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# GENDER FORUM

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## Illuminating Gender II: Gender and Illness

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abstracts (May 1),

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## About

*Gender forum* is an online, peer reviewed academic journal dedicated to the discussion of gender issues. As an electronic journal, *gender forum* offers a free-of-charge platform for the discussion of gender-related topics in the fields of literary and cultural production, media and the arts as well as politics, the natural sciences, medicine, the law, religion and philosophy. Inaugurated by Prof. Dr. Beate Neumeier in 2002, the quarterly issues of the journal have focused on a multitude of questions from different theoretical perspectives of feminist criticism, queer theory, and masculinity studies. *gender forum* also includes reviews and occasionally interviews, fictional pieces and poetry with a gender studies angle.

Opinions expressed in articles published in *gender forum* are those of individual authors and not necessarily endorsed by the editors of *gender forum*.

## Submissions

Target articles should conform to current MLA Style (8th edition) and should be between 5,000 and 8,000 words in length. Please make sure to number your paragraphs and include a bio-blurb and an abstract of roughly 300 words. Files should be sent as email attachments in Word format. Please send your manuscripts to [gender-forum@uni-koeln.de](mailto:gender-forum@uni-koeln.de).

We always welcome reviews on recent releases in Gender Studies! Submitted reviews should conform to current MLA Style (8th edition), have numbered paragraphs, and should be between 750 and 1,000 words in length. Please note that the reviewed releases ought to be no older than 24 months. In most cases, we are able to secure a review copy for contributors.

## Article Publishing

The journal aims to provide rapid publication of research through a continuous publication model. All submissions are subject to peer review. Articles should not be under review by any other journal when submitted to *Gender forum*.

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## Editorial

1        Resuming the discussion of gender, health, and illness begun in *Illuminating Gender I*, the contributions to our current issue continue to address discursive conceptualizations of illness. In their analyses of a wide array of women's narratives and poetry, dealing with illnesses so diverse as breast cancer, depression, and HIV/AIDS, the articles comprised in *Illuminating II* illustrate how women have contested normative notions of gender and illness. The discussion of these questions is completed by the outline of a newly founded health sciences master's program focusing on the nexus of gender and public health.

2        In "Policing, Politicizing, Poeticizing the Virgin/Whore Split: Contemporary American Women's Poetry About AIDS," J. Elizabeth Clark analyzes works by four American women poets — Lesléa Newman, Marie Howe, Tory Dent, and River Huston — writing in the emerging literary tradition of HIV/AIDS poetry. Conceiving of these women, caregivers and HIV-patients, as chroniclers and translators of the HIV/AIDS experience, Clark discusses the "poetic construction of HIV/AIDS" in their work and shows how they challenge the prevailing discourse on HIV/AIDS by subverting the culturally constructed virgin/whore dichotomy.

3        Discussing the respective limitations of strictly discursive or material explanations of depression, Amber Dean's "At the Limits of Materiality / At the Limits of Discourse: Feminist Struggles to Make Sense of Depression in Women" explores the possibility and the benefits of a theory of depression combining elements of both approaches. In her analysis of women's narratives on depression, Dean illustrates that neither discursive nor material explanations capture depression adequately and argues that undermining the materialist/discursive binary can enable a more comprehensive understanding of depression. In emphasizing how depression is the result of an interaction between material and discursive factors, a materialist-discursive theory allows us to take into account the lived experience of women's depression without having to disregard the ways in which (the experience of) depression, as well as the meanings that women assign to depression, are shaped by discourse.

4        Heike Hartung's "'Doleful Ditties' and Stories of Survival - Narrative Approaches to Breast Cancer in Frances Burney, Maria Edgeworth and Susan Sontag" presents a cross-reading of two nineteenth-century pathographies and Susan Sontag's 1978 essay *Illness as Metaphor*. Drawing on Mieke Bal's and Lorraine Code's concepts of second personhood and relational subjectivity, Hartung sheds light on the construction of narrative voice in Burney's and Edgeworth's texts and contrasts them with regard to the narrative strategies they employ.

While Burney's "Mastectomy Letter" is thus aimed at empowering the female patient by giving her a voice both physically (in the form of Burney's scream) and discursively, in Edgeworth's *Belinda* the representation of breast cancer primarily serves a moral and didactic purpose. By reading these narratives in transhistorical dialogue with Sontag's essay, Hartung illustrates how Burney and Edgeworth, although relying on personal narrative — the literary form dismissed by Sontag — appropriate and control illness metaphors and thus succeed in resisting their normative force.

5 Gabriele Kaczmarczyk's detailed description of the master's degree program "Health and Society: International Gender Studies Berlin" at the Charité - Universitätsmedizin Berlin is the first contribution in what is intended to become a series of articles focusing on approaches to the implementation of gender concerns and concepts in political, economic, or academic institutions. An innovative addition to both the fields of health science and gender studies, this master's course not only combines insights of the respective fields but also takes the intercultural dimension into consideration. If successful, this approach could contribute greatly to the trend of incorporating gender concepts in public institutions.

6 The issue is completed by reviews of recent publications by Kath Woodward, Frances Heidensohn (ed.), and Cara Carmichael Aitchison (ed.).

# **Policing, Politicizing, Poeticizing the Virgin/Whore Split: Contemporary American Women's Poetry about AIDS**

By J. Elizabeth Clark, City University of New York: LaGuardia Community College, New York, USA

## **Abstract:**

This article looks at four women poets: Lesléa Newman, Marie Howe, Tory Dent and River Huston and the impact their work has had on the literary, poetic construction of HIV/AIDS. Implicit in their poetry and their activism is a constant wrestling with their own subject position in relationship to HIV/AIDS.

1 In her groundbreaking 1978 essay "Illness as Metaphor," Susan Sontag argues that the language of disease is particularly damning for patients. She writes, "Any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious [. . .]. Contact with someone afflicted with a disease regarded as a mysterious malevolency inevitably feels like a trespass; worse, like the violation of a taboo" (6). Diagnosis, all too often in medical history, has been the proxy of blame. While illness, stigma, and social exclusion are not new to HIV/AIDS, the social stigmas associated with HIV transmission have created a new iteration of blame and reward that is particularly gendered.

2 Inherent in the treatment of women within the history of HIV/AIDS is a history as old as Lilith and Eve. I would like to posit two cultural conceptions of "woman" which inform the reaction to women in the AIDS community: the "virgin/whore" split, the cultural constructions of La Virgen de Guadalupe and La Malinche.<sup>1</sup> Or, to put it another way: the good girl/bad girl dichotomy. This dichotomy is a convenient social construction that reinforces women's social positions. Women who tend to those who fall ill are romanticized as philanthropic and noble; women who fall ill are social pariahs deserving of their illness because they have transgressed social boundaries. Despite their intentions and their subject matter, even twenty-five years into the pandemic, both of these constructions are important to the women poets of AIDS.

3 In the first decade of HIV/AIDS, women were virtually invisible except in care-taking roles. Playing into some of the oldest stereotypes for women, these care-takers represent the "good girls" who seek to help the unfortunate. They were present, but voiceless, in a pandemic in which they participated. Women positive for HIV were almost never mentioned.

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<sup>1</sup> The archetype of the virgin/whore split is abundant in literature. One particularly useful discussion and explanation of it is in Gloria Anzaldua's *Borderlands/La Frontera*. See especially pages 16-18 and 28-34 (San Francisco: Aunt Lute Books, 1987).

Katie Hogan and Nancy L. Roth comment in the introduction to their 1998 anthology, *Gendered Epidemic*, "An explosion of what theorist Cindy Patton calls a 'new visibility of 'woman' in discussions of HIV infection has occurred in the last five years" (xiv). "[T]his new visibility of 'woman,'" however, Hogan and Roth continue, "no matter how crucial, hard won, and necessary cannot explain the deeply entrenched historical silences and gendered distortions that characterized the first decade of the HIV pandemic, and that often continue to structure HIV/AIDS prevention efforts targeted toward women and representations of women and HIV/AIDS" (xiv).

4 According to Cindy Patton, the many white, straight, middle-class women serving as caregivers represent the Reagan/Bush years, during which charities began to fulfill services previously that were the purview of the government (*Inventing AIDS*). At the same time gay men were blamed for their illness at the beginning of the pandemic, women who sought to help them were culturally rewarded for their philanthropy.<sup>2</sup> They are blameless and honored for their work with the "unfortunates" of society. Yet their philanthropy often contributed to an extension of stereotypes and cultural roles rather than interrupted the dominant social paradigms to work for social change. As Cindy Patton explains, the arrival of this group of women represented a move within the AIDS community from activism to charity. The "good girls" of charity are culturally positioned in opposition to the "bad girls" living with HIV.

5 Culture's insistence on prescribed gender roles, however, has perpetuated the stigma of AIDS even more significantly for positive women than for women caregivers. Poet River Huston and photographer Mary Berridge transcribed oral histories of women positive for HIV in *A Positive Life: Portraits of Women Living with HIV* and took photographs of the women's family lives. Their stories emphasize the AIDS generation's virgin/whore split. Culturally, to test positive for HIV means that a woman has either defied cultural conventions by sleeping with too many men or is an "innocent" victim on whom such a horrible atrocity has been inflicted. Karri Stokely, who tested positive in 1996, explains: "People decide if you're worthy of empathy depending on how you were infected. It's really judgmental. Like you deserve it if you slept with 50 men, but you're an innocent if it was only one. People have turned it into a moral issue" (Positive 44). Society judges a woman positive for HIV on several levels: first, did she "deserve" to "get" it? And secondly, if the woman positive for HIV is a mother, there is a second, more compelling judgment: did she willingly abandon her child through her

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<sup>2</sup> In *Inventing AIDS* (New York: Routledge, 1990), Patton outlines the need for activism versus charity. She writes, "AIDS activists — many of whom had themselves received an AIDS/ARC diagnosis — worked with gay and heterosexual PLWAs in the context of community organizing rather than altruism, and understood their work in terms of political resistance rather than compassion" (21).

reckless behavior? While questions of blame are not specific to women (early HIV/AIDS literature is full of examples of social ostracism and blame for those living in the gay community), the inclusion of women's voices chronicling their HIV/AIDS experiences has added to our understanding of the stigma of HIV/AIDS.

6 Here, I will look at four women poets: Lesléa Newman, Marie Howe, Tory Dent and River Huston and the impact their work has had on the literary, poetic construction of HIV/AIDS.<sup>3</sup> Implicit in their poetry and their activism is a constant wrestling with their own subject position in relationship to HIV/AIDS.

7 The book-length works of Lesléa Newman and Marie Howe, published between 1995 and 1998, speak to the virgin/whore dichotomy as they redefine the elegy describing the AIDS pandemic as women caregivers. Writing as the "good girls" of AIDS, as friend and sister, respectively, these care-givers are left to witness to HIV/AIDS in a different way than the gay male community. Close enough to HIV/AIDS to know the social stigma, to have maintained a constant vigil at the deathbed, they are also always outsiders to HIV/AIDS, living in the seronegative world. Newman and Howe thus write from a particular moment of privilege in the HIV/AIDS pandemic. They are certainly affected by HIV/AIDS through their own losses and by their continued interactions within the HIV/AIDS community, but they are at a different distance than others in the HIV/AIDS community. As women, differently than their gay male counterparts, they don't see themselves as at risk for HIV/AIDS. Instead, because of the early ignorance around transmission — something that changed radically with a better understanding of the virus — AIDS was something that happened to people they loved. The grief inherent in their work differs from the grief-stricken and terrorized subtext of gay writers like Paul Monette and Mark Doty — my lover, then me?

8 What characterizes this poetry, and much early HIV/AIDS poetry in general, is the framing of a life. Howe and Newman are left behind with the responsibility for framing and defining the life and loss of the person they loved. Their books — much like other early collections such as Ron Schreiber's *John* or Paul Monette's *18 Elegies for Rog*—document the earliest HIV/AIDS era in the United States, but they do more than simply eulogize. In *Illuminations*, Walter Benjamin posits that "a chronicler who recites events without distinguishing between major and minor ones acts in accordance with the following truth: nothing that has ever happened should be regarded as lost for history" (254). While the

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<sup>3</sup> This article focuses on four poets. Some other U.S. women poets writing significantly about HIV/AIDS include: Rachel Hadas, Sonia Sanchez, Joan Logghe, Belle Waring, Joan Larkin, Marilyn Hacker, Jean Valentine and Charlotte Mayerson. Michael Klein's *Poets for Life* (New York: Persea Books, 1989) and the sequel, *Things Shaped in Passing* (with Richard McCann, New York: Persea, 1997), are good places to begin to explore the wide range of HIV/AIDS authorship in the U.S.

seronegative caregivers are immediately removed from the situation of HIV/AIDS, their nevertheless intimate contact and participation in the HIV/AIDS community serves to establish a different kind of gendered witness to the HIV/AIDS pandemic. Their role, as caregivers and as poets, is to act as a translator for HIV/AIDS. Living in the seronegative world, these poets understand and take in HIV/AIDS at a distance.

9        Accordingly, they can relate to those in society who are also negative for HIV and believe they are in no way at risk for the virus. However, the caregiver — here, Howe and Newman — also stands in proximity to HIV/AIDS, understanding the course of the illness and the social stigma arising from it. They are able to chronicle HIV/AIDS outside of one person's lived experiences and posit HIV/AIDS in a world that extends beyond the life of a loved one. Walter Benjamin believes the task of the translator is "finding the intended effect [*Intention*] upon the language into which he is translating which produces in it the echo of the original" (76). He differentiates between translation and poetry through language: the language (linguistics) is the aim of the poet while effect is the goal of the translator. For the poetry of HIV/AIDS, however, caregivers are mid-way between these two juxtapositions. They first translate HIV/AIDS for the community-at-large, which believes that it has no direct connection to the HIV/AIDS community. As poets, they seek to affect their readers and provide a translation of the experience of HIV/AIDS through language.

