that acknowledges the fragmentation process, but which encompasses and embraces the parts and brings them into dialogue with each other.⁵⁶

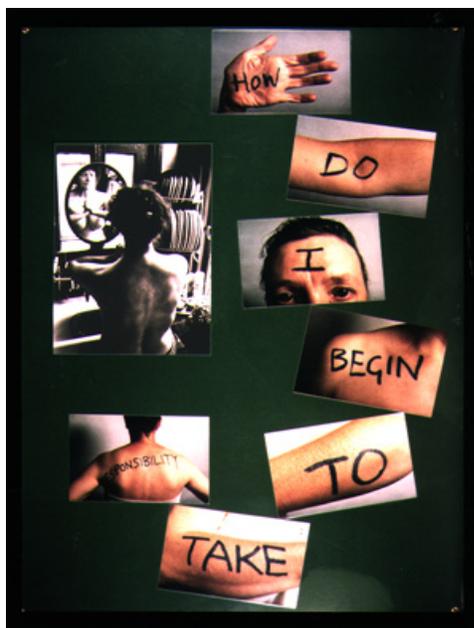


Figure Four. Jo Spence—Narratives of Dis-ease. 1989.

In an attempt to apply her thoughts via photographic means, Spence created one of her most fascinating works. The image as shown above reads, “How do I begin to take responsibility for my body?” Sitting naked in front of a mirror and using paint on some parts of her body, this image is just as shocking as it is rhetorically powerful. In front of a mirror, a body does not see itself. Put differently, a mirror does not project a reflection of our image as a whole, but it rather reveals the body as a hole, which when pierced into, it leaves behind the echo of its multifarious voices and desperate cries. In addition, the image that is temporarily reflected on a mirror functions like a two-dimensional painting, thus lacking depth. Suffice to say, our bodies are “tempores,” a semantic hybrid, a portmanteau, a jocund combination of temporal and pores, just as time transpires on the surface of our skin, permanently connoting our passing through life.

In their book, *A Thousand Plateaus*, Gilles Deleuze and Félix Guattari write:

Gregory Bateson uses the term *plateau* for continuous regions of intensity constituted in such a way that they do not allow themselves to be interrupted by any external termination, any more than they allow themselves to build toward a climax. [...] A plateau is a piece of immanence. Every BwO⁵⁷ is made up of plateaus. Every BwO is itself a plateau in communication with other plateaus on the plane of consistency. The BwO is a component of passage.⁵⁸

Like an archeologist who digs deeper and deeper into the soil so that he may restore the remaining parts of an artifact, philosophers such as Deleuze and Guattari try to deconstruct the human body. Furthermore, after restoring the pieces of an artifact, an archeologist glues them together, so that, through them, he would restore a part of a population’s (lost) civilization. But what would be Deleuze and Guattari’s project? They emphasize that our organism is situated at a crossroad of feelings and perceptions, and, consequently, “[d]ismantling the organism has never meant killing yourself, but rather

opening the body to connections that presuppose an entire assemblage, circuits, conjunctions, levels and thresholds, passages and distributions of intensities.”⁵⁹

But where is the distribution of intensity in Spence’s “How may I begin to take responsibility for my body?” According to the artist,

How do we deal with the abject loneliness of the long struggle for health (the most boring of subjects to other people who are ‘well’)? How to present yourself as a subject in daily struggle? People are used to the ‘narrative resolution’ of illness like cancer (in the media’s terms you are either ‘dead’ or ‘better’).⁶⁰

It seems to me that what Spence may assert is not only the suffering generated by having a terminal illness, but also the solitude of the ill person and the fear of communicating his/her pain to others. Moreover, when she exhibited the images of her body in pain, there were no reactions from the audience, as if those in the audience were struck by an unmotivated silence. How could we constructively problematize the body in pain if we reject it? As Spence records,

I looked for a discourse of cancer in the newspaper: I wanted to see how the medical profession sold its truths. [...] very quickly [I] could discern that what passes for ‘news’ is in fact a series of public relations exercises to keep certain ideas in the public domain which [...] help reinforce the power of the medical and pharmaceutical industries, but at the same time they also help to whip up more and more hysteria about the disease.⁶¹

She goes on saying that our notion of health (like all other notions) comes via mediated sources, and as a consequence, despite years and years of accumulated knowledge, we are still patients who are acted upon rather than acting out our most fundamental needs. Therefore, what I believe is Spence’s legacy is an attempt to open up these secularized and ineffectual discourses that damage our bodies and minds in very subversive ways. Spence points out that photographs “[a]ct as a tangible marker of something which could otherwise go back into the unconscious and remain dormant for a long time.”⁶² Put in another lexicon, when archived, photographs could offer us a more profound way to understand our bodies in motion, along with their several embodiments.

