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by

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**Recovering Women: Autobiographical Performances of Illness
Experience**

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**Recovering Women: Autobiographical Performances of Illness
Experience**

by

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Dissertation

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Dedication

For Anna
who nursed me through the valley

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*Everything takes longer
than you think it should
or thought it would.
Except your life.
-Merijane Block 22 April 1992*

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Recovering Women: Autobiographical Performances of Illness Experience

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This dissertation layers trauma studies theory with feminist theories of performance and autobiography to investigate how women's autobiographically based performances of illness experience disrupt and/or reinforce master discourses of medicine, identity, and knowledge. Feminist theories of performance and autobiography share with trauma studies the distrust of traditional frames and mechanisms of representation, and seek to discover new methods of interpreting experiences that lie "outside the realm" of normative discourse. These theories are further linked by their shared focus on agency and identity construction and an understanding of autobiography that emphasizes the limitations of language and memory which allows for aporia, contradiction, and dissonance, and the belief that testimony functions as a politicized performative of truth. Employing these theoretical perspectives, Carr investigates how

these performances witness to radical reconfigurations of identity through the transference of trauma into conveyable life narrative – even when those narratives fall outside the paradigm of traditional storytelling structures. Carr questions how the structures and content of these performances reveal what traumas are inflicted not only through illness, but also through treatment and care within the western medical model.

Throughout the study Carr examines the moments when the cognitive structures of trauma are transmitted into performance through a variety of feminist and avant-garde performance techniques. Carr investigates the work of specific performers and contextualizes the performances within popular culture and medical discourse. Performances analyzed include; Robbie McCauley's *Sugar*, Susan Miller's *My Left Breast*, Brandyn Barbara Artis's *Sister Girl*, and Deb Margolin's *bringing the fishermen home* and *Three Seconds in the Key*.

Carr questions how the formerly or currently ill female body performing in public disrupts notions of fixed and stable identity while examining the myriad identity constructions embedded within illness narrative. Rather than simplistic triumphant stories of individual cure and recovery, these complex expressions of traumatic experience reveal patterns of cultural oppression that keep the ill female body isolated and silenced. This study attempts to intervene in that silence by foregrounding these politicized performances.

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Chapter One: Re/covering Women through Trauma Theory and Feminist Theories of Autobiography and Performance

Disease and the woman have something in common- they are both socially devalued and undesirable, marginalized elements which constantly threaten to infiltrate and contaminate that which is more central, health or masculinity (Doane 152).

Research Question and Justification/Rationale

Employing case studies as an organizational basis, this dissertation layers trauma studies theory with feminist theories of performance and autobiography to investigate how women's autobiographically based performances of illness experience disrupt and/or reinforce master discourses of medicine, identity, and knowledge. Feminist theories of performance and autobiography share with trauma studies the distrust of traditional frames and mechanisms of representation, and seek to discover new methods of interpreting experiences that lie "outside the realm" of normative discourse. These theories are further linked by their shared focus on agency and identity construction through the formation of autobiography, an understanding of the limitations of language and memory that allows for aporia¹, contradiction, and dissonance, and an insistence that testimony functions as a politicized performative of truth. Employing these theories, I investigate how women's performances of illness experience witness to radical reconfigurations of identity through the transference of the trauma into a conveyable life narrative – even when that life narrative falls outside of traditional storytelling structures. I question how the structures and content of these performances reveal what traumas are

inflicted not only through illness, but also through treatment and care within the western medical model. My interest in this topic stems from my own experience with traumatic illness and my treatment within the Western medical establishment as a white middle-class woman.

In discussing the western medical model I am indebted to the work of medical sociologist Arthur Frank. In *The Wounded Storyteller: Body, Illness and Ethics*, Frank characterizes the modern medical era by its dependence upon “technical expertise and a complex organization of treatments” (6). In the modern medical establishment, that includes traditional hospitals, doctors’ offices, diagnostic facilities, third party insurance companies, etc., the person becomes patient as she surrenders her care to paid professionals who deliver this care outside of the daily existence to which she is accustomed. She is held in sequestered spaces, written about on charts that she (usually) cannot read, and her experience is defined by the mass of information that is gleaned from biological testing and medical narratives created by her caregivers. In this sense, Frank sees the patient’s integration into the medical model as not only a bodily surrender but also as a narrative surrender (Ibid). Quoting Howard Waitzkin, Frank explains that the patient is called into an identity by the medical establishment and that the “good” patient assumes this subordinate “diagnostic” identity as appropriate (66).² Being a patient becomes another form of colonization: “Just as political and economic colonialism took over geographic areas, modernist medicine claimed the body of its patients as its territory, at least for the duration of the visit” (10). While “humanistic” models of care, as defined by Alisha Lenning,³ also include mental health care when it is

directly related to bodily care, there is still a general distrust of “any significant movement beyond observable, biomedical approaches to healthcare” (34). All of the performances discussed within this study fall within the humanistic modern medical model. Frank outlines the potential for disruption within this model by the insertion of the sociopolitical into the interaction between doctor and patient.

For the purposes of this study, I define disruption as interrupting or throwing a dominant discourse into question or confusion— oftentimes this is accomplished simply by making visible an assumption or power relation that was formerly “hidden” or naturalized. Visual art scholar Jean Dykstra argues that the instability of the ill body is itself a cultural disruption as it dissolves the false divide between life and death and wellness and illness (17). I examine the performances for disruptions in several categories: medical knowledge, which ranges from popular culture myths and notions about the role of the patient versus the doctor to specific medical discourse about a specific disease; norms of identity with a focus upon gender and sexuality but I acknowledge that they are inflected by race, class, education, etc.; and knowledge, focusing upon how information about patient experience is constructed, valorized, or devalued as an example of the ways in which different ways of knowing are subjugated.

The autobiographically based performances of illness experience in this study function as personal politicized testimony (Park-Fuller, "Performing Absence" 22) about traumatic experience and incorporate a variety of theatrical forms. Often requiring little technical or financial support, autobiographical performances of illness appear in coffeehouses, therapeutic settings, traditional theatres, and even academic conferences.

Stylistically the performances in this study range from presentational personal narratives, to productions with a pastiche performance art aesthetic, to a fully realized theatrical production.

Pointing to the fact that much of illness experience is considered “inappropriate” for the public realm, there are few performances to choose from and subsequently limited options for case studies. Thomas Couser examines the similar phenomena within illness narrative studies⁴ and points out that the narratives that do exist do not come from a broad spectrum of people. Couser’s research shows that most writers of illness narratives are white, upper middle class and well-educated. “When such people experience serious illness or disability, it jeopardizes an already valorized individuality. . . “ (4). While there is some racial diversity amongst the performance examples I have found, Couser’s educational and economic characteristics are reflected within the performance as well. I hope that in the future the accessibility and "poor theatre" aesthetic of performance can afford the possibility to hear a broader range of women's voices speaking from different positions of race, class, gender performance, sexuality, and disability. Fortunately, I was able to choose pieces that represented a range from chronic to acute events of illness which differ significantly in the time spent in medical establishments, degree of interaction with caretakers, and implications for long term affects on identity.

My project takes a materialist and poststructuralist feminist approach in that it works to undermine a monolithic universal category of identity by examining the complex and varied identity positions and alliances revealed through women's

representations of illness. Performance theorist and critic Jill Dolan offers a concise definition of the value of poststructuralism for feminist performance inquiry:

Poststructuralism simply questions liberal humanist notions that men or women are free individuals capable of mastering the universe and points out the way in which ideology is masked in commonsensical truth.

Poststructuralist performance criticism looks at the power structures underlying representation and the means by which subjectivity is shaped and withheld through discourse. (*Presence and Desire* 94)

Examining these performances for the composition of the "I" claimed through race, class, disability, sexuality, and gender reveals how the experience of illness changes conceptions of identity and also foregrounds the labor necessary to maintain normative performances of identity. As I investigate the technologies of representation and their ideological underpinnings, I am participating in a feminist “ . . . moving away from sociological analysis based in assumptions that theater serves a mimetic function for the culture into an analysis of representation as a site for the production of cultural meanings that perpetuate conservative gender roles” (Dolan, *Presence and Desire* 86).

Additionally this project includes a materialist perspective in that I am interested in discovering the very real physical effects of uneven gendered power dynamics on the bodies of ill women. Therefore, this study will continue to extend feminist autobiographical theory and identity studies by employing women's performances of illness to examine the ways in which normative identity discourse is shaped by and shapes technological discourses of medicine.

This project also participates in the furthering of a feminist concept of trauma. Scholars such as Judith Herman, Laura Brown, and Marie Root have defined trauma as inclusive of the insidious and repetitive catastrophic everyday events that permeate many women's lives.⁵ Previously within trauma studies the primary focus of scholarship lay upon large national and transnational events such as the Holocaust, September 11th, world wars, and other major world catastrophes. Through the lobbying of these feminist scholars of psychoanalysis the definition of trauma in the *Diagnostic and Statistical Manual of Mental Disorders* has been expanded from an event "outside the range of usual human experience" to "actual or threatened death or serious injury, or other threats to one's physical integrity" (Cvetkovich 18).

Ann Cvetkovich incorporates this feminist psychoanalytic definition into a cultural studies perspective on trauma in *An Archive of Feelings: Trauma, Sexuality, and Lesbian Public Culture* as she explores lesbian experiences of trauma as a "foundation for creating counter-public spheres rather than evacuating them" (15). Cvetkovich includes a variety of cultural expressions such as activism, female music fandom, visual art, and performance as she investigates "how traumatic events refract outward to produce all kinds of affective responses and not just clinical symptoms" (19). Cvetkovich's queer theory approach depathologizes trauma and its cultural products and allows for complex readings of the way in which affective expression permeates public culture. Her groundbreaking project further collapses the boundaries between the public and private, the political and the therapeutic, the internal and external, and the complex relationship between memory and history.

While specifically focused upon sexual trauma, Cvetkovich's frame aids me in framing performances of illness experience as expressions of bodily trauma, thereby creating an interpretive method that can unpack the cultural and collective aspects of a seemingly individual event. As Susan Sontag⁶ has noted, illness is often substituted metaphorically for trauma (ex. A cancer upon our country) while the actual event of personal illness escapes notice and theorization as an experience that resonates with culturally inflicted injuries beyond the physical suffering of the body. Arthur Frank writes in *At the Will of the Body*, "When the body breaks down, so does the life;" however, these two breakdowns are not always so biologically contingent (8). The breakdown of the body is the biological trauma, but the trauma that is bound in the social occurs when the ill body must traverse a world that is fundamentally unfriendly to its needs. It is the unspeakable and silenced experiences of illness including the isolation from "healthy" and "normal" life, the inability to discuss that pain and isolation, the laboring attempts and subsequent failure to maintain gender norms, and the relatively powerless status of patients within the medical establishment that all result in the further traumatization of the ill. The performances that I have chosen all function as records of the cultural trauma inflicted through isolation, identity crises, etc. while also serving as creative, complex, and performative working through of traumatic experience. I seek to position these performances as public interventions into the silence and "unspeakable" aspects of illness, rather than consigning them to the fetishized realm of "victim art".⁷

Rather than offering a purely textual analysis, this project's focus on women's autobiographical and performance scholarship can critique and elaborate upon existing

illness narrative scholarship by examining what Sidonie Smith has labeled "the drag of the body" (Smith, *Subjectivity* 17). The uncontrollable somatic material by which we encounter illness and life cannot be written out of performance; furthermore, the multiple registers of signification that operate in performance communicate affective and artistic expressions of knowledge. Trauma theory, feminist performance theory and feminist theories of autobiography and personal narrative offer a further intervention into traditional narrative analysis by allowing for gaps, silences, aporia, and dissonance.

Methodology and Review of Literature

The story comes, after the accident, to identify the body.

Craig Gingrich-Philbrook, "What I 'Know' about the Story"⁸

In constructing this methodology, I am guided by the image of an ill woman stumbling, slowly falling and collapsing on a stage. She lays bewildered and stunned until she carefully pulls herself together, looks around in uncertainty, gathers her breath, rises to her feet, finds the spotlight, and haltingly speaks of her experiences. I seek to weave together the variety of theoretical nets through which she plummets, becomes entangled, slows and breaks her fall with, and finally casts forward filled with the words, movements, and gestures to speak of her journey.

Grounding this study in a feminist understanding of the modern concept of trauma, I explore the invention of trauma in modern life, definitions of trauma, and the characteristics of traumatic narrative expressions. Feminist theories of autobiography and performance guide me in finding the disruptions of master narratives contained within these performances by articulating the ways in which women's performances and writings are speaking a female subjectivity that is in opposition to patriarchal discourse.

By examining the potentially subversive nature of the female body in performance, questioning traditional frames and methods of representation, these theories can illuminate the danger inherent in the "abnormal" female body standing on the ideologically loaded stage and attempting to speak her truth. Trauma theory further augments this work through its method for reading the "departures from narrative" the gaps, silences, and dissonance contained within many "unspeakable narratives." Finally, a blending of the theoretical frames of trauma, feminist autobiographical theory, and personal narrative scholarship all of which focus upon the performative nature of testimony, can fully explain the significance and potential of these performances as acts of witnessing to reformed identities and as complex critiques of the treatment of the ill female body. Since trauma is the overriding frame with which I approach the study, the following literature review links the theories of feminist performance theory, poststructuralist/materialist theories of the body as a site of identity formation, feminist autobiographical theory and personal narrative scholarship together as they intersect with the components of trauma theory. While I recognize there are multiple layers of overlap, I sequence the theories together in a performative explanation of how I apply them to the case studies.

The Body in Performance

. . . in solo performance (I would add autobiographical) the body of the performer emerges as the primary site of representation, interpretation, and consequentially, possible intervention (Roman 117).

I begin with the body as the site where trauma is perceived and the medium through which performance is transmitted. It is through the context of performance that a

body has the opportunity to speak for itself, to others, and in cultural conversation with larger power structures and groups that are not present at the event. Highlighting the telling and interpreting body through performance contextualizes the narrative “ . . . first in the voice and body of the narrator; second, and as significantly, in conversation with empirically present listeners; and third in dialogue with absent or "ghostly audiences" (Langellier, "Personal" 127).

The female body's powerful presence and political implication is explored in Lynn Miller and Jacqueline Taylor's introduction to *Voices Made Flesh: Performing Women's Autobiography*:

The historical denials of women's agency, authority, and subjectivity, and bodily integrity combine with the centuries in which women were denied access to the stage and even to public speech to provide the backdrop for these contemporary performances . . . Women can now speak publicly and perform, but they do so, still against considerable odds. (5)

Heather Carver notes in "Risky Business: Exploring Women's Autobiography and Performance" “. . . that a woman's ownership over the telling of her story coupled with the embodiment of that story through a public staging is still a radical and intervening act of agency.” (15). Since the 1970s, a proliferation of solo female artists have used the body as a means of articulating the personal as political and resisting dominant culture by illuminating the links between individual pain and societal structures. Theatre scholars Elaine Aston and Geraldine Harris note how the female body in performance has become “. . . a screen for, ‘writing’ histories of gender oppressions and for the possibility of

‘speaking’ the feminine: marking present tense (lived) oppressions with the desires, the longings for lives lived differently; beyond the unequal social realities conditioning women’s lives” (5). According to Jeannie Forte, woman as speaking subject within a traditionally repressive frame calls into question numerous discourses. The speaking sexual woman relating experiences significantly at odds with her *representation* within the sign system of patriarchy creates a disruptive and resistant dissonance (260).

In pulling herself to her feet on the stage, the ill woman must untangle the language that has failed her, and find a means of capturing a piece of a piece of an experience that is unstoried. Weeks, months, years of trauma must be packed into an hour or two using poetry, dance, music, any means necessary, and sometimes silence. In performance even silence gives voice to the body as the performer continually speaks with or without language. These women performatively reclaim their narrative authority, an authority that is often taken from them by modern medicine. They refuse to become a monolithic “diagnostic” identity that partitions them into lumps of flesh to be treated, and they disrupt notions of what is appropriate expression for a woman in public.

As numerous scholars have pointed out, there is no one definition of woman that can be employed as an analytical frame, but rather there are multiple ways of configuring women, all inflected with race, sexuality, class, and bodily ability. Within patriarchal discourse, all female bodies to some extent share the limiting definition of selfhood as equivalent to biology. This definition situates the penetrable fleshy female in binary opposition to the bounded independent male. Sidonie Smith employs Judith Butler's explanation for the creation of this definition:

Consolidation of hegemonic identities requires the consolidation of the essentialized identities of the others, of all the abject, with the effect that, 'the body rendered as Other – the body repressed or denied and, then projected reemerges for this 'I' as the view of others as essentially body.'
("Identity's Body" 268)

Compounding this gendered overembodiment, medical discourse constructs sickness by partitioning a woman's body into parts containing symptoms and parts receiving treatments. How do these performances of illness experience function as a struggle for agency and voice against such powerful and silencing cultural discourse? How does the well body speaking experiences of illness disrupt notions of a stable and fixed self? How does performance further this splintering of identity? As Kristin Langellier theorizes, even as the performed personal narrative fixes the identity in the moment, the multiple registers of performance, such as sound, movement, text, bodily marking, and costume, fracture and multiply any particular interpretation ("Personal" 193). The multiple registers of performance thus echo the multiplicity of subject positions struggling for voice within the individual.

The concept of bodily integrity becomes a questionable marker when the performer's body carries traces and scars of illness, surgery, debilitation, etc. As Disability scholar Denise Riley points out the body is "an unsteady mark, scarred in its long decay" (224). As Susan Sontag cogently reminds us: "Everyone . . . holds dual citizenship, in the kingdom of the well and kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to

identify ourselves as citizens of that other place” (3). Disability scholar Rosemarie Garland-Thompson has written extensively about the potential for illness and disability to bring into focus the cultural belief that the body is somehow the “unchanging anchor of identity” and that disability can effectively undermine “our fantasies of stable, enduring identities in ways that may illuminate the fluidity of all identity” (“Integrating Disability” 11). Even when the performer is in an able-bodied state that reassures the audience of stability, these performances of traumatic illness experience are shadowed by the ill and disabled body.

How do performers traverse and narrate the experiences of the body, how are its scars, wounds, and pains marked as tools for contradicting and reinforcing grand narratives of medicine and gender identity? As performer and theorist Tami Spry writes, “The performing body offers a thick description of an individual's engagement with cultural codes and expectations; it is an ancient scroll upon which is written the stories of one's movement through the world” (“Illustrated”, 170). As Robbie McCauley, an African American performance artist in her early sixties, raises her shirt and injects insulin into her bare stomach, as she talks calmly about a diabetic’s need to understand chemistry while she chews a bite of avocado sandwich, what norms of identity is she visually defying? As Brandyn Artis, an African American actor and writer, embodies her white male oncologist’s reaction to her refusal of chemotherapy, what master narratives of medicine and knowledge does she undermine? When Deb Margolin performs “Mother”, her autobiographically based white Jewish protagonist in *Three Seconds in the Key*, she literally and figuratively borrows strength from the body of a New York Knicks

basketball player. How does she performatively shatter our conceptions of the bounded individual body? How does performing the piecing together of painful memories bring forth the trauma of illness and care differently than a traditional illness narrative? In the following section, I trace the history of trauma as a modern concept and the role of feminists in expanding its definition.

Trauma: Historical Construction and Feminist Expansions

As James Berger writes, according to nineteenth century medical anthropologist Allan Young, trauma literally means “the wound,” not only a physical wound but also a psychological wound. Developed by Sigmund Freud, the concept of trauma has become central to modern psychoanalysis and holds a position of growing importance in cultural studies. During the last twenty years the concept of trauma has been used as an interpretive methodology for global and national catastrophic events. Recently feminist scholars of psychoanalysis and culture have expanded the definition of trauma to include the insidious everyday events that mar many women’s lives, while also employing trauma as a means of linking individual pain with repetitive cultural patterns. All traumatic events, global, local, or individual share certain characteristics, the rough outline of which begins in Freud’s three works, *Studies in Hysteria* (1895), *Beyond the Pleasure Principle* (1920), and *Moses and Monotheism* (1938) (Berger).

Freud’s concept of trauma is built upon the premise that modern life itself is traumatic to human beings. He outlined three discoveries that collectively shattered the pre-modern conception of humans’ place in the universe. The initial trauma was the Copernican revelation that the Earth “is but a tiny fragment of a cosmic system of

scarcely imaginable vastness” (Kaplan and Wang 3). This was followed by the formulation of the theory of evolution, and the realization that the great God-like man was a descendant of a monkey. Finally the creation of psychoanalysis undermined the possibility of complete understanding and comprehension of human nature, when the ego was defined as not being a “master of its own house” and holding little ability to know its own nature (Ibid).

In *Studies in Hysteria*, Freud defined trauma as “an overpowering event- that is unacceptable to conscious” (Berger). Because the event is unacceptable to the psyche, it is repressed without being processed, causing it to recur in somatic symptoms such as nightmares, phobias, and flashbacks and repetitive self-destructive behaviors. In *Beyond the Pleasure Principle* Freud explored this idea with soldiers traumatized by WWI who were experiencing recurrent symptoms. Explaining the self-destructive behaviors as a death drive that was formed by the biological urge towards equilibrium, or a return to a pre-life status of quiescence, Freud ultimately disregarded the traumatic event and named instinctual drives and desires as the culprit for the symptoms. Freud returned to the concept of trauma and further developed the characteristics of latency, or the delay in the onset of symptoms, in *Moses and Monotheism*. In this work, Freud is looking for a “...theory of trauma that would account for the historical development of entire cultures” (Berger). He acknowledges that the period of symptom manifestation is often triggered by a new traumatic event; however Freud never reconciles to himself to the idea that it is the traumatic event that causes the symptoms rather than a repression of instinctual drives (Ibid).

Current scholars of psychoanalysis and cultural studies have furthered Freud's concept of trauma as a method for reading post-modern catastrophes. Feminist theorists such as Judith Herman, Laura Brown, and Ann Cvetkovich have expanded not only the definition of trauma, but also the application of trauma theory to cultural analysis. Laura Brown explicates and furthers Marie Root's theory of insidious trauma by expanding the definition to include the "...traumatogenic effects of oppression that are not necessarily overtly violent or threatening to bodily well-being at the given moment but that do violence to the soul and spirit" (107). Brown pushes for an understanding of trauma that includes the "secret, insidious" dangers that permeate women's lives; through such an inclusion she points out the dominant cultural definition of pain – one that includes war and torture, but eclipses experiences such as incest, and spousal abuse. Her analysis of the exclusion of many women's trauma foregrounds the fear inherent in acknowledging insidious everyday trauma; she also notes how this exclusion has shaped what is valued as "real pain" (102). Her project forces "...a spotlight on the subtle manifestations of trauma... We are forced to acknowledge that we might be next. We cannot disidentify with those who have already been the victims of a traumatic stressor when we hold in consciousness our knowledge that only an accident may have spared us this far" (108). Such an acknowledgement implies that we can no longer attribute a rampant cultural pattern to the action of isolated individuals. We must recognize the links between individual experiences of trauma and systems of oppression.

Feminist definitions of trauma include the experience of illness as well as the contingent insidious trauma often caused by interactions with care-givers, family

members, and the larger cultural institutions that often make the world a dangerous and isolating place for the ill body. Rather than focusing upon how one person copes with the breakdown and subsequent treatment of the body, feminist definitions of trauma look for the overarching factors that perpetuate systems of pain and isolation. Feminist conceptions of trauma, and the structures and characteristics of traumatic expression, function as signs alerting me to the patterns that may exist across the performances and across the experiences. Uncovering these patterns reveals the varying ways in which normative identity and medical discourse are complicit in furthering the trauma of illness.

Trauma: Structure and Representation

As I work within a feminist definition of trauma, Cathy Caruth's influential writings detail the structure of traumatic experience and characteristics of traumatic expression. As Caruth defines trauma, "the pathology consists rather solely in the structure of its experience or reception, the event is not assimilated or experienced fully at the time, but only belatedly, in the repeated possession of the one who experiences it" (Caruth, "Trauma and Experience" 4). This possession occurs through somatic symptoms of flashback, nightmares, repetitive self-destructive behaviors and is in part due to the destruction of language and consciousness caused by the overwhelming nature of the event. With the breakdown of language and systems of representation, traumatic events are silenced and lack historical witnesses. It is an experience that is "filled with affect but not with meaning" either symbolic or referential (Kaplan and Wang 5). It is "engrained on the body" but lacks a method of processing (Ibid). When a stuttering attempt at accessing traumatic experience occurs, it carries within the expression the

belatedness of historical experience since the trauma event is not experienced as it occurs; it is fully evident “only in connection with another place, and in another time” (Caruth, “Trauma and Experience” 7). Accounts of trauma are often characterized by disjointed stories, a lack of full understanding, cognitive dissonance, silences, and gaps. For Caruth, this amounts to an utter unknowability of trauma, an inexpressible gap between the event and its narration, that results in continual misinterpretation and misrepresentation as the event can only be known through another event (Ibid).

While Caruth is interested in the ways in which the “wound becomes voice” and how trauma functions as an instigator of historical narrative, she ultimately cautions that “the transformation of the trauma into a narrative memory that allows the story to be verbalized and communicated, to be integrated into one’s own and others’ knowledge of the past, may lose both the precision and the force that characterizes traumatic recall” (Caruth, “Recapturing” 154). If trauma escapes the existing methods of representation, what happens when attempts are made at its reintegration into the symbolic? E. Ann Kaplan and Ban Wang summarize the dangers as two-fold. The most insidious cultural outcome can be the “aestheticization of politics” or the modern state’s ability to co-opt trauma narratives into redemptive stories of self-representation (Kaplan and Wang 10). In this situation trauma, both personal and cultural, becomes a plot for a narrative happy ending, for the suffering in the service of an “ultimate good” storyline. Secondly, traumatized cultures can become spectacles for entertainment (Ibid). In this instance, exoticization and a flattening of difference occur to other-ize the traumatized into examples of “regressive episodes in human history” (Kaplan and Wang 10). Within both

of these potentially negative scenarios there is no room for aporia and dissonance, the very cognitive and social structures that characterize trauma (Kaplan and Wang 12). Implicit within these potential pitfalls is the argument that silence itself can become a witness for trauma, perhaps more effectively than a narrative.

Kaplan and Wang ask, if silence is the only appropriate response, how does trauma not land squarely in the “land of the occult” and continue to be mystified, unspeakable, and “evacuated” as a tool for critical inquiry (8)? How can traumatic events be remembered, recovered, and utilized as a methodology for interpreting not only individual experiences but also cultural events? They answer that trauma can be used as a method for understanding catastrophe by historicizing its invention and causes as man-made. Therefore, trauma becomes a phenomena that “... can be understood and altered by self-conscious human acts” (Kaplan and Wang 13). As I examine performances of illness experience, this understanding implicates the presence of characteristics of traumatic expression as evidence of the harmful effects of specific interactions with medical caregivers and institutions.

Cathy Caruth has alluded that perhaps trauma demands new communication methods, “that historical truth may be transmitted in some cases through the refusal of a certain framework of understanding, a refusal that is a creative act of listening” (Caruth, “Recapturing” 154). Accounts may contain gaps, silences, instances of aporia, expressions of cognitive dissonance, and a continual leaving or avoidance of the site of trauma. Ann Cvetkovich explores this structure in Lisa Kron’s performance work *Two Minute Ride*. Kron’s account of her visit to Auschwitz with her father who was

imprisoned there does not follow a simplistic plot pattern. Instead, it constantly veers away from closure and sentimentality to keep the audience aware of its own inexpressibility, thus performatively inviting the audience to experience the vicissitudes of trauma (Cvetkovich 23). Kaplan and Wang theorize that the creation of innovative and creative responses, born of the imagination, are necessary to recreate a self-image, to “re-assert the non-traumatic relation between human action and the world, individual and public life, one nation and another” without the collapsing of difference amongst experiences of trauma (Kaplan and Wang 13). While all scholars who examine trauma agree on its exact referential unknowability, there are many who look for possible models or methods for readings of traumatic narratives that will not eclipse aporia and dissonance, but rather embrace these as essential aspects.

Examining the dehumanization inherent within the traumatic events of war and torture, Elaine Scarry’s *The Body in Pain: The Making and Unmaking of the World* explains how bodily pain escapes the referential capacity of language. This inexpressibility and unprovability create doubt in the mind of the torturer and allow for the continuation of torture and war. While Scarry argues that pain deconstructs language, she also points out that it does not escape imagery. In discussing Scarry’s work, Kaplan and Wang note that, “...trauma is not something that representation falls short of, not the absolute undoing of the symbolic. On the contrary, trauma intensified the urgency of re-symbolization and reveals the bankruptcy of the prior symbolization” (14). Trauma in effect, screams for new cultural objects of expression. Accounts of pain are a “struggle by the wounded body to first imagine and then create a less traumatic, less painful

environment” (Kaplan and Wang 13). Furthermore, attempts at traumatic representation work to bring the trauma into the community- to “close the gap between private trauma and the community’s attempt to redress that trauma” (Kaplan and Wang 12).

Trauma Structure and Representation: Links to Feminist Performance

Theory and Practice

In this study I position women’s performances of illness experience as public expressions that explore traumatic experience while bringing it into the community. Often created years after the illness, these performances are stuttering attempts to make sense of unthinkable catastrophic events. They are unique cultural and artistic expressions that do not rely upon traditional theatrical or narrative structures because they are collages of experiences filled with contradictions. Conversant with such dissonant narratives are feminist postmodern performance styles⁹ and feminist theories of performance that offer frameworks for reading representation and the mechanisms of the stage, screen, and text without assuming neutrality, transparency, or the ability to convey a unified meaning. Ann Cvetkovich acknowledges this link between “performance art and testimony in terms of a shared desire to build culture out of memory” (26). Jill Dolan defines a postmodern performance style as one “that breaks with narrative strategies, heralds the death of unified characters, decenters the subject, and foregrounds the conventions of perception” (88). This list could also be given as the characteristics of the expression of traumatic experience.

Feminist performance scholar Elin Diamond’s work around understanding historicity and Marxist theatre practitioner Bertolt Brecht’s theories as a deployable strategy for

feminist performance can also be valuable for examining expressions of traumatic experience. Brechtian performance constructs both points of identification and moments of alienation for spectators, thus forcing them to oscillate uncomfortably between empathic submersion and distance from the performance. The ultimate goal of this strategy is to activate audiences by creating dialogue within the individual spectator as well as within a larger community. Diamond's work speaks to the manner in which feminist performance can employ Brecht in order to defamiliarize gender.

When gender is "alienated" or foregrounded, the spectator is enabled to see a sign system as a sign system – the appearance, words, gestures, ideas, attitudes, etc., that comprise the gender lexicon become so many illusionist trappings to be put on or shed at will. Understanding gender as ideology – as a system of beliefs and behavior mapped across the bodies of females and males, which reinforces a social status quo – is to appreciate the continued timeliness of *Verfremdungseffekt*, the purpose of which is to denaturalize, and defamiliarize what ideology makes seem normal, acceptable, inescapable. (47)

In this way, the performer never “disappears” into the character in a conventional theatrical way but constantly remains doubled to make the modes of production, or the ways in which meaning is made, highly visible. This double movement can also reveal the connections between memory and the present, thus illuminating the latent gap that the performer is attempting to access in expressions of trauma.

There is a double movement in Brechtian historicization of preserving the "distinguishing marks" of the past and acknowledging, even foregrounding, the audience's present perspective. When Brecht says that spectators should become historians, he refers both to the spectator's detachment, her "critical" position, and to the fact that she is writing her own history even as she absorbs messages from the stage...In historicized performance, gaps are not to be filled in, seams and contradictions show in all their roughness, and therein lies one aspect of spectatorial pleasure – when our differences from the past and within the present are palpable, graspable, applicable. (49)

In performances within this study, this technique may look like the use of humor to break deeply emotional moments and resist catharsis, direct address to the audience following scenes in flashback, or the juxtaposition of song with social commentary. Through this technique feminist performance holds the possibility of showing the cobbled together and process-oriented nature of creating expressions of traumatic experience.

Trauma: Working Through and Transference

Dominick LaCapra's work *Representing the Holocaust: History, Theory, Trauma* focuses upon Holocaust representations as expressions of traumatic experience that have entered the public realm as attempts at community redress. LaCapra's conception of trauma's representation in history is characterized by the discursive return of the repressed, "acting out" versus "working through," and centers around the implications for the psychoanalytic dynamics of transference (64-5). LaCapra's working through

involves exploring the difficulties in accurately reconstructing the past and the possibilities of creating a performative dialogic exchange with the past (Ibid). While acting out "...is a melancholy possession of the subject by the repressed past...working through is an attempt of breakout, not by completely freeing oneself from the trauma, but in facilitating the subject's freedom" (Kaplan and Wang 6) through a process of transference. He examines the differences between acting out and working through while avoiding any overly simplistic form of narrative closure. It is transference, the intentional and concentrated return of the repressed in a therapeutic setting, that allows for "a measure of critical purchase on problems and responsible control in actions which would permit desirable change" (as qtd. in Kaplan and Wang 6). As with Kaplan and Wang, the creation of new representations, or cultural objects, can serve as evidence of the transference. Within this study, the performances can be configured as attempts at transference.

In *An Archive of Feelings: Trauma, Sexuality, and Lesbian Public Culture*, Ann Cvetkovich examines cultural objects as examples of the creation of public culture as she looks for the ways in which "traumatic events refract outward to produce all kinds of affective responses and not just clinical symptoms" (19). Cvetkovich begins with the feminist conception of insidious trauma, as outlined by Brown, Root, and Herman and adds an expanded notion of citizenship and cultural participation to reposition lesbian cultural expressions of trauma as a means of animating rather than evacuating the public sphere. While acknowledging the work of feminist psychoanalyst Judith Herman as foundational within trauma studies, Cvetkovich takes issue with her heavy reliance on the

scientific and medical models of individualized treatment (31). She also critiques Herman's conception of trauma as a "discovery rather than an invention," meaning that Herman does not view trauma as a symptom of late capitalist culture but rather naturalizes it as a phenomenon that has been discovered. Cvetkovich also disagrees with Herman's implicit flattening of differences within various traumas through the focus upon an overarching model for symptoms and treatments. Cvetkovich resists the overarching model and calls for a move away from the Post-Traumatic Stress model of individualized therapy towards a more complex understanding of the societal implications and causes of trauma (33).

Cvetkovich takes a larger cultural view by expanding the definition of civic participation to include the cultural products of trauma such as "testimony ... new forms of monuments, rituals, and performances that call into being collective witnesses and publics" (7). Rather than evacuating public participation, which is the assumed outcome with events that leave no witnesses, Cvetkovich unearths an "archive of feelings" held within numerous examples of public cultures created by lesbians. She writes,

My goal is to suggest how affect, including the affects associated with trauma, serves as the foundation for the formation of public cultures. This argument entails a reconsideration of conventional distinctions between political and emotional life as well as between political and therapeutic cultures. (10)

She argues for recognition of the ways in which "affective life can be seen to pervade public life" (Ibid). Through her examination of cultural expression such as performances,

rock music fandom, and visual art, she recontextualizes the public arena and expands the notion of participation within it while illustrating trauma's ability to ripple outward rather than remain silent and unwitnessed (19).

An understanding of the symptoms, structures, and the potential pitfalls and possibilities of traumatic expression illuminates moments when women's performances of illness experience gesture towards new configurations of meaning. How do performer's point out and make present the event lived through, the inexpressible and unthinkable degradations of the body and spirit, and her overcoming/incorporating/forgetting of these experiences? This can be found through a reading across the use of the voice, the body, and the scripted words as an expression that makes public the private pain. This revelation reminds us that the pain and isolation of illness are not private, that they are in fact a public phenomenon created by our cultural structure.

Trauma: Witnessing to the Self

Within the relaying of traumatic narrative there are several levels of witnessing as outlined by Holocaust Studies scholar Dori Laub and English and Holocaust Studies scholar Shoshana Felman. These include witness to oneself within the experience, witnessing to the testimony of others, and witnessing to the process of witnessing (Laub 63). The testimony of traumatic narrative is inherently a performative speech act, and the teller produces "one's speech as material evidence for truth" (Felman 17). Testimony becomes the emergence of personal truth in a crisis, and as Felman writes that testimony cannot be transferred or "relayed, repeated, or reported by another witness" or it loses its

ability to function as testimony (Felman 15). Testimony becomes a performative communication by escaping its solitude in the presence of a witness, who may be both speaker and listener (Ibid). Identity is affirmed and re/created through the act of witnessing. “The witness is the *medium of the testimony* and also a *medium of the accident* (Felman 31). Because there is a temporal delay in the events narrated, and a cognitive inability to correlate words that do the event justice, the witness is always caught between the need to speak and the utter inability to tell the story completely. Therefore testimony does not offer “a totalized account” of the events (Felman 16).

For Laub, the act of telling allows one a way through “one’s own truth” to a degree of knowledge about unspeakable events.

What ultimately matters in all processes of witnessing, spasmodic and continuous, conscious and unconscious, is not simply the information, the establishment of the facts, but the experience of *living through* testimony, of giving testimony. The testimony is, therefore, the process by which the narrator (the survivor) reclaims his position as a witness: reconstitutes the internal “thou,” and thus the possibility of a witness or listener inside himself. (70)

The narrator/survivor only knows her truth through the testimony, the act cannot be separated from the identity and truth claimed. The act of testifying and its transformation into an act of witnessing function as a sort of signature – an affirmation of life in the face of events that attempted to erase life (Felman 53). While Laub and Felman are theorizing Holocaust survivor’s testimony, I employ their work to suggest that performances about

traumatic illness experience performatively reassert the woman's humanity and return to the social body.