10        Ironically, then, while Newman and Howe are perceived socially as "virgins" in contrast to the women positive for HIV, by their very subject position they are immersed in the world of HIV/AIDS. They are removed from their subject matter by the distance of direct experience, but they are also closer to their subject matter than those outside of the HIV/AIDS community. Their translation becomes the easiest entrée into the world of HIV/AIDS for the outside world. How much more palatable is the book of a woman care-giver than the book penned with the righteous anger of a gay man mourning to devastating losses in his community? Their position as translators gives them an incredible power for social change as they add their voices to the HIV/AIDS community because they are able to speak to the "outside" community.

11        These writers also wrestle with a grief, perhaps guilt, of living, something that characterizes the virgins/good girls of HIV/AIDS. The witnesses to HIV/AIDS, here the caregivers, continue life. That continuance, however, is yoked to HIV/AIDS everyday. The survivors ask the pressing questions of who dies from HIV/AIDS and why? They explore social inequalities of class, race, gender, and sexual preference, seeking to demonstrate the way in which these inequalities continue to affect access to HIV/AIDS services. The task of



the caregivers is to find meaning from HIV/AIDS and recreate HIV/AIDS, lest the dead be forgotten and history rewritten.

13 Lesléa Newman is the author of many books, including three with HIV/AIDS-specific content, a children's book entitled *Too Far Away To Touch*, an anthology of remembrances of loved ones lost to HIV/AIDS, *A Loving Testimony*, and *Still Life With Buddy: A Novel Told In Fifty Poems* (1997), a book of HIV/AIDS poetry dedicated to Newman's three "buddies," Gerard Rizza, Stan Leventhal and Victor Fane D'Lugi, who form the composite for the "fictional" Buddy in the poems. Newman's 1997 *Still Life with Buddy* is representative of the pre-protease poetry of HIV/AIDS, working to eulogize those lost to HIV/AIDS. The subtitle of *Still Life With Buddy: A Novel Told in Fifty Poems* reveals Newman's system of organization for this book. She seeks to represent not just an illness, but also an entire life as part of the HIV/AIDS narrative. This rhetorical strategy, to represent a whole life is common in HIV/AIDS narratives, extending even to the NAMES Project AIDS Memorial Quilt which represents people's lives through artifacts — photographs, clothing, loved objects, written narratives — incorporated into the Quilt. The retelling of a life takes on particular significance because it urges the reader to think beyond the stigma of "HIV/AIDS" to the ramifications of a life lost and to make connections between the specific life lost and their own.

14 Embodying the loss of HIV/AIDS, Newman's book begins with "Prophecy:"

When you get in the nineties, my grandmother said  
all the people you know are already dead  
In 1990 I turn thirty-five  
most of my friends more dead than alive. (3)

With this epigraph-like note to the book's beginning, Newman establishes herself as a particular kind of survivor: part of the surviving and much diminished gay and lesbian community in the 1990s left to grapple with the dying and death of so many loved ones.

15 Newman's book shares similarities with Doty's *My Alexandria* and his other HIV/AIDS poetry as she presents HIV/AIDS in the context of the gay community, struggling to make sense of so much loss in a society which seeks to marginalize homosexuals. In "The Politics of Buddy," part one, Newman and Buddy visit Macy's to try on make-up. When sent away by the salesclerk, Buddy responds:

"Is it a crime for a boy  
to wear make-up?" Buddy shouts  
"Or is it a crime for a boy  
to look so good in it?" (10)

Buddy, as Newman reveals here, challenges social norms in both obviously public moments as well as more private ones. This moment of societal disapproval — that boys shouldn't wear make-up — captured in the encounter between Buddy and the salesclerk, is quickly followed by part two in which Buddy and his lover, Guy, walk down the street in front of Newman. While Newman makes a point of telling the reader that "They do not touch," their physical proximity nevertheless draws a reaction from passersby who slow their car (10). Newman records the moment, stating that "Ugly faces leer/ 'Hey, faggots,' 'Hey sissy boy,'/ 'Hey, you goddamn queers'" (10). She follows these two moments of blatant homophobia with a subtler one.

16 In part three of the poem, Buddy and Newman visit Gay Pride. He is in a wheelchair:

A woman bounces up to us  
"Where's your red ribbon?" she asks,  
fishing out her supply.  
Buddy says no thanks  
and when she insists he pricks  
his thumb with her safety pin.  
A thin trickle of blood oozes down his skin.  
"Here's my ribbon. Is it red enough for you?" (11)

Here, Newman speaks to the presumption that everyone in the gay community must automatically support HIV/AIDS activism. She suggests that the realities of living with HIV are complicated; not everyone wants to be the poster-child for HIV/AIDS by wearing the now ubiquitous red ribbon. In fact, as Newman wrestles with her own subject position in relation to HIV/AIDS, she finds that she is more a part of the community than people like the red-ribbon distributing woman. She identifies with both the alienation and the ostracism Buddy endures. While she knows that she will always be at a distance from HIV/AIDS as someone who is seronegative, she also wants to clearly identify as part of that activist community and hence, at least by association, with the whore/bad girl side of the community.

17 Newman presents activism and the challenges of addressing HIV/AIDS in society in all of its complexities. "Oscar Night" presents a world in which celebrities seek solidarity with the HIV/AIDS activist community by wearing red ribbons on their clothing. Newman observes:

If I had a dollar  
for every red ribbon  
pinned to every jacket  
and every gown  
worn by every movie star  
whose billion dollar smile  
lit up my living room tonight  
I'd be very rich

and Buddy would still be dead. (58)

Red ribbons continue as a symbol, but a symbol of what? By juxtaposing the "bouncing woman" early in the book with the "billion dollar smile" celebrities, Newman asks just what the red ribbons mean. For Newman, the HIV/AIDS community is not a glamorous fashion show, but a real space where people struggle and, in the earliest years of the pandemic, die. As part of the community, Newman seeks to criticize those outside of the community who want to step in for a moment. Think of it as some kind of activist tourism.

18 She shows us the daily events of life with Buddy, from medications to hospital rooms while also offering glimpses of life before HIV/AIDS when she, Buddy, and Guy lived life differently, unaffected by the constant presence of death. Buddy chose not to wear the red ribbon at Gay Pride, yet Newman's narrative places him firmly in the grips of HIV/AIDS, representative of life with and without HIV/AIDS.

19 The title poem, "Still Life With Buddy," demonstrates the realities of life without Buddy in the context of the book, which shows life with Buddy. In six short lines, Newman addresses the constant concern in HIV/AIDS poetry of juxtaposing the living and the dead:

mahogany table top  
hand-made doily  
fluted crystal vase  
sprig of forget-me-nots  
photo of Buddy dressed to kill  
leaning against his ashes. (49)

Newman shows the material world of mahogany tables, doilies, crystal vases, and photographs against the natural, sprigs of flowers and ashes, and the spiritual, memories represented in the forget-me-nots. This tension, between abstract memories and palpable realities, marks much of the poetry of HIV/AIDS. While the flowers are poignant reminders of the beauty and fragility of life, the ashes, conversely, are an all too visible reminder of the fact that people die. Memories, ghosts, grief, and loss are not particular to HIV/AIDS, but HIV/AIDS represents tragedy, a life cut short, most often during what should have been the most vibrant years of life. For this, Newman writes the youthful photograph of Buddy, a tangible reminder of his absence, into the poem.

20 If Newman seeks to identify with those who are sick (and to some extent, one could argue, wants to be a part of the whore/bad girl world), if her counter-poetics lie in a desperate and angry attempt to critique the glaring homophobic and AIDS-phobic 1980s, Marie Howe's second book, *What the Living Do* (1998), represents almost the opposite. Written for her brother, John, the entire collection of poems is a book-length meditation akin to Newman's

"Still Life with Buddy." But, more than simply chronicling the dead, Howe transgresses her virgin/good girl status by exploring sexuality.

21 Her collection establishes several levels of complexity. First, it is a collection about coming of age, a female *Bildungsroman*, which emphasizes sexuality. This sexuality is almost always violent, unwanted attention from either the neighborhood boys or the father figure in the book. Later in the text, Howe's "I" narrator discusses her adult sexuality, which is a powerful counterpoint to her younger sexual experiences. Sexuality, then, becomes both ominous and celebratory, depending upon the parameters in which it is enacted, a powerful commentary on sex in the age of HIV/AIDS. As Howe explores her brother's process of death and dying from HIV/AIDS-related complications, however, it becomes clear that she links her own sexuality to that of her brother's to demonstrate the way in which heterosexuality is complicit in so many gay, HIV/AIDS-related deaths. As Howe immerses her readers in a sensual language of sexuality, she signals her desire, like Newman, to transgress the social norms required of her as a straight woman. She willingly becomes the bad girl of her own text, seeking to reclaim sexuality — both for herself and her brother — and turn what was previously taboo into something beautiful.

22 "Sixth Grade" marks the beginning of the sexual poems. Howe writes of "The afternoon the neighborhood boys tied me and Mary Lou Mahar/ to Donny Ralph's father's garage doors, spread-eagled" (16). Howe and Mary Lou, out-of-sight of parental intervention, have to rely on Charlie, Howe's brother's friend to stop the boys as "Donny got the deer's leg severed from the buck his dad had killed// the year before, dried up and still fur-covered, and sort of/ poked it at us" (16). This entryway to the sexual differences between young men and women, with women literally held up as sexual spectacles, bears an eerie similarity to a porno movie in which women are splayed out to be poked and prodded.

23 If "Sixth Grade" represents one side of Howe's sexuality, "Practicing" presents another. "I want to write a love poem for the girls I kissed in seventh grade,/ a song for what we did on the floor in the basement," writes Howe (23). Here, she offers the reader an episode in sexual curiosity. She writes of the experience of exploring sexuality at a slumber party with "maybe six or eight girls," and thus establishes powerfully, and poetically, a link to her brother's world (23). In "Practicing," Howe's only lament is the shame the girls felt after kissing. The girls don't discuss "Practicing" outside of the basement. In her poem, however, Howe acknowledges the possibility of desire for someone of the same gender. This poem, the hinge between her world and her brother's, marks the collection's two distinct halves: Marie's and Johnny's. "Practicing" is a love poem for the girls the "I" narrator kissed, but also for her

brother. Importantly, in a society filled with stigma, Howe sets down her ground rules for *What the Living Do*: they love and understand and live.

24 Howe's ease in connecting her own culpability presents readers with a challenge to connect their own lives to HIV/AIDS in a palpable way. Howe is both chronicler and participant in the HIV/AIDS pandemic. She does not separate herself as "other" from HIV/AIDS but rather as a ready, though unwilling participant (because shouldn't we all be unwilling to participate in HIV/AIDS?).

25 Howe doesn't run from the difficult moments; as a participant in her brother's death, she chronicles the poignant and the disturbing. Howe exposes the community between herself, her brother and his lover, Joe in "A Certain Light." The confident voice of the poet names the new vocabulary of the medications, the system of keeping them straight, the physical repercussions of the medicine on the body in an attempt to establish how intimate this community is; to participate in someone's death is the ultimate act of love.

26 Howe and Newman, by virtue of living in the seronegative world, serve as translators of their experience. In writing about Johnny and Buddy, they seek to pull down the barriers between the "positive" and the "negative" worlds, by examining the received social and cultural notions of sexuality and identity. Howe's languid sensuality insists that readers connect their own sexuality to a world of HIV/AIDS. Howe, not her HIV+ brother, becomes the sexual center of this book, inverting the expectations of the reader. Similarly, Newman uses her own identity as part of the lesbian and gay community to mediate between the "positive" and "negative" worlds.

27 While Newman and Howe seek to undermine the virgin/whore split implicit in HIV/AIDS as they seek to enter into the HIV/AIDS community with socially transgressive verse that confronts the heteronormative and patriarchal constructions of women, Tory Dent and River Huston, as positive women writing about their own HIV, create a powerful poetic witness against stereotypes as they seek to confront and rewrite cultural norms.

28 Tory Dent is the author of three book-length collections which address HIV/AIDS, *What Silence Equals* (1993), *HIV, Mon Amour* (1999) and *Black Milk* (2005). The recipient of the Academy of American Poets James Laughlin Award, the Eric Mathieu King Award, a John Simon Guggenheim Fellowship, and grants from the Barbara Deming Memorial Fund, the Whiting Foundation, and the PEN organization, Tory Dent writes about the complexities of living with HIV in a post-protease world. Rather than accepting the cultural rhetoric of "miracle drugs," Dent's work has consistently questioned those drugs and

their effects on women. Dent's poetry also confronts the social constructions of women, as she boldly challenges assumptions and neat categorizations for women who are positive for HIV.

29 In "The Deferred Dream," an essay about the complexities of wanting children and being HIV+, Dent echoes many of the sentiments the women in *A Positive Life* maintain about gender and HIV. She writes:

Stricken by a disease that affected so many gay men, as well as living in NYC where the disease was politicized and protested in the context of gay rights, the underlying prejudice against homosexuality exhibited in the passivity of the Reagan/Bush administration, I came to forget I was a woman in a way. I felt both caught up in the tidal urgency of HIV/AIDS activism and yet utterly isolated in my position as a heterosexual female, wanting to delineate my own path of reaction and response that was not only just true to myself but respected the integrity, the solidarity of the persecuted class. I was not a gay man. As a woman I had experienced the expectations of a patriarchal society. I knew I was subjugated, robbed of rights and privileges, but my fight was a different fight from that of homosexuals. (125)

Women, Dent posits, are in a very different subject position than men, particularly gay men, positive for HIV. They are at the margins of an already marginalizing disease. Dent, like many other HIV+ women was neither a part of the early HIV/AIDS community nor wholly separate from it. Yet gender is dismissed, forgotten, ignored as an important part of the construction of HIV/AIDS in the United States. Dent continues, offering her observations on the issue of women and culpability:

The closest I could come to understanding would be to witness the hardened faces and accusatory looks, the implicit repulsion when I revealed that I was HIV-positive. More often than not, I encountered this tenor of recrimination in the medical community, from nurses and technicians and even doctors. Then people would ask me how I was exposed (I wondered how often they would ask a gay man that). I would answer that I had a boyfriend who was a hemophiliac who died of AIDS in 1984 [...]. "I don't see why it matters," I would add. After a while, I would decline to answer when they asked how I was exposed. I know I was opting for the rougher attitude by not complying with their need to know if I was one of the "true" victims, but it didn't much matter since life had become so much rougher anyway. (125)

Dent's books speak to her unusual courage, to her facility in creating a form to address HIV in society and her life, to her recognition of the need to speak out about the position of a woman living with HIV. As the passage above indicates, women living with HIV confront a different set of prejudices and stereotypes, all of which reflect social constructions of womanhood; a "woman" has a certain place in society, with prescribed social and sexual roles to fulfill. What Dent gives to her reader, in a dialogue that begins in *What Silence Equals* and extends to *Black Milk* is a poetry speaking out of the tradition confronting silences surrounding socially constructed sexual roles.