[V]

There is Nobody with One Body—A Contemporary Reflection
on Our Bodies

Medicine, law, religion and other institutionalized and marketable sites of power try to keep us together, as a group, as a *flock* of individuals, putting us into certain categories. To medicine, we are either healthy or sick, to law we are either good citizens or wrong-doers, and to religion we are either moral or immoral. Other dichotomies could be created easily, thus perpetuating an ineffectual Cartesian way of reasoning. If we are anything at all, what I propose is that we are in-between, grafting our bodily tissues, and not knowing whether they would grow benign or malignant.

Arguably, from the inception of medicine and the art of healing until nowadays, there have been recorded indisputable achievements. Yet, because illnesses such as AIDS, cancer, Alzheimer's have not been cured yet, there is a constant pressure put on doctors who are blamed and whose efforts are unjustly disregarded. Why do we have this morbid pleasure and attraction toward annihilation and death? As Williams points out, "Mortality, in short, need not to be deconstructed but lived: rehearsed, consciously or otherwise, on a daily basis, thereby laying the ghost to rest."⁶³ Undeniably, it is quite easy to think about and/or accept our mortality, to ingest it in daily "non-deadly doses."⁶⁴ Nevertheless, an excruciating pain and/or the death of our beloved ones intoxicate us so profoundly that *even death* seems to be a joke. A cruel joke, but still a joke: we have been playing gods, but we come to realize we are not gods, and Prometheus' fire cannot (re-)heat the chambers of our being. It is our abominable pains and especially the death of others that wake us up from the dream of immortality.

In this essay I have also tried to expose the persistent notion of how a woman should look. Is the encyclopedia of our bodies printed with the same characters, print-settings, fonts, shades of colors, et cetera? No, each and every one of us has his/her own embodiments. Current medicine proposes to reconstruct the part of a person's affected body by means of plastic surgery. Ironically, while women who have lost a breast to mastectomy are recommended to reconstruct that physical loss from the (fat) tissue of their buttocks or belly, women who have experienced hysterectomy are not recommended anything surgically to replace the loss of a uterus. Put differently, while there is a false, artificial breast, there is no such equivalent for a woman's uterus. What exactly does this say about our perception of the ill person's body? I believe that this unpleasant situation reinforces the idea according to which what we see is what it is, thus erroneously putting an emphasis on the appearances and not on the body per se, as a whole. Because we cannot see a woman's uterus, we assume it is "there" where it should be. But when a woman is regarded "complete" when she has two breasts, and no similar attention is given when a woman's uterus has been surgically removed, then we move into a dangerous zone, highly dominated by appearances. The fact that we know how breasts look, but we do not know how a uterus looks is probably related to our fear of intimacy, lack of anatomical knowledge, and rare appointments to see doctors for CAT scans and/or minor, routine check-ups. Furthermore, as individuals, women should not have definitions of femininity imposed on them.

Consequently, when diagnosed with cancer we should be encouraged to talk about our pain. As Spence writes, "I begin to understand how power resides in knowledge, and how exclusion results not only in ignorance, but in a belief that there is only 'one truth' about ways in which the mind and body function."⁶⁵ Suffice to say, a rhetoric that tries to impose on us certain discourses, in the long run, proves to be useless. On the other hand, a rhetoric that combines as many discourses as possible could start to see life in its intensity, thus not pointing to a certain direction but moving us, just as it is impossible to say which stream of water touches the bank of a river.

[VI]
Post Scriptum

13 years have passed since the death of my mother. I see her now when my son smiles at me. I meet her in my dreams without being scared anymore. It is not sufficient, but then again when are we truly satisfied with ourselves? Her death taught me to be(come) vulnerable, and now I see more clearly that, etymologically, beneath the word vulnerable there is the Latin word vulnus, i.e., wound. I understood my mother's suffering only after I had given birth to my son; same year, on the Eve of Christmas my father died. Both these two recent major events in my life have reconfigured my attachments to selfishness. In other words, only after I became a parent, I have been finally able to understand my parents. Although they are not physically present anymore, certain "dialogues" between them and me do happen. I am not going to let death steal away those dialogues from me too. And I encourage my readers to have these vulnerable dialogues, as well as urge them to keep a diary.