Felman further articulates the need to testify as an examination of the wound, and an exploration of the injury that caused it. The wound becomes the site of accessibility to the "darkness that the language had to go through and traverse in the very process of its "frightful falling-mute" (Felman 34). The witness must examine the site of the loss of language in order to recover the event, or a piece of the event, or pieces of the event, in order to be able to move beyond the very muteness that was symptomatic of the trauma (Felman 53). It is the story of the survival of the story that marks testimony (Felman 47).

Sometimes the witness has prepared and thoughtfully assembled the testimony, and other times a compulsive need drives the witness to testify before he/she appears ready – in this case the witness becomes what Felman calls a "precocious witness" (29). Testifying in poetic language the precocious witness speaks prior to full consciousness and helps break through "...limits of its own conscious understanding" (Felman 30).

By its very innovative definition, poetry will henceforth speak *beyond its means*, to testify – precociously – to the ill-understood effects and to the impact of an accident whose origin cannot precisely be located but whose repercussions, in their very uncontrollable and unanticipated nature, still continue to evolve even in the very process of testimony. (Ibid)

The concept of precocious poetic witness is helpful in understanding performances that employ songs, poems and other non-linear communication methods.

Precocious witnessing serves as an artistic form of action and a means of moving through trauma. Even if an experience is ultimately repressed after testimony it is still potentially formative (Laub 70). As a means of moving through trauma, the internal and external dialogic process of witnessing thus explores and reconciles the world of the past and the world of the present. It is “inherently a process of facing loss- of going through the pain of the act of witnessing, and of the ending of the act of witnessing- which entails yet another repetition of the experience of separation and loss” (Laub 74). Cvetkovich examines the contingent ambivalence of witnessing, on both the narrator and audience’s part. The witness both fears and longs for the fulfillment of the “melodramatic fantasy” - that someone will finally be heard and validated; however, such validation implies a closure that trauma does not allow (Cvetkovich 28).

Witnessing through Performing Personal Narrative, and the Reconfiguration of Identity

The potential for performance, and specifically the performance of personal narrative, to serve as a medium for testimony and witnessing has been theorized by Performance Studies scholars. I layer that theorization with the work of trauma studies scholars as a basis for this study. Because much of the feminist scholarship within Performance Studies stems from feminist work within autobiography, I also incorporate theories of autobiography when they refract and reflect upon the work under discussion. This dissertation illuminates possibilities of agency for both the performer, by a public re/covering of self, and for the audience, through the storytelling's outward ripples into formations of community and support. Performance Studies scholar, Linda Park-Fuller

posits the speaking of the "self" foregrounds not only "the struggle disclosed (the narrated event), but also the struggle to tell (the narrative act)" ("Performing Absence" 24). The speaking of the self "enable(s) a re-appropriation of voice and reconstitution of self" (Park-Fuller, "Performing Absence" 21). For marginalized groups, such as ill women, speaking the personal narrative thus becomes a "struggle for agency" (Langellier, "Performance" 129). Speaking the self can rewrite stories that have been silenced or distorted, and can show the self and the audience possibilities for a better world (Park-Fuller, "Performing Absence" 26; Taylor, "On Being an Exemplary Lesbian"). Inherent within speaking a self is the implication that the performer, by affiliation, also speaks or testifies for others who have been silenced. The speaking of pain, humiliation, illness, and other private experience forces into the public a dialogue usually disclosed only to personal loved ones. This changes the dynamic of the public by remaking what may be spoken, and what bodies may speak. This can elicit what Park-Fuller calls the "Canterbury Effect" or the telling of similar stories by listeners, thereby creating the possibilities for the formation of communities that serve both therapeutic and political ends ("Performing Absence" 26).

In Performance Studies scholarship the use of personal narrative as a research methodology has gained prominence in ethnographic studies-- the study of performing biography-- and the performance and theorization of one's own autobiographical stories.¹⁰ The performance of one's own personal narrative and the theorization of the telling entered the Performance Studies scholarly dialogue in the late 1980's and garnered both recognition and criticism. I draw upon the theoretical implications of what Park-Fuller

defines as “ . . . the autobiographical staged personal narrative in which the autobiographical material performed is not collected from others and embodied by the performer, but is, rather, the performer's own story” (“Performing Absence” 21).

Personal narrative scholarship has not been unequivocally embraced. Critiqued as confessional and lacking self-reflexivity, scholars have questioned its “ethical ambiguity and valuing of the victim” (Benton as qtd. in Park-Fuller “Performing Absence” 21). In addition, some scholars question the Liberatory nature of speaking experience within “existing structures of domination” (Langellier, “Performance” 129). As Linda Kaufman questions, “ . . . writing about yourself does not liberate you, it just shows how engrained the ideology of freedom through self-expression is in our thinking” (qtd. in Langellier, “Performance” 135). Darlene Hantzis questions the “critiquability” of personal narrative since “experience is something *one* has” (205). Hantzis further questions whether or not the turn to the personal is merely an unwillingness to engage with the concept of “other” and a retreat into a place of speaking only personal knowledge (Ibid). According to Hantzis, this knowledge of the personal winds back upon itself to posit a knowable self that effectively “mutes the critique of its own production” (Ibid). From a feminist perspective Hantzis reminds performance scholars that “Teresa deLauretis cautioned almost a decade ago against the slippage of ‘the personal is political’ into an equation rather than an interanimation” (203). How can the telling of the personal possibly function as more than one person's “truth”?

Kristin Langellier counters these critiques by employing the concept of performativity and by calling for performances that engage the difficulties of difference

("Voiceless" 210). Langellier insists that viewing performance of personal narrative as performative, or constitutive, of cultural critique and struggle(s) for agency of either the individual or the group spoken "with" or "for" removes the work from the realm of the merely personal. To make this point Langellier quotes Elin Diamond,

A performance, whether it inspires love or loathing, often consolidates cultural or subcultural affiliations, and these affiliations might be as regressive as they are progressive. The point is, as soon as performativity comes to rest on a performance, questions of embodiment, of social relations, or ideological interpellations, of emotional and political effects, all become discussable. (qtd. In Langellier, "Performance" 130)

Performativity gives the performance of personal narrative a "theory of power" for dialoguing with questions such as who can speak, in what contexts, with what consequences, to whom, using what narratives and texts, etc. (Langellier, "Performance" 135).

In foregrounding performativity as a method of critique, Langellier offers three caveats for the future of personal narrative scholarship. First, she asks that performance be politicized by identity in "its embodied and material specificity – its problems *and* its privileges" both of which should be destabilized in performance (Langellier, "Voiceless" 210). Second, she challenges scholars and performers of personal narrative to "problematize the audience and the situation" and to consider how a text changes as the consuming audience differs (Langellier, "Voiceless" 211). She asks that we question how the consequences change, who is listening and how they are positioned. Finally,

Langellier calls for the production of knowledge about personal narrative. She reminds us the performance is not “an end in itself,” but should raise larger questions regarding the relationship of “...personal politics to the body politic [and] of individual anatomy to cultural anatomy” (Langellier, "Voiceless" 211).

Performatively, the performed personal narrative functions as both a political and artistic testimony. Linda Park-Fuller positions the telling of the personal as testimony in the sense that it brings to life an absent event; it identifies the trauma that has gone before. This "getting a life" that occurs through the telling of personal stories allows for the voice of the individual to reclaim and rename the self, speak an individual's truth, and to speak both for others, and with an audience. This "enabling fiction" (Spry, “Performative” 255) posits the concept that one(s) life does signify. As Miller and Taylor acknowledge in their introduction to *Voices Made Flesh: Performing Women's Autobiography*:

Creating an autobiographical narrative reconstitutes the self, the audience, the surrounding cultural contexts. It makes sense of the self, gives each part a voice and a body. We can safely say that until a life is shared through writing or performance, it does not exist at all, or at least it does not resonate in the broader realm of public consequence. (3-4)

Personal narrative can function as a “... transgressive political act without repentance. It is an artistic declaration of personal experience given by a witness despite constrictive taboos” (Park-Fuller, "Performing Absence" 22). Through such testimony, personal narrative can counter a dominant narrative and become a political taking of sides.

Witnessing to Others: Personal Narrative, Trauma, and Context

The crafting of the personal narrative performance must take into account not only the context but also the consequences of the telling within the context. Through these conscious choices the performance becomes performative, or constitutive, of a larger dialogue, one that resonates through the bodies present and that can also function metonymically as an embodiment of cultural conflict and identity formation "producing and reproducing that to which it refers" (Langellier, "Performance" 125). As Langellier writes: "Here personal narrative is a site where the social is articulated and struggled over" ("Performance" 128).

When the personal narrative includes expressions of traumatic experience, E. Ann Kaplan and Ban Wang delineate four possible audience configurations for the witness. The first three possibilities have negative results. A viewer or listener can be introduced to trauma through a narrative fetishized with closure; seamed up into a Hollywood ending that makes cohesive narrative sense of the event. The second position, that of the vicariously traumatized, creates a negative association within the viewer and causes a turning away from the event – a denial of the authenticity or bearability of the event; however, Kaplan and Wang admit that this positioning could also “productively shock” audiences into action. The third position is perhaps the most culturally dangerous and creates the voyeur viewer who is routinely subjected to images of atrocity on nightly news, etc. resulting in a “dangerous pleasure in horror” (Kaplan and Wang 10). The fourth and final position that Kaplan and Wang delineate positions the viewer as co-witness to the traumatic narrative. There is the possibility that this position of

responsibility, “may open up a space for transformation of the viewer through empathic identification without vicarious traumatization – an identification which allows the spectators to enter into the victim’s experience through a work’s narration” (Kaplan and Wang 10). This position is achieved by infusing the audience with a sense of responsibility while resisting narrative closure.

When the viewer/listener becomes a co-witness, the viewer becomes the point of communication for the traumatic event and “may promote inter-cultural compassion and understanding (Kaplan and Wang 10). Laub asserts that this encounter frees the narrator from the sole responsibility of bearing the event and “makes possible something like a repossession of the act of witnessing” (69). Together the narrator and audience create an emergent truth, a truth found in the moment of its speaking (Ibid).

Examples from the Field of Performance Studies: HIV Narratives in Performance and Narratives from Adolescents with Cancer

Personalizing the already highly politicized health issue of HIV and AIDS was the focus of a 1993 conference that explored the use of personal narrative as a tool for HIV Education. Co-hosted by Arizona State University and the Center for Disease Control, the conference was attended by many of the leading scholars on personal narrative, and the proceedings were collected by ASU professor Frederick Corey. Focusing upon both ethnographic and autobiographical personal narrative performance, the volume includes a theoretical contextualization section, essays on the composition process, performance texts, and a concluding essay that raises future issues for the use of personal narrative in HIV education. Several points within the collection resonate with my study. Joni Jones

reminds me to question the framing arch of the proscenium for what dialogue it invokes and forecloses (“Personalizing” 23). She also cautions the framing of illness discourse within a white paradigm that excludes African American cultural knowledge and mythology (“Personalizing” 28). Della Pollock et al. caution me on the framing of knowledge through the “infectious” discourse of medical terminology (125). In this vein, Kristin Langellier’s essay points to the potential for personal narratives of illness to claim a partial “native view,” or patient perspective (“Personal” 181). Resisting a facile solution to HIV/AIDS education, this volume stands as a performative polyvocal investigation into how we know what we know about HIV/AIDS and the incredible difficulty of shifting dominant discursive constructions.

Implicit within the Corey volume are several concepts for my own study, such as the importance of engaging context and consequence for each performer and performance. How does the performer create access to speak? How does she strategically align herself with other bodies both corporeal and discursive? Through, with, and against which master narratives is she speaking? These questions also aid me in analyzing the variety of settings and audiences included within women’s performances of illness. They also remind me to continually delineate the degree of risk engaged by each performer as she creates a representation of a taboo experience.

Marc Rich’s work with autoethnographic personal narratives from adolescents at cancer camps illustrates the damaging consequences for the patient who lacks a witness and consequently becomes medically overembodied, or identified solely by medical discourse and its configurations of treatments and symptoms. Positioned as “secondary

characters” within their own lives, adolescent cancer patients become conglomerations of physical symptoms narrated by the heroic oncologist's medical knowledge (136). Rich argues that teenagers with cancer are not allowed to be viable narrators of their pain experiences.

Rather than focusing upon the youth's accounts of pain levels, oncologists continually frame pediatric cancer pain as "minimal." After recording and transcribing in-depth personal narratives from teenagers with cancer, Rich agrees with Elaine Scarry's assessment that "physical pain does not simply resist language but actively destroys it," while he continues to look for the signification of pain through gaps and repetition within the accounts. Through a careful parsing of language, he shows how the repetition of phrases such as "living hell," "this unbelievable headache," "you know," and "it was like maybe", “. . . clearly indicate that if the pain associated with cancer and its treatment resists language and interpretation, it nevertheless dominates consciousness” (135). Finally, Rich points out the discrepancy between the medicalized accounts of pain and the experience of pain as revealed through the patients' accounts. Rich's work functions as a cautionary tale against a purely celebratory approach to personal narrative; the telling in and of itself is not necessarily configured as disruptive or progressive and can possibly have negative consequences for the performer.

Chapter Overview

Chapter Two: Robbie McCauley's *Sugar*

This chapter foregrounds the work of renowned performance artist, teacher, and activist Robbie McCauley with a focus upon her new autobiographically based work *Sugar*, the latest in a series of “works in progress.” This piece exposes the difficulties and challenges of living as a diabetic African American female. *Sugar* reflects much of McCauley’s performance aesthetic and performance history, and is uniquely representative as a blend of personal narrative based solo performance art and community based theatre. For the purposes of this study, *Sugar* intervenes as a dialogue with the medical community concerning race and illness, pushes the limits of acceptable feminine behavior, and creates a jazz riff on linear illness narrative. McCauley’s interweaving of the body as text with personal narrative and community ethnography creates a layered and intricate conversation.

I ask how this performance reveals the links between supposedly caring institutions and forms of discrimination – particularly in this case, racism? What aesthetic choices does each performer make to performatively demonstrate the structure and experience of her illness related trauma? How is memory negotiated in filling in the gaps of traumatic experience and bringing that experience to the stage? What traditional conceptions of identity are disrupted by illness experiences that force a removal from “normal” existence? Finally, I view McCauley’s performance for the potential it has to witness to specific communities and to a new configuration of self.

Chapter Three: Performances of Breast Cancer Experience

Susan Miller's *My Left Breast*, Brandyn Barbara Artis's *Sister Girl*, Linda Park-Fuller's *A Clean Breast of It*

This chapter examines the performance work of women coping with cancer – an acute illness that is often asymptomatic until diagnosis. In this chapter, I ask how this unique aspect of cancer changes the representation of the experience and how treatment and cure are implicated in traumatizing the patient. Again, I question how, within this different context, each performer makes aesthetic choices that performatively demonstrate the structure and experience of her illness related trauma. How is memory negotiated in filling in the gaps of traumatic experience and bringing that experience to the stage?

Because these performances intersect with arguably the most feared disease in the world, I investigate how these performances reinforce and/or counter popular and medical knowledges that circulate through media channels. How do the performers find means of testifying to new knowledge that might easily be suppressed within the information overload that accompanies cancer? Can this speaking of different perspectives reveal weaknesses within the medical systems knowledge producing systems?

I also question how the bodily changes caused by cancer affect each performer's conception of gender and sexual identity, and how each woman witnesses to this new understanding of self? What disruptions of normative ideas of femininity and sexuality are performed that further also undermine the concept of identity as a monolithic

unchanging category? How do these experiences of body as fragmented, parsed, and altered illustrate the ways in which our identities are as cobbled together as our physical beings are? How does each performer claim a “. . . ’subject in progress’ even if that subject is searching for a sense of wholeness” (Henke xvi)? Finally, I ask can these testimonies to negotiated identities and subjugated knowledges be heard within medical venues that often sponsor these performances?

Chapter Four: Deb Margolin’s *bringing the fishermen home* and *Three Seconds in the Key*

This chapter diverges from the performed autobiographical personal narrative to investigate two plays by Deb Margolin that differ significantly in structure and form from the previously examined performance texts. Based in autobiography, *bringing the fishermen home* (1998) and *Three Seconds in the Key* (2000) are both one-act plays that incorporate multiple characters into a surreal journey through a woman’s experience of illness. In a personal interview with Margolin, she states that both works are based in specific autobiographical experiences of Margolin’s journey with Hodgkin’s disease and were written as a means of examining those events. However, neither contains straightforward “truthful” personal narratives or medical information about specific illnesses.

I begin with *bringing the fishermen home* and investigate how the move to fictionalized autobiography allows for a more complex and harsh examination of traumatic illness experience. How can feminist performance and playwriting techniques be employed to reveal the structures and patterns of traumatic experience? Rather than

focusing upon disruptions within specific forms of medical and popular culture knowledge about specific illnesses, this chapter investigates how these performances can disrupt popular culture mythology about the caring nature of an institutionalized setting. How are uneven and harmful power relations between patient and caregivers exposed through the utilization of these feminist structures and techniques? Specifically, how are the power relations within a supposedly neutral hospital setting foregrounded? What are the consequences of these power dynamics for the patient positioned in a passive feminized role?

In the second half of the chapter I focus upon *Three Seconds in the Key* and discuss how Margolin performatively demonstrates the labor of reconfiguring gender, sexual, and racial identity through the distilled isolating experience of illness. I ask how representations of traumatic illness and transference, or integration of the experience, can function as potentially radical sites for the re/figuring of identity. Does the performance of this new, shared and interdependent identity create a utopian performative or a performance event “. . . where people come together, embodied and passionate, to share experiences of meaning making and imagination that can describe or capture fleeting intimations of a better world” (Dolan 2)? How does the use of fictionalized autobiography question the boundaries of what can be said about women’s traumatic experience of illness and the form that those expressions may take? Through these two plays Margolin offers both dystopic and utopic visions of a woman’s journey through illness, treatment, and recovery. In *bringing the fishermen home* Margolin portrays the potentially horrible consequences of the dehumanizing loss of identity within the medical

setting, whereas in *Three Seconds in the Key* she illustrates the utopic possibility of reconstructing a life with a new collective and contingent sense of identity.

Chapter Five: Conclusions and Further Directions

I begin this conclusion with a performative response to my own experience of traumatic illness with a pheochromocytoma, or adrenaline producing tumor. I attempt to incorporate the structures, psychic, emotional, and physical of illness and trauma into a performance art work. I try to speak back to the historical positioning of the hysterical white woman which I believe seriously affected my healthcare. Through performative and traditional scholarly writing, I detail the difficulties and successes of attempting to create a performance that reflects back upon events that were emotionally inaccessible at the time of experience. I also critique the pieces of the performance that I have had the opportunity to perform in public, and question the piece's ability to function as testimony.

How have these performances of illness experience disrupted normative discourses of identity and medicine? Have they pushed previously unspoken experiences into the public arena without allowing for their incorporation into simplistic and triumphant narratives of overcoming great odds? Have these women foregrounded the trauma inflicted by the inability to maintain appropriate gender and sexual identity performance in the face of the breakdown of the body? Has that inability to perform identity "correctly" resulted in a new and reformed sense of self that lies beyond traditional boundaries? Has the public exploration of these questions allowed for the formation of communities of witnesses, both therapeutic and political? In addition to

considering these questions, I discuss the possibilities for future activism and scholarship around women's autobiographical performances of illness experience.

End Notes

¹ “1. a difficulty, as in a philosophical or literary text, caused by an indeterminacy of meaning for which no resolution seems possible. 2. A condition of uncertainty or skeptical doubt resulting from this.” (Webster’s 65).

² See Kathryn Montgomery Hunter. *Doctor’s Stories: The Narrative of Medical Knowledge* for further discussion on the “necessity” of the translation of patient stories into medical narrative. Hunter acknowledges the power dynamics within this relationship and argues that doctors need to frame information in terms that are comprehensible to patients.

³ Alisha Lenning. *Health in Motion: Holistic Health, Individuation and Expressive Physical Culture*. Diss. University of Texas at Austin, 2003. Ann Arbor, MI: ProQuest Information and Learning Company, 2004. 3118042. [ProQuest Dissertation and Thesis](#). Lenning examines the relationship between what she terms “expressive physical culture” and other current health models. Her work extends the link between performance and health through an examination of the nineteenth century performance practice of Genevieve Stebbins and the contemporary practice of NIA developed by Debbie and Carlos Rosas.

⁴ Couser also challenges his colleagues in narrative studies to reconsider their bias regarding the literary merit of such works. “Yet the lack of acknowledged classics may have less to do with the inherent qualities of these books than with a system of values that marginalizes narratives about illness and disability as it does people with those conditions” (7).

⁵ For an explanation of Marie Root’s original concept and further elaboration see: Brown, Laura S. “Not Outside the Range: One Feminist Perspective on Psychic Trauma.” *Trauma: Explorations in Memory*. Ed. Cathy Caruth. Baltimore: John Hopkins UP, 1995. 100-112. See also, Herman, Judith. *Trauma and Recovery*. New York: Basic Books, 1992.

⁶ Sontag, Susan. *Illness as Metaphor*. New York: Vintage Books, 1977.

⁷ One of the most famous discussions regarding “victim art” began with Arlene Croce’s scathing commentary on Bill T. Jones’s 1995 production *Still/Here*. The resulting debate spotlights the cultural and artistic investment in maintaining the ability/disability dichotomy within mainstream culture and how that dichotomy becomes conflated with the representable versus the abject. Croce, a well-known dance critic, refused to see Jones’s production because it was based upon workshop material collected from and with terminally ill people. Jones transformed the workshop material into a dance theatre work incorporating video footage of the workshop participants, songs, and dance choreography performed by his professional dance company. Croce argued “. . . that by working dying people into his act, Jones is putting himself beyond the reach of criticism (54).” Croce went on to lambaste “victim art” and what she considered to be the horrific blurring between art and life.

As Marilyn Bordwell trenchantly recognizes in her essay “Dancing with Death: Performativity and “Undiscussable” Bodies in *Still/Here*,” Croce’s comments are attempting to performatively jettison the ill body from the possibilities of artistic representation. David Roman discusses this artistic elitist investment in *Acts of Intervention: Performance, Gay Culture, and AIDS*. Roman counters with his concept of “critical generosity” as a means of recognizing that some performances are also functioning as direct engagements with larger social issues. He does not call for a lack of critical rigor, but rather asks that critics “. . . rethink the traditional criteria by which evaluations are made, [and] . . . to acknowledge the ideological systems that promote canonical prejudice (xxvii). Croce’s assumptions that Jones’s work is “undiscussable” do not acknowledge these prejudices, but rather rest upon the difference she outlines between art and life, and her valuing of formal art over work that incorporates overtly political content. Bordwell points out Croce’s move to exclude the “real” body, “. . . the deformed, diseased, abject, AIDS-infected body (373) from the scope of intelligibility. Bordwell writes,

Croce's distaste for and avoidance of the old, diseased, and deformed can be understood as an expulsion of the abject from the space of legitimate art. In Croce's critical framework then, "the body must bear no trace of its debt to nature: it must be clean and proper in order to be fully symbolic (Kristeva 102).

This conservative move works to align the "real" sick body as unrepresentable and unspeakable.

Bordwell also argues that countering Croce's attack, *Still/Here* performatively challenges traditional representations of sickness to reposition the ill body as active cultural participant (375). Beginning with the reminder that illness itself, and here I would add disability, is performative and not "pre-social nor extradiscursive (375)," Bordwell positions performances such as *Still/Here* as "... challenging Croce's exclusionary definition of sick bodies and for resisting certain cultural norms governing what it means to have cancer or AIDS, or be HIV-positive (Ibid)." Jones uses illness as the "existential human condition" to highlight "... that the resources necessary to cope with life-threatening illnesses are the same as those necessary for truly owning one's life (376)." Bordwell ultimately finds that by blurring the boundaries between "art" and "life," and illness and health, *Still/Here* represents illness as speakable, understandable, and not too distant from the experiences of all bodies (377).

⁸ Gingrich-Philbrook, Craig. "What I 'Know' about the Story (for those about to tell personal narratives on stage)." *The Future of Performance Studies: Visions and Revisions*. Ed. Sheron J. Dailey. Annandale: National Communication Association, 1996. 298-300.

⁹ For more on performance and postmodernism see Marvin Carlson "Performance and Postmodernism" *Performance: A Critical Introduction* (London: Routledge) 1996, 124-143; for more on feminist performance art see Roselee Goldberg *Performanc: Live Art Since the 1960s* (New York: Thames & Hudson) 2004; Jeannie Forte "Women's Performance Art: Feminism and Postmodernism" *Performing Feminisms: Feminist Critical Theory and Theatre* Ed. Sue-Ellen Case (Baltimore: Johns Hopkins UP) 1990, 251-269.

¹⁰ For examples of the implications and complications of performing and/or researching the autobiography of another person see Stacy Wolf "Desire in Evidence." *Text and Performance Quarterly* 17.4 (October 1997) 343-351; Miller, Lynn C. "Gertrude Stein Never Enough." *Text and Performance Quarterly* 20.1 (2000) 43-57.

Chapter Two: Robbie McCauley's *Sugar*: Witnessing to Affirmative Counter-Narratives

Pain is full of information. It exercises my mind to deal with that information. Again, it goes back to the body, the release. What you know is something you can carry with you rather than be burdened by (McCauley, "Introduction to Sally's Rape" 212).

Stories, parables, chronicles, and narratives are powerful means for destroying mindset—the bundle of presuppositions, received wisdoms, and shared understandings against a background of which legal and political discourse takes place. These matters are rarely focused on. They are like eyeglasses we have worn a long time. They are nearly invisible; we use them to scan and interpret the world and rarely and only rarely examine them for themselves. Ideology – the received wisdom – makes current social arrangements seem fair and natural. Those in power sleep well at night – their conduct does not feel to them like oppression. (Delgado, "Storytelling" 61).

I'd have questions about balance if I didn't have diabetes. The tightrope image for me catalyzes clear thinking and change (McCauley, "Thoughts" 267).

In the following chapter I examine the only available solo work created by a woman of color that deals with an experience of chronic illness – Robbie McCauley's *Sugar*. I first examine how McCauley unveils the intimate relationship between whiteness and the U.S. medical establishment and how that establishment continues to perpetuate trauma in the bodies of African Americans seeking healthcare. Testifying through personal experience and embodied moments of poetically presented memories, McCauley witnesses to her own story of trauma, reclaiming her narrative and bodily integrity, and creating an emergent truth and a newly articulated identity. McCauley adds another layer of bodily intervention into hegemonic discourse by focusing the audience's gaze upon the form of a chronically ill body speaking experiences usually silenced and shamed into the public arena. Through speaking her truth into the public arena, she

disrupts essentialized notions of racial and gender identity as she tangentially speaks for and with African American and diabetic communities, affirming their experiences of neglect, miscommunication, and trauma at the hands of the U.S. medical establishment. I highlight how she reveals the multiple and contingent performances of identity that are inherently embedded within experiences of illness, foregrounding how she performatively creates a shifting and layered sense of identity that allows her to change in ways necessary for her physical survival. Throughout the chapter I include my autoethnographic experience of viewing two performances of *Sugar* at Ohio State University in January of 2006. I negotiate my own memory and notes taken at the performance in the italicized descriptive sections and therefore I do not quote McCauley directly but rather offer my interpretive recollections.

As McCauley disrupts popular culture notions of the medical establishment ranging from beliefs about the equality of treatment for patients to the appropriate public behavior of ill bodies, she creates a crisis of understanding, a trauma of sorts, for white audiences and an affirmation of experience for people of color who are negotiating a white medical system. This crisis and affirmation work together to allow for different perspectives of identification and possibilities of active witnessing within the audience. This performance is first and foremost a witnessing, to self and community.

Although this is the first time McCauley delves into diabetes as her performance content, her performance context of focusing upon race and history, and her form and structure can be seen through a brief examination of her earlier works and influences. McCauley's work as a performer began in 1965 when she left Columbus, Georgia and

traveled to New York City where she began participating in the burgeoning American avant-garde and experimental theatre scene. She worked as an actress for many years before she began composing her own performance pieces in 1979 (McCauley, “Thoughts” 267). Vivian Patraka categorizes McCauley’s work into the following eras: the early work with Sedition Ensemble; the family stories work, a series of solo personal narrative based performance art pieces entitled *Confessions of a Working Class Black Woman*, which includes *My Father and the Wars*, *Indian Blood*, and the Obie award-winning *Sally’s Rape*; collaborative pieces created with Laurie Carlos and Jessica Hagadorn in the ensemble Thought Music; and the site specific and community based theatre work in various parts of the world (Patraka 226). Incorporating community conversations and autobiographical stories McCauley positions *Sugar* as part of the community based work that she names *Conversational Music*.¹¹ Although the work is named a solo performance, in the performances that I saw in Ohio in 2006, McCauley incorporated another community member into the work. *Sugar* bridges the autobiographical with the community-based theatre (“Performance Notes”).

Sugar in Performance

When I enter the theatre building during the driving rain of an Ohio winter storm, I am amazed at the number of women pouring into the building. I am thrilled to see this many people coming to see McCauley’s work. It is astounding. I notice that many of the women are white and in groups, there are also African American, Asian, and Latino people making their way into the building. I approach the ticket office on the second floor and I see that there are two lines. Oh. Eve Ensler is performing The Good Body in the

mainstage theatre next door. I am deflated and then pissed off. McCauley's work is IMPORTANT! How could they put her up next to Ensler's Ticketmaster big theatre performance? The performances are even at the same time! I see no opportunity to buy a package, or any advertising of the two together. I think this is disastrous and yet another example of what is wrong with University arts programming. I buy my five dollar student ticket to see McCauley. I don't even ask about Ensler tickets.

The audience inside is mixed in race, age, and gender. There are at least one hundred and fifty people in the audience. Students, professors, community members - it is an impressively heterogeneous audience. There is a pre-show lecture by Marie Cieri. She worked as McCauley's producer on earlier community ethnography pieces.¹²

McCauley enters the theatre to the left of my section, standing in the space between the center and stage left risers, still unseen by much of the audience. She is a striking woman with close cropped grey hair and dark brown skin, her body is tall and graceful, and she moves confidently like someone who has danced throughout her life. In the "wings," her warm-up dance is small in its movements. Her legs sway back and forth and she moves her arms and hands in controlled movements, loosening her shoulders and torso. The Rolling Stones "Brown Sugar" begins playing on the speakers and a small smile crosses her face. As she moves to the beat of the music, I see that she enjoys the moment of reclaiming this song; I see it in the way the intensity of her movement changes as her beautiful black chiffon shirt sways gently. The shirt is decorated in a muted large floral

pattern of red and green. I catch the sparkle of a red bracelet on her wrist. She steps out from the side of the risers and raises her hand to signal the end of the music.

She approaches the simply configured black stage space. In the upstage left corner is a small stool, and downstage left a small straight backed chair with red vinyl upholstery. Off the edge of the downstage left corner is a black canvas courier bag that blends in with the black floor color. Upstage center sit three black acting cubes, stacked into a triangle, and to their right a small table holds another small black box.

McCauley crosses in front of the low stage, wondering aloud which pieces of her story to include: “Now there’s the piece about politics, and slavery, and the piece about sex, oh and the piece about healthcare...” She mounts the two small steps to the stage and backs her way across the space to the center, deciding how to construct the work she will offer.

Establishing Community and Context

From the opening moments of *Sugar* McCauley includes the audience in her process, unveiling the choices that go into scripting a work about a complex bodily and social experience. Revealing the multiple possibilities of how the story can be configured, McCauley does not delineate a hierarchy of components; rather she catches at fragments that give sense to her experience and develops those fragments before our eyes. She is negotiating her memories each night as she recalls events long past while simultaneously negotiating the cultural minefield of stereotypes about African Americans with diabetes. The audience is an actively engaged with McCauley from her opening

acknowledgement of our presence; our participation is clearly expected. All are welcomed into the process with her questions to and acknowledgement of the audience.

As with earlier works, McCauley's focus may be upon a specific circumstance, like diabetes, but her larger project lies within examining the contested history of black experience and racism in the United States. Specifically McCauley's work seeks "... to continue to struggle for black liberation and the best of human potential (McCauley, "The Struggle" 583). As African American cultural theorist Bell Hooks points out, McCauley is participating in a tradition of recognizable African American performance history, a history that has always seen performance as "... a space where folks come together and experience the fusion of pleasure and critical pedagogies, a space that aims to subvert and challenge white supremacy as a system of institutionalized domination. ..." (hooks 219-220). In privileging "an/other" story McCauley creates localized work for an African American audience that can answer Hooks' call to "... shift paradigms and styles of performance in a manner that centralizes the decolonization of black minds and imaginations, even if we include everyone else in the process" (219).

Throughout the analysis of McCauley's work I rely upon African American feminist and performance theorists. While I acknowledge that there is a fair amount of overlap between white feminist postmodern performance styles and McCauley's aesthetic, there are important differences that position her within an African American performance history that includes testimony and witnessing. Additionally, McCauley is speaking to a specific cultural trauma that only becomes visible by taking an/other perspective. McCauley furthers this politicized artistic intention by foregrounding a

distinctly African American aesthetic, one she identifies as drawing from black Southern traditions such as “... rap, blues, and soul, jazzin on a theme, and call-and-response antiphony” (Whyte 285). *Sugar* exemplifies what McCauley names as the “content as aesthetic” within her work, meaning she allows the “...content to dictate the form, rhythm, and flow of a piece” (Becker 520). Foregrounding the aesthetics of jazz to create her performance collage, McCauley continues the intentions of Amiri Baraka, to remind the public that “... the aesthetic is the activism itself” (Patraka 227). McCauley’s incorporation of African American aesthetics, performance practices, and political causes positions her as a credible and invested witness to African American communities, and her generosity and inclusiveness open the potential for other audience members to find points of identification. *Sugar* falls into what Lynn C. Miller and Jacqueline Taylor have noted as, “works that speak from the margins, seeking to position a life as connected to and as a distinctive instance of a particular identity. These pieces draw on a tradition of testimonial literature-bearing witness to experiences and perspectives rarely voiced in the culture’s predominant narratives” (“The Constructed” 177).

Sugar’s Jazz Aesthetic

Robbie sits on the stool in the upper corner of the stage. She shares a memory of a night in a café long ago when she argued with a man, who would become a lover, about the meaning of Jagger’s song “Brown Sugar.” Laughing in the past, she tells us how she and her friend, Laurie Carlos, agreed that they’d take the praise of their “magical beauty” in whatever form it arrived. She sobers, and tells us that was before she had a conscience, long before, before...she was brought across the ocean for sugar, before she

began trying to find the origins of the cultural addiction to the sweet and the havoc and pain that the addiction wreaks. She rises and moves to the center, stretching her arms across the space to find the beginning, of the story, of the history, of her body's struggle with her blood and pancreas. She gathers her arms together across her body, showing us how she feels the history, the stories, and the insulin resistance all residing inside. As suddenly as she dissolves into poetic language, McCauley pulls away from it, breaking her reverie and addressing the audience directly.

Walking to the edge of the stage, she asks us for one word to describe the war in Iraq. My mind whirls, what is going on? The words fly from the audience, obviously they can switch gears much more quickly than I can. "Immoral", "Illegal", "shameful", "guilty", "insane", McCauley repeats each word, acknowledging the contribution of each audience member. She stops her pacing and looks out at us, "I think they all have something to do with sugar."

Again she changes pace and lapses into poetic language. Crossing to the upstage stool she begins a story about the man whose poems she lost in the café that night. I think it is the man from the conversation with Laurie Carlos, but I do not know for certain. She tells us of the passion and intensity of the relationship. She knew that "sex was different than kindness. A bang in the body and a thrusting like horses, and what did he expect with all the storms in her father's house?" There is loss in this story, as well as confusion and anger. I try to grasp on to what she wants me to know...

McCauley's jazz aesthetic creates an alternately meandering and coherent use of story, movement, and chronology that structurally reflects a lifelong traumatic experience and an intricate conception of identity. Performance Studies scholar Joni Jones/Iya Omi Osun Olomo delineates the jazz aesthetic as a collage of components that include "non-linear, cross-genre, ritually driven" work (598). Jones/Olomo's jazz aesthetic explores work that is unabashedly subjective, and focuses upon the experience of a single character through the recalling of memory, time, and place that do not necessarily exist in a performance world ordered by psychological realism (598). This process driven work incorporates dance, movement, and "gestural language" that underscores and complements the "polyrhythmic musically driven language" of the verbal text (598-9). McCauley works within this tradition as she weaves together poetic impressionistic stories, strong repetitive gestural movement, and the seemingly incongruous education-oriented questions delivered in direct address to the audience.

Incorporating many of Jones/Olomo's components, McCauley's jazz collage form also creates a performative experience showing how the insidious everyday trauma of managing a condition like diabetes becomes assimilated into a life. McCauley's jazz structure mirrors the gaps and dissonance within the experience of trauma. Raewyn Whyte elaborates on McCauley's use of verbal text:

There's no beginning-middle-end to these stories, no narrative closure, no "once upon a time" or happy ending, no stereotyped, familiar characters, no comforting moral messages. Fragments, individual incidents, are pieced together in the course of a performance, becoming part of a bigger

picture through repeated images that extend the mininarratives and
through repeated phrases that connect the underlying themes. (Whyte 285)

McCauley's structure bounces from story to story to challenge the audience to fill in the gaps, to allow for the meaning to coalesce in the spaces between the stories. As the vignettes switch, always stopping short of revealing too much – of allowing us to escape into the morbid details of the body and pain and the subsequent emotional pathos or distancing, McCauley performs what Ann Cvetkovich names trauma's "affective resistance to vulnerability" (26). McCauley refuses the easy images and the emotional build towards catharsis. The opening example above illuminates the vast repertoire of stories and associations that reside within her memory, and the fluctuating chronology of how an insidious everyday trauma becomes cobbled together in a fragmented sense-making process. This structural flexibility and chaos is also characteristic of traumatic experience which must be told repeatedly and in differing configurations before it can be assimilated (Cvetkovich 18).