30 The title poem of Dent's first collection, "What Silence Equals," pits "wild grass" against the power of farming to conform the land. "Homogeneous, wild, quiet/Homogeny in a pretense of superiority," Dent writes (19). The land, and in particular "the wild grass," as a metaphor for the body of a woman, must all be the same, homogeneous; homogeneity, as the "superior" and commodity-driven concept defines the thrust of the poem. The machinery of farming, masculinized as "Plow, conform, unharrowed/Like strong men at the circus with handlebar mustaches" make such a commodification possible (19). The patriarchal construction of the plow develops the relationship between the masculine machinery and the feminine earth: "The plow will conform into manageability the unharrowed" (19). While the relationship between women's bodies and farming/planting/fertility is not unusual, it is Dent's subject position as a woman living with HIV that makes this connection all the more sinister. The "wild grass" must conform to social constructions of woman and the roles she plays in society.

31 Dent catalogs the images of silence, each as hurtful as the next. She measures and defines silence as: a plow furrowing under the earth, presumably into silence; a "saber-toothed plow of silence" reminiscent of a tiger; a phone call greeted by silence; and a locked Chinese box. "If we're not better than you, what are we better than?" asks Dent (19). This judgment is implied in the silence greeting the speaker of the poem. The homogeneity of the earth is silence opposed to the noise of the speaker, first, on the phone. The speaker observes someone making a phone call out of desperation, only to have that same call greeted by silence and a paralysis. Extending the idea of the essentially unanswered phone call, Dent writes "Ugly angels like buzzards circle overhead./Your prayers, their prey, they carry clenched between their teeth" (20). Even prayers, uttered in despair, remain unanswered and greeted by silence. Like the paralysis of the people receiving the phone call, the angels are sinister, silencing prayers by holding them, like hunted animals, in the mouth.

32 In poems like "Only Human," that homogenous society takes shape in the judgment of a lover who rejects the speaker. The woman speaker, HIV+, is categorized as other than woman; an altogether new category is created for this woman-transgressor within a diagnosis. The repeating phrase in the poem "human" and "humanness" seems to emphasize, on the part of the speaker, the need for the lover to recognize her own humanness. Definitions of humanness based on interactions and communication, on what they had shared before the revelation of a diagnosis change radically afterwards and redefine the possibilities for interactions and love:

It was the way I changed hallucinogenically before you,  
my wood-colored hair matted and graying,

my blue eyes circling like crazy dice in my head.  
All that materialized before you was somebody HIV positive,  
another one of those silhouetted figures interviewed on David Susskind,  
my true self, ghostlike, condemned to the back of your mind. (30)

The speaker becomes "somebody HIV positive," rather than a lover, a "somebody" — note the distancing effect of the language — relegated to a space of casual, unimportant thoughts; the location of the woman moved from the bed to the mind, left in the reader's mind with haunting exactitude.

33 Dent's formal approach to poetry is striking on the page. Her long lines evoke Whitman and Ginsberg. Dent's lines become even longer in her second collection, *HIV, Mon Amour*, which seems a lyric extension of the conversation begun in *What Silence Equals*. *HIV, Mon Amour* is a more sophisticated collection than *What Silence Equals*. Broken into three sections, "The Pressure" with fourteen poems, "Cinéma Vérité," a long, sustained poem, and "HIV, Mon Amour," thirty-five connected poems reminiscent of Baudelaire's *Paris Spleen*. Dent continues the thematic challenges in the new collection, working to activate readers. Each of the poems in the collection is balanced between emotion and intellect.

34 "Fourteen Days in Quarantine," the first poem in the collection, places the poet-speaker, struggling with the meaning of HIV/AIDS, in an unfriendly world. Formally, the poetic structure is broken into a series of fourteen related poems, presumably one per day. Dent overpowers her reader with images as she continues, in this poem and this collection, to place the body at the center.

35 She describes her own body, in a hospital bed as if it were a painting: "Hospital gown worn backwards, thus open at the neck, and I think what a great/Nan Goldin portrait it would make — 'Tory, New York Hospital, January 1996'" (3). The distance between the speaker and her own body develops the difficult relationship between HIV and the body in which it resides. The body becomes "other," something to be looked at, monitored, and cared for. In that respect, the woman's body is not so different than the portrait Dent proposes; the body, here, is an object.

36 While all bodies affected by the HIV/AIDS pandemic — and other diseases — become objects, the relationship between a woman's body and society is different; the history of art, religion, marketing, and fashion, among other things, centralize the role of the woman's body in society; women's bodies are looked at and constructed as central images in society. For the woman living with HIV, with a body ravaged by the effects of the virus, the gendered, and specifically female body as object takes on a much more central importance. Inherent in



the HIV+ female body are all the transgressions of the woman, all the ways in which the woman, this woman, does not live up to her prescribed social role.

37 Dent emphasizes this through her continual negotiation of the body. She describes the motion of her body, moving "until I receded in sync with the daylight/from chair back to bed as if falling backwards in slow motion, the way/a display dummy does during a rehearsed car crash" (4) The body is like a "display dummy," an inanimate object on which tests are conducted to ensure safety for other bodies. The metaphoric implications of this connection are obvious; Dent's body provides safety for other, future bodies. Living in quarantine secures that safety.

38 Also at the heart of Dent's work, an issue connected to the body, are questions of sensuality and intimacy. The constructions of desire and sexual gratification, often theorized in gay men's writing, are central to Dent's work. She writes,

But the pleasure of touch I never refused when he  
climbed gently into the narrow cot with me, winter jacket still on, the sudden  
cold of his earlobes against my cheek, the thick cardboard material of the  
quarantine mask which we would defiantly indent in order to kiss. (9)

Dent's voice, speaking for a sexuality within HIV/AIDS is an important — and controversial — view. Again, the implications of sexuality for a woman living with HIV, culturally, are different than for a gay man living with HIV. However, I would argue that in practice, the implications are the same. Dent, ostensibly, is to blame here by embracing her sexuality *living with HIV and in quarantine*. The Puritanical constructions of female sexuality almost demand that Dent repress her sexuality because of HIV; in essence, this is a prescription for life before the women's rights movement in the same way HIV/AIDS-era sexuality for gay men has been constructed culturally as pre-Stonewall. This element of Dent's work is crucial and something created out of the silences surrounding women and HIV/AIDS.

39 *Black Milk* picks up where *HIV, Mon Amour* leaves off and is one of the most interesting recent collections of post-protease AIDS poetry. *Black Milk*, as the virus continues its path through society, and as the government becomes increasingly regressive about HIV/AIDS prevention and treatment, begins to take on a militancy that post-protease AIDS poetry, from 1995 to the early 2000s had lost. Dent continues to be consumed by the disease. As HIV continues to progress in her own body, *Black Milk* presents a collection of poems that are angry, defiant, and accusatory. Here, Dent unapologetically writes her own epitaph, one which challenges any of the easy clichés society has come to use around HIV/AIDS.

40 Dent says, "My death began on April 12, 1988,/over a pay phone at an artist's colony in upstate New York,/in a windowless, wainscotted phone closet, where a single bare

bulb/suspended above me, the enucleated eye of some god surveying its work" (6) In this poem, Dent continues the work of *HIV, Mon Amour*, as she writes her rotting body onto the page. She is merciless in her transcription of physical deterioration. She writes, "Each level of the disease, the gradations of physical recession,/the lungs, the gut, the eyes, the brain — systems of torture,/instigated by an interrogator I cannot target beyond the decoy glare" (7). This physical demise is the counter to the angels. Death, as Dent writes it, isn't a beautiful, miraculous passing.

41 Dent's disease is painful and presents itself with many different symptoms and iterations of AIDS related complications. After waiting for an entire year, Dent is eligible to try a new drug and within a week it fails her. For the first time, the physical pain of the body overtakes Dent's language. What in *HIV, Mon Amour* was a connection to sensuality and sexuality here becomes useless. She can't describe her pain and she's "almost glad" that words fail her.

42 Dent also uses her poetry to subvert the heteropatriarchal expectations of her place in society. Dent lays blame for HIV/AIDS at the doorstep of a government that ignored the virus in the early years. And so, Dent explains her own illness in the limited terms she believes exist to define women's lives experiences and lives. She says,

I was laboring — for survival is like having a baby,  
my legs spread apart, my head thrown back — I was laboring but it was not  
optimistic, a stillborn birthing in which death is forced out  
from deep inside you, forced out with an effort excruciating and formidable,  
your dead body that threatens soon to become you. (18)

The act of survival is an every day laboring where, Dent graphically records, she must force out death. So, with her legs splayed, she works at survival, a "stillborn birthing" where the dead fetus is death itself, momentarily displaced from the body.

43 Dent, in these three collections, provides the most comprehensive and poetically aggressive presentation of women and HIV/AIDS. In her work, we find the confrontation and then acceptance of the idea of sexual transgression. By embodying sexuality and disease in her poems, Dent challenges readers to consider who isn't a whore/bad girl of society. In her poetic narrative, she suggests that she is, in essence, every woman. In the social construction of HIV/AIDS, she should be writing the poems Newman and Howe write; instead, her counterpoetics embody the living of a disease, the confrontation with the mystery of illness, and a serious challenge to the heteronormative and patriarchal expectations of her. It is an oeuvre that fully encapsulates the complexities of life with HIV/AIDS while also immersing the reader in the sensuality and desire of language.

44 Like Tory Dent, River Huston's work speaks out of the silence created for women living with HIV. Huston, as I have mentioned in previous chapters, is dedicated to women's issues and HIV through her two poetry collections, *Jesus Never Lived Here* (1993) and *The Bones of Susan* (1995); her column on women's issues in *POZ*; public lecturing at HIV/AIDS conferences; educational lectures in schools; and projects like *Living with HIV: A Book of Questions and A Positive Life*. Huston confronts the stereotypes about women and HIV/AIDS by incorporating and deconstructing vernacular language in common usage.

45 In "Those People," Huston responds to an article about HIV/AIDS. She writes:

An article lies on the dresser  
about an upcoming lecture  
the writer quotes the lecturer  
"Those people" (Meaning homosexuals and intravenous drug-users,  
meaning faggot, queers, homos, junkie, parasite, scumbags,  
meaning lowlife disposable garbage  
less than human types  
those people.) (*Bones* 22)

Huston's poetic dialogue is created often in response to something written or said; she writes poems as moments of repose and response. Like Dent's "another one of those silhouetted figures," Huston seeks to reconcile "those people" with herself. Implicit in the stanza quoted above is Huston's reappropriation of a vocabulary used to label, dismiss, and disempower those it describes. Huston's poetic move is to use the very same language as the basis of the vocabulary for the poem as she reveals:

I am that upcoming lecturer  
since I said "Those people"  
the way I always do  
in a sarcastic way  
in an angry way  
not a cut and pasted way  
to crucify  
justify my publicly perceived innocence  
in black and white  
in a local paper in Michigan. (22)

Huston embodies the terms she uses in the poem by claiming them as an extension of her self-identification, in contrast to "my publicly perceived innocence." She tells the reader:

for the record  
I was a prostitute  
an intravenous drug user  
I was homeless  
ate out of garbage cans  
I asked you for money  
in Washington Square Park

I took that money  
and bought quarts of  
Colt 45 drank it from a brown paper bag  
I robbed homes  
went to prison  
I danced naked for strangers and money  
I slept with women  
I slept with men  
slept with both of them at the same time  
I have trained men to bark like dogs  
and dance in high heels  
wearing pink tu-tus. (22-23)

Huston's embodiment of "those people" creates a symbiotic relationship between the reader and poet. Casual comments used to distinguish "us" from "them" become here, in Huston's verse, a means of defining "us" as "them." The reader is implicated on several levels from the "you" who gave money in Washington Square Park to those who so misunderstand HIV/AIDS and those it affects that they might invoke some of the language Huston deconstructs. Huston separates "those people" from a casual news headline or a CDC report by giving those people an "I" who shares in their lives, their pain. The "I," who takes on the identity of "those people" moves the reader from casual observation, the perennial postmodern move from "eye" to "I," to implication.

46 In this poem as well Huston cleverly defines her terms, presuming an audience unfamiliar with her vocabulary. She writes "I didn't share my works/(works — needle paraphernalia that lowlife junkie scum use to/get high with)" (23). In two lines she both tells readers about "works" and what they are while also, again, presenting the cultural implications/associations/judgments that accompany "street" vocabulary. The activism of Huston's poetry here is the constant motion between education and implication. She seems to say to the reader, "if I'm implicated in this, so too are you..." Perhaps the implication, as I said earlier, is using the very vocabulary Huston exposes. Huston turns the poem a third time, from "those people" to the speaker as "those people" to what the reader might not (Huston again deconstructs readers' expectations as they read the poem) expect of "those people." "Did I tell you I graduated from college?" she asks (24).