Finally, as Ellis remarks, "Arthur Frank says in *The Wounded Storyteller* that it is important to think *with* a story, not just about a story. Thinking with a story means allowing yourself to resonate with the story, reflect on it, become part of it."⁶⁶ In other words, thinking with a story allows us simultaneously to become the author, the character, and the critic of that story, thus viewing ourselves from multiple perspectives, accepting our strengths, and facing our weaknesses. To be human is to cry, laugh, and make time for us and our dear ones. To be human is also to make time to listen to what others have to say/share to/with us. This is the very first time I let my wounds be printed in an academic journal. I hope my essay becomes inspirational to other women and men "out there," who, most likely, have a story to tell.

Notes

¹ Elaine Scarry. *The Body in Pain: The Making and Unmaking of the World*. (New York: Oxford UP, 1985) 4.

² Carolyn Ellis and Arthur P. Bochner. "Autoethnography, Personal Narrative, Reflexivity: Researcher as Subject." *Handbook of Qualitative Research*. Eds. N.K. Denzin and Y.S. Lincoln. (Thousand Oaks, CA: Sage Publications, Inc., 2000) 752.

³ *Ibid.* 65

⁴ Carolyn Ellis and Arthur P. Bochner. "Autoethnography, Personal Narrative, Reflexivity: Researcher as Subject." *Handbook of Qualitative Research*. Eds. N.K. Denzin and Y.S. Lincoln. (Thousand Oaks, CA: Sage Publications, Inc., 2000) 738.

⁵ *Ibid.* 739.

⁶ David B. Morris. *The Culture of Pain*. (Berkeley: University of California Press, 1991) 9.

⁷ *Ibid.* 11-2.

⁸ Elizabeth Grosz. *Volatile Bodies: Toward a Corporeal Feminism*. (Bloomington: Indiana UP, 1994) 5.

⁹ Ibid. 5.

¹⁰ Carolyn Ellis. "‘There Are Survivors’: Telling a Story of Sudden Death." Sociological Quarterly. 34 (1993): 724.

¹¹ Elaine Scarry. The Body in Pain: The Making and Unmaking of the World. (New York: Oxford UP, 1985) 170.

¹² Susan Sontag. Illness as Metaphor. (New York: Farrar, Straus and Giroux, 1978) 66.

¹³ Tom Chambers. "What to Expect from an Ethics Case." Stories and their Limits: Narrative Approaches to Bioethics. Ed. Hilde Lindemann Nelson. (New York : Routledge, 1997) 179.

¹⁴ Margaret Edson. Wit. (New York: Faber and Faber, 2000) 37.

¹⁵ Ronald A. Carson. "The Hyphenated Space: Liminality in the Doctor-Patient Relationship." Stories Matter: The Role of Narrative in Medical Ethics. Ed. Rita Charon. (New York: Routledge, 2002) 171.

¹⁶ Ibid. 180.

¹⁷ Margaret Edson. Wit. (New York: Faber and Faber, 2000) 9.

¹⁸ Ibid. 15.

¹⁹ Ibid. 69.

²⁰ Elaine Scarry. The Body in Pain: The Making and Unmaking of the World. (New York: Oxford UP, 1985) 35.

²¹ Margaret Edson. Wit. (New York: Faber and Faber, 2000) 70.

²² Barbara Rosenblum and Sandra Butler. Cancer in Two Voices. (Spinsters Ink Books, 1996) 166.

²³ Margaret Edson. Wit. (New York: Faber and Faber, 2000) 4.

²⁴ Ibid. 53.

²⁵ Leonardo Cassuto. "Oliver Sacks and the Medical Case Narrative." Disability Studies: Enabling the Humanities. Ed. Sharon L. Snyder. (New York: MLA, 2002) 123.

²⁶ Margaret Edson. Wit. (New York: Faber and Faber, 2000) 44.

²⁷ Ibid. 47.

²⁸ Roland A. Carson. "The Hyphenated Space: Liminality in the Doctor-Patient Relationship." Stories Matter: The Role of Narrative in Medical Ethics. Ed. Rita Charon. (New York: Routledge, 2002) 180.

²⁹ Margaret Edson. Wit. (New York: Faber and Faber, 2000) 67.

³⁰ Ibid. 85.