McCauley's "content as aesthetic" approach serves her political project of furthering the well-being of African Americans by not only revealing the personal difficulties of living with illness, but by also intimately linking those difficulties with the history of slavery and the medical industry's complicity in marginalizing African Americans. *Sugar* adds to the dialogue within trauma studies of work that "... unveils another version of insidious trauma, by tracking how contemporary experiences of racism rest on the foundation of traumatic events such as slavery, lynching, and harassment" (Cvetkovich 38). McCauley's work creates a model that "... explains the links between

trauma and everyday experience, the intergenerational transmission from past to present, and the cultural memory of trauma as central to the formation of identities and publics” (Ibid). McCauley upends assumptions that the medical establishment is automatically progressive and caring, by showing us the multiple associations and links that she has forged in order to make sense of senseless events; in doing so she also unveils the intimate links between whiteness and the medical establishment. In order to understand the disruptions that McCauley is creating, I include a brief overview of the relationship between African Americans and U.S. medical practices.

Witnessing to Self and Community: African Americans and the U.S. Medical Establishment

She crosses center again and directly asks questions to the audience--

Why are African Americans more likely to have amputations, need dialysis, and to go blind from diabetes? Why did no one tell her about the itching skin, the chafing as her mother called it? When she was a child she had the chafing between her thighs, inexplicably her skin was tender and healed slowly. Her father was in the army, so they had healthcare. Yes, they had healthcare, but somehow they were different. When her parents took her to the doctor for the chafing in Columbus, Georgia. Columbus, Columbus, who came across the ocean looking for sugar, and now she finds herself in Columbus, Ohio – again she spreads her arms wide, reaching for the connections between her past, her present, and the weight of history held within the two, here in Columbus, Ohio. . .

African Americans and the U.S. Medical Establishment: History and Context

The history of health care in the United States is filled with examples of treatment inequity and exploitation based on race. In her article “Slavery, Segregation, and Racism: Trusting the Health Care System Ain’t Always Easy! An African American Perspective on Bioethics,” Professor Vernelia Randall exposes a detailed list of atrocities that participate in building the continued distrust of African Americans with the U.S. health care system. Beginning with experiments conducted during slavery, Professor Randall reminds readers that some of the “fathers” of U.S. medicine conducted their experiments in inhumane ways on uninformed and non-consenting slaves. These “great” doctors included Dr. Crawford W. Long, the inventor of anesthesia, and Dr. Marion Sims, “the father of gynecology” who addicted his non-consenting patients to narcotics in order to insure their immobility. In addition to the extensive examples of specific studies conducted on slaves, Randall also foregrounds the practice of “allowing” slaves access to healthcare in order to experiment on them randomly, and the practice of allowing slave’s bodies to be used for medical research upon their death. Dr. Randall points out that the U.S. healthcare system was literally built on the bodies of slaves. (Randall).

Rosalynn Watts echoes Randall’s findings and elaborates not only on the ramifications of the mistrust engendered by historical examples of the ill-treatment of African Americans at the hands of the U.S. medical establishment, but also the unrelenting consequences of the Tuskegee Syphilis Study. This study which was conducted from 1939 until 1972 in Tuskegee, Alabama involved African American men who believed they were being treated for syphilis. As Randall notes, the Tuskegee study

involved over four hundred African American men who were not treated, but given placebo treatments so that their syphilis would progress to a fatal stage in order to study the long-term debilitating effects of the disease. As Randall states; “The effects of the Tuskegee Syphilis Experiment of maintaining and strengthening the distrust in the health care system can not be underestimated” (Randall). Watts concurs and adds that although many African Americans may not know the details of the experiment, they know that “something terrible happened” and this knowledge dissuades some people from seeking medical care (Watts).

Although popular culture is filled with images and stories of heroic doctors and nurses, equality of treatment, and the hospital as a place where you are cared for and healed, there are also numerous studies of current medical trends that counter this dominant discourse. Watts examines the impact of the continued negative stereotyping of blacks as recalcitrant in their treatments and less intelligent, and explains how this stereotyping leads to difficulties in patient-doctor communication, as African Americans are less likely to fully participate and communicate openly with a white doctor. A Princeton Research survey conducted in 2002 showed persistent perceptions of inequality in four major categories: “patient-physician communication, cultural competence in health care services, quality of clinical care, and access to care” (Watts). Additionally ethnic minority patients were found to be less likely to:

. . . communicate with the physician, follow the doctor’s advice due to cost constraints, have confidence in their physician, be treated with respect, feel that the provider understood them, inform their physician of

the use of alternative therapies, report satisfaction with care, receive clinical services essential for monitoring chronic diseases, and have a regular doctor. (Watts)

All of the above factors are of major importance in the potential success of medical treatment.

Perhaps no disease magnifies the disparity and the difficulty of communication between African Americans and the health care industry more than diabetes. The disease affects the body's ability to process sugar and is caused by the failure of the body to produce sufficient insulin. There are two types of diabetes diagnosis: type one diabetes (formerly called "childhood diabetes"), an inherited condition that usually manifests prior to the age of twenty, and Type two diabetes, an adult-onset version that is the result of a variety of complex factors ranging from heredity to obesity and sedentary lifestyle ("Diabetes"). According to the American Diabetes Organization, African Americans are disproportionately suffering with the illness and are 1.8 times more likely to have the disease than non-Hispanic whites. One of the most disquieting statistics in a list of worrisome data is that one in four African American women will have diabetes. There are many disturbing statistics regarding African Americans and diabetes, such as they are "almost 50% more likely to develop diabetic retinopathy as non-hispanic whites...2.6 to 5.6 times as likely to suffer from kidney disease...2.7 times more likely to suffer from lower-limb amputations. Amputation rates are 1.4 to 2.7 times higher in men than women with diabetes" ("African Americans"). With such numbers is there any question why there might be an overwhelming feeling of inevitability and hopelessness about diabetes

in the African American community? Coupled with the cultural history of African Americans and the U.S. healthcare industry, a self-perpetuating cycle of distrust, lack of access to care, and communication problems continually repeats itself. Regardless of perspective, whether African Americans fear diagnosis and treatment and therefore eschew healthcare until conditions are more advanced, or whether the medical community lacks an investment in aggressive treatment and education that results in poor outcomes, or numerous other possible scenarios that could explain this horrendous and dangerous disparity – there is a tremendous need for alternative forms of dialogue. McCauley's *Sugar* examines these links between whiteness and dominant medical practices and affirms experience for audiences of color.

Later in the performance McCauley again draws the audience into her personal narratives. She says that there were always elders in the community in Columbus, Georgia who would look at the thin child and say "I think you have a taste of sugar." She was always hungry, active and hungry and her bruises would take much longer to heal than those of other children.

The chafing on her thighs and legs was an endless source of stress to her mother. They took her to the doctor for this condition, and the doctors gave a nine year old girl a test for syphilis. See, she says they had healthcare. Her father was in the Army, they were army, but yet they were different. Her Aunt Carrie took saccharin in her coffee, so there was some sugar in the family. Another memory morphs to the surface... her father is

beating a doctor, a white doctor, because they are refusing to allow Robbie admittance to the hospital. When she comes to again she hears a voice saying, "She is going to make it. She is going to make it." Although it wasn't known at the time, she was in a diabetic coma.

She reminds us of the stakes for African Americans and healthcare. "We didn't want to go to the hospital. You go up in there and you don't come home. You die. We all knew about Tuskegee."

Witnessing to the Self and Community

Using a poetic precocious form of witnessing to the self, McCauley employs elliptical language and structures that escape, refuse, and render useless a traditional Western dramatic schema. As literary scholar Shoshana Felman writes "precocious witnessing" employs poetic language and can ". . . speak *beyond its means*, to testify-precociously- to the ill-understood effects and to the impact of an accident whose origin cannot precisely be located but whose repercussions, in their very uncontrollable and unanticipated nature, still continue to evolve even in the very process of testimony" (Felman, "Education" 30). In pulling forth the physical and psychic degradations of a lifetime confronting chronic illness and racism, McCauley examines her "wound". As Felman explains, in such an intense examination of trauma "the wound finds access to the darkness that the language had to go through and traverse in the very process of its 'frightful falling mute'" (Felman "Education" 24). With stories such as the one when she was not admitted to the hospital linked to the reference of Tuskegee, McCauley

experiences and narrates the movement of memory across images and narrative fragments that cling together around moments of psychic and physical pain. These fragments accrue and reveal the institutionalization of racism within medicine and the resultant costs to individuals. McCauley morphs from story to story, memory to memory, in her search for the words that will make the experience comprehensible. It is an endless search and in the talkback following the performance, McCauley acknowledged that the accuracy of some of the memories is questionable, or rather as she put it, “where the real meets the song” sometimes gets blurry for her (McCauley, *Sugar* Jan. 13).

In witnessing to her lifetime of negotiating diabetes and racism, McCauley performs her contingent and layered conception of identity. Writer and activist Audre Lorde configured this difference within the self as strength to be embraced. “For the self to be fundamentally collaged – overlapping and discernably dialogic- is to break free from diminishing concepts of identity” (qtd. in Alexander 219). Throughout the performance McCauley morphs through identity positions ranging from heterosexual lover, to wife, to daughter, to mother, to teacher, to performer, to activist, to marginalized patient; her permutations seem almost endless as she tosses us from one moment to the next within the intricacies of memory. Elizabeth Alexander, an African American scholar of English, notes, that for African American women it is a matter of survival to collage together a conception of self that draws upon multiple sources both external and internal (219). Alexander acknowledges that a conception of self as oppositional to dominant culture is essential in defining a new identity; “The moment in which the narrator’s ‘right’ is presented in opposition to a public ‘right’ is an important trope in

Black Women's autobiography: without resistance, survival and growth are impossible in an unjust world" (228). As Chicana activist and writer Gloria Anzaldúa states, "I write to record what others erase when I speak, to rewrite the stories others have miswritten about me, about you" (qtd. In Langellier 126). McCauley's witnessing to self is a reappropriation of voice, and a working through of trauma that becomes the re-membered and re-presented life in performance.

While McCauley lives through this testimony, and performs the action of witnessing to self that "... reconstitutes the internal "thou," and thus the possibility of a witness or a listener inside" (Laub 70), this self is not fixed, other than performatively in the moment; rather it remains multiple and shifting, ghosted by bodily and narrative breakdowns that have gone before and will come again. For example, she tells the audience of the heart attack that she had even though she is a diabetic who takes care of her body as she has been told. Her ability to control her body is much less definite than her ability to control the narrative of the performance. McCauley chooses what is told; from her father's denial of her condition to the shock of being told that all diabetics of a certain age will most likely have a heart attack, she controls the pulling together of the fragmented memory into a narrative that not only tells of the trauma but is also performative of living through the trauma. Living through denotes moving within not moving beyond. She reminds us that with chronic conditions there is no closure to the trauma. McCauley performs her continual negotiation of memory and demonstrates the necessity for a mobile and constantly changing conception of identity as she finds new information and understanding of her condition by parsing and piecing her memories

together. It is evident that this understanding could change based upon the memories and moments that she chose to incorporate, just as her understanding of her identity changes each time she foregrounds a new and differing perspective regarding her condition.

The “Uncontrollable” Body Controlled in Performance

I see the show twice in Ohio. Each night towards the middle of the performance, McCauley crosses to the acting cubes that are stacked upstage center. She lifts the top cube, revealing a discrete black cosmetic bag that she unpacks. She carefully pulls out a small blood sugar monitor, test strips, insulin, and packaged needles. As she unpacks the daily necessities of managing diabetes, she off-handedly jokes that,

“You need to be chemist to understand your blood sugar.”

She remembers back when she had to pee on a ketosis strip to check her blood sugar,

“That’s all changed now. The blood test kit and strips are not cheap,”

she says, and

“no one tells you that with some models you can use the strips twice. Sometimes when I’m in long meetings I just pull this out and test at the table. I look down at the number and then say, now can we get on with this?”

On the first night she pricks her finger and reads out the number,

“156. Not bad. Not bad. So...” She lifts a syringe. “I’m not going to shoot this right now, because then I could be up here acting any old kind of way. I do call it shooting. I gave up a long time ago trying to think up different words.”

She tells us a funny story about a man she met years ago at a party. His name was Niko, and she thought they were flirting. Years later he tells her that seeing her inject insulin that night he thought she was a junkie; she tells him that’s okay because she thought he was straight.

During the second night of performance McCauley again checks her blood sugar. Her face pulls back in dismay and momentary anger; she is displeased with the number. She won’t tell us what it is. She becomes momentarily defensive, as if this is a tiring explanation she’s been asked about too many times. She insists that it isn’t because of something that she ate, although she admits it could be. She flashes to a memory of her first marriage – when she’d sneak off in New York- to eat strawberry shortcake without her husband knowing. She loads the syringe with insulin, and standing centerstage she nonchalantly raises her shirt to expose her stomach, and injects the drug. As she does this she calmly tells us that periodically she injects in public, even when she could find a private place.

“It’s like breastfeeding – get over it.”

In the layered self that she presents, McCauley reclaims her narrative authority while integrating and re/claiming her bodily experiences. Elizabeth Alexander explains the significance of such a move; “The narrative history of the body is a way of

interpolating difference and claiming wholeness” (235). As many scholars of autobiography have acknowledged, if all women are positioned as unreliable narrators within patriarchy – then this is especially true for African American women- whose bodies have been used to prop up conceptions of white identity, both male and female. As Raewyn Whyte notes of McCauley, her work subverts this history because, “her stories offer a body already inscribed as Other within dominant American discourses of power – the black body which has been treated by white masters as a blank text to be used according to the needs of dominant order” the position of narrator and agent controlling the performance text (290). Whyte further explains McCauley’s bodily intervention into hegemonic discourse: “. . . she inverts the power relations of the prevailing social order, placing herself, a black female subject, in the position of power, a position whereby she controls the flow of information, where she decides what is important, which history should be told” (292). McCauley employs her body as a visual and kinesthetic counter-storytelling device, defying “. . . the body of knowledge that has long constricted black women as simultaneously all bodies and nobodies” (McDowell 298) lacking narrative authority and agency. She positions her black female body as carrying the knowledge of a lifetime of managing chronic illness exacerbated by the chronic societal illness of racism.

McCauley also illuminates how the body is a mutable surface for the deployment of instruments of cultural war. As she monitors and manipulates her blood sugar onstage, she highlights the moments when the discourse of the dominant cultural body- in this case the medical establishment – exerts control and inflicts pain and surveillance upon

her physical body. In *Sally's Rape*, McCauley examined this theme through the explicit presentation of her naked body as a slave on the auction block. Referencing her body in *Sally's Rape* she states, "I thought somehow it could free us from *this*" (McCauley, "Sally's Rape" 229) – or the reduction of identity to racist assumptions linked to specific bodies which are in turn positioned as less than human. Drawing this same point to medical assumptions, she shared a personal anecdote with me about a white male dentist, a highly recommended specialist, she sought out for treatment when her teeth began to deteriorate. As she sat with novocaine in her mouth, literally numb, he refused to tell her what it would cost to repair her teeth; instead he walked away and gazed out the window. He turned to speak to another white male consulting dentist and told him that he was looking at a building on the west side. He then told the other dentist that "it was a cultural thing with them," referencing the diastema, or gap, between McCauley's front teeth. Speaking of African Americans as the othered "them" and speaking as if Robbie was not in the room, he continued to address the other dentist. "Oh yea, a cultural thing," replied the other dentist. McCauley recalled feeling numb all over and shamed as her agency as a patient was negated and the information that she may have needed for her dental health was withheld. McCauley stated that from that time forward she has only sought out dental care in urgent situations, and will not proceed with any attempts to correct other dental or orthodontic issues.

In *Sugar* McCauley discusses the economics of each treatment step that she enacts, while she demonstrates her competence as a patient. When she asks, "Did you know that some off these strips can be used twice?" she shares the knowledge that she

has gleaned, and the knowledge that has been withheld from others. She illustrates the tense and conflicted relationship that she has with the medical establishment as both a compliant and defiant patient, communicating the necessity of her treatment but not trusting the institution that defines that necessity. She pointedly comments on how the discourses and prejudices of culture have written themselves onto her body- through access to care, denial of care, lack of information, etc.- even as she works to performatively counteract that inscription (Whyte 277).

As McCauley enacts her tense relationship with the medical establishment, she also reveals stories of her ill and uncontrollable body juxtaposed with a physical performance of immense grace and bodily control. Her movement is filled with purpose and expertise, and her voice flows and fills the large space without visible effort. She is the well-trained actor, natural and deceptive in the naturalness. The opposition of this trained elegant body to the stories of that same body's collapse creates a troubling doubled image that questions assumptions of illness and health. On one hand, the audience is reassured of the integrated and complete nature of her body by the visual seduction of her physical presence, on the other hand, she reveals intimate moments without bodily control, including falling down on a public bus, crawling to a refrigerator for orange juice, and the pain suffered by a child with chaffed and raw skin. In each of these sequences she performs the body out of control. As she falls to the floor in delirium, crawls slowly and painfully across the floor for the orange juice, and rubs and soothes her thighs as her face contorts in pain at the memory of the chafing. This ghosting is unsettling and creates what disabilities scholar Rosemarie Garland-Thomson

has identified as the call for narrative- that will reassure audiences (and performer) that this body is controllable, can be normalized, understood and treated (“Staring” 335). McCauley therefore performs the good patient surveilling the unruly body for signs of disruptions, as both ritual and catalyst. She reads the monitor and injects, or does not inject, the insulin according to the vast knowledge she has acquired as a student of diabetes. All these physical enactments and narrative reassurances do not overturn or counteract her terror (and the audience’s) as she explains the unexpected heart attack she suffered in 2001. At the emergency room she is told, “Oh yes, you are a diabetic of a certain age. A heart attack is to be expected.” This is knowledge that McCauley did not have. As McDowell writes in the introduction of *Skin Deep Spirit Strong*, “Perhaps assertions of control are never more strident and insistent than when control is plainly out of reach” (298). McCauley’s strict attempts at surveillance and control could not prevent the heart attack she suffered or the possibility of future complications.

It is not surprising that the most problematic moment of embodiment within the performance occurs when McCauley overtly raises the issue of sexuality. Standing still in the center of the stage, McCauley asks in a small high pitched voice “where is the research on women with diabetes and impotence, where is the research on that?” As she walks off the stage to end the performance, Mick Jagger and the Rolling Stones begin to sing “I Can’t Get No Satisfaction.” This performance, or lack of performance, coupled with the earlier lyrical oblique reference to sex being different than kindness, implies a dissatisfaction and anger, a frustration with sex and the expectations of sex. The ability to write or perform about sexuality is one fraught with tensions for African American

women. As Elizabeth Alexander writes, “When we do write, we write our sexualities into existence against a vast backdrop, a history, of misrepresentation and essentializing and perversion, appropriations of our bodies and stories about our bodies” (235).¹³

Historian Darlene Clark Hine theorizes that black women have created a “culture of dissemblance” and a “politics of silence, evasiveness, and of displacement – in an attempt to protect themselves from sexual violence” (qtd in Collins 109). While McCauley does not go into detail about her difficulties with sex, there is clearly something that causes her to end her show with “I Can’t Get No satisfaction” beyond the obvious references to the inadequacies within the medical community. Again, McCauley’s reference ghosts for the audience a number of possibilities without giving the satiation of a specific story or example, thereby pointing to the trauma through avoidance. This is a problematic choice however. McCauley’s lack of performance regarding sexual impotency and women continues to make this issue embarrassing or shameful. While on one hand she is resisting the possibility of being framed through a regressive discourse that would position her as animalistic, on the other hand she does not claim a healthy sexuality deserving of attention and information. For an audience member without an understanding of the structures of trauma, this silence can easily be read as reproducing dominant notions of African American women’s sexual needs as either something uncontrollable or to be shunned and seen as shameful.

Witnessing to Community and Self: Strategic Alliances and Resistant Witnesses

“McCauley insists that dialogue is the key, that the continuing struggle to find the right language is an activist strategy, a possibility for transformation, an ongoing work-in-progress” (Nymann 585).

McCauley’s “precocious poetic testimony” in *Sugar* unabashedly witnesses her truth to community and self while also creating the possibility of active witnessing through audience members functioning as co-participants and validating listeners. McCauley aligns herself with African and African American performance traditions and performatively affirms a counter-narrative of American cultural experience while privileging alternative modes of knowledge production. As Ann Nymann writes of McCauley’s work, “by privileging oral history over the traditional text of American history, she attempts to restore connections to the past which have been traumatically interrupted by racial oppression” (581). Rather than taking the easier road of foregrounding her childhood diabetes, she focuses primarily upon adult experiences and blurs the line of which “class” of diabetic she belongs to, championing the entire diabetic community – not only through her own testimony but also through the alignment of the testimony of others alongside her own. In this section I examine how through the incorporation of another diabetic African American woman into the performance, and McCauley’s incorporation of performance ethnography, we hear a polyphonic chorus of African American people decrying the trauma of diabetes. Finally, McCauley’s content as aesthetic creates two potential positions for audience members, either the active role of co-witness, or the negative possibility of shock and turning away. I also investigate how

McCauley's work exemplifies these concepts and how she negotiates the ethics and questions of speaking with and for others.

An African American woman with short corn-rowed hair and a bright shirt and white skirt stands in the audience and moves with slow dignity towards the chair placed downstage left. She commands the room with her silence as she turns to the audience and a spotlight finds her. She begins to tell us a story about a blister that she noticed on her foot shortly before Mother's Day. Her foot was sore, but she thought little of it. She popped the blister because she "had a thing about bumps" and prepared to spend Mother's Day weekend with her family. . She drove several hours and spent the weekend with her mother. Upon her return home, she noticed that her foot was swelling.

"Something in my spirit was telling me to go to the doctor." After a somewhat nonchalant response from her physician, she decides to see a specialist. Upon examining her, the specialist said, "I was to go to the hospital immediately. He was trying to save my foot. SAVE. MY. FOOT." She says again with deliberation, exasperation, and shock.

"Save my foot?" she repeats to the nurses in the hospital. The doctor arrives at the hospital and with a sharpie marker, draws a line under her knee; this is where he will remove her leg if the black line of infection – creeping slowly up from her foot- does not recede. GailMarie tells us that she could not respond. She felt nothing, even as the black line receded and the medical staff celebrated, she remained numb. Upon discharge from the hospital she was trained to inject powerful antibiotics into a stint in her arm,

antibiotics that went directly to her heart. "TO MY HEART" she tells us matter-of-factly. Her spirit told her that she could do this, for three months, she could do this, even through the initial convulsions she suffered – at home alone – she could do this.

"And I saved my foot. I. SAVED. MY. FOOT."

McCauley's and Harris's explicit personal narratives disallow cultural amnesia about the realities faced by African Americans seeking health care. Such cultural amnesia is evident when "... the discrepancies between black and white material reality are used to justify theories of white supremacy" (Griffiths 8). Rather than focusing upon the material discrepancies and the underlying prejudices that create and maintain inequality, the individual becomes the culprit for her trauma. Harris and McCauley's stories reveal silencing, denials of care, and a general cultural callousness about diabetes which calls into question the links between education, poverty, and lifestyle *choices*. McCauley's stories include specific details that illuminate the cultural trauma inflicted upon her. Details such as a child's memory of being shamed by a test for syphilis, lying on the floor of a bus waiting for assistance, slipping from consciousness as her father hits a doctor who will not admit her into a hospital, are essential to foreground the "neglected evidence" of experiences that run contrary to dominant cultural narratives and to counter the "thousand details, anecdotes, stories" that make claims against the subjectivity of African Americans as valid historical witnesses (Fanon qtd. in Griffiths 4).

Operating within a critical race theory framework, these narratives assume racism as the ordinary condition which must be revealed. Critical race theory posits that a white audience can only learn something of the embodied nature of racism from the

experiences of a person of color (Delgado, *Critical* 9). Thomas Ross explains that such narratives must include explicit details, because those details are most likely no part of the individual audience member's lived experience or part of the larger culture's repertoire of stories (Ross 48). Rather than allowing an audience to "fill in the blanks" here, the details evoke realities that are not consonant with "universals" within the dominant culture. The counter-storyteller's inability to access such "universals" illuminates the false and ultimately white nature of the idea of universality (Ibid). By linking racism and medicine explicitly, McCauley shows another supposedly helping institution as a potential harbinger of terror within the imaginations of people of color, and specifically within the imaginations of African Americans.

Witnessing for Others

Through her focus on systemic patterns of oppression, McCauley has taken a seemingly solitary event, chronic illness, and created a performance that is simultaneously "private and solitary and public and communal" (Park-Fuller, "Performance" 24). In publicly performing *Sugar* she bears the "responsibility and danger of the telling" (Park-Fuller, "Performance" 24) because she does inherently speak for others, in this case African Americans and the larger diabetic community in general. The outcome of this risky endeavor can incorporate a political affirmation of an underrepresented community and the eliciting of "other" stories to further affirm a misrepresented identity, the "Canterbury effect" as Performance Studies scholar Linda Park-Fuller has named it ("Performance" 26). As McCauley substantiates subaltern interpretations of reality she enacts the progressive political strategy of what Coco Fusco

names as the “evocation of a shared past” in order to politically call out or constitute a community that has previously been named only in a derogatory manner (“Performance” 165).

Though McCauley offers no simple solutions, through her performative testimony, she does model a “way to be in the world” that offers alternative possibilities (Park-Fuller, “Performance” 26). McCauley strategically positions herself within the African American and diabetic community as she tells stories that reinforce “. . . alienation from everyday reality, a fragmented individuality and the loss of organized resistance - struggles that reach masses of black folks across culture” (hooks, “Performance” 210). She asserts her identity within these communities as extending beyond simple cultural signifiers such as food. In fact, McCauley quietly disrupts the notion of an essential “blackness” by demonstrating that she does not participate in the traditional southern African American diet. MacDougal points out how the examination of difference within the self also categorizes works that “metonymically refer to, but can never grasp, an entire culture. Hence it is always a partial truth, ‘subjective and incomplete’ that uses polyphonic strategies to convey specific aspects of black experience” (qtd. in hooks, “Performance” 214). McCauley examines differences within the self as reflective of differences within the cultural body and questions monolithic ideas of racial identity.

She moves to the downright corner of the stage after checking her blood sugar. She tells us that as a child she craved crisp green things.

“We ate a lot of hot brown things, but I wanted something crisp and green, crunchy that would clean out my insides that were dark green slimy red mud.”

She reminds the audience that growing up in Columbus, Georgia she had plums, figs, peaches, and pecans – foods that probably saved her life. After checking her blood sugar, McCauley moves to the small table upstage right. She begins to cut a ripe avocado into slices and puts it between a half folded piece of wheat bread. She eats the sandwich and talks around the food in her mouth as she tells us of the difficulty in asking black people to change what they eat – it is easier to get them to change their names she says.

Within this small section of the performance McCauley models to her community the possibility of change while also acknowledging the historical wisdom held within the community. Pointing to her ability to change her eating patterns, and retain her identity as a competent and informed member of the community, she demonstrates the ability to make small changes that could save lives. She reminds the audience that the traditional diet of Southern African Americans is filled with balance. In a personal interview, McCauley shared with me the importance of the balanced plate in her childhood. She was expected to eat her vegetables (overcooked though they may have been) in addition to the meat and cornbread included with the meal. The subtle inclusion of a radically alternative diet choice – the avocado sandwich- linked to her memories of a vegetable rich diet, creates the possibility of negotiating the present with the knowledge of the past. These ideas are in opposition to the inexpensive fast-food diet marketed heavily to

African Americans that is wreaking havoc in the bloodstream of the United States and especially within the African American community.

McCauley is also witnessing to the traumatic nature of being a member of the diabetic community. While McCauley has referenced having diabetes in print before, this is her first foray into a full public performance of her lifelong experience with diabetes (McCauley, "Thoughts" 267). The length of time that it has taken to create a performance about her condition, and the attendant "traumas and dramas" that it entails points to the difficulty in confronting a lifetime of experiences that are not necessarily socially appropriate. McCauley told me that this work feels more revealing, not only because she is disclosing her own vulnerabilities, but the vulnerabilities of others by "outing" many of her fears regarding diabetes and the healthcare system. Embedded within the performance is a brief glimpse into the direct activism of dialogue that is at the heart of McCauley's work, an activism that included "story circle" groups with "Columbus area witnesses," community participants who shared their stories of diabetes with McCauley in communal therapeutic settings. In these story-circles McCauley searches for the questions that will elicit stories that are at one time particular and bigger, or "personal/public" (Personal Interview; "Performance Notes"). McCauley names these participants as witnesses who generously gave their testimony to her. She wants the work to elicit "talk, reflection, and movement around charged topics that are often misunderstood or silenced" that can then move outward into the larger community not only through her performances but also through the continuation of the energy and interest generated within the story circle participants ("Performance Notes"). McCauley

recreates this experience through the portrayal of these varied community members' discussions' across her own interpreting body.

After McCauley finishes the sandwich, she crosses to the down right corner of the stage. She sits on the edge of the stage and props her arms on her knees. She holds her head in her hands and is silent for a moment. She begins a story, her voice slightly deepening, and I realize that she is performing someone else's story – a man who was thinking of suicide. His diabetes was tremendously difficult to manage, and he had no help with the daily tasks of monitoring his blood sugar and injecting insulin. He knew his condition was only going to get worse with time. Who would look after his dog if he killed himself? He chose to live in order to care for the dog.

She crosses to center stage and takes on a slightly more exaggerated version of an African American woman who is a diabetes educator. Her voice becomes sing-song and emphatic. "My life is bigger than diabetes;." she declares.

McCauley's body stiffens and her voice drops as she performs a man who is arguing with the educator. He doesn't even believe in diabetes. "If people took care of themselves there wouldn't be any diabetes."

She begins to pace as she changes back into the voice of a different woman. She vehemently addresses the man. She cannot let that argument stand. He cannot simply blame people for the condition that they have; it is more complicated than that.

McCauley moves to the center and pushes the “two” apart – once again embodying the educator woman. She wants to give people the information that is needed, so that they can make better choices.

While McCauley’s embodied tellings of her own traumas with diabetes are dramatically effective in witnessing to self and community, the incorporation of these community voices changes the political resonance of the work for the diabetic community. Robbie McCauley is a type one diabetic, a designation formerly known as “childhood diabetes” which was recently changed due to the growing onset of type two diabetes in children. GailMarie and most of the people from the community witness group are type two diabetics, or what was formerly known as “adult-onset.” This is evidenced by the fact that GailMarie had not had symptoms of diabetes until her late thirties. The larger political implications for this strategic inclusion of type two diabetics in the performance are evident through an examination of the rhetoric employed to discuss the “epidemic of diabetes” in America. The recent four part informative series in the New York Times featuring diabetes was entitled “Bad Blood: The Stealth Epidemic.” These articles focused upon the growth of diabetes in New York where one in eight New Yorkers will become diabetic. The articles feature Type Two diabetics and while interviews are conducted with many African American, Latino, Asian, and Caucasian

diabetics, the emphasis is clearly upon the idea that this disease is a class and race related problem and that “Type 2 can often be postponed and possibly prevented by eating less and exercising more” (Kleinfield 1).¹⁴ McCauley has what could be considered the “blameless” form of diabetes, while one in four African American women are much more likely to have type two. McCauley does not out herself as a Type One, (her slender frame and childhood stories point to this possibility); however, the inclusion of a major portion of narrative from a Type Two adult aligns McCauley with the diabetic community, without distinctions or cultural blame.

This inclusion coupled with the varied stories that McCauley performs offers multiple points of identification for audience members to intersect with McCauley’s performance from a variety of subaltern positions. As E. Ann Kaplan writes, this creation of a space for audience members to co-witness and identify “. . . may open up a space for transformation of the viewer through empathic identification which allows the spectators to enter into the victim’s experience through a work’s narration” (10). During the talkback sessions after the performance, numerous audience members shared stories, stories that included injustice and surveillance, humiliation at the hands of healthcare providers and family members– for their obesity and “self-destructive behaviors” (McCauley, *Sugar* Jan. 13). Continuing the practice of counter-storytelling begun by McCauley, Harris, and the other community witnesses, these audience members participate in the disruption of the master narratives of race and medicine that Performance Studies scholar Fred Corey acknowledges are deployed as an “artillery of

moral truth” sanctioning or excommunicating stories and the bodies attached to those stories (Schneider 250).

The possibility of witnessing is opened for audience members who align themselves with aspects of McCauley’s identity, but what of members who find themselves hearing explanations that defy and deny their conceptions of reality? The potential for vicarious traumatization is possible especially for audience members invested in a “white” conception of medicine and culture as egalitarian and based on the merit of the individual. This is a potentially “productive shock” that could result in a crisis that would “transvaluate, precisely, previous categories, and previous frames of reference” (Felman “Education” 56) resulting in new understandings. As Literary and Holocaust studies scholar Shoshana Felman explains, all learning is based upon the creation of dissonance and crisis. Rebecca Schneider has written about this possibility of confrontation in *Sally’s Rape*;

. . . McCauley doubles back to mine the residue, the wreckage that speaks across our own bodies in fitful historical counter-memories. Such memories do not exist in the past, but rather are part and parcel of the present, and they repeat across our social nervous system until we find a way to acknowledge their bones, to re-member. (Schneider 174)

While this trauma was evident in the talkbacks that followed, it was not evident in a productive manner. What I witnessed was the continual “leaving of its site” by the denial of the racial component of the performance by most white audience members’ comments. The commentary focused upon how these white people identified as the same as

McCauley, their diabetes giving them a “second class citizenship” without acknowledging the important differences within the experience.¹⁵ However as an audience member, I saw the evidence of the trauma caused by racism through the white audience members’ inability to engage. Such trauma is evident in the very rhetoric that “race is no longer a problem” in our country. In this moment, I realized that I had seen the collapse of witnessing, “. . . and by carrying that impossibility of knowing out of the empirical event itself, trauma opens up and challenges us to a new kind of listening, the witnessing, precisely, of impossibility” (Caruth, “Trauma” 10).

Conclusion

As a means of enslavement, both cultural and physical, sugar resonates as the central metaphor in Robbie McCauley’s most recent “work-in-progress solo performance that examines her struggle with having diabetes as connected to slavery, work, romance, and food” (McCauley, “Performance Notes”). Incorporating personal narratives, poetic anecdotes, gestural movement, performance ethnography, and music, *Sugar* runs an hour and fifteen minutes with no intermission. The accretion of stories and images does not follow a chronologically linear trajectory, but rather coalesces into a jazz-influenced collage that creates a performative evocation of the trauma that McCauley has experienced as an African American woman living with diabetes in the United States.

McCauley’s work engages the question of how the practices of the medical establishment collude with racial prejudice to create traumatic experiences for African American people, specifically within the context of those suffering with diabetes. Through a precocious poetic witnessing, McCauley demonstrates the ways in which her

identity must morph and change if she is to survive with diabetes as an African American woman. She publicly claims her chronically ill body and in doing so speaks of experiences that have been shamed and silenced. Finally, she witnesses to empowering counter-narratives that affirm experiences of degradation and racism felt by other members of the diabetic and African American communities while also challenging white audience members to acknowledge and engage with the racism inherent within the white dominated medical establishment. In the next chapter, I study three performances by women from different ethnic, racial, and sexual identity positions who all survived experiences of breast cancer. I build upon McCauley's revelations regarding race and the medical establishment, to point out how trauma is inflicted through many of the practices used to "cure" female specific diseases such as breast cancer. I also ask how these performers negotiate the altered, amputated female body in reconfiguring their gender and sexual identities. Finally, I examine the efficacy of these performances when they are performed in medical settings.

End Notes

¹¹ Prior to the performances of *Sugar* in Columbus, Ohio in January of 2006, Marie Cieri a former colleague of McCauley's gave a thirty minute presentation about McCauley's community based work. For an audience unfamiliar with McCauley's entire body of work, this positioned *Sugar* as part of that trajectory. While this may be McCauley's intent I see the work as blending the community based performance with the family narrative pieces.

¹² See previous note.

¹³ For more discussion of the sexual double-bind that African American have historically faced see Beverly Guy-Sheftall "The Body Politic: Black Female Sexuality and the 19th century Euro-American Imagination." *Skin Deep, Spirit Strong: The Black Female Body in American Culture* ed. Kimberly Wallace-Stevens (Ann Arbor: U of MI P) 2002, 13-35.

¹⁴ For a discussion of the tensions between fatness, African American women, and U.S. cultural representations of beauty see Doris Witt "What (N)ever Happened to Aunt Jemima: Eating Disorders, Fetal Rights, and Black Female Appetite in American Culture" *Skin Deep, Spirit Strong: The Black Female Body in American Culture* ed. Kimberly Wallace-Stevens (Ann Arbor: U of MI P) 2002, 235-254. Witt's article focuses upon the conflation of the African American woman as fatness in American culture and the move of the "Aunt Jemima" stereotype from cook to consumer. Witt argues that the rhetoric of this new fat consumer "Aunt Jemima" stereotype as a cultural norm is racist and perpetuates poor health in the African American community.

¹⁵ One woman in particular began the talkback on the second night with the comment, "You say you feel like you are a second class citizen because you are black, well I feel like I am a second-class citizen because I have diabetes." She then went on to relate a story of prejudice she experienced at the hands of her doctor due to her weight and inability to control it. There was no acknowledgement of the possibility that she was in fact "failing at whiteness" in the eyes of the doctor.

Chapter Three: Performances of Breast Cancer Experience

Susan Miller's *My Left Breast*, Linda Park-Fuller's *A Clean Breast of It*, and Brandyn Barbara Artis's *Sister, Girl*

This is my body-where the past and the future collide (S Miller 104).