47 The "I" of the poem, one of the "those people" becomes, presumably, one of the readers as well; the speaker invokes a class-specific lifestyle, from college to writing books, suggesting a very different lifestyle than the one lived by "those people." This connection between reader and poet creates a moment of interruption in the cultural perception of HIV/AIDS. Huston continues:

I advocate for women's rights to the treatment of their choice I volunteer at prisons,  
and drug rehabilitation centers and I cry at night and now in the morning in a hotel  
room somewhere in Michigan I cry for them, the other those people I cry for myself.  
(24)

At work in all of Huston's poems are moments like these, where she creates a connection between poet and reader which challenges many of the ideas people hold about those living with HIV/AIDS. The ending lines of this poem, with the poet in tears for "those people" who are ultimately herself, and the readers' other selves, confront readers with the ugly realities of prejudice and discrimination and the very attitudes that create the silence surrounding HIV/AIDS.

48 "101 Ways to Die Without Doing It" calls on many of the same poetic and emotional devices. Many of Huston's poems are conversational, something informed by her wide use of poetry in performances; early on in her poetry career she used to give out copies of the poems she had read in plastic baggies with condoms. She believes that all poetry should be exciting and interesting; her own work is always emotionally charged and accessible. Even more than these characteristics, however, Huston's work is brave as she opens her life through confessional poetry to expose the social stigma of HIV/AIDS.

49 "101" plays on the rhetoric of HIV/AIDS; one common talk that HIV/AIDS educators are often asked to give is "AIDS 101" (now a course offered by the Red Cross in which one can receive an official certification for giving HIV/AIDS education talks). Huston makes a catalogue in this poem of the "ways to die without doing it." One of the most horrific moments in the poem is revealed early on as Huston tells readers one of the ways is to:

Stand in front of two-thousand first-year college students  
have them laugh  
when I tell them about the time  
the doctor tried to break through the anterior surface of my ilium  
and told me  
it would be easier if my ass wasn't  
so fat. (11)

Here, Huston as poet is exposed, revealing to the reader the difficulties of disclosing public intimacies in the age of HIV/AIDS; students are corralled into an auditorium to hear a speaker when they see no connection between her life and theirs. Huston's other suggestions for "101" include: "Make friends with someone with one T-cell left" and "Be told that I am vulgar/for saying the words vagina, vaginal secretions, oral sex,/anal intercourse" (11-12). This poem also puts the rhetoric of "101" in conflict with society; "anal intercourse" and "vagina" are "forbidden" words, yet part of Huston's own regular vocabulary in giving lectures. Likewise, Huston presents the difficulties of negotiating people who believe they share a vocabulary

with Huston, but do not have the emotional intimacy to invoke it. One of the other "101" ways is "When I am asked if I want my name on the Quilt" (12). Huston points out the conflict between the questioner's focus on death and Huston's focus on life; this tension makes conversation difficult, impossible. Like Huston's other poems, the power of "101" lies in her ability to simultaneously share her own personal experience, use the language invoked against HIV/AIDS in order to expose it, affect the reader emotionally, and work poetically to create vivid images and clear, concise language.

50 Both Dent's and Huston's work establishes a potent activist voice by writing to revise the perceptions of women living with HIV. Significantly, their work fills in the gaps of a story often untold story; here are the stories telling the story opposed to the stereotype, the poems written out of frustration and anger at presumption and prejudice. In a literary tradition filled with poems that speak of an experience so different than that of women living with HIV, Dent and Huston redefine issues of equality and access, pain and desire. Characterized by society as the bad girls of HIV/AIDS, their counterpoetics embody a desire to ask how they are different than any other woman in society. In essence, they become all women and as such, they reject the social categorization of whore. Moreover, in demonstrating how common their experiences are, what it means to live and die, and to challenge the prejudices of society, they suggest that perhaps the entire equation of good girl/bad girl, whore/virgin is a misconceived social construction.

51 In fact, the inversion of their perceived social roles characterizes all four women poets discussed here. Their poetry provides an active witness to the gendering of HIV/AIDS. As women writing about AIDS approach their subject matter, they have to confront the good girl/bad girl dichotomy. Often overlooked, the women poets of AIDS provide an important and compelling perspective to the age of AIDS in the United States by resisting those social constructions that would limit their cultural and social authority. Their work begins to fill in the void of the first decade of HIV/AIDS literature by gendering it and giving voice to both the experience of the caregiver and those women positive for HIV. The culture of HIV/AIDS has created specific roles for women within the pandemic. By writing, as women in other generations have done before, out of the silences created by those gendered stereotypes, these poets interrupt the stereotypes. This crucial work lays the groundwork for a new literary tradition: the women poets of HIV/AIDS.

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# **At the Limits of Materiality / At the Limits of Discourse: Feminist Struggles to Make Sense of Depression in Women**

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## **Abstract:**

Depression presents feminist theorists with a significant problem: it makes sense to many of us to point out the ways that depression, as a concept, is constituted discursively. In particular, depression seems indelibly tied to powerful biomedical discourses, and also, for women, to the equally powerful discourses that dictate what a "good woman" should be. Yet to highlight these discursive dimensions of the phenomenon seems to preclude both an acknowledgement of depression as a source of pain and an acceptance of any form of treatment for this condition other than dramatic social change. This article explores the limitations of strictly material and strictly discursive explanations for women's depression, and suggests that a feminist model existing in-between these two dualities is essential to a more comprehensive understanding of women's depression experiences. The narratives of women who experience depression provide a rich source of knowledge by which to deconstruct materialist and discursive approaches to women's depression. A narrative approach also allows us to escape the confines of scientific/positivist research, which has proven inadequate to fully encapsulate the phenomenon of depression in women. The article concludes with an evaluation of the material-discursive models for understanding women's depression recently posed by feminist psychologists Janet M. Stoppard and Jane Ussher.

Is it tenable to discuss mental pathology as a socio-historical and linguistic construction and as a 'true' debilitating condition? (Fee, "Broken Dialogue" 2)

1 Depression is not a problem that is likely to disappear soon, as the numbers of people receiving such a diagnosis are on the rise almost everywhere. Its chilling effects are experienced by over 100 million people worldwide (Culbertson), and the Canadian Mental Health Association (2001) projects that by 2020, depressive illnesses will be the leading cause of disease burden in Canada and other developed countries. Women apparently experience this thing called depression at approximately twice the rate of men (Bebbington; Culbertson; Kramer; Nolen-Hoeksema; WHO), with recent research showing that the female to male sex ratio for depression is commonly 2 or 3 to 1 (Stoppard, *Understanding Depression*). Put another way, approximately 25% of North American women will experience depression at some point in their lifetimes (Schreiber). A variety of explanations for this statistic have been posed, including arguments based on women's unique biology, or suggestions that our greater likelihood to seek help when depressed causes us to be counted more frequently in statistics on depression (Culbertson; WHO). However, women's greater help-seeking behavior has proven inadequate to explain our over-representation among the depressed (Formanek and Gurian; McGrath, Keita, Strickland and Russo; Nolen-Hoeksema). Thus far, researchers



working from a scientific/positivist framework have been unable to adequately explain why so many more women than men experience depression. Not surprisingly, given the disproportionate numbers of women afflicted, depression has gained the attention of feminist scholars from across a wide range of disciplines. Working from different backgrounds, and often with divergent theories about material and/or discursive dimensions to depression, it is not surprising that feminist scholars have struggled to make sense of this phenomenon.

2 Depression presents feminist theorists with a significant problem: it makes sense to many of us to point out the ways that depression, as a concept, is constituted discursively. In particular, depression seems indelibly tied to powerful biomedical discourses, and also, for women, to the equally powerful discourses that dictate what a "good woman" should be. Yet to highlight these discursive dimensions of the phenomenon seems to preclude both an acknowledgement of depression as a source of pain and an acceptance of any form of treatment for this condition other than dramatic social change. Yet Prozac, only one among many antidepressants on the market, has been prescribed to more than 40 million people worldwide (Eli Lilly and Co.) and women make up about eighty percent of Prozac's users (Zita). Surely some of those 32 million women must identify as feminists, and many of them probably live with a deep inner conflict between their feminist ideology and their individual actions, a conflict that invokes silence and shame. Maria Caminero-Santangelo (1998) writes, for example, about hearing a woman at a Women's Studies conference speak about how her continued use of antidepressants was heavily criticized by many feminists whom the woman had previously considered allies, feminists who subscribed to a discursive understanding of depression which eschewed biomedical explanations or treatments. While the woman in question agreed with the critiques of her colleagues in theory, she also struggled with the fact that "when she was depressed, she could not work, write, or — often — even get out of bed" (10). *In practice*, then, her contributions to feminism would be virtually impossible *without* antidepressants. Gardiner (1995) discusses a similar experience of attending a feminist meeting that "assumed a consensus about social constructionism" (501) among participants, only to discover during meals and breaks that many of the women present were taking Prozac or other antidepressants. She notes that, ironically, "the potential contradiction between such private solutions and the publicly avowed ideology of social constructionism was never voiced" (501). Hence I would argue that the struggle between materialist and discursive explanations for depression is a particularly strained issue for feminism, and perhaps our only hope for a resolution is to locate our understanding of the

phenomenon "in-between" the two conflicting poles of this binary (as some leading feminist psychologists have started to do).

3 This article explores the limitations of strictly material and strictly discursive explanations for women's depression and suggests that a model existing in-between these two dualities is essential to a more comprehensive understanding of depression in women. The narratives of women who live with depression provide a rich source of evidence by which to raise questions about the limitations of materialist and discursive theories on women's depression. A narrative approach also allows us to escape the confines of the scientific/positivist research that has proven inadequate to fully encapsulate the phenomenon of depression in women, while at the same time ensuring that the lived experience of depression is not lost in the rhetoric of theories that posit it as merely a matter of discourse. The article concludes with an evaluation of the material-discursive models for understanding women's depression recently posed by feminist psychologists Janet M. Stoppard and Jane Ussher.

### **A Narrative Challenge to the Scientific/Positivist Paradigm**

Findings of research conducted within mainstream paradigms have provided few helpful directions for women in understanding and explaining their depressive experiences. (Stoppard, "New Perspectives" 81)

4 The methodology of this research starts from a different place than the mainstream (scientific/positivist) approach used to conduct the bulk of recent research on women and depression. In this paper I combine some of the principals of feminist qualitative methodologies with the literary method of narrative analysis, resulting in a feminist narrative analysis that is used to explore the meaning(s) of depression in women's recent writing on depression and in the transcripts of four oral histories conducted with women who live with depression.<sup>1</sup> Gluck and Patai (1991) indicate that narrative analysis is an appropriate method for interpreting oral history transcripts: "Contemporary literary theory," they explain, "made us aware that the typical product of an interview is a text, not a reproduction of reality, and that models of textual analysis were therefore needed" (3). The texts created from the oral histories conducted for this research are therefore read not necessarily as fact but as testimony about the meaning(s) of depression in these women's lives and about the ways in which these

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<sup>1</sup> These oral histories were conducted as part of the research for my Master's Thesis, which I successfully defended at Simon Fraser University in Burnaby, British Columbia, Canada, in 2002. For a more in-depth discussion of the methodology I employ in this article, please refer to that thesis, titled *A Melancholic Musing: Women's Narratives on Depression*. Information on accessing this document can be obtained at <http://www.collectionscanada.ca/thesescanada/index-e.html>

four women, alongside several recent women writing about depression, suggest that their understandings of depression are reflected (or not) by materialist and discursive theories on depression. It may seem contradictory to use "experience" as evidence in a paper that also has as one of its aims the furthering of discursive theories on depression. However, when lived experience becomes entirely unrepresentable in discussions of discourse, we no longer have a language to speak about the pain and impairment felt by people living with this thing we call depression. Also, when women speak about their "experiences" of depression they themselves often call attention to the ways in which they recognize this experience to be shaped by prevailing discourses. Hence experience, when viewed through this lens, need not be entirely antithetical to a discursive analysis.

5 Ussher documents the trend in the vast majority of research on women's mental illnesses to employ the "*realist/positivist* epistemology that has dominated science since the seventeenth century" ("Women's Madness" 209). Most researchers, whether operating from a biomedical or a psychosocial perspective, believe that knowledge is only possible through observation, and can therefore only be proven to be knowledge through the use of methodologies that promote standardization, replicability, and objectivity on the part of the researcher. Of course, feminist critiques of such methodologies, and in particular of the concept of objectivity, have been extensive (Code; Harding). This research looks to women's subjective experiences of depression not in the interests of uncovering the "truth" or locating a precise explanation for women's depression, but rather for the questions that these representations of experience raise about the limits of both material and discursive theories on depression.

6 Summerfield points out that the practice of oral history originally placed "an emphasis on truth rather than meaning, that is to say on discovering the hidden past through oral history and proving that this revelatory data was valid, rather than on exploring the complexities of its shifting meanings" (92). She goes on to suggest that the current practice of oral history is more concerned with the latter, which is also the approach guiding my exploration of women's first person narratives on depression in this research. Stoppard notes that a "persistent theme of [recent debates in clinical psychology] has been the need to broaden the conception of research 'methods' to encompass those that address meaning and subjective experience" ("New Perspectives" 81). Similarly, Lewis asserts that there has been "little consideration of what individuals themselves experience as depression or of the meaning of those experiences to them" (369). Inclusion of women's narratives on depression is presently lacking in mainstream research on depression, despite the fact that these and other authors

have advocated for the consideration of such narratives as a valid and important means of generating knowledge about depression; it is in part this lack of consideration of women's narratives, I believe, that upholds the binary between materialist and discursive understandings of depression.