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- ³¹ Ibid. 85.
- ³² See Diane Prince Herndl. "Reconstructive the Posthuman Feminist Body Twenty Years after Audre Lorde's *Cancer Journals*." *Disability Studies: Enabling the Humanities*. Ed. Sharon L. Snyder. (New York: MLA, 2002) 146.
- ³³ Audre Lorde. *The Cancer Journals*. (San Francisco: Aunt Lute Books, 1992) 13.
- ³⁴ Ibid. 27.
- ³⁵ Elaine Scarry. *The Body in Pain: The Making and Unmaking of the World*. (New York: Oxford UP, 1985) 7.
- ³⁶ Audre Lorde. *The Cancer Journals*. (San Francisco: Aunt Lute Books, 1992) 58.
- ³⁷ Ibid. 57.
- ³⁸ Ibid. 38.
- ³⁹ Ibid. 89.
- ⁴⁰ Ibid. 63.
- ⁴¹ Thatcher Carter. "Body Count: Autobiographies by Women Living with Breast Cancer." *JPC*. 36.4 (2003): 665.
- ⁴² As developed by the French psychoanalyst Jacques Lacan. For more information, read Lacan's *Écrits and Four Fundamental Concepts of Psycho-Analysis*.
- ⁴³ Allison Kimmich. "Writing the Body: From Abject to Subject." *Auto/biography Studies*. 13. 2 (1998): 224.
- ⁴⁴ Ibid. 228.
- ⁴⁵ Audre Lorde. *The Cancer Journals*. (San Francisco: Aunt Lute Books, 1992) 21.
- ⁴⁶ Veronica Vasterling. "Butler's Sophisticated Constructivism: A Critical Assessment." *Hypatia*. 14.3 (1999): 27.
- ⁴⁷ Jo Spence. *Cultural Sniping: The Art of Transgression*. (New York: Routledge, 1995) 140.
- ⁴⁸ Ibid. 130.
- ⁴⁹ Jo Spence. *Putting Myself in the Picture: A Political, Personal, and Photographic Autobiography*. (Seattle: The Real Comet Press, 1988) 155.
- ⁵⁰ Roland Barthes. *Image, Music, Text*. (New York: Hill and Wang, 1977) 44.
- ⁵¹ Jo Spence. *Cultural Sniping: The Art of Transgression*. (New York: Routledge, 1995) 135.
- ⁵² Jo Spence. *Cultural Sniping: The Art of Transgression*. (New York: Routledge, 1995) 120.
- ⁵³ See Angela Kelly. *Embodiment*. (Chicago: Randolph Street Gallery, 1991) 9.

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- ⁵⁴ Susan Sontag. Illness as Metaphor. (New York: Farrar, Straus and Giroux, 1978) 75.
- ⁵⁵ Jo Spence. Cultural Sniping: The Art of Transgression. (New York: Routledge, 1995) 213.
- ⁵⁶ Jo Spence. Putting Myself in the Picture: A Political, Personal, and Photographic Autobiography. (Seattle: The Real Comet Press, 1988) 198.
- ⁵⁷ In Deleuze and Guattari's definition, BwO stands for "Body without Organs." Their theory was very much influenced by Antonin Artaud, one of the critics of the Theater of Cruelty.
- ⁵⁸ Gilles Deleuze and Félix Guattari. A Thousand Plateaus: Capitalism and Schizophrenia. (Minneapolis: University of Minnesota Press, 1987) 158.
- ⁵⁹ Ibid. 161.
- ⁶⁰ Jo Spence. Cultural Sniping: The Art of Transgression. (New York: Routledge, 1995) 122.
- ⁶¹ Jo Spence. Putting Myself in the Picture: A Political, Personal, and Photographic Autobiography. (Seattle: The Real Comet Press, 1988) 188.
- ⁶² Jo Spence. Cultural Sniping: The Art of Transgression. (New York: Routledge, 1995) 176.
- ⁶³ Simon J. Williams. Medicine and the Body. (London: Thousand Oaks, California : Sage, 2003) 134.
- ⁶⁴ See Williams, page 134.
- ⁶⁵ Jo Spence. Putting Myself in the Picture: A Political, Personal, and Photographic Autobiography. (Seattle: The Real Comet Press, 1988) 158.
- ⁶⁶ Carolyn Ellis and Arthur P. Bochner. "Autoethnography, Personal Narrative, Reflexivity: Researcher as Subject." Handbook of Qualitative Research. Eds. N.K. Denzin and Y.S. Lincoln. (Thousand Oaks, CA: Sage Publications, Inc., 2000) 753.

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