*But what fascinates me most is that cancer is all about communication –
intercellular communication, about how the cells communicate (or fail to communicate)
with one another. When you think about it, cancer is just one big misunderstanding!
(Park-Fuller, A Clean 228)*

*After the third chemo, I say no more. Win one, lose one, let's see if she glows in
the dark, let's kill some cells so that others may live, turn this way, hold your breath,
don't put your hand there dear. Stay out of the sun. Have a nice weekend.
Sister, Girl Brandyn Barbara Artis*

While Robbie McCauley's work in Chapter Two featured the chronically ill body negotiating a lifetime of illness within a medical setting mired in racist history, this chapter examines the performance work of women coping with cancer – an acute illness that is often asymptomatic until diagnosis. In this chapter, I ask how this unique aspect of cancer changes the representation of the experience and how treatment and cure are implicated in traumatizing the patient. Again, I question how, within this different context, each performer makes aesthetic choices that performatively demonstrate the structure and experience of her illness related trauma. How is memory negotiated in filling in the gaps of traumatic experience and bringing that experience to the stage?

Because these performances intersect with arguably the most feared disease in the world, I investigate how these performances reinforce and/or counter popular and medical knowledges that circulate through media channels. How do the performers find

means of testifying to new knowledge that might easily be suppressed within the information overload that accompanies cancer? Can this speaking of different perspectives reveal weaknesses within the medical systems knowledge producing systems?

I also question how the bodily changes caused by cancer affect each performer's conception of gender and sexual identity, and how each woman witnesses to this new understanding of self? What disruptions of normative ideas of femininity and sexuality are performed that further also undermine the concept of identity as a monolithic unchanging category? How do these experiences of body as fragmented, parsed, and altered illustrate the ways in which our identities are as cobbled together as our physical beings are? How does each performer claim a “. . . 'subject in progress' even if that subject is searching for a sense of wholeness” (Henke xvi)? Finally, I ask can these testimonies to negotiated identities and subjugated knowledges be heard within medical venues that often sponsor these performances?

In order to fully parse the significance of these performances and to discover their ability to disrupt norms of medical knowledge and identity discourse and to function as acts of witnessing for both performer and audience, I must situate them within the context of cancer and specifically breast cancer discourse from the early 1990s to the present day. Understanding the culture and discourse of the breast cancer community is essential because medical institutions often serve as the venues for live performances, and biomedical knowledge is produced both through and around the performance events. Reading across the performances, I also point out the places where the pieces diverge

from each other in politics and structure. While I interweave these three performances as much as possible, there are times when I must move back and forth between particular sections and questions. I begin with a brief introduction of the pieces and an examination of how the performances reveal and reflect the insidious trauma of cancer diagnosis and treatment.

Performance Introductions and Structures of Trauma

Susan Miller's *My Left Breast*, Linda Park-Fuller's *A Clean Breast of It*, and Brandyn Artis's *Sister, Girl* all rely upon personal narrative as their structural foundation. Each performer employs her body differently, yet each relies upon a vigorous physicality within the performance. Telling her story of diagnosis, treatment, and recovery (not necessarily in that order), each performer reveals a variety of identity crises within the experience of illness. These women come from differing backgrounds and perspectives: Susan Miller is self-identified "... one-breasted, menopausal, Jewish, bisexual lesbian mom" (S Miller 104); Brandyn Barbara Artis is an African American heterosexual actor and playwright who has appeared in numerous film and television productions; Linda Park-Fuller is a white heterosexual professor of Performance Studies at a major U.S. university. My level of involvement with each artist varied: I had access to Miller's script, published interviews and reviews; Artis's reviews and video clips, televised interviews and a personal interview; and Park-Fuller's published writings, script, a personal interview, and I was able to view a live performance of Park-Fuller's work in October of 2005.

Structures of Trauma Within Performances of Breast Cancer Experience

Reading across these performances, there are structural similarities that reveal the insidious trauma of cancer diagnosis and treatment. I am not implying that the idea of cancer and the possible subsequent bodily degradation and death that such a diagnosis can imply is not a traumatic event; however, the insidious daily trauma of cancer is usually inflicted through experiences with the medical community and the aftermath of treatment. Ironically, the immediate experience of the trauma of losing bodily integrity and control is inflicted through the treatment for cancer. Cancer patients are often filled with ambivalence towards the treatment and care that saves life while also inflicting bodily trauma. From the first moments of being told that you had no knowledge of the potential death lurking within your body, to the new language of medicine that must be learned, to the amputation and chemical alteration of the body, these performances weave together disparate painful memories into collages of monologue, song, and scene. Lacking a linear structure, a common characteristic of traumatic narrative, these performances work “to reassemble an organized, detailed, verbal account, oriented in time and historical context out of fragmented components of frozen imagery and sensation” (Herman 177). The expression of the trauma is what allows for a therapeutic transference and witnessing. The witnessing includes not only a reconstitution of identity but also a witnessing as affirmation by the viewing audience. The performer is no longer the only keeper of the traumatic experience.

The movement in time and the collaging together of vignettes that does not follow a chronological structure separates women’s performances about cancer from traditional

oral narratives. As Mary K. Deshazer points out, women's performances about cancer deviate from the traditional "proaieretic code" of cancer narrative, "discovery, diagnosis, decisions about treatment, confronting possible death and life after treatment" (defined by Potts 2000 14 qtd. in Deshazer 4). The structural deviations within the performances often include memory flashbacks that link the emotional and physical pain of cancer to earlier life traumas and the incorporation of direct address to the audience in order to break from the in-scene flashbacks. Each performer engages losses both physical and emotional that accompany the cancer, as well as incorporating earlier or later psychic wounds that resonate with the cancer experience. Oftentimes, traumatic experience can only be accessed and explained by correlating it with other extreme losses that highlight how trauma can continue to wound beyond the experience (Gilmore, *The Limits* 27). Beyond these similarities, each performer employs other specific strategies that I will discuss individually.

Susan Miller's *My Left Breast*

Susan Miller's *My Left Breast* is arguably the most produced autobiographical work about illness experience that has ever been staged in the United States and yet there is a surprising lack of scholarship about this important piece. The work first premiered at the Actors' Theatre of Louisville's Humana Festival in 1994 with the author playing herself in the one-woman show running roughly seventy minutes (S Miller 104). Miller's play is collected in *O Solo Homo, The Best American Short Plays of 1993-1994*, *The Breast: An Anthology*, and *Plays from the Humana Festival 1994* (Rev. of *My Left Breast*). It has been produced in over fifty venues with Miller portraying herself, and

continues to be produced in other venues with other actresses performing the role of Susan. In addition to numerous U.S. productions in every region of the country, *My Left Breast* has been performed in Canada, France, and the United Kingdom (Rev. of My Left Breast).

Hailed by numerous critics as a writerly meditation that surpasses the individually therapeutic narrative, Deanna Jent's commentary is representative of *My Left Breast's* critical reception: "Ostensibly a play about surviving breast cancer, *My Left Breast* is really a series of poetic riffs on loss of all kinds: lost love, lost children, bone loss and the loss of structure (both real and narrative)" (Jent). Agreeing with this critical framing, Miller has continually asserted that her work is not "journalistic," "confessional," or "therapeutic" (Hartigan 76; Lincoln W01). She claims that she was attempting to capture "what's it like to live in a particular moment of time. That's what takes me from the personal to something larger. I like to call it autobiographical fiction" (Byrne 43). Miller alludes to the impossibility of linear structure for an experience that took years to coalesce in a manner that was "writable."

I wanted to create a balance of sadness and joy. . . There are intense moments. We are dealing with a character that is flawed and makes mistakes. It's someone in transition. That's why it helps to juxtapose scenes when my son was 8 (his age when Miller was diagnosed) with him as a 20-year old. It reinforces the structure of the journey. (Byrne 43)

Miller reinforces the shifts in time and comprehension indicative of traumatic experience when she speaks of the structure of the journey being included within the play. Speaking

of the change in her reality Miller states, “You come to the edge of the world as you know it . . . You either fall off or you create another world or you re-enter the world in a new way” (Rau 5H). Even though Miller does not position *My Left Breast* as a therapeutic vehicle, her commentary does reinforce the reintegration of self into the symbolic through works such as *My Left Breast*.

Composed nearly fifteen years after her initial diagnosis, *My Left Breast* serves as Miller’s moment of “finding the metaphor” to write and perform about breast cancer (Rau 5H). The structure of *My Left Breast* also links multiple life traumas together through shifts in time and space. The language of failing to find the metaphor is indicative of the incomprehensibility of traumatic experience and the necessary latency period before the event can be assimilated. That Miller continues to interpolate and interpret her experience with breast cancer alongside other difficult life events illustrates the manner in which we know trauma through linking losses together in order to find access to comprehension.

The removal of my left breast, she explains, is a metaphor for the transformations of our lives. I don’t write ‘journalistic’ pieces. It isn’t a confessional. This wasn’t a catharsis. I have to have some sort of literary metaphor, and finally I was able to put the breast cancer in a structure and context of other life-transforming experiences. (Lincoln W01)

Miller incorporates numerous losses that occur over a twenty year time frame; the loss of her infant son (S Miller 114), the loss of her publishing contract (S Miller 110), and the recurrent and painful theme of the loss of her lover Frannie (S Miller 114). Commenting

upon the play's structure a reviewer states, "It's heady and complex—like jazz—and you've got to let it wash over you and take you where it wants to go. You can't fight it or ask questions" (Jent). Rather than a linear telling of her experience, *My Left Breast* accrues substance as it progresses through vignettes that link disparate losses together. "For me, *My Left Breast*, is really about that last line. . . Something that is in pieces becoming whole again – and large...more than whole." (Rau 5H). As in all utterances about traumatic experience, the meaning coalesces in the spaces between the vignettes, and in the slow accrual of substance through the shifts in time, space, reference, tangent, etc. found within *My Left Breast*.

Linda Park-Fuller's *A Clean Breast of It*

Linda Park-Fuller's *A Clean Breast of It* is a much more conscious working through of the illness event with a performative structure that reflects not only the experience but also her post-cancer contingent life philosophy. The autobiographical one woman performance chronicles her experience with breast cancer, and the reconstruction of her life and body. The piece includes song, musical accompaniment, personal narrative, statistical data, and audience participation – at least on a nominal level. Park-Fuller, a white scholar of personal narrative in the field of Performance Studies, has performed *A Clean Breast of It* in over fifty venues within the United States since its conception for the Petit Jean Performance Festival in November of 1993 (Park-Fuller, *A Clean* 216). Park-Fuller has published two articles in *Text and Performance Quarterly* that interrogate a variety of aspects of the performance piece including how the work functioned as a performative working through of the traumatic experience of cancer.¹⁶

Park-Fuller also waited several years before beginning composition of *A Clean Breast of It*. In a personal interview she stated that she had to wait until she was no longer the protagonist of the story but rather the narrator (Interview). The distancing of the self through a shift from protagonist to narrator serves as another indicator of the traumatic nature of her experience. Narrating implies a distance, an omniscience regarding form and content while a protagonist exists inside a story, lacking the ability to see the metastructure of the story. A narrator controls and guides while a protagonist experiences. While Park-Fuller has stated that she wanted to “desubjectify” her experience against the “cancer victim” role she also openly admits to the fear of re-traumatizing herself (Park-Fuller, *A Clean* 215-216). Park-Fuller’s work emerged through a series of long walks and monologues told to her dog. She knew that she could walk the dog in beautiful surroundings and have a place to return to if the conjured memories became too painful. Becoming the narrator of *A Clean Breast of It* was a thoughtful and deliberate process (Ibid). This choice also reflects Cvetkovich’s understanding of trauma’s resistance to vulnerability; Park-Fuller has created a safety net for herself that she transfers to her audience by becoming the narrator. The audience knows that she is in control of the telling and they need not fear being over-inundated with information that could in turn traumatize them.

Wanting to create a structurally flexible script, Park-Fuller decided to interweave stories in an improvisational style to mimic her understanding of life after cancer. The work pulls together story, song, scenes in flashback, and direct address to the audience to accomplish this goal. Park-Fuller repeatedly uses one song, “It’ll Come to Me,” to break

from scene to monologue and to express sadness, joy, and longing. The song itself is simple in its lyrical content, “and it will come to me just like a song and I’ll make it up as I go along” and is performed in a straightforward manner (Park-Fuller, *A Clean Performance*) We learn later in the performance that Park-Fuller learned to play and sing after her cancer recovery. As Lynn C. Miller and Jacqueline Taylor have noted, the simplicity of the instrumental accompaniment and her untrained voice “positions her as a kind of folk raconteur” (Miller and Taylor 184). As an audience member I found the song to be poignant and wistful, calling to mind a melancholy yet hopeful feeling and reminding me of the moments that reside outside of the performer’s ability to express (Park-Fuller, *A Clean Performance*). Written in everyday language, Park-Fuller’s work has a folksy style reminiscent of her talks with Buster, but also includes a clear focus upon the diagnosis, treatment, and aftermath of her cancer experience (Park-Fuller, *A Clean* 217). Park-Fuller’s work is a pastiche of scenes in flashback, song, and direct address personal narrative. This structure allows audiences access to the most painful moments of diagnosis, treatment, and recovery while also allowing Park-Fuller an emotional safety net from her own traumatic memories.

Brandyn Barbara Artis’s *Sister, Girl*

Brandyn Barbara Artis’s *Sister Girl* premiered in 1991 at the Los Angeles Theatre Center, four years after her diagnosis and treatment for breast cancer. Composed from journal entries that she kept before, during, and after her breast cancer experience, *Sister Girl* relies completely upon personal narrative and direct address to the audience (Hammers 33). With the assistance of a grant from the National Endowment for the Arts

which Artis received to debut the work, *Sister Girl* has been produced for fifteen years in the United States and Europe. Artis, a medium height thin African American woman, normally plays herself; however, the work has been staged with five actresses splitting the lead role in London (Artis). The size of venue and audience has ranged from medium sized churches that seat several hundred, to Central Park with thousands in attendance, to medical conferences with hundreds of professionals, to a massive auditorium at the University of Iowa with over nine thousand people in attendance (Artis).

Artis's work is decidedly triumphant with a snappy energetic pace and has the least inference of traumatic structure. During her journaling she maintained contact with and access to her experiences through the intense cataloguing that she practiced. This cataloguing is later worked into the script. I do not have access to the entire script because it is not copyrighted, but I was able to see extensive clips through a series of televised interviews that Artis shared with me. The most characteristic aspect of trauma is the link that she makes to the grief and confusion that she experienced as a child negotiating the illness of her grandmother. She alludes to the silence and half-silence of whispers that the adults around her practiced in order to keep her in the dark regarding her grandmother's condition. In this scene she reinhabits the body of the confused and grieving child, rocking on the floor and cradling herself, while her voice is heard in a voice-over speaking in half understand phrases and whispers. This simultaneous embodiment of the grieving child and the incomprehensible adult voices is a melancholic expression of the comprehension schism within moments of trauma.

What possibilities do these performances of traumatic experience offer in disrupting norms of medical knowledge, both popular and specific? Can these experiences outside of the norms of everyday life point to the processual nature of identity as these women rebuild their understandings of gender and sexuality within an altered body? In order to discuss the disruptions of medical knowledge and identity construction an analysis of the culture of breast cancer discourse follows that includes an examination of the militaristic rhetoric of cancer discourse, a brief historical framing, and the gender issues within the breast cancer community.

Cancer and Breast Cancer Context

Cancer with its multiple incarnations and permutations is the most common disease in the United States. Until the rise of AIDS, cancer bore the mantle of being, arguably, the most feared disease in the world. Constantly spoken of using militaristic terms such as battle, fight, triumph, victory, etc., cancer is the disease that is uncontrollable, the disease that tricks the body into an unwitting suicide. Cherise Saywell et al. define cancer's unique pathology: "It is a disease of uncontrollable life whereby the boundaries of life and death are unrecognizable" (39).

Susan Sontag has written extensively about the danger of metaphor and illness, explaining how this metaphorizing of disease creates a hostile rhetorical world where the bodies of the ill become the "battlefields" upon which the war is fought. Sontag also explains how the "othering" of disease can easily result in a slippage that positions the patients suffering from the disease as the "others" to be fought as well.¹⁷ Despite her cogent critique, breast cancer is certainly still positioned squarely within the militaristic

metaphor of the good guys (patients, doctors – mostly doctors) versus the bad guys (cancer); if the patient does not accept the wisdom of the good guy doctor then the patient is clearly in collusion with cancer. Audre Lorde complicated this critique of militaristic rhetoric by casting herself as an Amazon warrior fighting against the injustice of cancer. Her militaristic rhetoric served her positively and allowed her to fashion an identity that valorized the one-breasted woman.¹⁸ Perhaps the problem lies within the casting of roles in much dominant cancer discourse. As Park-Fuller notes, “If there is any ‘dominant’ story at all, then, it is a story about the medical community-cast as both protagonist and narrator, with the patient serving only as the ‘scene’ or ‘field’ on which the battle with the ‘Cancerantagonist’ occurs” (“Narration” 620). Breast cancer is a particularly rich site for the investigation of the gendered metaphors associated with cancer since it affects women’s sexualized organs and reproductive organs.

Barron Lerner traces the roots of the militaristic metaphors of breast cancer by linking the rise of technologically sophisticated hospitals and research centers with the end of World War II. By understanding cancer as something that could be “battled,” in radical and violent ways, the U.S. medical establishment argued that early intervention was the only sensible method of treatment. From the outset, the focus was upon treatment and “cure” rather than prevention. Early dramatic intervention, even if unsuccessful, was clearly the most rational strategy from the medical establishment’s point of view (Lerner 33). Therefore, although potentially crippling, the Halsted radical mastectomy, which required the surgical removal of not only the breast but much of the muscle tissue of the chest wall, became the standard for breast cancer treatment until the

mid 1970s. In addition to the Halsted, a radical new high dosage chemotherapy (HDC) became the norm for breast cancer treatment. This procedure consisted of chemotherapy drugs that ranged from six to ten times the strength of regular chemotherapy and caused violent side effects; however, this treatment was recommended until it was proven that this additional strength produced no significant increase in remission or “cure” (Lerner 45-51).

During the 1970s women’s advocacy groups began agitating for a reappraisal of the Halsted mastectomy based on research that showed a less invasive mastectomy had the same results without the loss of muscle tissue. Lerner points out that there is an insidious relationship between gains in biomedical knowledge and the cultural acceptance and understanding given a disease. The self-feeding cycle begins when as a disease becomes more defined and understood through biomedicine usually because of its prevalence in diagnosis. With more information being produced about the disease, it then moves into the public arena for therapy, support, education, etc. This in turn feeds back into the amount of funding, research, etc. that is given to the disease within the biomedical community. This is problematic for people who suffer from rare disorders because their illnesses continue to be positioned as less legitimate and worthy of investigation (Lerner 28). For cancer research this loop has provided a growing legitimacy as more biomedical knowledge is produced for a disease that affects so many people.

Beyond the activism of the 1970s that slowed the rate of Halsted mastectomies, the largest move forward in breast cancer activism began in the 1990s - the time frame

from which all of the performances examined here emerged. Several factors converged to create this increase in attention and funding. A continued slow growth of women's activism regarding breast cancer stemming from the 70s activism built a level of grassroots awareness. The aging of the baby boomer demographic contributed to an increase in visibility since breast cancer is primarily contracted by women between the ages of 49-75. An increased visibility and a more focused investigation into "quality of life" issues associated with this aging population also began (Casamayou 7). According to Maureen Casamayou, other important factors included diminished taboos regarding women's body issues, an increased focus on health consciousness, an important study issued by the Congressional Caucus on Women's Issues that showed a gendered discrepancy regarding which illnesses received funding commiserate with their frequency rates, and the founding of the National Breast Cancer Coalition (NBCC) in 1990 (7).

From the founding of the NBCC in 1990 through 1993, the congressional funding for breast cancer increased by more than 134 million dollars. Prior to 1990 the average increase in breast cancer funding was 5.2 million dollars per year (Casamayou 6). While the lobbying of the NBCC was instrumental in this process, the coalition had a powerful ally in President Bill Clinton whose mother was suffering with breast cancer during this time. In addition to Clinton and the Washington lobby presence that the NBCC was fielding, breast cancer survivors began forming grassroots chapters across the country (Casamayou 10).

Many of these grassroots chapters began in hospital support groups where women were discussing a more direct and politicized approach towards reforming funding and

research for their illness (Casamayou 6-7). Support groups created bases where “such things as sharing, collaborating and cooperating became the new norms readily transferable from the support group settings to the newly formed political advocacy groups” (Casamayou 155). Many of these support groups were primarily populated with white middle-class professional women who felt that access to political power was a “natural” evolution from the therapeutic setting of the support group. A true coalition, built on grassroots chapters, the NBCC applied direct pressure to congressional representatives to focus funding on “. . . cure and not on developing more physical and economically costly treatments” (Casamayou 8).

While initially politically efficacious, the white middle class professional mentality of breast cancer organizing proved problematic in building a coalition representative of the diversity of breast cancer patients. The NBCC was particularly successful in getting breast cancer into public discourse through media attention. Focusing attention on the experiences of younger women with the disease was an initial strategy for realigning the public’s understanding of who was at risk for breast cancer. The NBCC wanted to redefine the disease as not just an older woman’s concern (Casamayou 8). This strategy inadvertently backfired when the media began spotlighting primarily young white middle-class mothers to the exclusion of other stories. The breast cancer patient that began to emerge was young, feminine, still sexy, white, and a mother. Casamayou and Saywell et al, point out this focus upon a feminine and sexualized young woman skews the accuracy of who suffers from the disease as much as a focus upon older women does (Casamayou 8, 158; Saywell et al. 37-62). The performances

examined here do not reinforce the young, white, heterosexual mother stereotype. Instead they offer perspectives that question the gender, sex, and racial norms that were being perpetuated.

Beyond misrepresenting the groups that are at-risk, this stereotypical focus also defines the range of responses that are “correct” or “acceptable” (Casamayou 158). Throughout the 1990s the press often referenced the sexuality and beauty of the victims of breast cancer (Saywell et. al 41). While this was a move away from the focus upon mutilation and amputation, this move repositioned recovery as a recovery of a very specific feminine norm that was certainly not available or desirable by all women suffering from breast cancer (Saywell et al. 43-4). As Lisa Cartwright adroitly concludes,

The problem we face is not that women are depoliticized, silent or separate but that the media savvy breast cancer activism that has emerged in the late 1990s constructs the breast cancer community around a set of signifiers that includes white, straight, middle and upper class, urban, educated, professional, and conservative. (123)

When the media’s version of appropriate responses to cancer promotes interactions and identifications between women who identify with normative performances of gender and sexuality, what then happens to women who are not configured within this set of norms? There is no understanding or acknowledgement that the “the disease is represented and lived through issues such as class, beauty, fashion and aging” (Cartwright 123). Again, Miller, Park-Fuller and Artis upend these assumptions and illuminate the limitations inherent within this perspective.

While this mainstream media movement was aligning breast cancer recovery with a normative femininity there were individual accounts entering the public dialogue that did not necessarily reinforce the same ideals. From the 1970s through the early 1990s several important literary accounts of breast cancer experience were published. Among the influential works were Rose Kushner's *Breast Cancer* (1975), Betty Rollins's *First, You Cry* ([1976], 2000), Susan Sontag's *Illness as Metaphor* ([1976] Reprint Date), and Audre Lorde's *The Cancer Journals* (1980) (Deshazer 2; Rosenbaum and Roos 156-7). Ranging from personal narrative accounts not specifically politicized to personal manifestos against the cancer causing corporations of big business (Lorde's) these illness narratives brought a different personal face and a more in-depth account into the conversation. Mary K. Deshazer examines the significance of the Lorde and Sontag accounts:

[they] . . . questioned the equation of illness with femininity and the pathologizing of cancerous bodies, examined the politics of mastectomy, reconstructive surgeries, and prosthesis, and documented the power of feminist communities to resist society's discipline and punishing of ill bodies. (Deshazer 2)

Along with the literary accounts came the first ever published images of women who had undergone mastectomy. The most famous of these images was of Matuschka, a high fashion model, published in New York Magazine on August 15, 1993 (Cartwright 128). While Matuschka's photograph was shocking in that it displayed her chest and mastectomy scar, it also was framed within the traditional lighting and posing of art

photography. She is a normatively beautiful woman: white, blond, thin, striking features, albeit missing a breast on her right side. “In this image, Matuschka has opted to reclaim the scar as an object of aesthetic and political significance and more profoundly, as an object of fascination, if not beauty” (Cartwright 128). During this era there was a dominant stereotype of the cancer patient, as well as a proliferation of voices from a variety of perspectives trying to speak. Premiering in 1991, 1993, and 1994 respectively, this is the popular, literary and artistic milieu within which the performances by Miller, Park-Fuller, and Artis are situated.

Disrupting Cultural and Medical Discourse: The Rhetoric of Personal Responsibility

[What is forgotten] . . . is the story of the often difficult to discuss, yet powerful ways that the social forces that we take for granted have deeply influenced and forged women’s experiences of breast cancer (Love xii).

*For example, by emphasizing diet and exercise as an individual choice, the media ignores such social factors as the production of unhealthy foods, the links between pesticides and other toxins and breast cancer, and socioeconomic inequalities in access to potentially healthier foods and medical care
Overall the emphasis on the individual in representations of breast cancer risk erases political, economic, environmental, and social factors. (Fosket et al. 315)*

The rise in visibility of breast cancer from the 1970s through the 1990s is linked to the rise in the rhetoric of personal responsibility and health that is now culturally pervasive in the United States. This rhetoric is a combination of medical facts and U.S. individualist philosophy – a sort of reductionist “now that you have education available to you about this issue, it is officially your problem.” Medical sociologists continually point to the often faulty media as “sources of cultural messages and ideologies about women, their bodies, and disease and illness” (Fosket et al 303). As Fosket et al. state,

“Self-help taken out of the context of feminist empowerment has become individualized and victim-blaming. It has also succeeded in taking health issues out of their social contexts and transformed them into individual problems” (309). While the positive political change that brought visibility and research dollars to breast cancer helped redefine “women as competent surveyors of the health of their breasts,” this shift also squarely placed the burden of that surveying upon the shoulders of individual women (Ibid).

The pervasiveness of personal responsibility in breast cancer rhetoric includes messages of women’s responsibility for: monthly self exams; appropriate diet; stress reduction; child-bearing choices that might impact breast cancer probability; and regular exercise. According to popular knowledge all of these factors supposedly play a part in determining a woman’s possibility of contracting breast cancer when in actuality, the only known *cause* of breast cancer is radiation. The ironic rhetoric of personal responsibility follows a circuitous and illogical path: once you have cancer you should surrender all bodily choices to your medical care providers; in fact, while your choices as an individual might be construed as being responsible for your contraction of cancer, once you have cancer all the data that is used to treat you is based on the masses collected from other bodies, and the specificity of your body – or your knowledge of your body – is erased (Potts 101) (Fosket et. al 307). This focus on the individual and individual choices moves the focus away from larger cultural inequities and problems that could be underlying factors such as environmental degradation, racism, poverty, etc. Women are expected to prevent, detect, and survive breast cancer (Fosket et al 304).

Each of the performers studied here engages this discourse directly, either in the performance or in ephemeral information surrounding the performances. While there are several examples within each piece, I have chosen the ones that I feel most directly engage with and disrupt or reinforce this harmful rhetoric of personal responsibility. The piece that most directly refutes the rhetoric of personal responsibility is Susan Miller's *My Left Breast*.

Miller directly engages the rhetoric of personal responsibility early in the performance. Interrogating the idea of "bringing it on ourselves" while also linking breast cancer to other struggles for human agency (Deshazer 11), Miller confronts the audience with a series of questions:

So I wonder, are there certain types of people who get raped and tortured?
Are there certain types who die young? Are there certain types of
Bosnians, Somalians, Jews? Are there certain types of gay men? Are there
certain types of children who are abused and caught in the crossfire? Is
there a type of African American who is denied, excluded, lynched? Were
the victims of the killing fields people who just couldn't express
themselves? And are there one in eight women- count em folks- who are
just holding onto their goddamned anger? (S Miller 104)

Breast cancer is not an atrocity committed by other human beings, but by connecting obvious injustices with the self-blaming rhetoric of personal responsibility, Miller exposes the psychological and physical damage done to the bodies of women suffering with breast cancer.

Miller's initial confrontation with the audience, and with larger societal structures, is tempered with ambivalence later in the performance. Showing the incredible power of the rhetoric of personal responsibility, Miller also ambivalently questions her "personal choices" that could have been factors in contracting breast cancer. She catalogues a list of possible causes including; taking a prescription for Provera to dry her breast milk after a stillbirth, having pesticides sprayed in her apartment, eating too much fat, using deodorant that contained aluminum, living near high power electrical lines, etc (S Miller 112). Her seemingly endless list effectively illustrates the blackhole of self-blame that is created by the rhetoric of personal responsibility in the mind of the cancer patient. Miller shows us her pain of self-blame again when she discusses her cocaine addiction from a third person perspective. Acknowledging that she "was not the kind of cancer heroine" that she thought she was supposed to be, she observes her past self and admits that she thinks that self could have done better, that she will in fact do better by kicking her addiction (S Miller 107). There is no easy subversion of the harmful rhetoric of self-blame and Miller's work demonstrates the power of this rhetoric to create doubt in the mind of the person struggling with a cancer diagnosis that in itself should be enough for a patient to address (Deshazer 14). Audience members may also begin questioning the performer's culpability in her cancer diagnosis as an attempt at distancing and protecting themselves from frightening identification.

Linda Park-Fuller echoes Miller's critique and ambivalence. Park-Fuller also questions the audience directly regarding the links between larger societal structures and the growth of cancer. She asks why the FDA approves bovine growth hormone when it

has clearly been linked with cancer in laboratory trials. She asks why healthy people don't ask the questions. She reminds the audience that when you have cancer, you don't have time to ask these questions because you are just trying to stay alive (Park-Fuller, *A Clean* 229). She points out the irony of being served a Shasta diet drink in the hospital; a drink with a clear warning label on the side that saccharin has caused cancer in laboratory animals (Park-Fuller, *A Clean* 230). After this event, she realized that whatever changes she needed to make regarding her health were changes that she had to instigate, as no one was going to help her with making healthier choices in her life. "They didn't tell me how to help myself. They were going to treat my cancer in just two ways – surgery and drugs. Drugs" (Park-Fuller, *A Clean* 230). Along with this trenchant critique of the lack of a holistic approach to patient care, Park-Fuller also questions her own responsibility in managing the stress of her lifestyle. As a full-time academic, she acknowledges her tendencies toward perfectionism and the pressure that she continually applied to herself. She wonders aloud about the effects of the cocktails to handle stress, the cigarettes (which she promptly quits after twenty years of smoking), and the anger that she held inside (Park-Fuller, *A Clean* 229). While Park-Fuller attempts a balance between societal and personal responsibility, she does blame herself in the reflective self-questioning moments. During performance this inner-closed focus becomes pondering and reflective revealing her inner struggle with the self-blame associated with the rhetoric of personal responsibility (Park-Fuller, *A Clean* Performance).

Brandyn Artis both disavows and furthers the rhetoric of personal responsibility in *Sister, Girl*. Artis's work is partially driven by the specific purpose of informing

African American women about breast cancer and the importance of early detection. Personal responsibility and “taking charge” of your own life are key in explaining the role of early detection – without the basic self-exam there is no early detection. In numerous television interviews on networks ranging from NBC to CNN, Artis pushes her message of early detection. In a segment on NBC Nightly News, Tom Brokaw states that “too many black women wait too long for treatment,” thus resulting in a higher mortality rate despite the fact that as a group African American women have a lower diagnosis rate than Caucasian women. Artis counters this lack of contextualization in her interview by explaining that, “There are cultural differences, there are economic differences, I think that women are more concerned with putting food on the table” (Artis Interview Brokaw). Her reasons for creating the piece focus upon the lack of role models for African American women and the lack of education about early detection in the African American community.

For Artis, the silence around cancer in the African American community changes the nature of the rhetoric of personal responsibility – the idea of personal responsibility becomes one of acknowledgement rather than of self-blame, of acknowledging that this disease does exist and does take many lives each year. She refutes much of the rhetoric of personal responsibility when she states in her performance that “I don’t fit the profile”; she elaborates during interviews when she repeatedly states that she ate right, did self-exams, exercised and meditated regularly and yet she contracted cancer. She reminds viewers that cancer doesn’t recognize what you do “right or wrong” (Artis, “Sister Girl”). For Artis, the rhetoric of personal responsibility is only partially linked to charging

women, and especially African American women, with their own well-being; it also includes talking about cancer, dispelling myths created by fear-filled silences, and demanding access to care and support. In this way Artis's message differs from the regressive message of personal responsibility found within hegemonic and white discourses of breast cancer.

Medical Disruptions: Subjugated Knowledge in Detection, Diagnosis, Treatment and "Cure"

Different knowledges about breast cancer are produced by social movements, by women with breast cancer, by those critical of biomedicine and by biomedicine itself. These controversies abound both 'within' as well as 'outside' the traditional, biomedical realm of knowledge production and problematize the notion of a clear boundary between 'inside' and 'outside' biomedicine, or between 'biomedical' and 'alternative' knowledge. (Fosket 16)

These performances also reveal an understanding of how much of biomedical knowledge is socially constructed while also holding out hope for a better life offered through biomedical interventions (Fosket 19). As numerous medical historians and sociologists have concluded, the danger within biomedicine is its self-perpetuating hegemonic knowledge. For instance, when certain markers or indicators are established as the standards for diagnosis and treatment, the research gathered from those same standards drives subsequent research that in turn doubles-back to legitimate itself. Within this dangerous self-contained loop alternative means of knowing or understanding the body's health or illness become suspect or unreliable. So while full self-disclosure is expected and demanded in the patient case history intake process, the patient simultaneously comes to be considered a somewhat unreliable narrator of her own bodily

experience once she enters the realm of biomedical knowledge. This paradox can be found and critiqued within the differences between lived narrated experience and the accounts created by biomedicine.

The performances examined in this chapter participate in the illumination of this gap in knowledges, and in the critique of biomedical knowledge as the *only* means of understanding the needs and ailments of the body while simultaneously relying upon biomedicine for the hope of a better cancer-free life. Commenting upon her examination of oral narratives of breast cancer, Jennifer Fosket notes,

Again, women's accounts reveal a demystification of dominant ways of knowing as they assert fundamental uncertainties and potential failings pertaining to these ways of knowing that in dominant discourses are seen as better and most reliable. By starting with women's experiences and taking seriously women's knowledge these hierarchies are problematized and critiqued. (28)

I will examine how these performances reveal the instability of medical knowledge through accounts of detection and diagnosis, the trauma of treatment, and by questioning the "cure" narrative so often told to and by breast cancer survivors.

Fosket has identified moments of detection and diagnosis as the most unstable site of biomedical knowledge. Through numerous accounts Fosket demonstrates the plethora of misdiagnoses despite the certainty expressed by the patient. Fosket also explores the manner in which the patient's personal certainty is undermined and invalidated until the diagnosis is made through imaging technology. She points out that despite the supposed

certainty of medical imaging technology, often times an MRI or a CT scan will not reveal cancer that is found in later stages, again despite the certainty of the detection by the patient (28). Even the most sophisticated equipment is often wrong in the face of patient's accounts of self-knowledge, yet despite this proof that the embodied understanding is valid, the biomedical community continues to rely most heavily upon imaging confirmation (26). Fosket notes this hegemonic interpolation within the women's accounts, as the doubting of self-knowledge is revealed.

What becomes clear in women's stories is that *how* one knows something places value on *what* it is one can legitimately claim to know. That is, knowing one's cancer through the legitimated, rationalized means prescribed by biomedicine – the clinical and technoscientific gazes of biopsies and mammographies – creates legitimacy for the 'truth' of that knowledge. In contrast, knowing one's cancer through embodiment and experience leads to dismissal of the possibility of certainty about the 'truth' of one's disease. (23)

Therefore, despite the certainty expressed prior to imaging, it is the imaging itself that cements knowledge and subsequently biomedical discourse becomes incorporated as lived experience.

While each performer examines the unstable site of diagnosis and detection through her understanding and "intuition," each ultimately "knows" her disease through the legitimization and naming of the biomedical imaging. Therefore, the ability to speak outside of this knowledge is hindered; however, each performer gestures towards a bodily

knowledge that was discredited prior to the imaging or biopsy diagnosis. Susan Miller and Brandyn Artis both reference their early detection and initial misdiagnosis. Miller's breast lump was initially detected by a lover. Upon visiting her gynecologist in Los Angeles, Miller was recommended to a surgeon for evaluation. Upon manual examination the surgeon told her "Someday you might want it removed, but no rush. It's benign" (103). Over a year later Miller was diagnosed with metastatic breast cancer. While she does not reveal any certainty regarding her personal knowledge and the misdiagnosis, her account does demonstrate the unstable and subjective nature of biomedical knowledge.

For Artis the moment of diagnosis is performed as a powerful moment of embodied recognition. A year earlier a doctor had told her the lump in her breast was just a cyst that she should not worry about; fast forward a year later and that same lump will not disappear. As she waits for the doctor to return from the biopsy, she tells the audience of nervously joking with the nurses and her husband. While she is narrating these tense moments she is standing with typed words being projected across her body and the backdrop that is visible behind her. In the large white dress, the words stand out in stark contrast and label her even before she is labeled with the official diagnosis. Even though the letters are not discernable, this marking of her body foreshadows the diagnosis about to be written upon her body. Artis acknowledges her embodied certainty, an embodied certainty that she did not know she possessed until she heard the surgeon approach. In that moment she states that she heard it in "the placement of his feet on the floor, the heaviness. I'm lying groggy but composed on a gurney in the recovery room, and when

we hear what the surgeon has to say, it is not the words that take the room by the throat, but the profound sorrow that splashed out onto the walls and makes me numb all over” (Artis, “Sister Girl”). As she acknowledges her unstated understanding of the situation, Artis stomps her feet to mimic the heaviness of the surgeon’s approach, and doubles her body in half with the remembered emotional pain. Miller, Park-Fuller, and Artis expose their experiences of detection and diagnosis as productive sites for investigating the gap between lived experience and biomedical knowledge.