7 Although the focus of the oral histories I discuss in this article is on each woman's thoughts about her depression and the concept itself, it seemed unlikely that I could adequately capture women's understandings of their depression or how they perceive their experience as reflected in either materialist or discursive explanations without exploring their life histories extensively. Jack argues that "the story a woman tells herself and retells others about the sources of her depression creates its coherence within the context of her life. Her narrative reveals her whole world [. . .]" ("Ways of Listening" 91). Clearly, then, the use of oral history seems to be the most appropriate method for exploring women's understanding of the sources and meanings of their depression experiences. Questions arising from the 'texts' of these four oral history narratives by women — whose pseudonyms are Percy, Danielle, April, and Maya — can be found throughout this article alongside questions raised by various fiction and autobiography on women's depression published over the last decade, in the interests of fully exploring the limitations of both materialist and discursive theories on depression in women.

### **At The Limits of Materiality: Understanding the Discourses That Constitute "Depression"**

Individuals do not experience symptoms in a sociocultural vacuum. (Ussher, "Women's Madness" 212)

8 While critiques of biomedical theories of depression proliferate within the social sciences, depression in the popular imagination remains bogged down by the prevailing discourse of biology-as-destiny. As Jam, the depressed protagonist of *Prozac Highway* (1997), points out: "You'd have to be really out of touch not to know what the treatment for my condition was supposed to be" (Blackbridge 30), referring, of course, to antidepressant therapy. Over the past few decades, depression has increasingly come to be recognized as more of a medical affliction than a spiritual, social, or even psychological one. This understanding of depression corresponds to the mainstreaming of a belief in the biological origins of many conditions formerly thought to have origins that were at least partially social (Karp; Kramer). There is nothing wrong *per se* with the idea that biology might play a part in women's experiences of depression (and the efficacy of treatment). But when biomedical

theories function as a discourse — and an extremely powerful discourse at that, one which presently marginalizes all other possible explanations for or understandings of depression — the concept becomes highly problematic, primarily for the ways it precludes possibilities of understanding depression differently.

9 The early anti-psychiatric writings of Thomas Szasz (1967) were some of the first to question the validity of the very concept of mental illness, arguing instead that mental illnesses are merely metaphorical expressions of human suffering. While the sixties and seventies saw a proliferation of theories that critiqued the power of psychiatrists to define mental illnesses (and thereby the boundaries of "normality") along with the rise in biomedical explanations for them, the eighties and early nineties ironically saw the further entrenchment of biomedical explanations for and treatment of these conditions. This entrenchment likely owes its existence at least in part to the cultural backlash against social movements of all kinds that occurred during this time period, but another explanation for the biomedical take-over is surely found in the increasing research on and development of medications such as antidepressants, and the extent to which such medications came to be seen as the primary form of treatment for mental illness.

10 The resurgence in critiques of biomedical theories of mental illness of the last decade has focused more closely on the power associated with biomedical discourses than on the power associated with individual psychiatrists or the psychiatric profession (although of course noting that psychiatry is heavily implicated in the shaping of biomedical discourses). Some feminist researchers have in particular been interested in how biomedical discourses construct the role of the female body in relation to mental health, and the ways in which these discourses often unquestioningly adopt misogynist values and beliefs (Caplan; Ussher, *Misogyny*). However, unlike earlier critics of biomedical models, amongst whom the "most popular attitude towards the mental illnesses was to deny their very existence" (Sedgwick 4), more recent researchers are not so much opposed to seeing a connection between biology and mental illness as they are concerned with the premise that biology is the primary or only possible cause. As Stoppard argues, "evidence that biochemical processes may be associated with experiences defined as depressive symptoms is not the same as concluding that depression is caused by biochemistry" (*Understanding Depression* 13).

11 Women themselves express a great deal of skepticism about the relationship between their material bodies and their depression, and their narratives tend to suggest that their depression is largely shaped both by symbolic notions of idealized femininity and by their experiences of oppression. When asked about her first experience with depression, for

example, Danielle — one of the women I interviewed for my MA thesis — begins by talking about the impact of a three-year period over which she was sexually abused as a child, clearly indicating her belief in a connection between this traumatic event and her depression. However, she is not immune to the power of biomedical discourses, and while her initial instinct is to suggest that the abuse is a source of her depression, she also ponders the role that her innate biology might play when she states: "I . . . don't know if that [the sexual abuse] is what started it, or if I already had it and that incident really brought it out." Later, she explores this uncertainty further:

Maybe later on in life, if I didn't have that incident happen to me, then maybe later in life it [depression] would've come out. Or maybe it wouldn't, or if it did it wouldn't stay, it wouldn't be so strong.

Dormen echoes Danielle almost identically when pondering the impact of her experience of incest on her depression:

Did depression find me because of my stepfather's touch? Did depression rush to fill the shocked space left when he withdrew his touch? Or was depression a consequence of my essential chemical constitution? Or did events themselves create the chemistry? I don't know. (239)

Both of these women hesitate to locate their abuse as the primary or only cause of their depression, but nonetheless they are resisting the idea that their depression is merely biochemical. They each have a clear sense that their experiences of violence are unquestionably implicated in the onset of their depression, pointing to the limitations of strictly biomedical theories.

12 Many other women also suggest in their narratives that their depression was primarily caused by experiences of discrimination and oppression rather than by their biology. While discrimination and oppression often impact women's lives in material ways, they also owe their ongoing existence to powerful discourses that underpin male dominance and social expectations for what a "good woman" should be. When asked to talk about her first experiences with depression, Percy refers to her growing awareness of an inconsistency between how she saw herself and how discourses of normality and appropriate femininity dictated she should be. She explains:

I seem to remember when I was in high school, times when I felt kind of alone and definitely out of place because by then I was fairly sure that I was gay, and in the context of small-town southern Alberta there was really no outlet to talk about that and it bothered me a lot because I thought that I might be crazy because of that.

A material explanation for Percy's depression might include her experience of discrimination or oppression as a lesbian, but would be inadequate to address the impact that the discursively

constituted and sustained belief that to be lesbian is to fail at being a "good woman" might have on her feelings of depression.

13 Some women indicate in their narratives that they are well aware of the powerful nature of biomedical discourses on depression and the impact that these discourses have on how they understand and interpret their own experiences. For example, Jam in Blackbridge's *Prozac Highway* exposes the power of the biomedical discourse on *depression* when she states that she uses the term depression as "a description of how I feel, subliminally shaped by drug ads and my new shrink" (153). In this statement Jam admits that she is susceptible to the picture of depression painted by "drug ads" and her "new shrink," and that these forces have the power to shape the meaning she ascribes to the word *depression*. Yet her *awareness* of the power of these forces to "subliminally" shape her understanding also indicates that she is resisting or undermining them, because discourse depends on an acceptance of itself as a taken-for-granted reality in order to fully uphold its power.

14 Similarly, in her memoir *Prozac Diary* (1998), Lauren Slater indicates her awareness of the power of biomedical discourse when she states: "it could have been [. . .] something she [sic] was born with, a simple physiological fact pressed into her genes. She knows that's the fashionable explanation these days, and it's way too simple, of that she's sure [. . .]" (141). Her awareness of the pervasiveness of biomedical explanations — that they are presently the "fashionable" explanation for her depression — shows that she is obviously not accepting this discourse uncritically. Yet she goes on to talk about how, in looking at her family history of mental illness, it does seem possible that biology plays some role. Because she makes it clear that she is both aware of and resistant to the power of the discourse to define her experience, she is able to discuss biology as one possible factor of her depression without positioning it as the main or only cause, which suggests that there are limitations to the ability of either strictly material or strictly discursive explanations to capture the meaning of depression for Slater.

15 A wholehearted acceptance of biomedical explanations for depression might actually contribute to making women's depression worse rather than better, indicating again that a strict emphasis on the material is inadequate to encapsulate the complexity of women's understanding of their depression and their interpretations of its meaning. Meri Nana-Ama Danquah's memoir *Willow Weep for Me* (1998) points to the dangers of such a wholehearted acceptance; after learning that her sister has also been diagnosed with clinical depression, Danquah believes she can no longer avoid facing the fact that "[her] own depression was most likely biochemical. That conclusion," she continues, "did me in" (214). Danquah is distressed

by this new awareness because in her mind, if her depression is an innate part of her biology rather than a result of her experiences of racism, sexism, and poverty, as she believed until this moment, it is therefore inescapable. This realization sends her into a downward spiral of deepening depression and alcohol binges. It does not occur to her at this time that biochemistry might be merely *one* (not *the*) cause of her depression, likely because of the overwhelming power of biomedical discourses to assert themselves as the primary or only explanation for this condition. Danquah later admits that at the time of her sister's confession she had no way of understanding that it is "not as if nature were not heavily influenced by nurture and vice versa" (214), and that this realization was necessary for her to be able to function again on a day-to-day basis.

16 In her memoir *Prozac Nation* (1995), Elizabeth Wurtzel also implies that her resistance to a complete faith in biomedical discourses was a source of her ability to understand and make meaning from her depression:

I have gone from a thorough certainty that [my depression's] origins are in bad biology to a more flexible belief that after an accumulation of life events made my head such an ugly thing to be stuck in, my brain's chemicals started to agree. (306)

Here, Wurtzel introduces the notion that biology might be influenced more by environment and experience than the other way around — a theory that holds potential to severely undermine the dominance of strictly biomedical explanations for depression, for if biology is shaped by experience then surely we must take into account the ways in which depression is constituted socially, in the interests of showing and accounting for the ways in which experience itself is largely constructed through prevailing and powerful discourses.

17 A resistance to biomedical discourses is an important aspect of women's depression narratives, and through their descriptions of their hesitation about or outright resistance to accepting these models wholeheartedly, women are in turn re-constituting these discourses, with a difference. The growing amount of published first-person narratives on depression also functions to constitute new or different discourses on depression, while at the same time the experiences of those writing the texts are of course also being *shaped* by the prevailing discourses on depression. For example, Fee ("Pathology") argues that Wurtzel's memoir *Prozac Nation*, likely in part because of its status as a bestseller and now a major motion picture, "is now itself *constitutive*" of the meaning of depression (87, emphasis in original). Because of the skepticism of Wurtzel and other women writers about the sole power of biomedical discourses to encapsulate their depression experiences, the very fact that these narratives have become constitutive of the discourses on depression themselves is also in effect contributing to a *reconstitution* of biomedical discourses. This reconstitution is



significant in that it stands to undermine the ultimate defining power of biomedical discourses without throwing out entirely the notion that biology likely does play some role in depression — in a sense, women's resistance to these discourses without rejecting them entirely will allow us to avoid throwing "the baby out with the bathwater," as Jane Ussher argues (*"Biological Politics Revisited"* 426). When women are aware of the pervasiveness of biomedical explanations for depression and yet resistant to them, insisting on pointing to the ways in which their depression is also a social experience, then they contribute to reconstituting biomedical explanations as only one — rather than the — possible factor contributing to their experience of this thing we've coined depression. In doing so, they effectively undermine the power of biomedical discourse without discounting that which is useful within it, which in turn leads us towards a theory of depression that can exist "in-between" material and discursive approaches.

18 A failure to address the ways in which women's depression is constituted through the very pervasive discourses that both create and reinforce socio-cultural standards for femininity or "good womanhood" is perhaps the most significant limitation to materialist discourses on women's depression. While strictly material explanations for women's depression may include some discussion of the impact of a woman's social status on her susceptibility to depression, they fail to address how these powerful discourses on femininity tremendously shape women's lives and must therefore be intimately tied to depression. There is evidence from many of the narratives used in this research to indicate that there is a definite link between the pervasive power of "good woman" discourses and women's feelings of depression, which points to the limitations of a strictly material theory of women's depression. As Maya — another interviewee — explains:

there's definitely messages about what good girls are or what good women are and there's no way to ever achieve those things or feel satisfied if you've got some aspect of them, because then you're just doing something wrong in another area.

Women strongly connect the impossibility of living up to socially constructed standards for "good women" to their feelings of depression. This connection has also been noted in a number of feminist studies (Bart; Jack, *Silencing*; Scattalon and Stoppard; Schreiber; Stoppard, *Understanding Depression*; Lafrance and Stoppard; McMullen and Stoppard). However, Stoppard suggests that the impact of societal standards for "good women" on women's depression remains "unaddressed" by mainstream research, which frequently tests for "sex-differences" in depression but "neglects symbolic aspects of gender" (*"New Perspectives"* 86). Hence an exploration of the places where experiences of depression and

awareness of these discourses overlap in women's narratives is central to uncovering the limits of materiality as related to women's depression.

19 Blackbridge explores standards for "good women" and the cost of failing to live up to them in *Prozac Highway*. She describes the dilemma thus:

Jam hadn't been raised to go to college. She'd been raised to marry young and be a housewife, which was sort of what she was doing [. . .]. Unfortunately, she was messing up on the wife part. She kept breaking up with her boyfriends and having miserable one-night stands with women. She knew enough to keep her mouth shut about the women [. . .]. (109)

At the point at which she's making this confession, Jam is in therapy and her depression is so bad it is causing her to cut her arms as a means of relieving the pressure of what she is feeling, which is: "*hate myself, hate myself*" (110). Jam's feelings of self-hatred are clearly connected at this point in the text with her inability to do what she has been raised to do — synonymous with what "good women" are expected to do. Later, she also discusses how her inability to live up to standards of "good radical-lesbian rebel art grrrl womanhood" also contribute to her self-doubt: "She hadn't forgotten she was over forty when she put on that outfit [. . .]. You couldn't be a rebel art grrrl at forty. You were supposed to have a teaching job, or a show in a museum, or disappear" (189). Jam has eventually overcome her anxiety around failing to measure up to mainstream standards of good womanhood by getting involved in a feminist counterculture in which she is able to cultivate acceptance from herself and others. But in the above scene she finds herself faced yet again with the inescapable nature of these "good woman" standards, even within countercultural or feminist communities. Hence even those who embrace feminism are not impervious to discourses that constitute appropriate femininity — the expectations are different in feminist circles, but the discourse of course pervades even the boundaries of feminist and other countercultural communities. Indeed, one could argue that there is a powerful discourse shaping what a "good feminist" should be, and that our failure to interrogate this discourse may also contribute to women's feelings of depression and their ability to admit and respond to those feelings.

20 Recently, new research by Michelle N. Lafrance and Janet M. Stoppard (2006) has identified a connection between individual women's abilities to distance themselves from "good woman" standards and recovery from depression. This is a fascinating finding and key to feminist understandings of depression in women. It also supports arguments that the discursive dimensions of depression must be taken seriously even when it comes to "treating" the condition. Lafrance and Stoppard also found, however, that recovering from depression by distancing themselves from "good woman" standards (e.g. "letting go of caring, cooking, and

cleaning, saying no to others' demands, and taking care of oneself" [318]) caused women "to be faced with a discursive double bind where caring for oneself was central to their well-being but threatening to their identities as women" (320). This finding suggests to me that individual efforts to shirk the power of discourses on appropriate femininity may be insufficient for recovery from depression in the long-term: the discourse itself may require radical shifts and changes in order to have an ongoing positive effect on depression in women. Lafrance and Stoppard similarly conclude that we may need further "research and social action aimed at investigating identity options that may be more useful to women" (321).

21 Discursive constructions of appropriate femininity also show variation by cultural or racial background. Danquah talks about the impact of symbolic standards for "good black women" on her experience of depression in her memoir. She recalls that she has always been made aware that the most important characteristic of a "good black woman" is her strength: "Black women are *supposed* to be strong — caretakers, nurturers, healers of other people — any of the twelve dozen variations of Mammy" (19; emphasis in the original). These standards of "good black womanhood" are maintained in a variety of ways, from the proliferation of 'Mammy' imagery to the insistence of many black women themselves on strength as a birthright. Danquah describes the responses of other black women when she discusses her depression: one common reaction is "'What do you have to be depressed about? If our people could make it through slavery, we can make it through anything'" (21). White people also play a part in upholding the image of the strong black woman; at a dinner party, Danquah was once told by a white woman that "when *black* women start going on Prozac, you know the whole world is falling apart" (20). All of these remarks pressure Danquah to conform to this construction of black womanhood, and her feelings of inadequacy feed her depression. It is not the material reality of racism, but rather the discourses that underpin it that contribute in this instance to Danquah's depression, again underscoring the limitations of strictly material models for understanding women's depression.

22 Similarly, April — another interviewee — discusses the different standards that define "good aboriginal womanhood":

There's some really fucked up messages out there about how to be a woman, you know, for aboriginal women [. . .] they tend to put a lot of onus on women being responsible for the ills of a nation. And that's really fucked up, you know, it's like it doesn't matter that the men have been drinking and beating the crap out of their wives and doing whatever, it's apparently our fault. If we would be just a little happier, a little more loving, if we stayed home and cleaned our houses and did this and did that, then things wouldn't be so awful.

So the responsibility for the desolation of aboriginal communities, the result of years of racist oppression, gets placed through this discourse onto the shoulders of aboriginal women, as though the power to change the circumstances of aboriginal people lies solely in their hands. April also notes that a common critique of aboriginal women is that they are not "traditional" enough:

Being an aboriginal woman, you can be creative, but it has to be at basket-weaving, you know, it has to be at doing dream catchers, or beading [. . .] you can be creative in that way, but don't think you're going anywhere else! There's not a lot of permission [to do things differently] in the aboriginal community [. . .] I mean, it's there, but few and far between, you know? And [. . .] it has to reflect positively on us as aboriginal people [. . .]. What's really really sad is [. . .] living in the community we're living in [a small native community in northern Canada], well God forbid if you're an educated aboriginal! And how dare you be an educated aboriginal woman! [. . .] Because now you're white, you're not Indian!

April's awareness of these very specific ideas about what constitutes "good aboriginal womanhood" and her inability or unwillingness to measure up to them has been a source of anxiety and depression at various points in her life. These discourses are shaped by aboriginal communities themselves as well as by the outside (white) world. Clearly, a failure to consider the impact of these discourses on April's feelings of depression would not encapsulate her depression in all of its complexity, and points again to the limitations of strictly material models which might suggest that April's depression stems in part from racism but would fail to see how these powerful discourses that exist within her own community are also implicated in constructing her experience.

23 Both biomedical and "good woman" discourses clearly interact in dialectical relationships with depression in women. These discourses are inescapable for women, even those women who have the knowledge and time to deconstruct the impact that they might have on their lives, or those who embrace feminist or countercultural communities that do not subscribe as readily to mainstream ideas about what a "good woman" should be. While the standards of good womanhood vary across time, culture, and community, it is clear that they continue to significantly impact women's feelings of depression. The role of biomedical and "good woman" discourses in shaping the meanings women attribute to their depression indicates that a strictly material explanation for women's depression does not adequately capture the phenomenon, and is therefore inadequate as a theory on which to solely base understanding or treatment of the condition.

## **At The Limits of Discourse: Being Responsive to The Real And Present Pain of Depressed Women**

We cannot dismiss mental health problems as linguistic constructions or mere justifications for regulatory control. We need to offer something more concrete than critique for women who come forward for help. (Ussher, "Women's Madness" 208)

24 Some critics of either biomedical or material theories of mental illness might be inclined to dismiss any theory which considers biology or materiality as factors, even when such factors are indicated by those who suffer from the symptoms of depression or other mental illnesses. Such critics argue that those who experience depression are as susceptible to the power of biomedical discourses or materialist rhetoric as any unstudied or non-critical thinker unpracticed in the art of discourse analysis would be. However, it is important to give credence to women's own thinking about their depression experiences and recognize that their ambivalence about the role of biology or materiality may have to do with more than the competing discourses that they are subject to. While discourse analysis is an important tool for feminists, it can sometimes result in attempts to "dismiss mental health problems as linguistic constructions or mere justifications for social control" (Ussher, "Women's Madness" 208). As Ussher has more recently (2004) reminded us, even early feminist critics of biomedical models did not intend to imply that we should "completely reject" biology's role ("*Biological Politics* Revisited" 426), and she asks: "[a]s we escape into debates about discourse, do we not forget the materiality of women's lives?" (428). Similarly, Fee points out that "the realistic and observable suffering of persons has not been part of the narratives of critics and theorists emphasizing social and linguistic dimensions of mental disorder" ("*Broken Dialogue*" 13). While both of these authors ultimately believe that discourse plays a tremendous role in how depression and/or mental illness is experienced and understood, they recognize that to insist that mental illnesses are *only* discursive greatly limits our ability to acknowledge and be responsive to the undeniable presence of suffering in the lives of those who experience such phenomena firsthand.

25 Feminist research has long argued that women's over-representation among those labeled mentally ill is due in large part to the tendency of the psychiatric profession to pathologize those women who for a variety of reasons fail (or choose not) to live up to socially constructed standards of good womanhood (Caplan; Chesler; Ehrenreich and English; Gilman; Showalter; Ussher, "Misogyny"). Gardiner points out that "feminists have considered women's depression a result of women's circumstances under patriarchy" (502) since the second wave of feminism. Chesler's seminal work on women and mental illness (originally published in 1972) argues that women's overabundance in mental institutions and psychiatric

treatment throughout history is in fact one of the main means by which women are oppressed. Her research paved the way for the development of the predominant feminist theory on women's depression: that depression in women is an understandable response to living in an unjust, misogynist, patriarchal world; that it therefore has no basis in biology but is purely socially constructed, and is irremediable except through undermining both the material conditions and discourses of appropriate femininity that uphold such inequalities.

26 Yet obviously, a complete refusal to acknowledge any possible biological or other material connection to depression — an insistence on the correctness of discursive explanations — functions in a way that is potentially as totalizing and oppressive as the very biomedical models that feminists and others have worked so hard to destabilize. When we as feminists refuse to recognize or acknowledge the impairment and pain that results from depression, whether or not the concept itself is largely discursive, we offer little to the predominantly female population that suffers from it. Further, we create a dramatic conflict within feminism where those feminists who experience suffering as a result of depression are left without a language to discuss the resulting impact on their lives and on their very participation in feminism. As indicated by the stories recounted by Caminero-Santangelo and Gardiner earlier in this paper, if we deny the material dimensions of depression entirely, we create an environment in which depression is collectively talked about as discursively constituted, while on a personal level we turn to antidepressants and other medical solutions as private, and often shame-filled, attempts to ease the pain and suffering of an experience that has become unspeakable; an environment where women's very real pain remains cloaked in confusion and conflict.

27 A serious limitation of a discursive perspective that remains entirely unwilling to address material aspects of depression lies in the reality that if we scorn all forms of individual treatment for the condition, we sacrifice a comprehensive knowledge about these treatments or about the ways that they might effect women differently than men. Rachel Perkins, a lesbian feminist and clinical psychologist, discusses this risk in her article "Choosing ECT," which explores her difficult decision to choose electroconvulsive therapy to treat her own depression. Perkins tells us that many women asked her how she, "a radical lesbian feminist and a psychologist [. . .] [could] choose to submit [herself] to such torture" (623), a question that she seemed to find unhelpful at best and highly judgmental at worst. She also echoes the feminist described earlier by Caminero-Santangelo when she explains that depression kept her from "working (or doing anything very much) for about six months" (624); that her pain was debilitating to the point where, when faced with a recurrence, she

wondered whether she could deal with it at all. For Perkins, ECT provided a possible solution to this pain and debilitation, and in her article she describes the highly unhelpful responses of friends and colleagues whose discouragement of the practice was often ill-informed. As she explains: "the classic feminist line of regarding ECT as a single, awful entity is inadequate" (625). This "line" prevented Perkins from knowing several things that she should have known before choosing ECT: details about sex-difference in the treatment, which she outlines in the remainder of the article, presumably in the interests of preventing other feminists faced with a similar decision from being forced to choose ECT in the face of feminist-constructionist discourse that would insist that such a solution to depression is unthinkable, inadequate, or just plain "torture," with little thought to the torture that transpires through this entity known as depression.

28 What is required, clearly, is a way through the materialist/discursive binary to an understanding of depression that can balance a responsiveness to individual women's suffering from depression without losing sight of the fact that both the very concept of depression and women's experience of it are also constituted discursively. Gardiner seems to lament the loss of a time when "the necessary cure for depressed women was neither drugs nor psychotherapy but social change" (511), yet she nonetheless suggests that as feminists we need to remain "wary of [. . .] the automatic dismissal of biochemical medications" (515). Thanks to poststructuralist critiques of concepts such as "natural," "essential," and "authentic," an acceptance of the use of Prozac and other medications to treat women's suffering as a result of depression need not necessarily be antithetical to feminist discursive theories on depression. As Zita insists, a "drug-free female body is only one of many physicalities of the body that could be called 'natural'" (76).

29 The trick for feminists wishing to accept Prozac or other medications as one possible response to the material suffering stemming from depression without compromising their discursive views lies in recognizing the ways in which the drug can be useful in combating symptoms of depression while at the same time resisting the ways in which the drug is used to reinscribe biomedical discourses that locate depression solely within the individual sufferer. We each have the potential to become, "if need be, a Prozac-tipped but not Prozac-promised feminist" who exists both "with and against" the drug and all that it signifies (Zita 78). Indeed, Slater goes so far as to suggest that the common side-effect of decreased sexual desire while on Prozac could be read as a decidedly *feminist* characteristic of the drug; she positions Prozac as a new tool of radical feminism by envisioning millions of women "who have become indifferent to the mating game, who care less about their bodies in general, who have

aged prematurely and celebrate their spinsterhood" (162-63), and as a result of this triumph she imagines "Gloria Steinem becoming the spokesperson for Eli Lilly" (163). While she ultimately decides there are too many flaws in this idea to provide her with much comfort, Slater's desire to help feminists become more accepting of Prozac is likely motivated not only by her personal desire to reconcile her use of the drug with her own feminism, but also by her awareness that to remain responsive and relevant to women with depression, feminists must find a way to make peace with Prozac. Zita argues that so long as we remain committed to a "more radically and collectively spirited feminism" (76) that locates the sources of depression outside of the individual, there is no reason to fear that responding to women's material experience of depression automatically undermines our attempts to recognize the ways in which the notion of depression is also constituted discursively.

30 Recent feminist writings on depression and mental illness call for a material-discursive (Stoppard, *Understanding Depression*) or material-discursive-intrapsychic (Ussher, "Women's Madness," "Biological Politics Revisited") framework for understanding women's depression. Such frameworks attempt to oppose strictly material understandings of depression by addressing how a woman's depression experience (and indeed *all* experience) is shaped by the discourses that constitute it. Yet at the same time, these approaches also encompass a material understanding of women's depression — they look at the symptoms women experience and the impacts of depression on women's psychological and physical well-being, and give these factors as much weight as the discursive analysis; in short, they offer both a framework for understanding and a response to women's depression that exists in-between the stark dualities of strictly materialist or strictly discursive theories.

### **Searching for an "In-Between:" Reframing Women's Depression With Material-Discursive Models**

In-between. There's a phrase that is far too underappreciated. What a great day it was, what a moment of pure triumph, to have discovered that there are in-betweens. (Wurtzel 330)

31 In an attempt to incorporate discursive theories of depression with a desire to be responsive to the materiality of depression, feminist psychologists such as Stoppard and Ussher have developed models for understanding women's depression that attempt to incorporate both the material and discursive aspects of depression in women without privileging one over the other. In their approaches, they argue that biological, psychological, social, and discursive understandings of women's depression can co-exist on equal terms. Ultimately, the goal of applying a material-discursive framework for understanding



depression in women is to reframe women's depression as "the outcome of a process involving reciprocal interactions between a woman's physical embodiment and her discursively constructed experiences" (Stoppard, *Understanding Depression* 108-9).