All three performers reference their disagreement with the logic of the biomedical model for cancer care as they examine the trauma inflicted by the treatment they received. While each performance can be positioned as ultimately triumphant due to the performer’s survival, each piece still contains tremendous ambivalence and loss. Living through cancer and living beyond cancer are honestly examined in light of the difficult journey caused by the very “cure” that allows each woman to live. Cancer treatments are counter-intuitive to ideas of health that focus upon a holistic approach to the body. As Shoshana Feldman writes of traumatic stories, “the story of survival is, in fact, the incredible narration of the survival of the story, at the crossroads between life and death (“Education” 47). The ramifications of chemotherapy and mastectomy recovery are the central focal points for investigating the conflict each performer feels within her care regimen and her own psyche as she submits to or rejects the counter-intuitive treatments she is prescribed.

Susan Miller chose to discontinue chemotherapy after eleven months of treatment. Throughout her diagnosis and treatment Miller had only a few positive relationships with

care-givers and the final chemo treatment proved to be more than she could bear.

“But at my next to the last treatment, after they removed the IV, the oncologist and his nurse looked at me with what I distinctly recognized as menace. I thought, ‘They’re trying to kill me. If I come back again, they’ll kill me.’ I never went back” (Miller 103).

A few moments later in the performance, Miller explains the long-term ramifications of her chemotherapy. Early menopause at thirty-seven, followed by extreme osteoporosis resulting in numerous fractures from easy exertions such as golf swings, hugs, and shifting in her seat at the movies, culminates in a rage that she still carries seventeen years later. Miller shares the frustration of her “cure” as she steps to the edge of the stage and screams (S Miller 109). Despite the pain and disability, Miller continually states in interviews that the play is still about the last line for her, a line that reads “I miss it, but I want to tell all the women in the changing booths that we are still beautiful, we are still powerful, we are still sexy, we are still here” (S Miller 120). The tension between the accounts of loss and disability and the rebellious resilience to carry on illuminates the personal narrative of cancer that cannot be positioned as simplistically triumphant.

Miller’s work is the most poignant and unflinching in examining this paradox.

Unlike Miller who consistently uses direct address, Linda Park-Fuller examines her ambivalent relationship with the biomedical institution by employing several modes of address. While Park-Fuller talks to the audience through much of the performance, she also portrays moments “in-scene” with her doctors, so the audience is not continually being engaged in direct address. When she chooses to break the fourth wall deliberately, and remind the audience of their participation, she draws upon Brechtian performance

strategies that refuse the collapse into suspension of disbelief. As feminist performance theorist Elin Diamond explains, this division of the performer as both an in scene character and a person commenting upon the performance creates a similar divide within the spectator and results in an engaged dialogic conversation within the spectator (51). In her role as narrator Park-Fuller interrupts the possibility of audience identification and draws their attention toward the “fable” of the story – with a focus upon the societal factors that are often ignored (Diamond 123). Park-Fuller admits her pre-cancer ignorance as to the significance of “chemo,” and her misunderstanding that chemo stood for chemical – toxins. In a straightforward educational manner she explains, “The idea is that most of the poison will be absorbed by any rapidly dividing cell masses, so that the tumor will die before you do – of either the cancer or the chemotherapy” (Park-Fuller, *A Clean* 230).

Park-Fuller acknowledges the “luck” involved in being able to withstand the treatment and recover (*A Clean* 233). As she continues to narrate her experience of chemotherapy, she stops and questions the audience about why there is no focus on causes, only on treatment and “cure.” She questions whether the audience understands the significance of the difference in the cost of drugs within Canada and the United States (Park-Fuller, *A Clean* 232). These questions performatively interrupt the “logic” and inevitability of chemotherapy. Park-Fuller positions her socially conscious questions in order to break the well-known narrative of drugs and “cure” associated with cancer patients. Later, I will discuss how Park-Fuller effectively disrupts the cancer cure narrative as well.

Like Miller and Park-Fuller, Brandyn Artis also engages the ambivalence of her relationship with her treatment and her care-givers. Artis discontinues her chemotherapy in an altercation with her oncologist. Embodying both patient and doctor, Artis voices her concerns over a treatment plan that counters all the logic she holds dear regarding her own body. Her performative overtaking of the role of care-giver, both by embodying the doctor and by taking control of her treatment plan, exemplifies the ways in which patients may subvert systems that feel intuitively wrong for their bodies. In a personal interview Artis explained that she believed in order for chemo to work,

You've got to embrace it – emotionally, physically, and in every way.

You've got to say yes, this is something that is good for me, this is something that will heal me, this is something that will make me better, this is something that I know will run into my body and nourish every cell.

It is like visualization, you've got to see it working, and all the images that I got were negative ones and it would not work. (Artis)

Artis's reliance upon a counter-knowledge has been reinforced by her cancer-free status nearly fifteen years later. Despite this status, Artis is often challenged for making a rash and potentially foolish decision by questioning the biomedical model of cancer treatment.

Further Disruptions: The Cure Narrative and Breast Cancer

According to Barron Lerner in his article "Inventing a Curable Disease: Historical Perspectives on Breast Cancer" the definition of cure has morphed repeatedly over the years with advancements in biomedical knowledge. Beginning in the early nineteen-seventies a method of screening for metastasis was discovered that allowed doctors to

track the path of cancer through the body. This furthered the prescription of chemotherapy and radiation to aggressively treat any renegade cells that showed up in other parts of the body. Lerner argues that although the current marker of five years cancer free may be effective in some cases, this is in fact an artificial marker that is only predictable in certain cases. Furthermore, he finds the statistics on cure misleading because the overall percentage of women within the total population of the U.S. who are dying from breast cancer *has not changed* over the years. There are in fact more benign and slow growing tumors being treated, but the aggressive forms of breast cancer do not show improved survival rates (Lerner 25-50).

Linda Park-Fuller effectively disrupts the suspect “cure” narrative that makes breast cancer such an attractive disease to fight with dollars and research. Park-Fuller has written about her direct engagement with the cure narrative in her article “Narration and Narratization of a Cancer Story: Composing and Performing *A Clean Breast of It*.”¹⁹ Implicitly triumphant in that she is alive to tell the tale, Park-Fuller’s performance resists an “upbeat” tone especially regarding the cure narrative. Personal narratives and flashback scenes are interspersed with the song that continually refers to the instability and unknowability of life. The lyrics of the song read, “and it will come to me just like a song, and I’ll make it up as I go along” (Park-Fuller, *A Clean* 222). The instability of life, and her own “luck” take centerstage in this piece that speaks “with” others rather than “for” them. A cooking timer sounds every thirteen minutes reminding the audience of how many women die each day from breast cancer. Throughout the performance this timer rings, interrupting Park-Fuller and causing her to pause, reflect quietly, and reset

the timer before continuing on with her narrative or scene. Park-Fuller has written that the timer symbolizes how many women die, marking the presence of those who have not lived to tell their tale to the audience (Park-Fuller, *A Clean* 218-219). Park-Fuller speaks directly to the cure narrative as well when she states that “we all know people who have met their ‘cure date’ and been rediagnosed. So you take it one day at a time” (Park-Fuller, *A Clean* 233). The overall tone of Park-Fuller’s performance is one of measured reflection. The combination of the timer, the poignant song of life’s improvisatory nature, and her direct engagement of the cure narrative create an ambivalent tension with her own story of recovery and cure that leaves the audience with an open-ended exploration of cancer experience not easily resolved as triumphant.

The Altered, Amputated Female Body: Disruptions of Identity Norms

I miss it, but it’s not a hand. I miss it, but it’s not my mind. I miss it, but it’s not the roof over my head. I miss it, but it’s not a word I need. . . . I miss it, but it’s not her.
(S Miller 100)

How do you make love to a woman with one breast? With no breasts?
Answer? (plucks guitar string)
Well, you might tell her that with all her other charms, she doesn’t need breasts. You might tell her how strong and courageous she must be, and how glad you are that she survived (Park-Fuller, *A Clean* 227).

After I unwrap the bandages, my Jim Dandy to the rescue kisses me where it used to be and says ‘Baby you can only put one of them in your mouth at a time anyway
(Artis, “Sister Girl”).

This section examines how the bodily changes caused by cancer affect each performer’s conception of gender and sexual identity, and how each woman witnesses to this new understanding of self. What disruptions of normative ideas of femininity and sexuality are performed that undermine the concept of identity as a monolithic

unchanging category? How do these experiences of body as fragmented, parsed, and altered illustrate the ways in which our identities are as cobbled together as our physical beings are? How does each performer claim a “. . . ’subject in progress’ even if that subject is searching for a sense of wholeness” (Henke xvi)? In order to maintain the complexity with which each performer interweaves the already/always entangled aspects of self, I examine each piece individually and each performer’s use of her body to articulate the implications of the loss of the breast as well as other aspects of her changed sexual and gender identity.

Cultural norms tend to create a mystique about the female body that is difficult to subvert. Throughout the history of the Western world Woman has been variously defined by her biology, her “mysterious” and “dangerous” hormone laden parts seen as inextricable to the conception of self.²⁰ What happens when a woman no longer has those gendered parts, or when her bodily chemistry is permanently altered sending her into an early menopause? How do these performers engage and argue with the cultural myths that would align them on the sidelines of life post-cancer as altered, grotesque and lacking femininity?

Normative discourses of femininity construct a passive, sexual and yet maternal, attractive, heterosexual female. This ideal femininity is depicted in women’s magazines as “. . . nonconflicted, carefree, youthful, and healthy, among other things” (Fosket et al. 305). This is a problematic image when cancer is added to the picture. Central to the youthful carefree femininity is the perky, pre-menopausal, and non-diseased breast. As researchers Susan Ferguson and Ann Kasper point out, “No body part plays a more

defining role in those expectations [of femininity] than the female breast” (3). The diseased and cancerous breast is neither sexual nor maternal. Beyond the breast, the chemotherapy associated with cancer often causes early onset menopause, turning young women post-menopausal within a matter of months. This life-changing alteration creates an entirely new experience of the body and of the identity associated with the biological links to femininity and sexuality.

Miller, Park-Fuller, and Artis negotiate these changes differently; however, each woman reclaims her body performatively with a joyous and at times manic energy. Each performer directly addresses the negotiations of identity necessary to embrace and reclaim this new conception of body. The stuttering negotiation of self that each performer speaks reveals the shifting and unstable nature of identity.

Susan Miller distinctly reveals the links between her gender identity, her sexual identity, and her understanding of her bodily changes. Miller is already positioned on the margins of femininity because she is openly bisexual. She focuses much more upon how this change impacts her sexual identity and in doing so she reveals some of the specific challenges faced by lesbians and bisexuals with breast cancer. She also interpolates her scar and her lack of a breast as a new badge of identity.

From the opening moments of *My Left Breast*, Miller makes her joyous reclamation of her body clear to the audience by dancing onto the stage (S Miller 73). Disrupting audience expectations for the tone of a serious performance, Miller’s opening words illustrate her defiant attitude toward her bodily changes: “The night before I went to the hospital, that’s what I did. I danced.” She cups her breasts and asks, “One of these

is not real. Can you tell which?” (S Miller 98). Miller’s initial playful tone offsets audience unease about the sobering subject matter, while also introducing the audience to her fluid negotiation of the complex meanings of her bodily changes.

Throughout the piece Miller discusses not only the meaning of the breast and its loss, but how the loss of the breast and the resulting treatment impacted her entire body and her sexual identity. Sexualizing her breast from the outset, Miller shares an anecdote about the first time a boy touched her breast when she was fourteen. She follows this with an aside, wondering aloud why actresses are supposed to maintain professionalism while their breasts are being caressed in scenes. She argues that she doesn’t think this is a fair gender standard (S Miller 98). Directly following her acknowledgement of the sexual pleasure of the breast, she tells the audience about the maternal significance of her breast. She immediately contextualizes all these statements with powerful words:

I miss it, but it’s not a hand. I miss it, but it’s not my mind. I miss it, but it’s not the roof over my head. I miss it, but it’s not a word I need. It’s not a sentence I can’t live without. I miss it, but it’s not a conversation with my son. It’s not my courage or my lack of faith ...I miss it, but it’s not *her*. (100)

Miller weaves together her complex understanding of her sexual identity, as a self-proclaimed bisexual, and the meaning of her bodily changes on this identity. In the first five minutes of the performance she claims her bisexual identity and tells us that her female partners may see her scar as evidence of mortality. She acknowledges that women might not want to see her scar, not only because of the aesthetic change, but

because they might not want to be reminded of their own risks of contracting cancer. Miller believes this scar could lead to her rejection as a lover and companion for more reasons than those faced by heterosexual women (S Miller 101).

Miller's work is suffused with her detailed description and understanding of her bodily shortcomings. What is most remarkable is that her work also boldly claims her active sexual identity within this body that has been so traumatized and changed. Immediately after Miller describes the meaning of the mastectomy she delves into her past: "Skinned on the left side like a girl, I summon my breast and you there where it was with your mouth sucking a phantom flutter from my viny scar" (S Miller 100). Refusing a sexless existence, Miller reminds the audience that the body is a polymorphous site of pleasure. Disrupting notions of mourning the breast, Miller describes the night she returned home from the hospital as one of intense lovemaking with her partner Jane:

I didn't care if my stitches came free. Let them rip. I shouldn't have been able to move in ways I moved to her, but I was powerful. The possibility of death nearly broke our bed. In a few days I would start chemo, but that night I was not in possession of the facts. I was a body in disrepair, and somebody was healing me. (S Miller 118)

The references to her active sexuality are woven throughout the performance, so as she meditates on a loss, whether it be physical or emotional, she also performatively reminds us of the power of sexuality and connection to aid in reshaping how we think of those losses.

Miller's physical losses include more than her breast. Because of the intense chemotherapy that she received to treat her cancer, she became menopausal at age thirty-seven. She describes the emotions and "aching ovaries" that left her "having hot flashes and panic in the left-hand-turn-lane" (S Miller 108). As mentioned earlier, the long-term effects of the chemotherapy also included advanced osteoporosis (S Miller 108). Again, she interweaves these stories of bodily loss with images of her body being physically loved by other people. She refuses an asexual and crone-like existence even as she acknowledges her difficulty in accepting this body that includes the "old person's" disease, osteoporosis, which she sees as "the anti-feminine, the crone" (S Miller 109).

Miller foregrounds the physical alterations of her body and how living through those embodied changes has reconceptualized her understanding of identity. Reviewers across the country have commented upon her ability to teach audiences about the ways in which we change and our abilities to live through and embrace those changes. Commentary about Miller's work repeatedly refers to how loss helps us "say goodbye to the person that you were" (Dent), and the realization of how many different roles and identities we engage throughout life as we mark the evolution of the self (Magid D1). Miller clearly marks this with the positioning of her mastectomy scar as a reminder, ". . . a permanent fix on the impermanence of it all. A line that suggests that I take it seriously. Which I do. A line that suggests my beginning and my ending. I have no other like it" (119). She acknowledges that there is not a thicker skin growing over her heart, but rather a more exposed and vulnerable place, "closer to the air" (ibid). While many reviewers name her scar a "badge of courage" (Bruckner) or some such triumphant

configuration, Miller names it as a marking of a specific moment that has moved into other moments, leaving her with a new configuration of self that will in turn give way to another and another. As she unbuttons her shirt to reveal the scar at the end of the performance, the lights fade as she looks contemplatively back at the audience. The closing moment is both defiant in its revelation of the “mutilated” body and recuperative in that the lights fade as she reveals the very marking that we have come to know so intimately. This moment is problematic in that she says “you are still beautiful” while the lights are being lowered; could we not see the scar earlier, could we not bear to see the scar in the full light of day? To show this “fixed reminder” of a body and identity that have changed and will continue to change forces an audience to acknowledge their potential vulnerability, to acknowledge that illness and age come to everyone. Audiences could see themselves as Miller describes herself: “This is my body-where the past and the future collide. This is my body. All at once, timely. All at once, chic. My deviations. My battle scars. My idiosyncratic response to the physical realm. The past deprivations and the future howl.” (S Miller 104) Although Miller states, “A scar is a challenge to see ourselves as survivors after all” (120); we are not strong enough to look fully upon the scar before the closing moment and even then it is a “tasteful” moment with fading light. The staging choice undermines the message without completely subverting the meaning; while this is performative of the ambivalence of cancer recovery and the negotiated altered body, I find the moment ultimately disappointing as a statement of feminist reclamation.

While Miller's work foregrounds the fluctuations in identity that are linked to bodily changes, Brandyn Artis's performance traces the vigorous labor of maintaining continuity of identity through such changes. Artis also opens her piece with dancing; her entire body fills with the energy of the activity. She dances with the control of a trained performer, her shoulders shimmying, her head thrown back and her hips twisting to the music ((Artis Interview Brokaw). She embodies the triumphant joyfulness that characterizes the upbeat tone of *Sister Girl*.

Artis explores the meaning of the breast and its loss with humorous anecdotes that mockingly question the cultural significance of a single body part. In a clip from a Reader's Theatre style performance of *Sister Girl* excerpts, Artis reminisces about her girlhood understanding of the breast's significance:

At twelve years old when my mother went shopping I laid down on the kitchen floor and put on mounds of soap suds because somebody told us that would make them grow. Our heads were filled with wishful thoughts of would they be big enough? Suckable enough? Fondleable enough? Not saggy enough, stand out enough, fill out enough with nipples hard or soft enough? We were mesmerized, tantalized, by the floating image of a pooched out chest offering the perfect image of perky melons in every flesh tone, shade, and size selling everything from cocktail nuts to car wax. (Artis, "Sister Girl")

This monologue is delivered with gently mocking laughter as Artis belittles the significance of the breast even as she recounts how as a girl she was held in the longing

thrall for breasts. Artis tells of replacing her missing breast, before she had healed sufficiently for a prosthetic, with a silk scarf filled with foreign coins. She wore this makeshift prosthetic to a taping of *Dynasty* which she'd been cast in during the middle of her chemo treatments. Her greatest fear was not that the look of the substitution would give her away, but that the sound engineer would repeatedly hear an unexpected and inexplicable rattling noise. Woven throughout these two stories is the implicit understanding that the breast, while culturally valorized as an irreplaceable part of what makes up a woman, is actually easily faked, altered, and replaced. Artis exposes her “faking” of the signs of femininity and highlights the constructed nature of gender performance.

While Artis does not show her mastectomy scar in *Sister Girl*, she has shown the scar in performance and she has posed for a nude photograph specifically to reveal her scar. This willingness to confront “it” as she states in a personal interview works to demythologize the importance of the breast. In the photograph collected in Sylvia Dunnavant’s *Celebrating Life: African-American Women Speak Out About Breast Cancer*, Artis appears in a full-page photograph. She is nude and holds a floor-length red robe over the left half of her body. The right side of her body is exposed. She is a slim woman wearing only pearl earrings with short cropped black hair and large brown eyes that look directly out at the viewer. Her mastectomy scar is fully exposed on her right side and she looks out without self-consciousness or defiance as if to reaffirm that it really is not anything to be frightened about. Across from Artis’s picture is a reworking of the apocryphal Sojourner Truth poem “Ain’t I a Woman?” that now includes the

experiences of women altered by mastectomy and cancer. In a phone interview, Artis told me that she posed for the photo not only to show the continued beauty of the post-mastectomy body but also to break the visual silence around mastectomy within the African-American community.

Artis, like Miller, boldly claims her continued sexual identity in her performance. After returning home from her surgery Artis locks herself in the bathroom with her husband to see the scar for the first time. After she unwraps the bandages “my Jim Dandy to the rescue kisses me where it used to be and says ‘Baby you can only put one of them in your mouth at a time anyway’”(Artis, “Sister Girl”). Her relationship with her husband and his continued support are important components of how she negotiated her cancer experience. With her partner’s encouragement, she lays claim to her amputated body as sexual and worthy of sexual attention. She refuses to be configured as maimed or deficient.

Linda Park-Fuller discusses the changes to her sexual identity through straightforward questions to the audience and matter of fact revelations about her interactions with her husband. She states that it felt like a choice between losing her breast or her life and that there was really no question about the matter. She asks the audience to consider how you make love to a woman with one breast. She answers her own question, “show her your ability to find all of her erogenous zones, talk of her courage, her beauty without breasts” (*A Clean* 227). Park-Fuller does not reveal a specific link to her sexual identity and the breast, but she does reveal that the other bodily changes more directly affected her perceptions of femininity.

Discussing hair loss and the early onset of menopause, Park-Fuller acknowledges that these aspects of the disease were more traumatic to her than the loss of the breast. “I guess because it represents to us something about our attractiveness, our youth, our sexual identity” (*A Clean* 231). Early in the performance Park-Fuller explains that upon diagnosis her doctor told her that a lumpectomy was not possible for her because “my breasts were so small and the tumor was so large, talk about adding insult to injury” (*A Clean* 225). She explains that while her femininity had never been closely tied to her breasts, her hair was another issue. This is an oft-repeated statement by women facing chemotherapy. For Park-Fuller, the potential loss of her hair along with the early onset of menopause made her feel as if she was being turned into an old woman. She openly admits to the anger that she had to work through. Interestingly enough there is a particularly gendered response to this anger-- shame. She tells of once waiting impatiently (only once) for her chemotherapy and being shamed by a young boy’s patience as he waited quietly for his treatment (Park-Fuller, *A Clean* 231). While she witnesses to an expansive concept of self that incorporates a different body as sexual and attractive, she also reveals her struggle with the norms of behavior that silence women’s traumatic experiences.

These performances serve as statements of the life continued beyond the trauma and the ways in which the particulars of each experience rewrite each woman’s identity. Leigh Gilmore explains the significance of this witnessing in her work with fictionalized autobiography:

What all these . . . have in common is an author attempting to fashion an enabling discourse of testimony and self-revelation, to establish a sense of

agency, and to unearth a panoply of mythemes that valorize a protean model of female subjectivity, women daring to name themselves, to articulate their personal histories in diary, memoir and fictional form, reinscribes the claims of feminine desire onto the texts of a traditionally patriarchal culture. (xvi)

In doing so, each performer in her own way refuses a desexualized existence and claims her new body as beautiful and desirable.

Witnessing and Community

This theory of subjugated knowledges reveals ways in which what comes to be counted as legitimate knowledge in society is replete with power and implicates larger structural and social relations in society. It also reveals the corresponding emancipatory potential of knowledge and implicates ideas as sites of resistance and transformation. (Fosket 24)

Beyond witnessing to new configurations of self, these performances each witness to new configurations of knowledge about cancer experience and add the dimension of patient perspective to medical discourse, a dimension that is sorely lacking. Breast cancer elicits a unique experience of trauma because it is normally an asymptomatic illness. Unlike the chronically ill woman such as McCauley, or the acutely ill woman, these women only know their illness through the intervention of medical treatment upon their bodies. They are uniquely situated to examine the ambivalent patient/medicine relationship because they are offered no physical relief of pain or suffering through medicine, but rather their pain and suffering are created by medicine. This allows for the potential of a critical distance that straddles the line between personal understanding of bodily experience and the framing put upon them by medical discourse.

These performances serve as ambivalent witnessing that illuminates the gap between the lived experience of breast cancer and the biomedical knowledge produced about breast cancer. Because all of these performances have been produced within medical establishments, and at medical conferences, much of the witnessing has been to a community of other cancer survivors, doctors, or caregivers - - people already intimately connected to the hierarchy of knowledge surrounding breast cancer. Therefore, unlike McCauley who has more ability to speak from an “outsider” perspective, much of what these women have to say is in fact framed through a biomedical model of cancer that upholds traditional gender norms and values the doctor as warrior hero.

Community within such a setting is a contingent and tenuous entity. As Lisa Cartwright explains, illness is a tremendously unstable identity category that usually creates equally transient and unstable communities around it. With breast cancer a woman’s experience may range from patient, to caregiver, to survivor, and back to patient again over the course of her lifetime. How, when, and if a woman chooses to identify with the breast cancer community changes throughout her lifetime as well. Within this highly contingent community there has been real political action and therapeutic support organized over time as evidenced by the founding of the NBCC and its local support groups. Cancer survivors who have participated in support groups are already adept at acting as co-witnesses to stories of breast cancer experience and have been influential in foregrounding more patients’ experiences (Cartwright 118-120). For this audience contingent, these performances act as reaffirmation and reconstitution of that tenuous community.²¹ Each performance also creates multiple identification points

through which audience members not affiliated with breast cancer could find an empathetic connection. All three women reference their family connections, including being a mother and a partner in a relationship. At different points in the performances professions and professional obligations are discussed as are the networks of friends and associates that the disease affects. Structurally the pieces rely upon direct address to the audience with varying levels of participatory possibility for further engagement. Park-Fuller's work is the most directly engaging, and as mentioned previously, she stops periodically and asks rhetorical questions to the audience. (Park-Fuller, *A Clean* 218). She makes the most conscious effort to show the relevancy of the disease to those not directly affected. She ends her performance with the direct challenge for the audience to become involved and reminds audience members that sick people are too busy being sick to ask these important questions (Park-Fuller, *A Clean* 234).

Performing solo autobiographical works about breast cancer cannot be unequivocally celebrated within the medical setting, however. While there is a powerful poignancy and courage to the solo performance, there is also the potential dismissal of the work as "one woman's perspective" without relevance or credibility. Gilmore explains the machinations by which the fearful audience member can question the veracity of the account:

If you are an autobiographer, then you stand in the place of the representative person. Your position there enables the kind of identification that characterizes autobiography. If you act, then, as the mirror of the self (for me), then in my identification with you I substitute

myself for you, the other. If I am barred from doing that by your nonrepresentativeness, I withdraw my identification and, quite likely, the sympathy that flows from it. Thus trauma narratives often draw skepticism more readily than sympathy because they expose the conflict between identification and representativeness. (22)

This possibility of disidentification is strengthened by the subjugated position from which the patient speaks to begin with. Therefore, the ability for performance to function as “an intervention against the silence surrounding the disease” and as an “intervention against the dominant medical discourse that privileges abstract knowledge over individual stories about cancer” (Park-Fuller *A Clean* 215) can become seriously compromised.

Surprisingly, the reason that these performances may be compromised as such interventions can be the presence of experts within the audience or on a talkback panel after the production. Linda Park-Fuller acknowledged that oftentimes at the end of the performance it is the doctors on a talkback panel who take over the discussion with the audience. She works diligently to keep her perspective in the dialogue, but the anxiety within the audience manifests through specific questions regarding treatment options, prognoses, and other specific biomedical questions directed to the doctors. Brandyn Artis relayed similar information about discussion after her performance. Since Artis chose to reject chemotherapy she is sometimes challenged by doctors and audience members alike, despite her cancer-free status, as having made a questionable choice (Artis). In a review of a *My Left Breast* production that included a talk-back with Miller’s oncologist characterized as “a marrying of medicine and performance,” the doctor is featured in the

article and states that “we” will determine whether this work could be helpful to other cancer patients, implying that there needs to be a medical establishment stamp of approval as to the worthiness of the work (Brozan 20). The disparity between the language used and the vast differences in authority and credibility exposed when a performer sits beside a panel of doctors, who supposedly know more about her experience than she does herself, creates a dissonance that highlights the alter-reality of the power dynamics between patient and medical establishment.²² While this silencing alter-reality is evident in the text of the performances, it becomes performatively realized in the talkback settings and can undermine the efficacy of the performance to act as an intervention into the silence surrounding patient experience.

Ironically, through their personal testimony these women performatively witness to the lack of a clear boundary between knowledges outside of the biomedical model and inside of the biomedical model, as Fosket has previously noted (16). Their performance within medical settings and with medical experts commenting upon and sometimes reframing the subjugated knowledge that is being spoken illustrates the permeable barrier between hegemonic and counter discourses. But as Fosket argues, this interaction proves that not only is the biomedical constructed through the social but that the social is also constructed through the biomedical “. . . highlighting the ways in which even biomedical constructions are profoundly social and emerge out of the complexities of women’s experiences and their interactions and positions in society” (16). This foregrounds the fact that medical knowledge is not asocial or “universal” and should be held accountable for including more knowledge produced from patient experience. Even when these

performances “fail” as interventions, they are still productively illustrating the problematic construction of knowledge that lacks a patient perspective.

Conclusion

Pink ribbons on Special K boxes, the Race for the Cure, Breast Cancer Awareness days, and the ubiquity of the Susan J. Koman Foundation all illustrate the degree to which breast cancer has captured the imagination of the U.S. public. Well-funded and researched, the publicity that drives breast cancer fundraising has made a previously unspeakable ailment “the topic of our times” (S Miller 104). Despite the amount of information available regarding preventative measures such as diet and exercise, and the importance of early detection and intervention, the traumatic experience of diagnosis, treatment, and recovery are still spoken quietly lest they undermine the perception of “curability” that makes breast cancer such an attractive disease to fight with dollars and labor. The speaking of loss and pain, even by “cured” patients, constantly threatens to undermine the triumphant narrative of cure.

Through a variety of structural choices ranging from scenes in flashback to direct audience address to personal narrative and song, the performers in this chapter illuminate the trauma inflicted not only through the diagnosis of cancer, but they also speak to the difficult and ambivalent experience of treatment and care that leaves the body physically and chemically altered. Linda Park-Fuller, Brandyn Artis, and Susan Miller use solo performance to both embrace and resist the triumphant cancer narrative by questioning the popular discourse of personal responsibility and cancer, and by undermining the certainty of the cancer “cure” narrative and the medical models for detection and

diagnosis. Foregrounding her altered, amputated and re/covered female body, these performers recontextualize and witness to their post-operative sexual and gender identities and refuse a desexualized existence. Finally these performances witness the dissonance between the biomedical knowledge produced about breast cancer and the lived experience of patients. Even when the performances are reframed by medical experts in talkback sessions, the dissonance between the knowledge systems is evident.

In the following chapter I investigate the implications for a fictive autobiographical text to intervene in normative discourses of medical knowledge and identity. I focus upon two autobiographically based plays, *bringing the fishermen home* and *Three Seconds in the Key*, written by performance artist and teacher Deb Margolin.

End Notes

¹⁶Linda Park-Fuller, "Narration and Narratization of a Cancer Story: Composing and Performing A Clean Breast of It." *Text and Performance Quarterly* 15 (1995): 60-67; see also Linda Park-Fuller, "Performing Absence: The Staged Personal Narrative as Testimony." *Text and Performance Quarterly* 15 (1995): 20-42.

¹⁷ See Susan Sontag *Illness as Metaphor and AIDS and Its Metaphors* (New York: Picador USA) 2001. This new edition contains a final chapter that is devoted solely to the analysis of AIDS rhetoric.

¹⁸ See Audre Lorde *The Cancer Journals* (San Francisco: Aunt Lute Books) 1980; for an in-depth examination of Lorde's traversing of cancer trauma through several texts including *The Cancer Journals*, *Zami*, and *A Burst of Light* see Suzette Henke *Shattered Subjects: Trauma and Testimony in Women's Life-Writing* (New York: St. Martin's P) 1998.

¹⁹ Park-Fuller's article focuses upon her process of becoming the narrator rather than the protagonist of her cancer narrative. She frames much of the work through narrative theory that positions narratizing an illness experience as a therapeutic tool for recovery.

²⁰ This conception of Woman within medicine is inflected by her race and sexuality. For a discussion of white women and Victorian medicine see Chapter Five. See also Ludmilla Jordanova. *Sexual Visions: Images of Gender in Science and Medicine Between the Eighteenth and Twentieth Centuries*. Madison, WI: U of Wisconsin Press, 1989. For more information regarding African American women and the U.S. medical establishment see the context sections of Chapter Two.

²¹ Tim Miller and David Roman address the importance of the reconstitution of marginalized communities in their article "Preaching to the Converted." While focused upon countering the argument that gay and lesbian theatre audiences are uncritical of gay and lesbian performance work that might be found overly didactic by non-gay audiences, Miller and Roman articulate that audiences are never static and must be continuously remade especially audiences that are under constant attack from normative discourse. They also point out that it is important for performances from marginalized positions to have a public forum by which they can articulate and affirm identity in a safe and supportive environment. Miller, Tim, and David Roman. "'Preaching to the Converted.'" (gay theater)(Gay & Lesbian Queeries)." *Theatre Journal* 47.n2 (May 1995): 169(20).

²² In "Narration and Narratization of a Cancer Story" Park-Fuller examines how the dominant narrative is created: "Statistics 'tell' a story of sorts, of course, but it is a story of numbers not human beings, and being positivist, it is a story with *no point of view* (which is to say it has a privileged, omniscient point of view-godlike in its authority)" (63).

Chapter Four: Exploring Traumatic Encounters and the Reconstruction of Identity: Deb Margolin's *bringing the fishermen home* and *Three Seconds in the Key*

Jane: And I see tears in her eyes goddamnit, and she says "But sometimes I want to go backwards." What am I supposed to say to this child? I've just dealt her the first of many blows, I know, and I feel like saying: I didn't invent these systems, I'm just trying to explain them! (bringing the fishermen home 19)

I don't like a sick identity, I have found it very delimiting, and belittling due to my encounters with the medical establishment. Nobody sees your humanity. They see your hysteria, your weeping. They see your glands. Your humanity has no place when your body is being considered by people who don't love you. To put it dumbly and quickly, it is really awful. (Deb Margolin Personal Interview)

Thus far I have focused my analysis on solo performers whose work reveals the experience and structure of traumatic illness through an emphasis on personal narrative. In these performances the performer's physically "well" body speaking of trauma also invokes an implicitly triumphant narrative of stability, recovery, or cure. McCauley's work unveils the trauma inflicted by the links between racism, misogyny, and the medical establishment's treatment of African-Americans while at least nominally reassuring audiences about the controllability of her body. The work of Susan Miller, Linda Park-Fuller, and Brandyn Barbara Artis illuminate the trauma inflicted through harsh cancer treatments and cures while also functioning as specific interventions into normative constructions of female identity and breast cancer discourse. Even as they speak of these experiences, audiences know that they are watching women who are "cured" or in remission. This chapter diverges from the performed autobiographical personal narrative

to investigate two plays by Deb Margolin that differ significantly in structure and form from the previously examined performance texts. Based in autobiography, *bringing the fishermen home* (1998) and *Three Seconds in the Key* (2000) are both one-act plays that incorporate multiple characters into a surreal journey through a woman's experience of illness.

Bringing the fishermen home is an unpublished script that was workshopped at Dixon Place, included in the New Work Now! Festival at the Joseph Papp Public Theatre, and premiered under the direction of Randy Rollison at the Cleveland Public Theatre in April of 1999 (Margolin, *Three Seconds* back inside flap) whereas *Three Seconds in the Key* is a published work with a more extensive production history. Both works are based in specific autobiographical experiences of Margolin's journey with Hodgkin's disease and were written as a means of examining those events (Margolin). However, neither contains straightforward "truthful" personal narratives or medical information about specific illnesses.

I begin with *bringing the fishermen home* and investigate how the move to fictionalized autobiography allows for a more complex and harsh examination of traumatic illness experience. How can feminist performance and playwriting techniques be employed to reveal the structures and patterns of traumatic experience? Rather than focusing upon disruptions within specific forms of medical and popular culture knowledge about specific illnesses, this chapter investigates how these performances can disrupt popular culture mythology about the caring nature of an institutionalized setting. How are uneven and harmful power relations between patient and caregivers exposed

through the utilization of these feminist structures and techniques? Specifically, how are the power relations within a supposedly neutral hospital setting foregrounded? What are the consequences of these power dynamics for the patient positioned in a passive feminized role?

In the second half of the chapter I focus upon *Three Seconds in the Key* and discuss how Margolin performatively demonstrates the labor of reconfiguring gender, sexual, and racial identity through the distilled isolating experience of illness. How does the use of fictionalized autobiography question the boundaries of what can be said about women's traumatic experience of illness and the form that those expressions may take? I ask how representations of traumatic illness and transference, or integration of the experience, can function as potentially radical sites for the re/figuring of identity. Does the performance of this new, shared and interdependent identity create what Jill Dolan theorizes as a utopian performative or a performance event " . . . where people come together, embodied and passionate, to share experiences of meaning making and imagination that can describe or capture fleeting intimations of a better world" (Dolan 2)? Through these two plays Margolin offers both dystopic and utopic visions of a woman's journey through illness, treatment, and recovery. In *bringing the fishermen home* Margolin portrays the potentially horrible consequences of the dehumanizing loss of identity within the medical setting, whereas in *Three Seconds in the Key* she illustrates the utopic possibility of reconstructing a life with a new collective and contingent sense of identity.

Deb Margolin – Background and Context:

Deb Margolin is an acclaimed performance artist, playwright, and teacher whose work is often noted for her incredibly dexterous and beautiful use of language. Margolin began her performance career as a founding member of the Split Britches theatre company. Along with Lois Weaver and Peggy Shaw, Margolin wrote and performed works that have been hailed as formative in the history of lesbian and feminist theatre in the United States (Case 1). During the 1980s and early 1990s, the group collaboratively created productions that included *Split Britches*, *Beauty and the Beast*, *Upwardly Mobile Home*, *Little Women*, *Belle Reprieve*, and *Lesbians Who Kill* (Case 1-33). This early part of Margolin's career reveals the roots of her artistic practice including much of her process, which she later documents in academic articles, as well as her development of a pastiche form of performance that ranges from song and dance to intensely crafted monologues.²³

In the late 1980s Margolin began writing and producing her own solo performance. Lynda Hart has written eloquently about Margolin's solo work and edited the anthology, *Of All The Nerve*, the only compilation to date of Margolin's solo practice. Hart's anthology includes critical commentary that prefaces each of the following scripts, *Of All The Nerve* (1989), *970-DEBB* (1990), *Gestation* (1991), *Of Mice, Bugs and Women* (1993), *Carthieves! Joyrides!* (1995), *O Wholly Night and Other Jewish Solecisms* (1996), and *Critical Mass* (1997) (Hart 198). Since the publication of this anthology, Margolin has also written and produced *bringing the fishermen home* (1998),

Three Seconds in the Key (2001), *Why Cleaning Fails* (2002), and *Index to Idioms* (2004).²⁴

During the mid nineteen-eighties when Margolin began circulating her solo performance work through experimental performance spaces such as Dixon Place and PS122, critics labeled her a “performance artist.” She initially took exception to the name, considering herself to be a “...playwright who wrote little plays for herself and performed them” (Langworthy 38). As her solo career progressed, she embraced the label and began defining her work in relationship to the differences between performance and traditional theatre. According to Margolin, in performance the performer and the character typically are not separate, but function together to reveal the choices, the construction, and thus the political resonance of the performance (Margolin, “Artist’s Notes” 244). Additionally, in performance art the performer and the writer are typically the same person.

Drawing upon the collage effect developed during the Split Britches era, Margolin’s texts encompass a variety of experimental techniques and forms. Douglas Langworthy provides a detailed description:

Margolin’s performance pieces are tightly structured variety shows, where she may play anything, from an exterminator, to a philosophizing waitress, to the letter ‘silent n.’ She may dance like Madonna, do the lambada with a hula hoop or sing “Summertime” to the rhythm of a busy signal. Her wild humor and sharp intelligence bubble through her monologues like carbonation in a Coke, spritzing the audience with images and insights like surplus effervescence. (38)

Margolin further defines her brand of performance as one that does not need the traditional trappings of the theatre, as she insists that performance can occur anywhere (“A Perfect” 69).

Bringing the fishermen home and *Three Seconds in the Key* include Margolin’s trademark use of linguistic elegance and pastiched form although there is more formalistic play structure to the texts. Both plays include direct address to the audience and dreamlike collage sequences in which characters speak in dialogue, or overlapping monologues, which connect across time and space. Margolin states that her illness experience changed her playwriting: “There is a structure that involves many people and I suddenly saw how to do that through illness. I came through the other side of illness and I saw how to bring voices together” (Margolin). The roots of her performance art style are evident in both texts and when applied to multiple characters, allow for a polyvocal and multi-layered portrayal of the often surreal experience of illness and trauma.

Margolin and Autobiography: Mining the Personal

Bringing the fishermen home and *Three Seconds in the Key* are part of what feminist autobiography scholars determine as life-writing that pursues the definition of traditional autobiography in order to include “. . . other personally inflected fictional texts” (Henke xiii) that resonate as politicized attempts by women to regain narrative authority over traumatic events. Feminist autobiography scholar Suzette Henke expounds upon the significance of this expanded genre:

As a genre, life-writing encourages the author/narrator to reassess the past and to reinterpret the intertextual codes inscribed on personal consciousness by society and culture. Because the author can instantiate the alienated or marginal self into the pliable body of a protean text, the newly revised subject, emerged as the semifictive protagonist of an enabling counternarrative is free to rebel against the values and practices of a dominant culture and to assume an empowered position of political agency in the world. (xv-xvi)

Margolin's theories of autobiography and fiction coincide with feminist scholarship on autobiography to position both of these texts within the genre of life-writing as fictional "working through" of trauma as well as powerful counter-narratives that reveal traumatizing aspects of illness experience.

Mining her own experience is paramount in creating work that resonates as personal and political. Her scripts revolve around ". . . the intimate image, the autobiographical stories, the moments between moments, and the accidentally political and extremely powerful presumption of personal significance." (Margolin, "Artist's Notes" 244). Margolin has often stated that she believes fiction to be nothing more than the redistribution of autobiography (Margolin "Talking"). Henke elaborates upon this contingent relationship between autobiography and fiction: "To a large extent, every autobiography imposes narrative form on an otherwise formless and fragmented personal history, and every novel incorporates shards of social, psychological, and cultural history into the texture of its ostensibly mimetic world" (xiv). Margolin also continually

reinforces the political resonance of discourse written, spoken, or performed. As she stated in a personal interview, “All work signifies politically. Period. It is framed, it is chosen. It is not just something that happened in a coffee shop. It is what you chose. And that is a politically resonant choice.”

In *The Limits of Autobiography: Trauma and Testimony*, Leigh Gilmore explores why a turn toward fictionalized autobiography might actually garner more credibility for such personally inflected politicized narratives. Much of Gilmore’s scholarship addresses women’s ability to serve as credible witnesses, especially to incidents of trauma, within a patriarchal culture that makes them ineligible as truth-tellers.²⁵ A turn towards the fictional positions a woman writer as speaking from a more credible perspective and perhaps amalgamating incidents and occurrences into a “larger more symbolic truth” (Gilmore, *The Limits* 4). As Gilmore explains:

A first-person account of trauma represents an intervention in, even an interruption of, a whole meaning-making apparatus that threatens to shout it down at every turn. Thus a writer’s turn from the primarily documentary toward the fictional marks an effort to shift the ground of judgment toward a perspective she has struggled to achieve. (23)

Gilmore also argues that the rules of testimony as representational of events may exclude accounts of trauma whose affective emotional content may exceed direct representational language (24).

Representing the traumatic experience in a poetic and sometimes elliptical form, Margolin brings her personally humiliating and enraging story of bodily and emotional

degradation to the public arena through creative autobiographical fiction. Based on her experiences through the diagnosis and removal of a mass in her nasopharynx that would later be diagnosed as the beginning of Hodgkins' disease, *bringing the fishermen home* amalgamates the core of several experiences through fictionalized autobiography and produces a disturbing and courageous critique of the medical establishment. Her critique includes an examination of "what happens to your sexuality, to one's beauty, what happens to one's ability to interact" as Margolin states (Margolin). In *Three Seconds in the Key* Margolin continues "her" story more directly as she explores the alienation from the body and society caused by the isolation of illness. However, in *Three Seconds in the Key* Margolin's autobiographical heroine (originally played by Margolin) finds a new identity through her illness and recovery.

***bringing the fishermen home*: Performative Power Dynamics within a Medical**

Setting

You know that is a power dynamic - how you are always naked and they are always dressed? That is a power dynamic and I came to see that very clearly. At the place where I had the roof of my mouth cut off, in ambulatory surgery, they made you wait in those outfits with fully dressed people. Now that is so wrong.
(Deb Margolin, Personal Interview)

In *bringing the fishermen home* Margolin unfolds a critique of the medical establishment's power dynamics including the role of the patient versus the caregivers and the dehumanizing effects felt by all. In this critique Margolin employs the structures of traumatic experience including: an explicit and detailed examination of the failure of language to express trauma; and the female patient's physical and figurative silencing through the complex uneven gendered power dynamics that exist between the feminized

(or unempowered and passive) patient versus the masculinized (in power and active) doctors, nurses, and support staff. When Margolin's protagonist, Jane Sand, asserts her subjectivity and attempts to upend the uneven power structures, she is physically silenced and brutalized. Margolin further brings trauma to life through nightmarish and dreamlike imagery, disjointed and juxtaposed narratives, and an explicit physicalization of the loss of bodily and narrative control experienced by the patient. Through this structure Margolin pinpoints specific power mechanisms that leave the patient both literally and figuratively naked, vulnerable, and constantly fighting to reassert her subjectivity in a world that positions her as a nearly inanimate object. Margolin also employs feminist performance and playwriting strategies such as a non-linear structure and a careful investigation into class and gender power dynamics, including the role of the naked female body within medical settings

bringing the fishermen home follows the lives of medical workers and fellow patients who come into contact with Jane Sand, a 37 year old academic (Margolin, *bringing* 6). The play is set in a sparse boxcar-like series of rooms,

. . without fourth walls, railroad style from stage right to stage left;

The first two are rooms where patients are seen for examinations; the next is a surgical operating room, the fourth is a bedroom. It is possible to glide from one to the other through doors connecting them. Downstage is bare; it is the site of various monologues, prayers and "interviews."

(Margolin, *bringing* 2).

Additional stage directions indicate that the “gatekeeper”²⁶ receptionist sits within a glass booth that separates her from the waiting room patients (Ibid).

Jane Sand ricochets through these rooms during her encounters with the medical world. We never see or hear about Jane’s home or work world. The plot of the play progresses from the time Jane first seeks treatment for being “unable to breathe” until her surgery to remove the mass. During the course of the treatment several doctors enter the story: Dr. Tim Algeliter, a thirty-two year old radiation oncologist from Australia who is a younger amusing and flirtatious subordinate physician; Dr. Trottus, an older anesthesiologist; and Dr. Peter Correre, 38 years old, (also known as Don) “whose business card identifies him as follows: Otolaryngology, cranial base surgery, otology and facial nerve disorders” (Margolin, *bringing* 3). It is the relationship with the surgeon, Dr. Correre, that is central to the work.

The play opens with Sand standing downstage in the bare space for monologues and prayers. Margolin gives Sand the first words of the play, words that ironically foreshadow the loss of language and inexpressibility of what is to come. Sand reminisces about the unanswerable questions posed by her young daughter:

Mommy are tulips roses? Are tulips *roses*, Mommy? So then, what can you say to that? You can say: No. Tulips are tulips and roses are roses. But that doesn’t work, so you say: No, a tulip is one kind of flower and a rose is another. They’re both flowers, but different *kinds*. And then she asks again: Are tulips roses, Mommy? And I know that she’s asking me

something else, something else, and I don't know the answer. (Margolin, *bringing 2*)

From the outset Sand grapples with her inability to express answers that lie beyond her linguistic capabilities. Later in the script, Sand obliquely speaks to the closed symbolic system that leaves her unable to articulate her experience to her daughter:

...and a song came on the radio that she didn't like and she said; Once you get inside the song, Mommy, how do you get out? And I said, O, you just climb out, like you climb out of the sandbox, and she said, No, Mommy, we're stuck in that song, and there's no door, Mommy, and I can't see the sky, we're stuck in that song, Mommy, who can get us out?" (Margolin, *bringing 16*)

Margolin poignantly explores the edges of language and the frustrations of the inexpressibility of much female knowledge and experience. Sand senses that she will be left inside of a moment from which she cannot escape – the silenced witnessing of traumatic experience.

From this poignant beginning, Margolin delineates the disjointed moments of degradation and deprivation that ultimately leave Jane Sand silenced and unable to witness to her trauma. The audience witnesses Sand's trauma through observing the dehumanizing stripping of agency from the patient caused by the physical power relations imposed upon her by gatekeepers, doctors, nurses, and institutional structures. Sand's occupation and education level do not proclaim her an everywoman – but rather a specific type of white academic from a position of relative privilege who would

seemingly feel more at ease within such an institutionalized setting. However, within the medical setting Sand loses the cultural power she has gained within an academic setting and becomes a “type” of patient – stripped of her outside world status. Following in feminist theorist Elin Diamond’s explanation of the Brechtian aesthetic, Sand as a specific character is not Margolin’s primary aim because “the character is never the focal point on the brechtian stage, but rather the always-dissimulated historical conditions that keep her from choosing and changing” (44). The protagonist’s name, Jane Sand, reminds us of her insignificance within the institutional system. Jane is the sobriquet most often applied to any missing female, and Sand represents the smallest discernible particle of dirt – the essence of the Earth. Margolin uses the protagonist’s name to show that the “class” dynamic has been refigured within the medical setting, thus showing the “contradictory forces within social relations” that characterize much feminist playwriting (Diamond 44).

Sand is embattled from all sides as she attempts to maintain her identity in the face of an unrelenting system that does not acknowledge her as an individual. Sand first encounters the caged “gatekeeper” receptionist when her appointment is scheduled incorrectly. Previously the audience has been introduced to the gatekeeper who sits behind a glass cage frantically answering phones and putting callers on hold. The frontline of medical offices – the receptionist- makes sure that patients only approach the inner sanctum of care when the appropriate time arrives. Margolin exemplifies this power dynamic by putting the gatekeeper behind a glass cage that protects her from the

patients' aggression. In an absurdist exchange, Sand goes round and round with the receptionist about her appointment.

RECEPTIONIST: Good morning. Your name...?

SAND: Jane Sand, I'm here to see Dr. Correra.

RECEPTIONIST: Pardon me?

SAND: I'm here to see Dr. Correra.

RECEPTIONIST: You're here to see whom?

SAND: Dr. Correra

RECEPTIONIST: On what day?

SAND: What *day*?

RECEPTIONIST: On which day were you scheduled to see Dr. Correra?

(silence)

SAND: You mean what day did I make the appointment?

RECEPTIONIST: Yes.

SAND: Well, I made the appointment about five weeks ago.

RECEPTIONIST: So why didn't you come in five weeks ago?

SAND: Because I made the appointment for *today*.

RECEPTIONIST: You have an appointment for today?

SAND: Yes.

RECEPTIONIST: Which doctor are you scheduled to see? (Margolin
bringing 11-12)

This absurd exchange continues with Sand ultimately having to reschedule the appointment. This scene offers insight into the simultaneously ironic and poignant tone of the script while also illustrating a key aspect of traumatic narrative – the inability of the witness to feel she is being heard (Laub 71). Throughout the play Margolin inserts several instances where Sand speaks eloquently of her needs only to be misunderstood or turned away from her goal.

The harmful effects of this dynamic gain consequence as the play progresses and Sand moves into different relationships with medical providers who hold increasing amounts of power over her body. Sand not only cannot be heard, but she does not have the power to visually witness what is happening within her own body. That power is held by the doctors, nurses, and technicians who have access to the radiological imaging information that Sand cannot see. Sand has a Magnetic Resonance Image (MRI) of her skull taken and she asks the technician what he sees. Unable to answer her definitively, he tells her that he does see a mass but that he cannot elaborate and that she will have to consult with her doctor. This visual power dynamic places Sand in the passive/feminized position of woman to be looked at, objectified, and dissected by the active masculine gaze.²⁷ In her frustration Sand asks the technician, “Did you ever play monkey in the middle when you were a little kid?” (Margolin, *bringing 7*) She explains that in this game one person stands in the middle flanked by two others. The two on either side attempt to keep something from the “monkey in the middle.” Sand recognizes that information is being kept from her and that she must play a frustrating game in order to gain the information that she needs. The frustrating interactions with the gatekeeper/receptionist

and the MRI technician occur within the first ten pages of the text and set the tone of the continual frustration that Sand experiences as she gradually loses control over her own body and her ability to construct her own story.

The relationship between Jane Sand and Dr. Peter Correre complicates how Sand has access to care and involves several emotional and physical intimacies, but I want to focus my attention on the ways in which Margolin exposes the implicit sexual nature of the relationship. This work illustrates the difficulty in disrupting traditionally gendered positions within the medical institutional setting while also showing the dangerous consequences for the female patient. The power dynamic is sustained by the doctors' ability to maintain a sexual identity while the patient is denuded of hers.

Prior to a scene in which Dr. Correre is seen having sex with an unknown woman in the 'bedroom' (located next to the operating room), Sand ruminates on the structure of sexual relationships via Baudelaire. Sand states that in a relationship ". . . one of the two will always be cooler or less self-abandoned than the other. He or she is the surgeon or executioner; the other, the patient or victim. . . It would perhaps be pleasant to be alternately victim and executioner" (24). Although Sand will continually attempt to assert herself and be the "executioner", the dynamics of the power relationship do not allow for this reversal. Directly after this monologue is delivered in the downstage prayer area, the scene shifts to Correre in bed with someone; "a woman's seductive laughter is audible" (25). Correre commands the sexual encounter, telling the woman what to do to please him. When there is the interruption of a phone call (from the office, or for the office, as there is an implication that the woman in bed could be the "gatekeeper"

receptionist), he says “c’mere ...c’mon...if someone’s dead they’ll still be dead in half an hour, oh, what is with you and the phone, the phone, the *phone*. . . sweetheart, yeah...”

(25). The juxtaposition of Sand’s monologue of longing for more power with Correre’s experience of sexual satisfaction within the work setting highlights the power differential between the two and points out how patients become invisible non-sexual beings while doctors can accrue a hyper-sexual power status.

Sand forces the issue with Dr. Correre; she refuses to be silenced without at least trying to make him recognize that she is a person. She begins telling him about her life and then turns the tables to question him. She pushes for his responses asking him what he thinks about during surgery, and if it is the same as what he thinks about during sex. Correre tells Sand that surgery is not like sex. “It doesn’t matter what I think about during surgery. You’re so precious about surgery. Surgery is like sculpture. It’s like typing. It’s like writing an article. It’s work” (42). Despite this denial, Correre is angered into an intimate link with Sand because she has forced him into a less powerful position by answering. He takes over the text completely when he begins to rant about his work and how he is put in an untenable position everyday through the expectations of patients. During this passage Margolin gives the doctor humanity by allowing him the words to articulate the weight that he carries each day. Correre rants in frustration:

I’m a doctor, not a priest, but you’d never know it, they pray to me, I make them pray with money, they pray anyway, I’m supposed to see and do, I’m Christ, I’m the healer in the valley, the forgiver of sin, the one who desomatizes, sin, that’s what I am . . . I want to undo my robes and take a

beer, I don't want to be a priest anymore, I want to undo my vows and
come out of the phone booth, I want to pick up a girl on the corner, at a
party, I want to come, to sleep, I want a new car. (43)

Correre continues as he begs the patient to "just go, just go and live, leave me alone, just go and live" (Ibid). Through his expression of anguish, the need to become somewhat robotic in order to cope with the pain and frustration of doctors' daily interactions with patients becomes plausible, if not entirely understandable. Margolin gives the doctor the benefit of the doubt; perhaps he too is traumatized by what he must accomplish in a day, by the weight of responsibility put upon him. The entire institutional frame is problematized in order to avoid assigning personal blame to individual caregivers. This creates a deep context that allows for the institutionalized power dynamics to become visible.

Immediately following this monologue, when Sand has pushed Correre to respond, to acknowledge his own humanity, the scene shifts abruptly and the consequences of this power dynamic become the paramount issue of the text. Sand is wheeled out groggy in a wheelchair and Dr. Correre reintroduces himself and asks if the technicians had taken a dental impression. Sand is bewildered; she questions why she has no underpants on and why she had to sit in nothing but a thin gown in the ambulatory surgical area filled with strangers. Correre does not respond to her questions; instead he tells her that "I may go through the roof of your mouth" (45). He assures Sand that he did this to a fisherman who healed very nicely. Sand is incensed. She rises from the wheelchair and shouts at the doctor "Don't you fucking cut my mouth. You fuck . . . you

promise me, you don't cut my mouth . . . That's where I speak" (45). Despite her pleading, Correre lifts Sand up and carries her to the operating table and tucks her in. "They appear as much like a guard and inmate at a lethal injection execution as like a bride and groom on their wedding night or a parent with a sick child" (46). Correre has reasserted his dominance in the relationship, and he will violate her in any way he sees fit. He tells her that she will not remember and she will not care what he has done once it is over. Her ability to rattle his nerves, to make him acknowledge his feelings has resulted in her complete degradation and supplication. This scene represents the structure of traumatic experience that ". . . threatens the integrity of the body and compromises the sense of mastery that aggregates around western notions of harmonious selfhood" (Henke xii). Margolin argues that the patient who attempts to assert herself – to in fact force acknowledgement of her individuality – can be punished and have her identity, in this case her ability to speak, physically and figuratively, taken from her.

Throughout the play, Margolin employs a non –linear structure often called upon by feminist playwrights and directors. Moving quickly through time and space, the last seventeen pages of the play morph through a complex dream sequence that moves from Sand's observance of herself under anesthesia, to a "date" with Dr. Correre where Sand is naked in a restaurant and is served her tumor on a plate, to the final "primal" scene of Correre devouring her on the operating table. These surreal scenes are not uncommon in feminist work that suspects realism as being a method of representation that merely replicates uneven power relationships. As Ellen Donkin notes, feminists often "tend to gravitate away from realism and away from Aristotle, as if in some deeply intuitive way

they recognized a hostile environment. We wonder if traditional dramatic structure doesn't routinely impose certain distortions on women's lives and women's experience" (150). In this case Margolin brings to life the trauma by refusing a linear structure and instead reveals to the audience the disjointed manner in which Sand experiences her treatment within the medical system, thus creating an amalgamated truth that cannot be contained within traditional structures. Margolin's disruption of linear narrative points to realism's inability to imagine non-traditional viewpoints such as experiences of trauma. (Sullivan 23).

The complex and sometimes confusing structure of the play follows Laub's description of the loss of time within trauma:

The traumatic event, although real, took place outside the parameters of "normal" reality, such as causality, sequence, place and time. The trauma is thus an event that has no beginning, no ending, no before, no during and no after. This absence of categories that defines it lends it a quality of "otherness," a salience, a timelessness and a ubiquity that puts it outside the range of associatively linked experiences, outside the range of comprehension, of recounting and of mastery. (69)

During Sand's surgery the doctors step forward, along with the receptionist/nurse, and recite the children's lullaby "Wynken, Blynken, and Nod." This surreal moment labels the doctors and caretakers as idealistic and possibly incompetent dreamers hoping for an impossible escape from the daily realities of their jobs. This is immediately juxtaposed with Sand rising naked from the operating table and watching the surgical procedure

unfold. Dr. Correre is naked from the waist up now as well and lying on the operating table. The scene morphs into an intimate exchange between the two in which Sand tells Correre that she wants to have sex with him – in her desperation she tells him that this is the only way people will hear him – through his touching her body. The other doctors re-engage in the dialogue and we are back in the surgery (46-49). Something goes wrong and we hear the details as Margolin performatively displays the linking of trauma across time and memory.

DR. TROTUS: You're going against nerves, a lot of nerves.

CORRERE: I'm in charge here. Suction that, do it!

RECEPTIONIST: Call her! Just call her! She'll come back!

TIM: She doesn't know.

RECEPTIONIST: Just call her.

CORRERE: The bone is out; tilt her head further, adjust that light.

I'm going to need to cauterize quickly, have that ready.

MR. FORTENSKY: You heal people by burning them! You doctors, you're like the lawyers! You heal people by burning them! Like in the camps, that's what they said! It's to clean them! That's what they said! (49)

In this exchange the trauma of the Holocaust is suddenly introduced into the middle of Sand's surgery by the character of Mr. Fortensky, an elderly Jewish man Sand met in the waiting room. The exchange between the Receptionist and Tim (Dr. Algeltier) could reflect an affair, which has been intimated earlier in the text, or it could relate to calling

Sand to come back – to not die. The fear of imminent bodily disintegration and loss of identity that characterizes traumatic experience is captured in this disjointed exchange.

The Naked Female Body Onstage

. . . this Brechtian feminist body is paradoxically available for both analysis and identification, paradoxically within representation while refusing its fixity (Diamond 52).

Margolin's most powerful critique of the uneven power dynamic between the female patient and the medical establishment is realized through the use of feminist Brechtian performance strategies and the incorporation of the nude female body onstage. Following the nightmarish dream sequence in which the audience learns that something has gone horribly wrong during the surgery, Sand and Correre move to a table set for dinner. This table could be the operating table converted into a dining table. Sand is completely naked and Correre is fully dressed; they appear to be on a date. As they discuss chatty items such as the menu, Sand tells Correre that he never did get her the name of the fisherman whose mouth he operated on. They order from the waiter, played by Dr. Tim Algelitier, and he serves them a large tumor on the table. Suddenly "the texture of their conversation changes, with terrifying abruptness" (53) according to Margolin. The scene becomes a battle of wills as Sand pushes Correre to see her as an individual, to acknowledge her as a human being. In her rage at her helplessness she yells at him. During the intense argument that follows he grabs her and begins kissing her, presumably as a means of silencing her rage. This is an ominous action. He carries her to the operating table and lies on top of her. Margolin describes the ending in her stage directions as, "she is naked, fully his now. He climbs on top of her and the end has begun; the viewer keeps expecting a blackout, which doesn't come, and doesn't come,

and finally, rising from her station, the Receptionist gets up, comes over, and gently closes the curtain” (55).

Through this explicit employment of the naked female body Margolin foregrounds the gender dynamics of the relationship. Feminist performance theorist Elin Diamond explains the significance of the female body onstage:

The body, particularly the female body, by virtue of entering the stage space, enters representation – it is not just ‘there’, a live, unmediated presence, but rather (1) a signifying element in a dramatic fiction; (2) a part of a theatrical sign system whose conventions of gesturing, voicing, and impersonating are referents for both performer and audience; and (3) a sign in the system governed by a particular apparatus, usually owned and operated by men for the pleasure of a viewing public whose major wage earners are male. (Diamond 52)

Diamond’s explanation resonates for the female patient within the medical establishment as well as the representation of that patient on a theatrical stage. We see that Sand is a naked woman, overpowered and silenced in the face of the doctor’s onslaught – she is completely within his power. She has ceased to struggle at the end. In a personal interview Margolin stated that she wanted to examine this dynamic; “You know how you are always naked and they are always dressed? That is a power dynamic and I came to see that very clearly.” The audience is suddenly exposed as watching, participating in Sand’s objectification as the scene continues past the point where realism would end it. Sand’s gender identity, her contingent subordinate status, and the consequences of that

status are highlighted. As Elin Diamond points out, “when gender is ‘alienated’ or foregrounded, the spectator is able to see what s/he can’t see: a sign system *as* a sign system. The appearance, words, gestures, ideas, attitudes that constitute the gender lexicon become illusionistic trappings that are *nevertheless* inseparable from, embedded in the body’s habitus” (47). The moment of Sand’s exposed nudity in a public setting where everyone else is “protected” by clothing becomes a moment of Brechtian gestus, “. . . a moment of theoretical insight into sex-gender complexities, not only in the play’s “fable” but in the culture which the play, at the moment of reception, is dialogically reflecting and shaping” (Diamond 53). Margolin’s work thus comments not only upon the power dynamic of the female body onstage, but also offers a critical acknowledgement of the power dynamics that continue to harm female patients in medical settings.

Margolin strategically employs feminist performance techniques to roughly suture together a dystopic world that exposes the callous cruelty inflicted upon a female patient who is literally and figuratively silenced through the systematic stripping of her agency and identity. Unlike earlier works examined in this study, there is no implicit triumphant narrative by the well body speaking of trauma, but rather the stark conclusion of a silencing even unto physical disintegration and disappearance. Through her portrayals of the feminized role of patient versus the active masculine doctor/medical practitioner, Margolin exposes the painful and humiliating effects of the unequal gendered power dynamic. This representation counters popular narratives of the doctor hero, caring nurses, and benevolent establishment. Embedded within this critique of the medical

establishment are specific characteristics of traumatic experience such as the patient's numbed confusion, a self-contained reality that exists outside of daily routine and time, and a figurative and literal silencing of the victim. This pointing up of traumatic structure continues to reveal the ways in which insidious trauma is inflicted upon women daily and how supposedly caring experiences are instead potentially damaging in a life altering manner.

Three Seconds in the Key Exploding Binaries: Popular Culture and the Disembodied

III Patient

"See, it's three seconds with the ball and forever and a day without it." Player

"Such moments make spectators ache with desire to capture, somehow, the stunning, nearly prearticulate insights they illuminate, if only to let them fill us for a second longer with a flash of something tinged with sadness but akin to joy." (Dolan, Utopia 8)

While *bringing the fishermen home* performatively reenacts the structures and causes of Jane Sand's trauma, Margolin's more directly autobiographical text *Three Seconds in the Key* performatively transfers or integrates the trauma into a recognizable narrative and creates a path back to life for the protagonist, Mother.²⁸ Recently published by Playscripts, Inc., *Three Seconds in the Key* has more extensive production history that includes a premiere starring Margolin and her son playing themselves at PS122 in Manhattan in 2002. The production was further workshopped at the Public Theatre, and was fully produced by New Georges Productions at Baruch Performing Arts Center in 2004 ("Three Seconds in the Key"). Neither Margolin nor her son Bennet appeared in the New Georges Production. *Three Seconds in the Key* has been critically well-

received²⁹ and won Margolin the Kesselring Prize for Playwriting in 2005 (“Deb Margolin Wins”).

Three Seconds in the Key is set solely within the home of an ill woman, Mother, who is suffering from Hodgkin’s disease. Mother wanders through her living room, often tethered to a surreal I.V., watching basketball with her son while she recovers from chemotherapy treatments. The set is a simple living room setting with a television set and a small sofa, except for the fact that this living room is set within a basketball court complete with backboard and running time clock. In a review of the performance at PS 122, Claudia Barnett notes the clock’s symbolism as reflecting Mother’s obsession with time, and how much time she does or does not have left in her life. The clock does not count down sequentially but randomly resets to ninety minutes periodically. The playing time begins to seem infinite. For Barnett the clock positions the audience within Margolin’s fears and fantasies because like Mother the audience has no idea how long “the play” will last (501).

As Mother makes self-deprecating comments, she entertains the audience with direct address monologues confiding her fears, anger, and humor. Mother spends her time with her son, initially played by Margolin’s real-life son Bennett, and together they watch a season of the New York Knicks epic basketball struggle. As Mother’s interest and identification with basketball builds, the Player – the leader of the team- steps from the television and into Mother’s home. Barnett writes that the two “engage in a series of topical dialogues ranging from race and religion to motherhood and sex, which resemble both duets and duels” (501).

In this section I follow how the characters' interactions disrupt notions of monolithic and fixed identities as Margolin delves into Mother's negotiation of her ill patient status and how she uses the help of other healthy and ill bodies. How can fictive autobiography illustrate the possibility of a borrowed, shared, and collective sense of identity? How can this understanding of a collective and shared identity not only disrupt monolithic and prescriptive concepts of identity but also imaginatively free the ill and isolated woman from a debilitating disembodied state? How does this surreal re/covering of self symbolically witness to possibilities of collapsing boundaries between other isolating separations such as racism and misogyny and prejudices and fears about ill bodies? Does this collapse of categories enact what Jill Dolan theorizes as a utopian performative?

Throughout my analysis I layer moments from the New Georges production, which did not feature Margolin playing herself, with a videotape of Margolin playing herself in the performance at PS122. The published script differs from the production that Margolin mounted at PS 122, so I focus upon moments that are reproduced in the final script unless otherwise indicated. I also include Margolin's stated intentions for the work and how she realized the expression of her autobiography through the character of Mother. Margolin's work deliberately shows the "collapsible boundaries" (Hart, "Introduction" 2) between fiction and autobiography; thereby, effectively resisting "the authority of experience," according to feminist autobiography scholar Dee Heddon. This refusal to consolidate experience into a singular storyline, a "true" story, highlights the

possibility of multiple interpretations and narrative trajectories and illustrates that the creation of autobiography is always a re/visioning of a life (Heddon 135).

Exploding Binaries: All Body and No Body

Elaine Scarry has written eloquently about how pain (and subsequently illness) reveal the body- call the body into being through corporeal suffering.³⁰ Ironically, while illness makes a person acutely aware of the body and its limitations, it also creates a schism from the everyday experiences of bodily ability that the person had prior to illness. Therefore, the ill person simultaneously knows herself as “all body” and “no body,” at least no body that she has known herself to be. Margolin examines the dichotomy felt by the ill patient as Mother is tethered within her home, bound by a surreal IV line that extends from her arm to an unknown point above and moves with her. Even when the scene shifts to a Hodgkins support group, the space is contained within the living room scene and created by actors repositioning the same chairs that the basketball players use. The containment that Mother faces as she shuffles in bedroom slippers around the set illustrates the circumscribed space that the ill person inhabits. Without the strength or energy to continue life at a “normal” pace, the world of the ill patient shrinks. The trauma of this disintegration of routine, familiarity, and bodily normality result in a numbing “psychic mush” (Lorde qtd. in Henke 115). Margolin’s shuffling, tired, confused and yet feisty Mother shows the audience the difficulty in fighting off this terror of losing the world that one defines as “normal.”

Margolin exposes the complexity of this ambiguous embodied relationship through Mother’s utilization of the popular culture messages she receives from watching

television. The two ends of the spectrum of disembodiment and embodiment are symbolized by a commercial for a casino in New Jersey named Foxwoods and by the New York Knicks basketball games respectively. Mother and Child are enthralled by the Foxwoods commercial. Whenever the commercial comes onto the television (as it is simultaneously projected onto a large screen) Mother and Child scramble to find pen and paper to capture the words. The commercial is filled with the symbolism of wealth and sex. It begins with a woman running down a hallway to the singing voice-over of “The Wonder of it All.” The woman joins hands with a man as they excitedly open a door to a hotel room. This is intercut with ejaculatory images of champagne bottles erupting and fireworks exploding (Three Seconds in the Key/PS 122 Performance). In a personal interview Margolin explained the impact of this commercial upon her sexual identity;

I would watch these commercials when I was ill and feel so marginalized.

I was so far from the world that this was representing that I would sob my eyes out. To this day when I hear that music, get me a box of tissues. It marginalized me profoundly. There was no place for me in the landscape of that commercial, within a thousand mile radius of that commercial.

(Margolin)

Mother performs this alienation by looking longingly at the television while she listens hard to hear the words, sometimes bursting into tears because she cannot figure out the second verse. In PS 122 performance, Margolin squinches up her face into a painful look of desperation as she writes furiously (Three Seconds in the Key/PS 122 Performance).

Each time the commercial comes on Mother is pushed further away from any conception of bodily ability or pleasure that feels attainable or realistic in her current circumstances.

In opposition to the Foxwoods commercials are Mother and Child's magical times watching the New York Knicks play basketball. The stage directions describe their enthusiasm in viewing the games: "We see them deeply involved and physically lively. Mother seems almost to shed her body; she seems as young as her son" (*Three Seconds* 13). Mother and Child share statistics about the players, tease out definitions to complicated basketball plays, and generally exchange their knowledge and joy about basketball. It is a medium of communication for them (13; 55-56). It is something that gives them hope for the future as they wait for the next game. Later in the play, the relationship with the basketball Player and Mother becomes paramount in her finding her way back into her body and a sense of her sexual and gender identity. All of Mother's explorations of identity come through her relationship with the Player.

The Player is described as "African-American man, late 30s. A professional basketball player, in the later stages of his career, with the New York Knicks. Team captain and the team's star player; quiet, intense, passionate" (*Three Seconds* 4). From the first moment that he magically enters Mother's house he physically dominates the space not only with his height but with his sheer vitality and health. Margolin describes Mother's reaction ". . . she is forced to recognize fully the physical beauty and vitality of Player. It is marvelous, mystical, horrifying" (19). His mobility, wellness, and physical ability stand in stark relief to her tethered, ill, and suffering body.

Refusing an Identity Based in Illness

In opposition to the Player's spectacular embodied physicality is Mother's shambling, out of time disembodiment. Mother is divorced from her everyday existence to the point that the audience does not know what that existence is – it is as if she and the Child live in this self-contained world without any other interactions. This feeling of lost time suffuses the play and is indicative of traumatic experience. *Three Seconds in the Key* is a basketball reference to how long a player is allowed to stay under the basket in the painted area that extends from the half circle above the foul line to the basket. “The paint,” as this area is called, is the closest proximity to the basket and obviously the easiest place from which to score. Mother is angered initially by this time limited concept, but through the course of the play she begins to understand that three seconds is enough; if you are prepared to use your time wisely. Margolin's reference to the terminology of “dancing in and out of the paint” not only marks the quick and agile movement necessary to “score” but also reflects the continual shifts and changes that our identities undergo as each of those rare opportunities presents itself. The Player explains to her the importance of the easily lost three seconds:

Whether you got the ball or you tryin' to get it. Everybody's got the same limit. Keeps the game movin, Ma. Every game's about some fucking kind of problem, Ma, some struggle, like, hit the ball with the bat, get the ball in the hoop, pass the ball to the zone, drop the ball in the cup, it's a struggle, and the struggle's the game. (34)

Mother's ambivalence about the fairness and understanding of the three second rule is countered by the Player's unquestioning acceptance of "the rules." When the Player prepares to leave in order to return to "the game" Mother tries desperately to keep him there with her. He has shown her the possibility of a world that she thinks has left her. She doesn't believe that she can have three seconds, and by the end of his first extended visit, she is trying to keep him there and insisting that she wants her "three seconds in the key" (35). The Player tells her that she has had her three seconds and needs to seek the company of people like her, other sick people.

Mother and the Player share a physical and emotional attraction from the outset, but both are wary. The Player tells Mother that she needs to be with a supportive and similar community:

Player: Mother, you sick now, you need to talk, I know that, Mother, I want to talk to you, that's why I'm here but I gotta go now, Mother, I gotta leave you to yourself, Mother, what you need now, that kind of talkin', I ain't got. Ain't never had, it ain't my fault, don't be lookin' at me, Mother. I'm telling you mother, ain't never had it. You gotta find other people got what you got, Mother. That's where I go after a game, I go out with other people who got the same game I got. . . you get wisdom from them and game from me, okay, Mother? Go talk, mother, go out and find it. (35)

Mother takes the Player's advice and tries to find comfort in a Hodgkins' support group. This scene morphs between players portraying the Hodgkins patients and a simultaneous scene of Knicks players in a prayer huddle before and after games they continually lose.

The dialogue within the two groups is interwoven into a complex overlapping of personal narratives from Hodgkins patients with conversations between the Knicks players. “There is an almost musical quality to the rising and falling of voices, as in the scoring for many instruments in a fugue” (36).

Mother and the Player continue to speak to each other, although it is an imagined conversation, as they both move between “games” that they continually lose. Mother is unable to connect with any of the Hodgkins survivors and the Player cannot connect with his teammates. Margolin describes this section as both the Player and Mother being caught in “false prayer” circles where they can find no comfort. In the earlier version of the work performed at PS 122 the personal narratives from the Hodgkins patients were much longer; however, due to dramaturgical considerations these were shortened in the final version. The shortened published version performatively demonstrates Mother’s inability to hear and witness the stories of the other Hodgkins’ patients. As Margolin stated in a personal interview, she did not want a sick identity. She felt like a “Jew who hated other Jews” because she could not find identification and comfort within a community of people who had the same illness that she did. This is a difficult and courageous statement to make; it flies in the face of conventional wisdom regarding support groups. Instead Mother finds her community with her son and this dreamlike relationship with a basketball player.