32 Ussher has expanded on the material-discursive framework to include intrapsychic factors, as she believes such factors as the psychological effects of women's efforts to conform to "good woman" standards are not given adequate weight in material-discursive frameworks. In her article outlining a material-discursive-intrapsychic model for women's mental illness, she suggests that the material component involves looking at the "factors that exist at a corporeal, societal, or institutional level" ("Women's Madness" 219) such as a woman's physical (bodily) symptoms of depression, the presence or absence of a social support network, and the barriers she may face to gaining economic independence. The discursive component involves consideration of the impact of "social and linguistic domains" (219) on a woman's experience, such as how discourses creating constraints for "good" womanhood impact her feelings of depression, or the way a woman interprets the phenomenon. And finally, the intra-psychic component involves consideration of the factors which operate at the "level of the individual and psychological" (220), such as exploration of the reasons why a woman might blame herself for staying in an abusive relationship, or the impact that psychological methods of coping with abuse, such as splitting or dissociation, might have on a woman's wellbeing. Broken down in this way, it becomes apparent that this model allows for a very thorough interpretation of women's depression.

33 Another advantage of material-discursive approaches lies in the potential for such approaches to remove the pathologizing elements of women's depression by acknowledging, particularly through the incorporation of the discursive analysis, that depression need not necessarily be seen as a strictly material experience in order for women's depressive symptoms to be taken seriously. Material-discursive models also open the door for a variety of different treatments for depression to be taken into consideration, and to be seen as equally reasonable or valid forms of treatment — from a decision not to do anything in particular to combat depression up to feminist activism for social change. Under these models, neither medical, psychological, discourse analytic, nor social resolutions are given status as "more" or "the most" effective in combating depression, and in fact none of these types of resolutions is seen as being adequate in and of itself. A combined approach to resolving depression becomes a necessity when one understands depression through a material-discursive or material-discursive-intrapsychic framework. For example, in the case study provided by Ussher ("Women's Madness"), possible interventions into "Clare's" depression include

discourse analytic resolutions that explore the ways in which discursive constraints dictating "good" womanhood impact Clare's feelings of depression and her tendency to blame herself for staying in an abusive relationship; intrapsychic resolutions, such as therapy to deal with these self-blaming tendencies; and material resolutions such as outside interventions to deal with her husband's violence and safety-planning to try to ensure that Clare has alternative housing should she decide to leave her husband.

34 A material-discursive approach also creates space for a woman's bodily experiences of depression to be incorporated into both our understanding of her depression and the types of treatments sought or offered. As discussed earlier, when we argue that women's depression is merely discursive, women's bodily (and emotional) experiences or expressions of depression can be dismissed or marginalized. By contrast, material-discursive approaches address women's bodies as simultaneously material *and* discursively constituted entities. Such a position on embodiment allows us to acknowledge and seek resolutions for women's physical and emotional symptoms of depression without requiring us to believe that depression is *only* a biological (and not at all a discursively constituted) experience. Stoppard offers an explanation for how the discursive aspects of embodied experience intertwine with material or lived experience when she writes: "under certain circumstances engaging in practices of femininity can exhaust a woman's body, while undermining her morale and sense of well-being" (*Understanding Depression* 92).

35 Unfortunately, material-discursive or material-discursive-intrapsychic models appear to be having little impact on mainstream understandings of and treatment for depression in women, at least in Canada. A recent study by Linda M. McMullen and Janet M. Stoppard concluded that "feminism is having, at best, only a negligible impact on clinical psychology in Canada" (282). The authors note that fact-sheets on depression published by the Canadian Psychological Association include no discussion of the impact of "good woman" discourses on depression in women (even in a fact sheet on post-partum depression), fail to mention "the consequences of gender discrimination or violence" (282) and offer "[n]o routes to alleviating depression other than through individual behaviour change" (282). Feminist psychologists have been at the forefront of developing and championing these more comprehensive models for understanding and treating depression in women. Yet they are up against a missing paradigm shift in how psychology (or biomedicine for that matter) is practiced: until such disciplines embrace discursive theories and move beyond strictly individualized understandings of "illness" and "treatment," the impact of feminist theorizing will likely continue to be alarmingly minimal.

36     Material-discursive approaches attempt to blend or encompass both the material and the discursive aspects of women's lives in a way that allows for a variety of possible individual, discourse analytic, and social approaches to resolving women's depression. Such models also acknowledge the reality that conventional treatments for depression do work for some women, and that "women can recover from depression without the kind of broad-ranging social changes in material conditions which some feminist analyses would suggest are required" (Stoppard, *Understanding Depression* 203). In so doing, advocates of material-discursive approaches also suggest that when women are given information on and access to a greater range of choices for understanding and responding to their depression, they will have a better chance of finding a resolution that works for them. Material-discursive frameworks provide new and exciting ways of understanding and resolving women's depression that exist "in-between" the stark duality of material and discursive explanations. But until such models are incorporated into mainstream or conventional approaches to understanding and responding to depression, and until medical plans and insurance companies no longer endorse or cover the expenses of strictly biomedical approaches to treatment while dismissing others — in short, until these institutions take seriously and incorporate the wealth of feminist research on depression in women, it seems unlikely that most women will be able to experience these potential benefits.

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# "Doleful ditties" and Stories of Survival — Narrative Approaches to Breast Cancer in Frances Burney, Maria Edgeworth and Susan Sontag

By Heike Hartung, Berlin

## Abstract:

The article looks at two early nineteenth-century narratives concerned with breast cancer and reads them in the context of Susan Sontag's twentieth-century analysis of the cultural and linguistic over-determination of illness. Frances Burney's "mastectomy letter" (1812) is an early example of a patient's narrative which uses the discursive conventions of sentimental fiction to achieve female empowerment. By contrast, Maria Edgeworth moralizes illness in her novel *Belinda* (1801) and uses it as a cultural metaphor. While Edgeworth's and Burney's narratives share the historical moment of a shift in illness attitudes and in the technologies of medical diagnosis in the early nineteenth century, Susan Sontag, in her essay *Illness as Metaphor* (1978), analyses the articulation of an idea of individual illness as a hostile burdening of the individual person with guilt and responsibility. From a transhistorical perspective, all three texts provide further insights into the generic and gendered differences of illness experience and meanings.

1 In a recent collection of critical essays on *The Voice of Breast Cancer in Medicine and Bioethics* (2006), Susan Sherwin illustrates the contradictory perspectives on breast cancer in American society by drawing up an extensive list of "common thinking" about the disease, which she supplements with the critical alternatives less widely shared. Here are a few examples from her list:

Breast cancer is curable if detected early. Breast cancer can be lethal no matter when it is diagnosed. (Lerner 2000, 2001)

Breast cancer is primarily genetic. Breast cancer is primarily environmental. (Rothman 1998; Steingraber 1998; Eisenstein 2001)

Breast cancer begins in a specific location and spreads cells from that site in a gradual, orderly fashion to expanding circles of surrounding tissue; if caught early, it can be fully removed by excising all affected tissue. Breast cancer is systemic; its cells spread through the body before any particular tumor can be located. (Lerner 2001, 3-4)

The dominant knowledge represented by the anonymous statements is related, Sherwin argues, to the use of two war metaphors in the public discourse on breast cancer: the disease as the enemy, with whom we are at war, and the woman's body as battlefield. While Sherwin's observation about the link between war metaphors and illness is not new<sup>1</sup>, her argument highlights the limits of the public discourse on breast cancer. After having long been regarded

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<sup>1</sup> In her book on patient narratives, *Reconstructing Illness, Studies in Pathography* (1993), Anne Hunsaker Hawkins describes warship metaphors as belonging to one of the possible myths of illness around which patient narratives are organized — and as one that is very much in tune with Western medicine. This connection between war and the rise of modern medicine is also established in medical histories, see Daniel de Moulin, *A Short History of Breast Cancer* (51) and Peter Stanley, *For Fear of Pain* (97-129).

as belonging to the private domain, often adding shame to a woman's painful experience of illness by the need to keep it secret, breast cancer emerged into the public domain in the context of the 1970s second wave of feminism. The feminist slogan that the personal is political has effectively politicised breast cancer, and has also influenced European campaigns for better methods of treatment for women and for giving them an informed choice with respect to those methods of treatment (Schmidt 2000). In the media, the discussion of breast cancer tends, however, to be restricted to certain aspects of representation, which favour "heroic tales of personal confrontations with breast cancer. Generally, such stories are structured around an optimistic formula of hope and strength, though occasional reports of tragic outcomes serve as reminders that the battle is not yet won" (Sherwin 7). The dominant public discourse on breast cancer, then, rests on the common metaphorical framework of war, reinforcing the shared perspectives of the American cancer establishment (medicine, science, commerce). As a result, the choice of the individual woman's approach to her illness is limited by the force of this institutional perspective, which restricts, or even excludes, a diversity of research approaches to cancer.

2 Taking Sherwin's critical analysis of the recent public discourse on breast cancer as my starting point, I wish to put into dialogue three different kinds of narrative approaches to breast cancer: Frances Burney's "mastectomy letter" (1812) as a personal (and also semi-public) letter which describes a patient's perspective, Maria Edgeworth's *Belinda* (1801) as a novel which (mis-)represents breast cancer for moral purposes, and Susan Sontag's *Illness as Metaphor* (1978) as an essay which analyses the cultural meanings attached to illness, while also being part of a personal strategy of coming to terms with it.<sup>2</sup> In order to illustrate the complexities of narrative voice in Burney's letter, I will compare it to the "eye-witness" account of a mastectomy in the Edinburgh physician John Brown's story "Rab and his Friends" (1863). Before describing the theoretical frame of illness representation, I wish to draw on for placing these three narratives in a transhistorical dialogue, I will briefly introduce two related concepts that are important for my analysis: second personhood and relational subjectivity.

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<sup>2</sup> Lisa Diedrich, too, has read Sontag's essay as "paradoxically, a depersonalized personal narrative of illness" (54). In comparing Sontag's rationalist and depersonalized approach with Eve Kosofsky Sedgwick's performative and affective engagement with breast cancer, she gives preference to Sedgwick's relational strategy as the one more adequate to a postmodern illness experience that "queer[s] the experience of patienthood" (65). While Sontag's work does not challenge the binaries of health and illness, her approach is, however, seen as "effective in challenging the normalizing judgements attached to the experience of illness" (64). Since Diedrich's article has focused on criticism for Sontag's complicity with the dominant "biomedical approach," I will put my emphasis instead on the (mis)readings and rewritings of her essay, including her own in *AIDS and its Metaphors*, that have proved productive of new/adapted metaphors as well as providing dialogic positions for illness experience.



3 The concept of "second personhood" has been introduced into narrative theory by Mieke Bal in order to register a mistrust in narratives which mask their voices and conceal the subjects about which they speak. The distrust in third person narrative, which assumes a tone of objectivity that renders the subject of enunciation invisible, leads Bal to ask how the second person, which is often implied and referred to in narrative, can be addressed as the object and/or subject of knowledge. Her example for illustrating the importance of making the second person explicit is ethnographic writing. As a kind of academic writing which promotes a self-reflexive awareness of the "other" it constructs as second person, ethnographic writing provides Bal's model for an analysis of shifting subject positions which she defines as "second personhood." Furthermore, she draws on the work of the philosopher Lorraine Code, who has criticised the Cartesian conception of knowledge with its emphasis on the first person, on isolated individualism, as a self-contradictory notion. While the Cartesian *cogito ergo sum* is "*itself* a mininarrative in the *first person*," the epistemological notion of objective truth and impersonal knowledge that it sustains "is bound up with the narratological notion of 'third-person narrative'" (Bal 171; emphasis in the original). Code proposes to mediate between the positions of a self-contradictory objectivity, on the one hand, and relativism, on the other, by highlighting the importance of narrative structures for establishing forms of knowledge. The paradigm she advocates for the construction of knowledge is based on a model of friendship, setting relational subjectivity against an isolated, autonomous subject.<sup>3</sup> Particularly in the context of illness and medical ethics this preference for relational models of subjectivity seems more adequate than sticking with the ideal of autonomy which, in the words of David Callahan, "'shrivel[s] our sense of obligation' toward one another and impoverishes health care by taking as the norm 'physicians who, far from treating us paternalistically, treat us impersonally and distantly, respecting our autonomy *but nothing else*'" (emphasis in the original; qtd. in Code 79).<sup>4</sup>

4 The concept of second personhood in Bal's subject-oriented narratology indicates the derivative status of personhood. Also, it draws attention to the reversible relationship of complementarity between first- and second-person pronouns, highlighting deixis as an important function of language and narrative. It is these two aspects, especially, that make

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<sup>3</sup> Code argues for a shift in emphasis towards communality rather than for a rejection of the idea of autonomy, since "[t]heorists who start from communality and interdependence can accommodate the requirements of autonomy better than theorists for whom autonomous existence is the 'original position' can accommodate the requirements of community" (79).

<sup>4</sup> Sherwin, in her analysis of public discourses on breast cancer, also introduces her concept of "relational autonomy" which measures "the social and political conditions" under which a woman's choices for treatment can be made. Even more pointedly, in the context of mental illness relational subjectivity becomes an issue. In the application of performance theory to dementia care this has been explored by Anne Davis Basting 2000 and 2005, see also Annette Leibing 2006.

Bal's approach to narrative both inclusionary and able to expose power relations. In my analysis of the three texts I will draw on this relational narratology in order to examine the subject positions involved. Additionally, I will use a form of transhistorical comparison to put the texts into a dialogue in order to expose the ways in which the ill person is conceived in these narratives, and how illness as second personhood emerges between interacting first and third person voices.

### **Illness Experience — Patient Narrative: A Twentieth-Century Literary and Autobiographical Genre**

5 Frances Burney's detailed account of the mastectomy she underwent in Paris in 1811 is a singular document that is referred to as one of the rare historical precursors of the genre of illness narrative emerging in the late twentieth century (Hawkins xiv). Anne Hunsaker Hawkins describes the advent of the genre, which she terms "pathography" and defines as the patient's narrative of his or her illness experience, as coinciding with a moment of both scientific triumph and crisis in technological medicine, drawing attention to the "human factor," and to the perceived lack of the ill person's voice. She describes different kinds of myths (the battle, the journey, death and rebirth, healthy-mindedness) on which pathographies draw in order to come to terms with the destructive experience of illness. She attributes therapeutic function to pathography, regards it as the "missing part" which complements the medical case study, draws attention to its relation to autobiography and life writing, and hails it also as a new kind of literary genre: "In some sense, the pathography is our modern adventure story. Life becomes filled with risk and danger as the ill person is transported out of the familiar everyday world into the realm of a body that no longer functions and an institution as bizarre as only a hospital can be [. . .]" (1).