A Shared, Negotiated, and Collective Identity: Mother, The Player and the Child

The most radical component of Margolin’s work is the way in which Mother borrows strength and vitality from the Player and Child thereby reconfiguring her

conception of herself as linked to bodily abilities that she alone possesses. As noted, Mother feels disconnected from her body when the play begins, so much so that a commercial for a gambling casino brings her to tears. During the course of the play, Mother is forced into her body and into an identification with her body as necessary for her survival and the survival of her son. The Player pushes this issue as his relationship with Mother deepens.

The relationship between the Player and Mother is both complicated and deepened through their racial and ethnic differences. As previously noted, Mother is a white Jewish woman and the player is an African American male. The Player at one point tells Mother that she is the equivalent of the opposing team (30). He does not want to be configured into the familiar seduction narrative of a white woman exploiting a black man for her own physical pleasure. Jill Dolan argues that Margolin cannot be read as “white” so simplistically: “By talking too much, and using such obsessively elegant language, Margolin removes herself from white privilege and power. She performs a kind of Jewish excess that marks her as affectively outside normative whiteness” (Dolan, *Utopia* 60). This applies to Mother as a character as well; she not only uses excessively elegant language but she foregrounds her Jewish heritage by teaching the Player Yiddish. The Player asks Mother why he has often heard Jewish people say “Schvartze” in reference to African Americans. He asks Mother if it means nigger. Mother begins what becomes an extended lesson in a very comical scene where the Player works diligently to pronounce the Yiddish phrases Mother teaches him (30-33).

Margolin engages the characters' differences as a means of negotiating a relationship. Mother demonstrates her love of language by the dexterity with which she expresses herself. The Player is magnificent in his physicality, a physicality that he relies upon to complete his job everyday. While Mother teaches the Player Yiddish, he tries to explain to her the poignant urgency of three seconds in the key. They have no doubt that they are extremely different, and yet there is an energy and tension that crackles between them from the first moments of contact. They spar not only as they negotiate the small physical space that circumscribes the living room, but also with words as they punch and duck trying to continually outsmart each other. Even as they fight their attraction to and need for each other, they are drawn together. However, they are both able to acknowledge the humanity and dignity of the other person and to carefully build a relationship that is meaningful to each of them.

Margolin breaks down the barriers that align identity as bounded, separate, and individual by allowing Mother to change her understanding of her body through the Player's actions and words. He will not allow her to maintain a sexless identity. He tells her:

PLAYER: . . . You're everything beautiful, Mother, a flower in the storm, okay, Mother? Your petals falling off, still sweet, Mother, Mother you could dance in front of a train and make it stop from the sheer stubbornness of your body, Mother, the will of your body, it's that will that I can't shake loose of, Mother. I want to touch that will, I want it, I get lit up by that Mother, I want to touch You. . . (54)

Speaking about this section, Margolin stated that although Mother is unable to hear that she is beautiful, this is one of the first steps in her return to a sense of bodily integrity. He seduces her with words to see herself in a new light.

This escalates when the Player clearly challenges Mother by accusing her of attempting to play basketball, which is metaphorical for the larger concept of “game,” with words. He tells her: “Mother, use your right arm! Mother, *use* your hips, you *use* your ass, you got a BABY out of that ass, mother *use it*” (65). Mother takes up his challenge and begins to physically play basketball with him, dribbling, protecting the ball, moving without expertise but with determination. In the New George production, Mother moved somewhat clumsily with the ball, nearly dribbling off of her slippers. Yet, each time she made a mistake she would chase the ball down and begin again until a sort of beginning competency emerged. When she began to master the dribbling, there was a radiant smile on her winded face (Margolin, Deb, and Alexander Aron, dirs). At this point, the Player encourages her even further, telling her:

PLAYER: Use me! Use me, Mother, I’m on your team now, dribbling right, sense where I am, head up, head up, turn and bounce-pass! Yeah! Yeah! And alley-oop! You and me, Mother! (*He turns and shoots; perfect shot, ball falls out of the net and on the floor like a shocking piece of information. Neither of them retrieves it. They lock eyes. Their breath is audible.*) (66)

The revelation is that bodies rely upon each other, especially in times of illness.

Margolin says of this section:

The strength that was taken from watching these well bodies play basketball, she really was borrowing. It was like borrowing from a bag. . . At the end when they dribble together, in her typical --- you're all that -- she is back in her body whether she lives or dies- it is a reincorporation and he by going into her body with her and by inviting her into his body.

(Margolin, Personal Interview)

She shows the audience the possibility of an identity in progress that can borrow and appropriate characteristics that the individual may not possess. Margolin creates a tender realization of the interdependence of well and ill bodies and how that reliance upon each other extends beyond the physical reality into our fantasy life from which we also draw strength and possibility.

Mother and the Player celebrate this revelation in a beautiful final dance that could easily be read as a heteronormative romance moment. She sheds her bathrobe to reveal a simple slip type nightgown and as the music of the Foxwoods commercial begins playing on the television, she and the Player whirl around the small space together. Poignant and moving, this moment is also quite comical in performance. The absurdity and fantasy of the situation are brought home in this "Cinderella" moment as the tiny white woman in the satin nightgown dances through her living room with a large African American man in a basketball uniform. As a spectator, this moment functioned as a Brechtian reminder of the fantasy playing out, a fantasy that could hold troubling racial and gender implications except for the complicated power dynamics that are implied. Undeniably, the Player is sexualized, but he is not objectified or powerless within the

relationship. The Player leads the dance; however it is Mother's self-healing that is occurring. It is through the fantasy of *Three Seconds* that Margolin avoids creating another story of a woman having her identity restored through the attraction of a man. This is further reinforced by the final interaction with the Player. After the dance, they face each other and recite the Gatorade mantra that the Knicks players have recited many times throughout the play:

PLAYER AND MOTHER: I refuse

I refuse to lose

I refuse to fail

I refuse to die

I refuse to be afraid

I refuse to be taken

I refuse (66)

Each character equally asserts agency and will. The Player reconstitutes his commitment to resist forces that would defeat him. For Mother, the mantra that was initially outside of her life is now central to her existence and the Foxwoods song that alienated her has been reclaimed as a joyous celebration of her return to her body.

Mother also gains physical and emotional strength from her son and the sturdy urgent strength of his well body. Throughout the performance the Child is continuously in close proximity to Mother. There is no doubt that she is the only care-taker present. In the New George production, the Child (played by Malcolm Morano) ran around the set, jumped on the couch, fidgeted, collapsed into sleep, etc. with the ferocious energy of an

eight year old boy. In the PS 122 production, the familiarity between Margolin as Mother and her real-life son Bennett is evident through their comfort levels in touching, laying down and resting together, cuddling on the couch, etc. At times the Child becomes an energetic extension of Mother's body. The Player reminds Mother that her identity is also to be found in caring for her child, another physical demand that she must meet – even as Mother demands to be seen as having an identity outside of being a mother (54-55). Margolin stated that at least partially she was on the Player's side with this and that during her personal illness her connection with her son forced her to stay alive at times.

I'm sort of on his side in this thing in a way, because everyday I kept putting off wanting to die because of my son. 'Mom get me a glass of milk.' Okay, I'll kill myself after the milk. 'Mom he hit me.' Okay, I'll kill myself after I take care of this. 'Mom he hit me again.' Okay, I'll kill myself later after that. There was something about the day to day, I was nothing without my role. There was something very *vital* to my role.

(Margolin, Personal Interview)

Like Margolin, Mother is not allowed to truly mourn the loss of her body, in fact, as much as she might want to – mother is not allowed to leave her body.

Margolin examines how the collapsible boundaries of identity facilitate not only borrowing strength and a sense of bodily wholeness but can also allow access to frightening feelings of illness and mortality. Early in the play the Child expresses how he begins to interpolate Mother's illness as his own:

CHILD: I'm tired of you being sick! It makes me sick!

MOTHER: I understand, but that doesn't mean I can just get up and play basketball any time you ask me!

CHILD: I'm not very healthy! I'm getting sick!

MOTHER: Sweetheart, sweetheart, come here, I'm so sorry. . .

CHILD: I'm getting very sick! Everything you are, you make *me*! You're making me sick! You're probably going to make me die. . . (24)

The Child recovers from this moment and does not become physically ill. Through this poignant exchange Margolin refuses to simply show the positive side of support and care and courageously examines the fear of proximity felt by many family members and caregivers. This painful sequence reveals not only how the ill person borrows strength from the well bodies around her, but also how illness moves into the psyche of caregivers and other family members, thereby changing their conceptions of themselves.

The three main characters in *Three Seconds in the Key* borrow from each other the strengths that they need while leaning on each other emotionally and physically to compensate for their weaknesses. Through this we see the changing of identity, as Mother morphs from ill and disembodied into willing to fight for a new definition of wellness that includes working with the limitations of her body. As a manifestation of feminist performance theory this creates what materialist feminist scholar Sue-Ellen Case has named a postmodern "collective subject" that claims partial knowledge while recognizing the fluctuating and often contradictory nature of identity formation (10). As Dee Heddon writes the multiple selves we see performed reject any authentic self and foreground the ongoing process of creating identity (135).

The negotiation of identity through the space of illness, of trauma, of events that happen outside of “normal” time is furthered when Margolin opens a deeply powerful discussion of racial identity and the simmering hostilities and cultural misunderstandings built around racial stereotypes. Towards the end of the play, when Mother and the Player have come to have a degree of comfort with each other, an argument erupts when the Player accuses Mother of being too angry towards life. She counters by accusing him of being a terrible parent. Suddenly the game clock becomes the 24 second shot clock and the spotlight tightens down on an opposing Mother and Player. Each has twenty four seconds to argue his or her point. What follows is an intense exchange about racial stereotypes that begins with the Player accusing Jews of playing up the Holocaust at the expense of millions of African Americans being held in jails and killed unjustly. Mother yells at the Player that he has not done anything to fight for freedom and questions why black people always discuss their disadvantages and blame them on slavery while at the same time men like him take no responsibility for raising their own children. The harsh exchange goes on for several more minutes until both are spent (63-64).

As Margolin has stated, “Blacks and Jews are painfully close and I think the whole gulf between them was created by those who like to divide and conquer” (Talking With). The painful and potentially devastating dialogue forces a shattering openness of communication between the Player and Mother. This dialogue performatively aligns Jews and African Americans as having sustained many similar discriminations at the hands of dominant culture while also showing the misunderstandings that keep two potential allies separated. The honest exchange of both their prejudices pushes the

characters past an “us” versus “them” mentality and allows them to acknowledge their complex interdependent relationship. Margolin asserts that this aspect of the play moves it beyond the world of illness and into larger sociopolitical dialogues (“Three Seconds in the Key”).

Witnessing to Possibility: The Utopian Performative

But this was different, it is the difference in how you feel before war and after, like the novelist before he shipped off to Iraq and after he came back. These are things that you can never un-be. I feel like a different person now in some ways than I did before . . . You are fundamentally changed, in ineffable ways. Which is why performing about it was so important. There has to be some level in which we reflect upon and we talk critically about these profound transformations. (Margolin, Personal Interview)

In the above quotation Margolin references the troublesome tensions within the aftermath of life-altering experiences of traumatic illness. She deeply understands the ambivalence felt towards the depth of self-knowledge gained at such cost. One on hand, she honors her illness experience through the writing of *bringing the fishermen home* and *Three Seconds in the Key*, while simultaneously rejecting an identity based in illness within the texts. *Three Seconds in the Key* does reinforce the “fighting” patient narrative working through an illness by sheer determination; however, each time this narrative is referenced it is countered and partially undermined with the uncertainty of the future. This is clearly evident in the closing monologue of the show. Mother steps forward and meditates on time and how she does not know how much time she has. She tells the audience in direct address of how she loves time dependent art forms like music and theatre, and the timelessness of Michelangelo’s *Pieta* where “the dimension of time is exchanged for the dimension of suffering” (69). In the final moments she begins to softly chant the New York Knicks’ game chant “Go New York Go New York Go!” and the rest

of the cast chimes in with her until the final blackout (69). The tension between her yearning for time and her determination to fight as exemplified in the potentially triumphant chant are in opposition with the loss acknowledged when she discusses how little time there is in a human life. Through this tension, Margolin gestures towards the loss that is inevitable in life even as she celebrates her willingness to hold onto the bittersweet beauty found within that loss.

I argue that the calling forth and witnessing to the profound beauty of our time based existence creates a utopian performative as defined by Jill Dolan. These are the moments of live performance “ . . . where people come together, embodied and passionate, to share experiences of meaning making and imagination that can describe or capture fleeting intimations of a better world” (Dolan 2). Dolan’s utopian performative is not a seamless reality enclosed within perfection, but rather a world in process, struggling, “. . . always only partially grasped, as it disappears before us around the corners of narrative and social experience” (6). Margolin’s collapse of the rigid boundaries both physical and emotional that define identity creates a dreamscape that makes us long for its implementation in reality. As Dolan states, Margolin’s work leaves me “melancholy but cheered” seeing the possibility of a world where the ill can borrow from the healthy and where racial boundaries built on stereotype can be shown for the falsehoods that they are (8). Margolin tells us that we can borrow the pieces that we need, pieces of emotional insight, knowledge, and bodily ability. Through this sharing of strengths, Margolin aligns previously separated characters and communities into an imagined world of compassion and empathy.

Conclusion

By choosing fictive autobiography Margolin is able to explore beyond the edges of personal experience in creating both a dystopic and utopic visions of a woman's journey through illness, treatment, and recovery. In *bringing the fishermen home* Margolin portrays the potentially horrible consequences of the dehumanizing loss of identity within the medical setting including the harmful power dynamic between the feminized patient and the masculinized medical establishment. In *Three Seconds in the Key* Margolin illustrates the interdependence between ill and well bodies and the possibility of reconstructing a life with a new collective and contingent sense of identity. In the next chapter I offer a personal narrative response to a historical framing that greatly affected my experience of traumatic illness. Additionally, I summarize the chapters within the study and offer concluding analysis and future possible directions for this work.

End Notes

²³ See Deb Margolin "A Performer's Notes on Parody" *Theatre Topics* 13.2 (2003) 247-252 and Deb Margolin "A Perfect Theatre for One: Teaching 'Performance Composition'" *TDR* 41.2 (Summer 1997) 68-82.

²⁴ See John Leland "For Clutter, a Command Performance" *New York Times* 10 Jan. 2002, Final ed., sec. F; Column 3; house & Home/Style Desk: 8. and Deb Margolin "Talking with Deb Margolin." Interview with Melissa. *Culturebot* 22 Apr. 2004. 20 Sept. 2005 <http://www.culturebot.org>

²⁵ See also Gilmore's earlier work on gender and confession—"Policing Truth: Confession, Gender, and Autobiographical Authority." *Autobiography and Postmodernism* Eds. Kathleen Ashley, Leigh Gilmore, and Gerald Peters (Amherst: University of Mass Press) 1994, 54-79.

²⁶ This is a common term used in medical settings for the receptionist who makes appointments and manages the flow of patients into the treatment rooms.

²⁷ Laura Mulvey first articulated the active male gaze theory within film theory in 1975. Initially, Mulvey had positioned the bearer of the look as male, but later revised her work. Mulvey's work is still important in understanding the power dynamics of looking in a visually dominated culture. See Laura Mulvey "Visual Pleasure and Narrative Cinema" *Screen* (1975) 22-34.

²⁸ See chapter one pgs. 15-16 for Dominick LaCapra's discussion of transference.

²⁹ See Anita Gates, "Disease, The Clock and the Will Not to Fail." *New York Times* 22 Feb. 2001, Final ed., sec. Section E; Column 4; The Arts/Cultural Desk: 3.; Jefferson, Margo. "Layups for Love in the Heart of the Arena ." *New York Times* 20 Apr. 2004, Final ed., sec. Section E; Column 1; The Arts/Cultural Desk: 5.

Russo, Francine. "Slam Dunk." *New York Times* [New York] 20 Feb. 2001, sec. Theatre : 71.

³⁰ See Chapter One discussion of Scarry.

Chapter Five: Response, Discovery, and Future Directions

*The relations among brain chemistry (the effect of noradrenaline on the parts of the brain associated with memory and perception, for example), the psyche, and the body are difficult for the survivor of trauma to separate. For example, a flashback is both a somatic experience (the survivor of rape may experience disorientations in place and time through flashbacks that prompt a range of observable, physical symptoms such as shaking, sweating, and a trancelike gaze) and a mental phenomenon, a disorientation of the mind. So, too, it produces and draws on psychic residue even as it derives from and produces changes in brain chemistry. Research focused on the brain locates the hippocampus as the seat of memory, and studies the changes that occur in it during and after trauma. (Gilmore, *The Limits* 31)*

In this chapter I offer personal narratives and fragments of reconstructed memories intercut with a history of clinical hysteria – or the forerunner of modern trauma studies – to speak a counter-narrative to the medical history into which I was interpolated. At the end of the personal narrative section I have included a game show performance that describes my hospital stay. I performed this piece at the National Communication Association Convention in 2005. I conclude the dissertation with an overview of the chapters before moving to discoveries that arch across the chapters and a brief discussion of future directions for this scholarship.

This dissertation originated from a traumatic flashback born out of my own experience with serious illness. One moment I was driving my car, reveling in my newly found sense of health after my tumor was removed, and the next I was slamming on the brakes to avoid rear-ending a dump truck. As the normal flood of adrenaline hit my bloodstream, I panicked. Shaking, sweating, dry-heaving and crying, I gently pulled my car off the road and wept until my emotions were spent. That same night I had my first somatic recurrence in a nightmare. My illness, which I was re-experiencing in my

dreaming and waking moments, had first become known to me while I slept. If I turned onto my left side, my heart would begin slowing, until I awoke in a panic with a sick “sinking” feeling of suffocating. Initially the symptoms passed quickly. These were diagnosed as panic attacks, anxiety problems - your typical psychological diagnosis for a graduate student. My nightmares following the “cure” of my illness were recurrences of the same events; only this time when I finally awoke I remembered that I was “well.”

Physiologically, trauma is memory imprinted on the brain through the release of massive amounts of noradrenaline during moments when there is an overwhelming fear of the loss of bodily integrity or life. So what happens when your body begins regularly releasing enough adrenaline to stop your heart or cause a massive stroke? What happens to your memories, your cognitive abilities when your body circulates so much adrenaline that any startling noise, alarming thought, or sudden movement sends you into a paroxysm of anxiety? This physiological and psychological trauma circulated through my bloodstream, pounding inside my head, inside my heart, until I knew I was no longer the “same” person and I felt myself on the verge of both dying and/or becoming something and someone completely unknown. As my brain chemistry changed, I spiraled into uncontrollable stress that circled back to make me question my sanity in the face of a medical establishment that could only diagnose me as an/other hysterical woman. I was “unmade” in the process, as my body failed me and the establishment that was supposed to help me told me that I was not a trustworthy narrator. My illness was trauma. I was sick nearly unto death with trauma, and later its aftereffects - post-traumatic stress disorder.

Be being read within the medical history of the hysterical white woman I was left undiagnosed and suffering for three years. Within the following excerpts, I note the race of the medical workers with whom I interacted as a means of noting my own prejudices and perceptions that ultimately proved incorrect. Each time I had a doctor positioned “outside” of the traditional medical power frame, meaning not a white obviously heterosexual male, I assumed that I would be seen more clearly – somehow acknowledged as a complete person rather than a morass of symptoms. Unfortunately this hope proved false and nearly all of the doctors who treated me approached my care from a perspective defined by the institution. Despite my attempts to repeatedly give a detailed narration of my body, I was told by all the doctors that I needed to “relax,” “calm down,” “take some time off,” that a graduate career was perhaps more than I could handle psychologically.

Ironically, I was shell-shocked by a tumor that did in fact leave me unable to deal with a great many aspects of my life. There was a bona fide medical basis to my “hysteria,” to my trauma; however, I do not claim that basis as a means of discrediting women who do not have “genuine” medical ailments. Rather, I include these aspects of medical interactions as evidence of how I was further wounded by the establishment that was supposed to help me. Again, the irony that I am able to write this account because of that very establishment does not escape me, and I am not ungrateful for my life-saving surgery. I feel that it is my responsibility to speak these moments – not as a heroine of a great epic – but to stand with the women in this study “out” in the open as an/other example of the unsteady nature of the body upon which we build so much of our identity.

Characteristic of traumatic experience are my blank journals during the two years that I could not assimilate what was happening. Upon diagnosis, when my trauma was officially named within the medical establishment, I began writing and trying to reconstruct the blank time that had gone before. All of the accounts contained here are reconstructions of memory and I present several versions of my “self” within the following pieces. There is the scholarly persona trying to make sense of the unthinkable through a historical and theoretical framing; there is the flashback voice within the italicized sections – a persona cobbling together a few pieces of memory from thousands of possibilities; there is the persona speaking directly to the doctor’s in an intimate attempt to be charming, presentable and rational; and my most current persona who is trying to call forth the event that is still beyond my capacity for language.

Hysterical Historical Ties

The patient knows full well that most of those inflicting torture are sincerely trying to help; thus he cannot hate them, but neither can he offer them the gratitude that the intensity of their efforts seems to demand (Frank, Wounded 174).

During the nineteenth century, the rise of a white upper and middle class and the changing role of the male physician combined to objectify, label, dissect, and render silent the ill female body. As the woman of leisure became the ultimate status symbol of upper and middle class white society, the male physician began to make inroads into respectability through his frequent examinations of the “lady” of the house. In a symbiotic relationship, he validated her increasing “sickness,” elusively labeled

neurasthenia, which included symptoms of nervousness, anxiety, exhaustion, and a lack of interest in marital duties and childrearing. She in turn provided him with a patient in need of ongoing care whose male spouse was willing to pay for treatment. Wealthy white women's increasing agitation with a life of confinement and inactivity was defined and broadly medicalized as "sickness." Ironically, this "sick" and "weak" status became one signifier of appropriate white womanhood (Jordanova, *Sexual Visions* 56-7).

I'm nervous. You're always nervous the first time (defensively); well I'm nervous every time. I imagine you, I don't know if your eyes will see me, or if you'll look beyond me as you find me lacking, wanting, not enough, not sufficient for my own story. At this point, it doesn't matter to me if you are a man or a woman – I just want you to be present with me; to touch me, to hear me, and to see me. I prepared for you; I rehearsed for you (charmingly). I wear my best clothes, I smell good, I look as good as I can, and I hope that it will matter to you, I hope it will give you compassion when I lay naked and cold before you.

*You see...
I am going to a new doctor.*

As the century progressed the romanticization of the invalid white woman became widespread. Images of her included the declining domestic wife and the pitiable but lovely "fallen" tubercular patient.³¹ In numerous publications doctors lamented the "natural" diseased status of the upper class, white woman. Due to her supposed susceptibility to hormonal changes (which over the course of the century shifted in focus from the uterus, to the ovaries, to the brain) her very femininity and "femaleness" supposedly made her unable to bear the burdensome circumstances of daily life (Ehrenreich and English, *Complaints and Disorders* 14-19).

At the doctor's office you can't just confess your body and how it is betraying you – no, you have to confess the whole damn family; you have to write the words, and answer the questions that remind you of the genetic legacy you carry inside.

I know the family history and enough about medical history to know the way that an anxiety filled white woman with vague symptoms will be configured. I choose my words carefully. I know they are inadequate before I begin...

(Speaking to the doctor)

There's this sinking feeling. It feels like my blood is draining out of my body, especially when I turn on my left side at night. Sometimes I wake up with an intense headache, but it goes away quickly. My heart feels like it is pounding slowly, and I feel a strangely elevated level of anxiety.

While seeking a "cure," the idealized white woman was seen as always susceptible to further sickness and in need of continual monitoring by her physician, even after her "cure." Some feminist medical historians have theorized neurasthenia as a form of resistance to an incredibly limited world of ornamentation and childbearing. However, for the women seeking a "cure," there were real consequences of physical and mental violation (Ehrenreich and English, *Complaints and Disorders* 14-19).

Many "cures" for neurasthenia resulted in hysterectomy, ovariectomy, or the "... strengthening (of) the uterus with bracing doses of silver nitrate, injections, cauterizations, bleedings, etc (Ehrenreich and English, *For Her Own* 131)." Equally as disturbing was the "rest cure" directed at manipulating the patient's unruly behaviors and reactions to daily life. The "rest cure" was only possible through complete bodily and narrative surrender. Dr. S. Weir Mitchell, the renowned inventor of the "rest cure", prescribed what in this century accounts for brainwashing and torture - complete isolation and sensory deprivation. Along with the enforced feeding of only soft foods (primarily milk), the female patient was to abstain from any intellectual or physical pursuit, as she

reclined on her bed for at least six hours per day. Dr. Mitchell repeatedly admonished women against education and the possibilities of a "sprained brain." Perhaps the most famous patient to attempt the "rest cure" was Charlotte Perkins Gilman. Upon her first appointment, she presented Dr. Mitchell with a lengthy narrative of her ailments, which he promptly discounted and instructed her never to repeat. That she would undertake the narration of her bodily knowledge was reprehensible to Dr. Mitchell (Fensham 150).

I call my sister Anna, who is a nurse practitioner, "Is it weird that my heart is slowing down and making me feel like I am going to pass out? Yeah I thought so." I hang up. I call her back a few days later, "The good news is that my heart is okay, they think it is some weird vagal spell, but the bad news is that my blood pressure is really high, 150/105. I know, I keep seeing myself having a stroke." (Excerpt from my Comp Essay Personal Narrative March 2002).

I go back to the health center repeatedly. "You need to relax, you need to get this anxiety under control. We're starting you on some medication but you should be exercising to bring your blood pressure down. I know your comps are stressful, but you have to manage that pressure." I echo to myself what my kindly young white male doctor and many others have said. I cannot sleep without feeling as if my blood drains out when I turn onto my left side. I am so nervous that any unexpected noise or sound makes my stomach clench.

I try exercising more vigorously. I tear my soleus muscle in an aerobics class filled with twenty-year-old fit bodies. My white plump thirty-two year old body is ceremoniously processed out of the student rec center in a wheelchair. At the emergency room my blood pressure is astronomical. The medication seems to be causing the blood pressure to rise. How can this be? The anxiety is unspeakable. I cannot sleep. I have long since finished my comps and am into the summer. I am given a "walking boot" to stabilize the torn muscle. As I drag my leg up the stairs to my apartment, I feel my heart slow down. I feel faint. I take my blood pressure and it reads 220/140. I call my doctor at the health center; when he calls me back he tells me that the cuff must be wrong. I am beyond questions; but I do not think the cuff is wrong. I must find the ability to "relax."

The "rest cure" was effected by the doctor's force of will as he directed the woman to reconcile herself to the comforting normality of domestic life (Ehrenreich and English, *For Her Own Good* 130-33). Taking the "rest cure" became a defining aspect of the ideal

upper class white woman's life. Having no say in the duration or form of the “cure,” a woman had to suffer physical and mental infantilization in order for the “cure” to succeed.³²

I move to North Carolina, where I know few people. I begin seeing a male African American internal medicine doctor at the practice where my sister works in Georgia. Although it is a difficult arrangement since I must drive to Georgia frequently. Even though it is a five hour drive each way, I feel safer with people I know.

Aside: Your thoughtful eyes are a darker brown than your skin. I think you see me, but I baffle you. In your notes of me you wrote that I was “a well-developed white female” – oh I know that is just the standard way of saying that I was grown and all, but it meant something. I came to you for a long time, and you never doubted me – even the time when I lay on the gurney and said that I was seeing the world through broken pieces of brown glass filled with bright purple pinwheels. You were vigorous in your interrogation of my body: CT scans, ultrasounds, medicines, heart monitors, we tried it all...but ultimately you had to send me away...

Months of CT Scans, MRI's, ultrasounds, and blood tests pass, as I am increasingly debilitated. On February 6, 2003 while in North Carolina, the back of my head feels like it implodes and I begin vomiting uncontrollably. I lose feeling in my arms as my partner drives me to the local emergency room during a snowstorm. I try to tell the white skinned male ER doctor what has been happening. I am sent home with a narcotic pain reliever that causes constipation. Using the toilet seems to create massive headaches with uncontrolled vomiting. Eight days later, while in the bathroom, I fall onto the floor with indescribable pain in my head. My African American male internal medicine doctor sends me immediately to a male Chinese neurologist.

The moments I most want to remember are the worst ones, to somehow put words to that unmaking of myself. The feeling was one of disintegration, a fine and quick breaking apart as if all the Perrier I had ever consumed was suddenly bubbling within my bloodstream and the only thing holding those vessels together was a thin tube of tissues. I felt their need to fly apart, to release the unbearable pressure, as the fizz started in my head and I felt myself contracting into the bubbles. I wondered if they would carry me

away somewhere, or if I would transform into a bubble too. The pain that resonated through my body was not as unbearable as the constant fear for my sanity. I will not describe this pain for you; not because it is inappropriate, not because I worry for your welfare in this account; but because it brings the saddest memories of loneliness and I know that trying to tell you will only leave me feeling unwitnessed once again. I write this now with no fear for my sanity, so both you and I can forget those unseemly moments when I feared that I might harm someone I loved or myself. This is one of the gaps. This is the space of unmaking where I felt my understanding of language and expression bubble up and then seep away inadequately.

A new doctor?

I can't prepare; I can't rehearse; my brain won't work. I am left at times without words.

You are the imminently respected Chinese neurologist. I take comfort in the fact that you have not only an MD but also a PhD.

I have traveled miles for your care.

I can hardly see you, you refract, and I don't think you can see me.

You sent me to EEG in the middle of a migraine. I throw up in the trashcan during the test,
but

you

are

sure

that I am not having a seizure.

You see there's this sinking, sweating, stinking, fearing, hurting, vomiting, vomiting, vomiting, shaking, and my blood pressure...

There is a moment when you could have seen me. There is a moment when my confession and my charts and my knowledge lay next to your judgment and hoped for kindness, for compassion rather than definition.

I hear "Classic Migraine" "condition for life." "Learn to manage."

Later I find out I have manifested what is called an unbreakable migraine. It lasts for twenty-two days. Each day I inject two Imitrex shots to constrict the blood vessels in

my brain, ingest four Neurontin (for neurological pain), six Soma (for muscle relaxation), and ten milligrams of Valium (for sleep). The financial cost of this medication is over two hundred dollars per day. I feel my unearned privilege acutely as my sister sends me samples of medication (which I can not afford) as often as she can. This new male neurologist, who has never taken my blood pressure, pronounces that the year's worth of testing I had undergone with other doctors was worthless. I only have "classic migraine" disorder. He discontinues my blood pressure medications.

As Freud's writings on female hysteria circulated in the United States, they began to replace neurasthenia as the female malady. With the birth rate for white upper and middle class children declining in opposition to rising birth rates amongst immigrants and women of color, the idea surfaced that perhaps upper class white women were merely avoiding their childbearing responsibilities. Hysteria, a disorder manifested in the brain but bound to the uterus (hysteria comes from the Greek word for uterus), replaced neurasthenia as the female disease needing constant medical intervention. Hysteria identified behaviors included violent fits that could involve sneezing, coughing, laughing, and screaming (Morantz-Sanchez 481).³³ Documented as a distinct ailment of upper class white women, hysteria quickly became known as a "petty" means to power by "manipulative" women. Doctors became punitive in their prescribed treatments, which ranged from partial suffocation, head shaving, and cold showers to the more painful beating of patients with wet towels (Ehrenreich and English, *For Her Own Good* 133-40).³⁴ As Freud's psychoanalytic talking "cure" became popular, expert knowledge shifted from the white male physician to the white male psychiatrist.

Suzette Henke writes that the return of the soldiers after World War I witnessed the symptoms of "hysteria" in men for the first time. As veterans began to manifest depression, flashbacks, self-destructive behavior, etc. Freud shifted his diagnosis to "shell

shock.” Only associated with war or other major catastrophes, the modern concept of trauma was born. It would take more than sixty years before the daily insidious dehumanizing experiences that permeate many women’s lives would be added into the understanding of this man-made concept (Henke xi-xv).

With the migraine diagnosis, I become the woman who must learn to live with her pain. I speak to numerous other women with migraines, trying to find out how they manage their lives. Everyone assures me that eventually my doctor will find the right medication combination to manage the headaches. It is never just headaches. As the neurologist increases the dosage of Topomax, an anti-seizure medication used to prevent migraine, I become increasingly disoriented and unable to concentrate. I drive my car off the side of the road; I tell him that I cannot handle this medication. He tells me that he thinks this is a "good" dosage for me. I need to remember that "migraine is a condition that you manage for life." I continue having breakthrough headaches, projectile vomiting, uncontrollable anxiety, insomnia (which resists the highest dosage of Ambien, a consciousness altering sleep medication), spells of shaking, muscle contractions, instances of my heart pounding so slowly and powerfully that it is visible to the naked eye, and intermittent occurrences of a deathly white skin pallor.

I can tell how bad my "spell" is going to be by how gray my skin becomes as I await the symptoms (I love the term spell. It is an official medical term for the episodes that I experienced, but I like to think that I suffered under something supernatural.) I look in the mirror and know what I will look like when I am dead.

I lose weight because of the appetite suppressing function of the seizure medication and my continued episodes of vomiting; people tell me how good I look. My body begins conforming to norms of shape and size I have always wished for; secretly there is an awful pleasure in these compliments. I weep over my satisfaction with weight loss and a feeling of femininity that comes at such a price; how can I be such a pathetic "feminist"? How can I somewhere inside embrace this feeling of helpless sickness and dependency even as I rail at the loss of my life? It fills me with self-loathing. Within two months, I fire the male Chinese neurologist and seek "alternative" treatment with a white Belgian male chiropractor, who in turn insists that I see another (white female) neurologist.

At the end of the nineteenth century, the "knowledge" necessary to effectively treat mental and physical sickness had been configured as decidedly masculine. This masculine pathologization and infantilization of the wealthy white woman's anatomy had

serious implications for female healers. I use the term healer to denote women providing healthcare, a few of whom were schooled in the burgeoning medical establishment, but the majority of whom were taught by informal apprenticeship to other women. While the consolidation of power was underway within the growing American Medical Association to name male physicians as those most fit to administer medical expertise, there were some female doctors such as Mary Putnam Jacobi who spoke out against the "rest cure" and the inordinate amount of attention given to wealthy women's health.³⁵ Often calling upon the ideology of domesticity to position themselves as "understanding" women's ailments, female doctors and midwives became caught in a double-bind. As the hegemonic definition of white femininity became one of "sickness" and "weakness", women healers were categorized as unable to effect cures because of their femaleness. The female healer and midwife was doubly confounded – positioned as a failure at appropriate gender behavior because of her active lifestyle and at healing because of her femaleness (Ehrenreich and English, *Complaints and Disorders* 23-25). This is not to imply that white male doctors delegitimized these healers within all communities; however, the male physicians' movement did work to delegitimize female healers within dominant culture. Not only did the ability to act as a subject slip from the hands of female patients, but also the bodies of knowledge both experienced and passed down were effectively shut out from the growing male-dominated medical establishment (Morantz-Sanchez 483).

The white-skinned female neurologist prescribes a different neurological drug. I continue to call her office and tell her (through a "gatekeeper" receptionist) that I am not getting better. My ability to work and maintain my regular schedule is gone; I prepare to teach only to be left shaking and exhausted on the bathroom floor minutes before my

class is to begin. Since this is a condition I must "manage for life", I try to maintain some semblance of normality.

This time I am persistent.

I've been here for months in your office, calling, leaving messages, through the "gatekeeper" receptionist – I AM NOT GETTING BETTER despite several changes in medication. but I am only a woman with a migraine disorder.

This time when you come in, with your lovely long blonde hair I see how shocked you are at my pallor and my astronomical blood pressure, my uncontrollable vomiting. I appreciate your validation of my body if not of my story.

From this point forward, she begins to actively investigate my bizarre ailment. Through consultation with my first internal medicine doctor, she decides to test my adrenal levels.

And while I am standing in an airport, I receive a call that tells me that the inside of my body from chest to pelvis must be scanned to find the tumor or tumors.

The results come back and I find out that I have fatal levels of adrenaline circulating in my body everyday. I am immediately referred to a surgical oncologist (cancer doctor) and subsequently an endocrinologist. I have what is most likely a "benign" adrenaline- producing tumor called a pheochromocytoma. It is enraging to finally feel vindicated because someone has told me what I knew all along - I am very close to death..

I am sent to have multiple CT scans. Did you know that when a woman has a pelvic CT Scan she is asked to insert a tampon into her vagina as a "marker"?

As I lay on the metal slab awaiting my insertion into the donut shaped ring of the CT machine, I wonder about this marker that I am now wearing. Do men have to insert tampons somewhere as markers? Or are their parts more easily identified, less mysterious, less prone to move around during the radiological photographing process? Later, I see an endocrinologist for the first time.

You're the new endocrinologist – another imminently qualified head of internal medicine sort of guy- the nurses tell me that I must be "something special" to see you. One call from, my well-known surgical oncologist from a famous teaching hospital and I am in the door. You tell me that endocrinologists wait their entire careers to see what I have.

You want the whole story; you seem so interested, scribbling notes. I think you hear me. Then like all the others, you go and ruin it.

To my astonishment and fury, he decides he will retest my adrenal levels-" merely a

formality"- before I can start the medications that will prepare me for surgery. Then he decides we should look at my CT scans. The CT scan shows a horizontal slice of my internal organs. The tampon shows as a silvery black inanimate circle in the center of the photo. To the right of this, he points out my tumor as it rests on top of my right kidney. Then he shows me the dark spots on the tumor. He pauses for a moment and says that we will start the medication now. The tumor has exceeded its blood supply and may be bleeding into my body. This is incredibly dangerous, as it can pour blood and adrenaline directly into my body cavity. The tumor touches my liver. It will still take at least six weeks to prepare me for surgery. I feel terrified, exposed, and ashamed.

Through two months of drug therapy, I am prepared for a surgery to remove the pheochromocytoma, adrenaline-producing tumor, that has caused my symptoms. The preparation for surgery involves stopping my body's natural ability to regulate blood pressure. There is no way to suppress the amount of adrenaline that the tumor pours into my body, only a way to suppress my body's ability to respond. The drug of choice is called dibenzolene. It is used for no other purpose, as it makes the person too tired for daily routines. I begin to feel better as the drug is increased in dosage because I no longer have the debilitating spells. Although I am tired, I hope that I will one day participate in daily life with some degree of continuity. When my blood pressure is unable to respond to a change in position from lying to standing, a condition called orthostasis, I am ready for surgery. My ability to become lightheaded and nauseous upon standing signals my medical preparedness.

Patching Me Together: Identity in a Hospital Setting A Show within a Show starring Tessa Carr

My illness was rare. It isn't something that will happen to you, or maybe it could. Maybe you are also the unlucky lottery winner like me? As a teaser for this audience, I'll tell you that I am published – in several studies more than likely – unfortunately none of them bear my name or any recognizable photographs. No sense of time and space - no understanding of the layout of the building that my body was processed through on gurneys in wheelchairs – this performance isn't about the years of my life that were spent along a trail of misdiagnoses, it isn't about the hundreds of test that I underwent, the thousand dollar pharmacy bills for medications that I didn't need.

My illness tends to take over the narrative when it is allowed to participate. So today, I wanted to examine the event of surgery. And since most of my caregivers didn't know what was wrong with me, I don't think you need to know either. This performance features the thirty-six hours I spent in a research facility as an interesting physical anomaly, a research specimen, a relatively privileged white woman, a graduate student, a wife, a sister, and a daughter.

(The Game Show host ranges from manic to sympathetic in emotional tone – hyperbolic is the word I would use most often to describe her. She wears either a Groucho Marx nose and glasses or a red clown nose. The host has a large bag from which she pulls glittered signs with Door number One, etc. on them.)

Tessa as Game Show Host: Welcome ladies and gentlemen, welcome bodies both well and ill to everyone's most dreaded and random event: Your Hospital Stay. During your stay in the hospital you hope that all are equal – all are welcome, that our individual identities, privileges, prejudices, can just disappear and that we can all access the milk of human kindness, *(searching for the right words...)* the embrace of compassion, the bedside manner of kind soap opera like doctors and nurses who gaze upon you with dewy eyes and... well whatever.

We're about to join our contestant as she begins the whirlwind, and I do mean whirlwind, laugh a minute thrill ride that is a hospital encounter. You will see here moving as she changes her clothes, as she is pushed through corridors of fast-paced activity, as her family moves and shakes to position her in just the right room... well I'm getting ahead of myself.

Let's join our contestant as she discovers what is behind door number one.

Tessa: *(This is the warmup I've been preparing for – I jog as I answer these questions.)*

Yes, I am aware that this facility is considered out of network by my insurance company. Here's the receipt for the 250.00 charge that I paid when I scheduled the surgery. My pre-cert is confirmed right? Yeah, I signed all the papers about scientific research and donation. I hope I'll get a publication credit. *(the person I am addressing doesn't get the joke)* Down the hall, first left, second, left, fourth door on the right behind the impossibly well hidden potted ficus for pre-op? Thanks.

Game Show Host: This is a good part. She's now being stripped of all those comfortable trappings, watches, glasses, wedding ring, shoes, socks, shirt, pants, bra, and panties. Here comes two big ones: Door number two- pre-op prep, and Door Number three: The inner sanctum of the OR.

Tessa: *(Take out hospital gown, unfold and put on chair, fidget nervously with the props – also have a surgical mask, cap and shoe covers.)* I am given the blank hospital garment and TED hose. I laugh hysterically with my sister and husband as I put these tight white thigh high stockings on my terrified body. Thinking of seeing myself naked except for these hose, brings to mind all sorts of ridiculous naughty schoolgirl outfits that really seem inappropriate for surgery.

I am left alone in a curtained off cubicle after my sister and husband are asked to leave. I sit giggling and scared. When Leroy starts my first IV, I ask that he please not put in the arterial lines in

my neck and arm (I've done my research) until I am asleep. It is five minutes after seven when I am pushed through the swinging doors of the operating room. I am astonished at the number of people I see – it doesn't look good that it will take eight, ten, twelve people to do this??? A moment of exquisite human kindness, my surgeon stands beside my gurney suited in his green scrub armor, wearing his shell necklace, he gently strokes my arm as I fade away.

Game Show Host: Oh the problem of time and the game show format: well, here we'll pause for oh say ten seconds and think about what could have been happening to our contestant during the six hours of time before she wakes up... (Pause ten seconds) (Wiping away a tear) It's beautiful isn't it? The dependency of the thing, the blood, the knives, the pure sweet heroism of the surgeon, the complete surrender of bodily control, such an intimate physical act – without memory, what constitutes experience – I wax... *(pulling herself together...moving on)* Door Number Four arrives: She doesn't really see the passing through, but we'll give her a break here:

(Ideally, the game show host would continue to play the recovery room nurse, since I will be performing this myself, I will transition out of the game show host role and into Tessa/patient)

Tessa: Mrs. Carr what do you do?

Mrs. Carr what day is it?

Mrs. Carr who is the president?

Mrs. Carr it's time for you to wake up now, you've been asleep a long time.

Mrs. Carr?

Yes? It's October 17th.

Very Good. What do you do Mrs. Carr?

I'm a student.

Of what Mrs. Carr.

Why does he keep bothering me? I open my eyes. I am in a grocery store full of gurneys filled with ill people and nurses and loud ugly lights. The space seems huge and we are all scattered around. My nurse tells me his name is Dennis. He is a white man with a neatly trimmed beard and glasses, I think he must be around fifty years old. He keeps bugging me with questions. *(discovering these areas)*. My neck hurts very badly, so does my right side.

What do you do Mrs. Carr:

I am a graduate student and a teacher.

Of What?

Performance. Performance Studies. (Oh God, I can't bear to explain what Performance Studies is right now, please don't ask...) He doesn't ask. Instead he begins to query me about the differences in attending a small college versus a large university. He draws this information from me in a series of specific questions. I appreciate his questions, but I find myself working very hard to sound intelligent, coherent, you see I have taken many tests in my life and I know when one is being administered. He declares loudly to the grocery store that I am the smartest patient he has had in weeks. Most of them don't do anything interesting he says, and neither do his colleagues. I am vaguely embarrassed and yet pleased; he begins to tell me that he is an RN not an LPN (which he says with disdain) just as he injects morphine into my IV so that he can remove the arterial line in my arm. I fade out from the pain in my arm. When I rejoin the conversation, he is again announcing how smart I am and how dumb his colleagues are. I know that I am somehow being used to prove a point to the nurse at the central station located twenty feet or so from my gurney. I ask for more pain medicine, Dennis turns to the central station and raises his voice to ask if I have any doses left? The male African-American nurse at the station shouts back that I have one – I think he looks at me somewhat sympathetically.

Game Show Host: She's about to get moving – and I mean fast: she talks too much, so I'll cut to the chase. She's on that gurney and flying, I mean flying down another hallway, the lights flash overhead, she is really in an episode of ER now. The two gurney movers talk back and forth above her. They don't really see her though, she's just another mission to be accomplished, another destination to be reached in an endless round of sorties that must be carried out over the course of the day.

Oh wait- is she trying to talk to those guys? Does she really think they will respond? They look at her blankly, did she say something? Man they hate the ones that are that conscious out of recovery – always wanting attention, notice me, notice me, can't you see I'm a person, yeah yeah whatever....

Door number Five is a big disappointment.

Tessa: Why am I in the hallway? What? My family members are all clustered around my gurney in the hallway. There are so many people everywhere, all going somewhere I think. My room isn't ready. Why is the TV on? Please turn that off. There is someone

else in here? Mrs. Bland? Is that her moaning next to me? Oh my God, I cannot get well in this room, I was supposed to have a private room.

I am supposed to have a private room.

I know I said I wanted a private room.

Why don't I have a private room?

I am more upset about this than anything that has happened. I am helped to the toilet by my nurse Francesca, she is younger than me, I think she is Latino but I'm not sure. We pass Mrs. Bland in her bed on the other side of my curtain, we can't be more than three feet apart. Mrs. Bland is in pain, asking for help fitfully. She is an African-American woman in her sixties maybe, I think she has been in the hospital for a long time.

Tessa in the present: We must look differently as a family in Alabama than we do in California. In California my father had a seizure in Yosemite national Park. My mother was with him, and my sisters and I were out on a hike. My mother told the park rangers that he would be okay after it passed. He has had a seizure disorder for years and my mother, a registered pharmacist, knows what to do when it happens. The park ranger looked at my mother in her vacation Wal-Mart Winnie the Pooh shirt and her southern dialect, and said, Ma'am if it is a matter of money we can take him to the hospital for free. In virtually the same outfit in Alabama, my mother and my father were told by Francesca, that I could have a private room in a very posh area of the hospital for an additional two hundred dollars in Cash. CASH – my husband goes outside to an ATM and withdraws the money. I am transferred into the Camelia Wing (with a deep southern accent) complete with faux cherry furniture and a curved sink in the bathroom. I feel happy and guilty.

Game Show Host: Don't you worry though, she'll get what's coming to her for throwing that little privileged white girl routine and the guilt won't make it any better. Things are not always what we plan behind Door Number Six:

Tessa: Please, please, If I am hurting too much. If I wait until I wake up it is too late, can't you just bring it every four hours and wake me up to take it? Please, it's too late then. I can't stop hurting.

The night after I'd had surgery, and I cannot get pain medicine until I wake up in agony and ask for it. It cannot be administered other than on an hourly dose basis. I am told this repeatedly as I ring for the nurse. This wasn't a problem during the day, but this new nurse, this Brunhilde, this bitch in her white polyester zip front nursing outfit, hates this me she has found in her Camelia Wing Suite. She insinuates that the idea of recovery is to need less pain medicine not more, that laparoscopy isn't that bad, and that I am becoming an Oxycontin addict.

The next morning I tell my surgeon about the pain and the altercation. He rewrites the order and tells me there was morphine as a backup that I could have had. As he leaves the

room with the resident, and four shuffling and awe-filled medical students, I hear one of them ask:

Why is she in here?

The surgeon replies: The hospital must be overfilled and they will sometimes put overflows in here.

Oh well, I guess we don't look that different in Alabama.

Game Show Host: *(Pulls grungy flowers from her bag and lays on the hospital gown)* We're out of time again, and really who wants to hear that much about this anyway. This is your prize for participating (roses). Join us next time, when we play the same episode over and insert, the role of the sister- not just an RN but a nurse practitioner, a new co-star – we'll get a glimpse into the future as our contestant deals with the fear of recurrence and meet the kindly LPN who discusses the problems of Prince William and Prince Harry, along with other forgotten stragglers who make YOUR HOSPITAL STAY possible.

Tessa: *(Looks at flowers, picks them up)* That's it? It's over? I can go home now? Oh, okay. *(Leaves the stage slowly and confused.)*

Even as I try to narrate "my experience" it is filled with medicalized jargon and does not begin to fill in the unspeakable gaps – where so many pieces of my life disappeared, relationships imploded, loved ones deserted and uplifted me, and my body became both a horror and wonder.

As the euphoria of my surgical cure fades, I find myself moving in fits and starts towards some understanding of the last few years' trauma. As I try to find some meaning I also attempt to start working on my dissertation question of whether theatre holds the potential to enact radical democratic practice. Days pass where I throw myself into the adjunct teaching and costuming positions I hold, without thoughts of the dissertation. Other days pass more slowly when I find myself again trapped in the past, reliving moments of intense trauma and the sense of "impending doom" that has permeated my illness. Some days are filled with the terror of recurrence, a ten percent mathematical chance that haunts me. Recurrence could mean malignancy and a "fifty percent" mortality rate. In moving through my new and strange life, I decide to write about illness, performance, and the female body, or write nothing at all.

The narratives and the history circle back to the beginning of the dissertation process. This ending leaves me with a sense of transference, a sense that I too have created my public witnessing, not only through this personal narrative but through the

dissertation itself as a performative witnessing to the patterns that I found within women's autobiographical performances of traumatic illness experience. This is one performative witnessing to the unspeakable. It is not my only witnessing – I am committed to lobbying for post-traumatic stress disorder to be added as an aftercare diagnosis for people suffering from the rare adrenaline producing tumor that I endured. Fifty percent of the people who have this tumor die undiagnosed of heart attacks and strokes. I wonder how many women shut away from society due to anxiety had uncontrollable bodies that produced their madness? This is not to suggest that women who were labeled hysterics all had these tumors, or that their dissatisfaction with their circumscribed and limited lives would not drive anyone to madness. I have no doubt that a hundred years ago, I would have been shut into a quiet room, and my heart would have stopped from the trauma my body generated. Because I am working through an inscribed history and cobbling together memories and imagination, I consider myself, like Linda Park-Fuller, the “adaptor” rather than the writer of this work (*A Clean* 216).

I have covered myself in words to find that they are all inadequate to organize, make sense of or even confess the inadequacies of the words I couldn't find -- I still can't find for those years of anxiety and loss. This research will continue to aid me in restoring pieces of the narrative, but it also allows me to and leave pieces as just pieces.

Survivors of trauma are urged to testify repeatedly to their trauma in an effort to create the language that will contain trauma as well as witnesses

who will recognize it. Thus the unconscious language of repetition through which trauma initially speaks (flashbacks, nightmares, emotional flooding) is replaced by a conscious language that can be repeated in structured settings. Language is asserted as that which can realize trauma even as it is theorized as that which fails in the face of trauma. This apparent contradiction in trauma studies represents a constitutive ambivalence. For the survivor of trauma such an ambivalence can amount to an impossible injunction to tell what cannot in this view, be spoken. (Gilmore, *The Limits* 5)

Overview of Chapters

In this study I ask: How do women's autobiographical performances of traumatic illness experience disrupt and/or reinforce master discourses of medicine, normative identity, and knowledge and thereby witness to new insights regarding medicine as an institution, identity formation, and knowledge construction? In answering these questions I examine the relationship between trauma studies, feminist autobiographical theory – with a focus upon performance studies' contribution of the theorization of personal narrative performance and the body as a site for performative identity, and feminist performance theory that deconstructs the traditional meaning making apparatus of both stage and text.

In Chapter One I identify the shared focus within trauma studies, feminist autobiography, and feminist performance theory of a distrust of traditional frames and

mechanisms of representation. The theories of trauma studies and feminist autobiography also share a belief that identity can be reformed through a revising of autobiography. For trauma studies this revision occurs through a witnessing to the traumatic event when the experience can finally be translated, even if inadequately, through language. I position these public tellings as a politicized form of witnessing – not only because they speak of women’s traditionally marginalized experiences, but also because they represent a willingness to speak out against a cultural silencing that leaves the ill patient in isolation. I also claim these performances and my analysis of them as a means of furthering feminist definitions of trauma that focus upon insidious harms that permeate women’s lives. I argue that ill women are further traumatized by the isolation from “healthy” and “normal” life, the inability to discuss that pain and isolation, the laboring attempts and subsequent failure to maintain gender norms, and the relatively powerless status of patients within the medical establishment.

Following a discussion of feminist theorizations of the female body onstage, I offer a brief history of trauma as a concept and then move to a discussion of the feminist definition of trauma as outlined by Judith Herman, Marie Root and Laura Brown. The work of these feminists changed the definition of trauma found in the *Diagnostic and Statistical Manual of Mental Disorders* from “outside the range of usual human experience” to include “actual or threatened death or serious injury, or other threat to one’s physical integrity” (qtd in Cvetkovich 18). An expanded definition of trauma provides a lens for finding the cultural patterns within individual accounts of trauma. Chapter One also includes a discussion of Ann Cvetkovich’s concept that trauma does

not evacuate the public sphere but rather permeates our daily lives in the form of public expressions such as monuments, memorials, etc. Working with the feminist definition of trauma, Cvetkovich adds an enlarged notion of citizenship and cultural participation to reposition lesbian expressions of trauma as a means of animating rather than evacuating the public sphere. Dominick LaCapra's work on the transference of trauma through a variety of cultural expressions speaks with Cvetkovich's work in helping me discover the various cultural products beyond individual therapy) that arise from traumatic experience.

Coinciding with trauma theories of dissonant narratives are feminist theories of performance that offer frameworks for reading representation and the mechanisms of the stage, screen, and text without assuming the ability to convey a unified or direct referential meaning. I examine the overlapping characteristics of feminist performance theory that distrust realism and linear narrative.

The potential for performance, and specifically the performed personal narrative to serve as testimony has been theorized by Performance Studies scholars. I layer the theorization of the performance of personal narrative to serve as a medium for testimony and witnessing with the work of trauma studies scholars. Trauma testimony is defined as an emergent performative speech act that recalls and articulates events that occurred in the past filtered through the lens of the present; thus, always including a gap that makes all traumatic testimony partial and lacking referential exactness. These acts of testimony and witnessing serve as transferring agents that allow the possibility for re-integration of identity as well as a re-entry into the social body – in this case through public performance. Employing Kaplan and Wang's concepts of audience witnessing, I contend

that forms such as feminist performance may allow the audience to co-witness these experiences.

Finally, Chapter One maps Performance Studies scholarship on the performance of personal narrative. I position the performed personal narrative as a constituent of life-writing within feminist autobiographical practice. While performed personal narrative has been critiqued as “beyond criticism” and as “too personal,” Kristin Langellier’s theory of performativity and personal narrative which frame personal narrative as potentially constitutive of a reclaimed and politicized identity, refutes this notion of non-critiquability. Concluding this discussion, I rely upon Linda Park-Fuller’s notion that the speaking of the “self” can foreground not only “the struggle disclosed (the narrated event), but also the struggle to tell (the narrative act)” (“Performing Absence” 24). The speaking of the self “enable(s) a re-appropriation of voice and reconstitution of self” (Park-Fuller, “Performing Absence” 21). For marginalized groups, such as ill women, speaking the personal narrative thus becomes a “struggle for agency” (Langellier, “Personal” 129). Speaking the self can rewrite stories that have been silenced or distorted, and can articulate possibilities for a better world (Park-Fuller, “Performing Absence” 26).

In Chapter Two I focus upon the most recent solo work by performance artist Robbie McCauley to question the disruptive possibilities of the chronically ill woman of color speaking her experiences on the stage. I begin with McCauley’s utilization of an African American performance aesthetic and history to create a setting for open audience participation. I rely upon Joni Jones/Omi Olomo’s jazz aesthetic theory to more fully

articulate the specific artistic choices that McCauley includes to make her work particularly readable to an African American audience. I position McCauley's *Sugar* as drawing upon a tradition of testimonial literature that bears witness to a counter-narrative within U.S. history. Through a brief history of African Americans treatment within the U.S. medical establishment and the specific case of African Americans and diabetes in contemporary U.S. culture, I argue that McCauley's *Sugar* unveils the intimate relationship between whiteness and the U.S. medical establishment and exposes how that establishment continues to perpetuate trauma in the bodies of African Americans seeking healthcare. I employ literary scholar Shoshana Felman's concept of "precocious witnessing" and examine how McCauley employs poetic language that can ". . . speak *beyond its means*, to testify- precociously- to the ill-understood effects and to the impact of an accident whose origin cannot precisely be located but whose repercussions, in their very uncontrollable and unanticipated nature, still continue to evolve even in the very process of testimony" (Felman, "Education" 30).

I examine how McCauley performs a layered and evolving sense of identity through the lens of identity as constructed by African American feminist theorists. Scholars such as Elizabeth Alexander and Audre Lorde inform my study of McCauley's witnessing to conceptions of self that must be overlapping and processual in order to negotiate a culture that continually denies affirmation to the perceptions of African American women. McCauley performs her continual negotiation of memory and demonstrates the necessity for a mobile and constantly changing conception of identity as she finds new information and understanding of her condition by parsing and piecing her

memories together. I argue that McCauley disrupts notions of gender identity by performing “inappropriate” acts of femininity, such as talking with her mouth full and injecting insulin onstage. McCauley also challenges assumptions regarding racial identity (both from within the African American community and racial stereotypes of dominant discourse) by demonstrating her ability to change what she eats, how she exercises, how she interacts with her healthcare regime, etc.

McCauley also disrupts notions of the “compliant” patient with her vigorous investigation into her condition and her employment of that information in her healthcare regimen. By incorporating a woman living with Type II diabetes into her performance, I argue that McCauley strategically aligns herself with the entire diabetic community, rather than taking the less stigmatized route of self-identifying as a Type I diabetic. I employ a critical race theory framework to argue that McCauley challenges popular culture notions of the medical establishment ranging from beliefs about the equality of treatment for patients to the appropriate public behavior of ill bodies; she subsequently creates a crisis of understanding, a trauma of sorts, for white audiences and an affirmation of experience for people of color who are negotiating a white medical system. This crisis and affirmation work together to allow for different perspectives of identification and possibilities of active witnessing within the audience.

Chapter three looks at the work of three solo autobiographical performances about experiences of breast cancer. Susan Miller’s *My Left Breast*, Brandyn Barbara Artis’s *Sister, Girl*, and Linda Park-Fuller’s *A Clean Breast of It* serve as examples from different cultural perspectives. I argue that all three artists incorporate the structure of

traumatic experience by interspersing memory flashbacks, monologues, scenes and music throughout narratives that reveal the pain of cancer diagnosis, treatment and recovery. I then examine each piece for other traumatic expression characteristics. While Susan Miller's commentary regarding her work suggests that she resists the idea of *My Left Breast* as therapeutic transference, I argue that the text is structurally symptomatic of traumatic expression through its shifts in chronology and linking of traumatic moments and also specifically points to a reintegration of self. Linda Park-Fuller has explicitly identified her creation of *A Clean Breast of It* as a working through of the trauma of breast cancer. I argue that Park-Fuller creates an emotional safety net for her audience and herself by her deployment of a clearly delineated narrator that is in control of the performance at all times. Brandyn Barbara Artis's work differs greatly from the other two performances because it is based on journals kept during her ordeal rather than recalled after a latency period. This points to the fact that Artis did have access to much of her experience as it occurred and her performance cannot be completely configured as responding to traumatic experience.

In order to understand how these performances of traumatic experience disrupt norms of medical knowledge I include a brief history of cancer and breast cancer discourse that contextualizes these performances within the early 1990s. I identify the most damaging aspect of breast cancer rhetoric as the rhetoric of personal responsibility and I investigate the ways in which each performance challenges, critiques, or reinforces this concept. This investigation highlights the ambivalence created in cancer patients through this harmful rhetoric. I consider how the patient's experience of bodily

knowledge is often undermined through a biomedical reliance upon imaging technology in spite of the certainty of diagnosis and detection by the patient. I explore how each performer disrupts the certainty of medical knowledge with her testimony of detection and diagnosis, the trauma of treatment, and by questioning the “cure” narrative so often told to and by breast cancer survivors.

Finally in chapter three I consider how the bodily changes created by cancer and cancer treatment affect the performer’s understanding of gender and sexual identity and how each performer incorporates that new conception into the performance. To contextualize this discussion, I investigate the importance placed on the breast in late twentieth century patriarchal culture. I argue that these women all refuse a desexualized identity and explicitly claim their active sexual identity post-mastectomy. I also discuss the problematic tensions between recuperative femininity and disruption – focusing upon the ending of Susan Miller’s *My Left Breast*. The final section of this chapter considers the difficulty in the audience’s ability to witness these pieces within a medical setting. I argue that talkback sessions within these settings may ultimately subvert the disruptive potential of the performances.

Chapter Four focuses upon two plays by performance artist, scholar, and teacher Deb Margolin. I begin by continuing my exploration of how performances of illness experience incorporate the structures of trauma. Employing Leigh Gilmore’s theories of feminist autobiography and the potential of a move to fictionalized text, I position Margolin’s work as feminist “life-writing” that includes women’s attempts to regain narrative authority over traumatic events. I explore how Margolin’s theories of

autobiography and fiction overlap with other feminist scholarship. I examine *bringing the fishermen home* and *Three Seconds in the Key* both of which are fictionalized accounts of Margolin's experiences with Hodgkin's disease.

My analysis of *bringing the fishermen home* centers around Margolin's performative incorporation of the structures of trauma not only in the form of the play but also within the reactions of the protagonist, Jane Sand. I argue that through feminist playwrighting strategies Margolin brings trauma to life through nightmarish and dreamlike imagery, disjointed and juxtaposed narratives, and an explicit physicalization of the loss of bodily and narrative control experienced by the patient. Through this structure Margolin pinpoints specific power mechanisms that leave the patient both literally and figuratively naked, vulnerable, and constantly fighting to reassert her subjectivity in a world that positions her as a nearly inanimate object. I contend that Margolin reveals the disempowered status of the patient through her employment of the naked female body onstage. Unlike earlier works examined in this study, there is no implicit triumphant narrative by the well body speaking of trauma, but rather the stark conclusion of a silencing that extends to physical disintegration and disappearance.

I examine *Three Seconds in the Key* for the implications of fictive autobiography to illustrate the possibility of a shared and even collective sense of identity as the ill patient, Mother, draws strength from the healthy bodies around her. Margolin captures the means by which popular culture notions of beauty and sexuality work to disembody the ill female body which cannot identify with normative representations. Margolin reveals the ambivalent nature of this disidentification by also showing how Mother does

utilize popular culture to her benefit by watching basketball with her son. This is both a means of communication and a touchstone representation of healthy bodies from which Mother draws psychic and physical strength through her surreal and magical relationship with the Player. I maintain that through her interactions with the Player and Child, Mother refuses an identity based in illness and disrupts the concept of the illness support group. Instead Mother creates an identity that allows her to share her strengths and weaknesses with others despite their differences. I also examine how Margolin imbeds a difficult and illuminating discussion of racial identity inside of this illness experience. I contend that Margolin creates a utopian performative by illustrating the interdependent nature of ill and well bodies, an interdependence that extends beyond physical realities and into psychic fantasy life.

Discoveries and Applications

Trauma and Performance

In live performance, the presence of human beings brought together in time and space creates a different communicative testimony than other mediums. Karen Malpede explains the significance of performance:

This witnessing experience is visceral - - information resonates inside the bodies of both the teller and the receivers of testimony, and in this process both are changed. Because theatre takes place in public and involves the movement of bodies across a stage, theatre seems uniquely suited to portray the complex interpersonal realities of trauma and to give shape to the compelling interventions

that become possible when trauma is addressed by others who validate the victims' reality. (169)

In her work, "You Are Here: The DNA of Performance," performance scholar Diane Taylor outlines the possibility for performance protest to pass traumatic memory from one generation to the next. Taylor points out that like trauma, performance is a repetitive act that is emergent in the doing (152). Her arguments reinforce how performance is an ideally suited medium for the witnessing of traumatic experiences.

Feminist performance structures and playwriting techniques are equally well-suited to carry traumatic expressions. I was aware of these structural similarities from the outset, but as the project progressed I began realizing how much of feminist expression is most likely rooted in trauma – the insidious quiet continual pain that women live with in hostile surroundings. I argue that an understanding of the structures found within expressions of trauma can lead to the unmasking of "helping" power structures that continue to inflict physical and psychological damage. While it is not unusual to think of extreme or acute bodily illness as traumatic, it can in fact be shocking to many to realize that much of the trauma discussed and implicated within women's autobiographical performances of illness experience is in fact the trauma of *care* and the inability to maintain an identity that was at least somewhat rooted in normative conceptions of gender, sexuality, and bodily ability.

Disruptive Possibilities: Women on stage

While this study is in no way an unabashed valorization of women speaking an experience, I still find tremendous pleasure and hope in witnessing women take over

public space and speak their lives. As numerous feminist performance scholars have discussed, this seemingly simple act is still a radical intervention.³⁶ Deb Margolin reminds me that women “steal the stage” each time they step upon it (“Talking With”). The performances in this study resist easy closure and return to “normality” – an accomplishment that is in conflict with the underlying anxiety that resides within every person who has lived through an event of chronic or acute illness.³⁷ These women not only speak their lives as if they matter, but they refuse to ‘get over it’ through denial. By sharing this labor of signification with the audience, the performer also reveals the labor in negotiating an understanding of identity as a process.

Witnessing to Self

Illness reveals the unstable nature of the body which in turn creates a crisis of identity. This crisis resides in the realization of the degree to which our conceptions of gender, sexuality, and race are linked to bodily integrity. With serious illness comes a descent into a different reality and the immediate response to that alter-reality is to want to return to a state of “normality.” Michelle Crossley explains the dangers within this response: “The dissolution of traditional structures holds within it a terrifying and awesome responsibility. This is because our lives take on the ‘object of a quest’ (Crossley 1685). The performances in this study resist the simplistic triumphant quest narrative – and instead take on a deeper, more complex quest to incorporate this new information about self and body into the fractured life that is being performatively reconstructed. Perhaps it is performance itself that resists the heroic quest closure, as the performing body is read through multiple sign-systems simultaneously. Arthur Frank

discusses the difficulty in resisting a heroic quest narrative in *The Wounded Storyteller*; “Many if not most North Americans share a cultural reluctance to say that their lives have gone badly in some significant respect and to mourn the loss of what was desired but will never happen” (63). These performers acknowledge their losses and that “their lives have gone badly” while also showing possibilities for moving beyond trauma other than through a simplistic celebration of a return to health.

However, as feminist theorists of autobiography point out, articulating identity – even identity that is mutable and changing – can still be a regressive project. Gilmore states that “in the cultivation of an autobiographical conscience, one learns to be, and even strives for a sense of being, overseen. Thus autobiography can be viewed as a discipline, a self-study in surveillance” (Gilmore, *The Limits* 20). We must remember that stories of traumatic illness experience need not be “coherent” or understandable. Frank furthers this notion and voices concern that the exhortation for ill people to story their experience not become another form of cultural surveillance that endorses specific narrative patterns and closure based endings in order to reassure an anxious audience (Frank, “Stories” 330). Feminist study of women’s performances of illness experience must also be sensitive to the numerous discourses acting upon a woman attempting an expression of traumatic experience lest we enforce the very cultural surveillance we are trying to resist. McCauley’s poetic witnessing reflects this resistance to a traditionally coherent narrative through its brisk movement through time and location mapped across her interpreting body. While this asks audiences to pay close attention and to allow the meaning to arrive through the coalescence of the stories, it also reflects the performer’s

attempts to integrate traumatic events. The efficacy of analyzing performances of traumatic illness experience lies in their ability to reflect multiple meanings about experiences that escape existing forms of expression.

Possibilities for Audience Witnessing: Power Dynamics of the Biomedical Establishment and Construction of Medical Knowledge

Bearing in mind the degree to which biomedical knowledge typically constructs the accounts of traumatic illness experience that women are able to voice, these performances powerfully testify to the patient's perspective that is sorely missing in much medical dialogue. By exposing specific behaviors and ideologies enacted by medical professionals and other caregivers that resulted in the patient's loss of agency, the performances within this study witness to the power dynamics that leave a patient in a vulnerable and even dehumanized position. Ironically, this loss of agency was most clearly exposed through the breast cancer pieces and the subsequent talkbacks within medical settings. In contrast to the reframing of women's experiences of illness by medical authorities in these performances, Robbie McCauley's creation of a thick context through community workshops and the inclusion of community members within the performance embedded predisposed witnesses within the audience. While many white audience members were not able to witness to McCauley's understanding of racism within the medical establishment, the majority of the audience fully participated in the talkback session and contributed more examples of the missing patient perspective within diabetes discourse.

Complications

When I began this project I thought that I would find the most emotionally and intellectually moving performances to be those enacted by the women who represented the illness in firsthand accounts. I thought the authenticity of experience contextualized within the formerly ill body would somehow carry with it a “truth” more powerful than a fictive account could. Leigh Gilmore’s work on the limits of autobiography reframed my thinking. As Gilmore reminded me, autobiography has traditions of “truth-telling” that may not be able to contain expressions of traumatic experience – particularly because of autobiography’s need for outside corroboration of the story (*The Limits* 20). The insidious trauma that accompanies the breakdown of the body and the isolation from “normal” existence often occurs without any corroborating witnesses. Because Deb Margolin’s *bringing the fisherman home* was not bound by the conventions of autobiography, nor did it imply the recuperative narrative of the well body, she was able to most fully capture the *actual* silencing experience of trauma. Likewise, in *Three Seconds in the Key* her ability to incorporate fantasy allowed the audience a view into the integration of trauma into the psyche and the complicated interactions between self, other, and popular culture.

Throughout the writing process, I felt that my ability to critique these performances was at times impaired due to my own proximity to traumatic illness. The performers within this study created work out of experiences that are so often left unspoken and unstoried. The act of bringing this work to the page and the stage is one that demands a return to a time that most people would rather forget. I found their

courage and honesty humbling and inspiring, and I know that my feelings at times possibly clouded my ability to see problematic aspects of their performances. I did not feel as Hantzis argues, that I would be critiquing a life, rather I found my critical shortcomings stemmed from my sheer admiration for the performances.³⁸ These performances also inspired and encouraged me to represent and complicate my own experience of traumatic illness in performance.

Further Directions

This study offers an example of the importance of trauma studies theory to feminist investigations into cultural representation. The overlap between the cognitive structures of traumatic expression and feminist performance and playwriting strategies points to the possibility of interpreting another layer of meaning within many women's artistic endeavors. For me, the implicit political project is in continuing to isolate the specific structures that create trauma within the individual and to discover how trauma informs representation within contemporary culture.

Within the field of illness narrative scholarship I believe performance offers a means of theorizing beyond the written word. The body, central in performance, figures strongly in illness narrative and yet is often absent in the telling. By restoring the body to the narrative, performance both raises and lowers the stakes for audience members. While the well-body speaking the illness story reassures the audience of recovery, it simultaneously speaks through the scars, debilitations, and embodied memories of pain. This creates a critical tension for audience members by reminding them that although this

body is well in the moment, it bears the marks from where it has been and where it may go again.

Specifically, I am interested in further analyzing performances of illness experience to look beyond the disruptions identified in this study and find the networks of support that reside within these complicated works. What are the systems of support - implicit and explicit - that encourage the reintegration of the ill woman into society? This leads me to the caregivers within families and networks of friends that are vital to recovery yet who are often underrepresented in performances of illness experience. I am curious how articulating the trauma can perhaps mute the inclusion of these crucial characters and how these voices might complicate, tell and retell the experience in collective and useful ways.

Finally, I believe that the foregrounding of illness experience through performance, narrative, or other expressive forms is an activist project that can create communities of people willing to offer aid and deeper forms of empathy in a time of crisis. If we can continue to learn that illness is a continuum of health, that able-bodiedness is a temporary state, and that disability and pain come to everyone, perhaps we can consider having those from the “other land” among us and nurtured in their time of need. As Linda Park-Fuller reminds me – ill people do not have the time to ask these questions, they are too busy trying to survive and heal (*A Clean* 229).

End Notes

³¹ For detailed accounts of tubercular metaphors and images see Susan Sontag's *Illness as Metaphor* (New York: Vintage Books) 1977.

³² It is important to stress that by century's end many women had spoken out against the rest cure. Perhaps most famously, Charlotte Perkins Gilman explores the maddening effects of the cure in *The Yellow Wallpaper*. Gilman was prescribed the rest cure and ultimately "failed" to recover, instead she took up her paper and pens and lived the life of a writer.

³³ Feminist medical historians have theorized that these fits functioned as a way for women to release energy in a world that rewarded limited displays of physical and emotional activity, and as a means of rebelling against unattainable Victorian ideals of femininity. see Carole Smith-Rosenberg, "The Hysterical Woman: Sex Roles and Role Conflict in Nineteenth Century America," *Social Research* 39 (Winter 1972): 652-78.

³⁴ For a complete discussion of the hysteric and American history see Carroll Smith-Rosenberg, "The Hysterical woman: Sex Roles in Nineteenth Century America," *Social Research*, 39 Winter 1972, pp. 652-78; Phyllis Chesler *Woman and Madness* (New York: Doubleday) 1972. Chesler's work has been the germinal thesis on linking femininity to madness. Chesler delineated how women were more likely to be labeled as mentally unsound than men. For an international contextualization Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (New York: Pantheon Books) 1985.

³⁵ From much of the research I have surveyed the majority of white women doctors employed the rhetoric of domesticity in order to legitimate their healer status. Their understanding of "women's work" and women's sphere was used as a means to argue their ability to deliver care; however most of these doctors still concentrated on upper and middle class patients. On a different front, the few African-American female doctors, at the turn of the century, such as Dr. Matilda Evans, showed a marked difference in focusing healthcare reform and delivery upon a wider economic range of African-Americans. (See Edward H. Beardsley, "Race as a Factor in Health," *Women, Health, and Medicine in America*, ed. Rima Apple, New York: Garland Publishing, Inc. 1990, pp. 121-142).

³⁶ See Jill Dolan's "Introduction" in *Presence and Desire* (Ann Arbor: University of Michigan Press) 1993) and Lynn C. Miller and Jacqueline Taylor's "Editor's Introduction" and M. Heather Carver's essay "Risky Business" in *Voices Made Flesh: Performing Women's Autobiography* (Madison: University of Wisconsin Press) 2003.

³⁷ For a complete discussion of the role of underlying anxiety in recuperative illness narratives, see Thomas Couser, *Recovering Bodies: Illness, Disability and Life-Writing* (Madison: University of Wisconsin Press) 1997.

³⁸ See my discussion of Dorothy Hantzis' critique of personal narrative in Chapter One.

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