6 While Hawkins also draws attention to the ideological implications of the myths around or against which pathographies are written, her literary enthusiasm about the form is, perhaps, surprising. The autobiography critic Thomas Couser comes to a very different conclusion at the end of his extensive analysis of personal breast cancer narratives, when he writes: "It is to be hoped that one day, having served its purpose, the form will be obsolete, like the slave narrative, and that the narratives will be of interest largely to historians trying to reconstruct women's experience in late twentieth-century America" (*Recovering Bodies* 77). He sees the link between narratives of breast cancer and slave narratives in their similarly political motivation, written "in the hope of abolishing a threatening condition that their narrators were fortunate enough to escape" (37). Couser describes the emergence of breast

cancer narrative as an autobiographical subgenre during the 1970s as a consequence of the women's movement. While mortality rates are higher among poor and black women, those who narrate their illnesses are generally white women of the middle- and upper classes, so that "[a]utobiographical accounts tend to describe best-case scenarios" (38). Also, by generic definition, breast cancer narratives as well as autobiography in general are written in the comic mode: "it ends 'happily,' with some significant recovery" (39). Yet even though structurally the plots of these narratives are comic, the narratives are underwritten by a subtext of anxieties. Despite "sometimes being extravagantly affirmative" (40) the texts are haunted by a specific type of lingering fear due to the uncertainty of the cure's permanence.

7 Couser agrees with the general suspicion of narrative which is prevalent in Sherwin's dismissal of the media's love for "heroic tales of personal confrontation with breast cancer," and which has been formulated by disability theorist Lennard J. Davis in *Enforcing Normalcy*: "by narrativizing an impairment, one tends to sentimentalize it and link it to the bourgeois sensibility of individualism and the drama of an individual story" (4). Couser, however, modifies this claim by arguing that some examples of the subgenre of disability autobiography may realize their counterdiscursive potential by their ability to "resist or undermine objectification by some presumptive medical or medicalizing authority" ("Signifying Bodies" 117). Reading Frances Burney's letter, I will argue that she resists objectification in her narrative of a painful operation by turning against medical authority those very sentimental conventions she employs in her novels, as well as by opening up a number of dialogic "voices."

### **Frances Burney: "A Mastectomy" — Survival Strategies and the Autobiographical Letter**

8 Burney's "mastectomy letter" is also an early example of a narrative intervention into medical history from a female patient's perspective. Written in 1812, it is a pathographic narrative which coincides with the shift in the treatment of illnesses from analogical classifying practices to clinical diagnosis in the nineteenth century described by Foucault in *The Birth of the Clinic*. The objectifying gaze of the physician reads bodies for the signs they reveal, sometimes against the patient's narrative of symptoms. These signs are transformed into a narrative account of the etiology and progress of the disease in medical case histories, for which a notation system is established in the early nineteenth century (Epstein, *Conditions* 32). Burney attaches the medical report, which briefly recounts the operation and details her recovery from it, to her letter. It serves as a further reassurance to

herself and to her sister Esther in England, to whom she addresses the letter with detailed instructions about the distribution of "this doleful ditty" (Burney 612), that "all has ended happily" (615). One of the medical explanations for breast cancer in the eighteenth century linked it to the cessation of menstruation, dating back to the Hippocratic belief in a "consensus" existing between the uterus and the breasts (de Moulin 37). The observation that more women develop breast cancer after menopause resulted "in a complicated 'biological' blame tied not to the women themselves [. . .] but to female anatomy" (Epstein, *Pen* 79). Burney's repeated insistence on the "happy ending" of her story illustrates her awareness of a moral triumph over cancer and its attendant sufferings. In this respect, Burney's letter fits with the individual "heroic" mode of illness narrative criticized by disability theory.

9 However, in her letter Burney does not remain "patiently heroic." Rather, she uses narrative conventions associated with female writing and with privacy — autobiography, the letter, sentimental fiction — to analyse, and sometimes to direct, the subject positions shaping her illness experience. As a narrative of survival and recovery from illness, Burney's semi-public retreat from silence can be read as a strategy of female empowerment, which shows many of the plot structures of pathographies, like the statement of an initial awareness of symptoms, followed by consultations with female friends, with her husband, and the final decision to see a doctor. Also, by making her illness experience known to others, it serves as a "warning" to other women, "should any similar sensations excite similar alarm" (Burney 598) — an act which is "itself a courageous acknowledgement that one's body is no longer intact" (Couser, *Recovering Bodies* 43). In the process of narrative transformation, in her writing about a dangerous, painful, and traumatic event, she redirects conventions of domestic writing in order to gain some measure of control over the situation. In her consultations with some of the best-known surgeons in Paris, Antoine Dubois, obstetrician and surgeon as well as doctor to the Empress Marie-Louise, and Dominique-Jean Larrey, military surgeon to Napoleon, she familiarizes the fearful situation by casting them in the roles of sentimental villain and hero, respectively (Wiltshire, "Burney's Face" 258). With regard to their specializations, it is interesting that the military surgeon Larrey is cast in the role of the trustworthy though unworldly hero, while the courtly Dubois acts as "commander in chief" (Burney 610) at the operation scene in which the letter culminates. During the preparations for the operation, Burney directs the pity usually reserved for the patient towards her husband, General d'Arblay, in her decision to shield him from the pain of witnessing it. Through this strategy of substitution by which she gains agency through depersonalization — "as if I were directing

some third person" (608) — she manages to control her own fear and to counteract her powerlessness as a patient.<sup>5</sup>

10 Moreover, Burney's letter is interesting in terms of its management of "voice." Burney's contemporary status as a well-known novelist, her instructions to her sister for its distribution among friends and family as well as its careful manuscript transcription for later publication mark its semi-public status, which is matched by her mingling of public and private discourses in order to make sense of her illness experience: to the sentimental constellation the discourse of law is added, when she casts herself in the role of the criminal who is sentenced to the unavoidable trial of the operation, her doctors becoming her judges. The framework of criminal law is transformed into that of a military invasion, when Burney describes the actual operation as the moment at which her room is invaded by "7 Men in black" (610). The oscillation between public and private discourses becomes most urgent and painful when she tries to gain knowledge of the surgeons' activities. Initially, she literally struggles to regain her voice, when the surprising entry of the seven surgeons has left her speechless, but Dubois' order to remove her supporting nurses reactivates her: "This order recovered my Voice — No, I cried, let them stay! qu'elles restent

Yet — when the dreadful steel was plunged into my breast — cutting through veins — arteries — flesh — nerves — I needed no injunctions not to restrain my cries. I began a scream that lasted unintermittingly during the whole time of the incision — I almost marvel that it rings not in my ears still! So excruciating was the agony. (612)

11 "Voice" has discursive and physical meanings in Burney's letter, and the first person narrative voice oscillates between the private and the public in order to objectify her experience for her own therapeutic purposes as well as to make it emphatically present for others.<sup>6</sup> The complexities of the divided stance of Burney's narrative voice can be observed in the range of focus which her first person narrative allows, shifting from the detached interiority of the preparations, described by her as a third person stance, to the intense closeness of the first person perspective achieved by representing the enduring scream. A different kind of first person narrative of a mastectomy is that of the eye-witness in John Brown's story "Rab and his Friends" (1863). While Burney's text is situated both in the context of personal breast cancer narrative and in that of medical histories from the patient's

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<sup>5</sup> For a more detailed analysis of the gendered discourse on pity and the strategic uses of subject positions related to it in Burney's work see my "Mitleid und Geschlecht im sentimental Diskurs: Das Subjekt als Aggressor und als Opfer bei Frances Burney."

<sup>6</sup> Julia Epstein has drawn attention to the divided narrative voice between "social self/proper lady" and "private self/angry lady" in Burney's writing; a detailed analysis of the divisions between the public and the private in the mastectomy letter is provided in her *The Iron Pen*, 53-83, see also my "Frances Burney's *Mastectomy Letter*: Die Krankengeschichte als Syntax der Schmerzerfahrung."

perspective (see Wiltshire, "Pathography"; Dorothy and Roy Porter 107-110), the Edinburgh physician John Brown's text, by contrast, is cited as a source in more traditional medical histories which privilege the surgeon's view.<sup>7</sup> At the center of the story is a mastectomy that took place in 1830 in the operating theatre at Minto Hospital in Edinburgh. The first person narrator is identified as John Brown's younger self, medical student and clerk at the hospital. He is an eye-witness to the operation conducted by the well-known surgeon James Syme (de Moulin 52). Before the operation takes place, Alison Graeme, accompanied by her husband James and their dog Rab, consults the narrator about a tumour in her right breast. "Ailie" is introduced by the narrator as a beautiful old woman who is "gentle, modest, sweet [. . .], clean and lovable" (11) with an "unforgettable face — pale, serious, lonely, delicate" (10). The hyperbole with which he describes her face provides the contrast to the "immoral" organ that defeats her by turning from a condition of purity — "that had once been so soft, so shapely, so white, so gracious and bountiful, so 'full of blessed conditions'" (11) — to one of disease: "hard as a stone, a centre of horrid pain, making that pale face, with its grey, lucid, reasonable eyes, and its sweet resolved mouth, express the full measure of suffering overcome" (11). The title of John Brown's story draws attention to the curious framing of this narrative of a mastectomy: Rab is the Graeme's large dog, whose perception, as an extension of the narrator's voice, shapes the story's main event, his mistress's operation.

12 In this narrative, the suffering female body does not suffice to evoke sympathy in the male world which surrounds it, but canine intervention is necessary to enable a human reaction. "Rab and his Friends" is a strange variation of what Thomas Laqueur has described as the "humanitarian narrative" of the early nineteenth century that "came to speak in extraordinarily detailed fashion about the pains and deaths of ordinary people" (177) in order to arouse compassionate action. Brown defines the pity of the medical students that crowd into the operating theatre to witness Ailie's operation in a direct appeal to the reader:

Don't think them heartless; they are neither better nor worse than you or I: they get over their professional horrors, and into their proper work; and in them pity, as an *emotion*, ending in itself or at best in tears and a long-drawn breath, lessens, — while pity as a *motive*, is quickened, and gains power and purpose. (13-14; emphasis in the original)

In order to counteract this callousness of the public operating theatre and the (necessarily) pitiless gaze of the medical student, the privacy of the scene is highlighted by focusing on

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<sup>7</sup> In his recent history of British surgery before the advent of anaesthesia, Peter Stanley uses Brown's story to highlight his motivation of gaining insights into "the depths of our common nature": "Victorian sentimentality and Presbyterian piety cannot mask the profound feeling of Brown's description of Allie's last hours, and of James's grief" (8). Regarding the gendered aspect of this "common nature" which Brown's story reveals and the perceptions it focuses on (namely, the surgeon's and the dog Rab's), Stanley's invoking this particular tale at the beginning of his study is revealing for the very "unsuspicious" approach he chooses for his subject.

Rab. While Ailie is sublimated into a superhuman and unworldly being, whose body does not register pain and who remains silent throughout the operation, Rab the dog is given a voice instead:

The operation was at once begun; it was necessarily slow; and chloroform — one of God's best gifts to his suffering children — was then unknown. The surgeon did his work. The pale face showed its pain, but was still and silent. Rab's soul was working within him; he saw that something strange was going on, — blood flowing from his mistress, and the suffering; his ragged ear was up, and importunate; he growled and gave now and then a sharp impatient yelp; he would have liked to have done something to that man [. . .]. It is over: she is dressed, steps gently and decently down from the table, looks for James; then turning to the surgeon and the students, she curtsies, — and in a low, clear voice begs their pardon if she has behaved ill. The students — all of us — wept like children. (14-15)

Some days after the operation an infection develops and Ailie dies in a delirium in which she imagines holding a long-dead baby against her bandaged chest. Ailie's almost unbelievable silence, her "admirable self-restraint" (de Moulin 53) throughout the operation, contrasts with Burney's piercing scream. The situation of both women as well as the narratives in which they figure differ very much: Burney is an upper middle class woman who experiences her operation in the privacy of her bedroom, while Ailie is a working class woman displayed to an audience in a public operating theatre. Burney is a writer who controls her own narrative, which she opens up into a dialogue with her sister Esther, while her husband also is given a voice in her letter: after having spared him the pain of his physical presence at the operation, she includes him into her narrative of it (Burney 614). Ailie's husband James is present at her operation, but is mercifully distracted by having to keep his dog under control. While Ailie emerges from Brown's narrative as a saintly figure, she also remains completely silent. Any glimpses of her face, her body, or her — delirious — mind are controlled by the narrator's voice, who projects the disruption of the silence during the operating scene onto Ailie's dog. The dog's growls and yelps and the student's tears are nonverbal expressions of emotion in this narrative, which focuses on the interiority of the eye-witnesses, but remains distanced from the sick person. The second person addressed here is the reader, not Ailie, and John Brown's first person narrative is concerned with coming close to understanding the motivations of the professional eye-witness to Ailie's operation. The woman patient herself is perceived throughout from the outside. She gains her onlookers' compassion only when her polite behaviour after the operation and her superhuman endurance have almost depersonalised her.

13 Perhaps because of its fundamentally dialogic nature Burney's letter has actually initiated something of a transhistorical dialogue. It has been taken up in late twentieth-century

fiction: Helen Dunmore has written a reply to Burney's letter in her short story "Esther to Fanny." The narrator, a middle aged "orphaned" Esther who has witnessed her seventy-year-old mother's dying from an incurable cancer in a hospice, addresses her story to "Fanny." The narrator is fascinated by the historical distance between Fanny Burney's experience and her own. While Burney's narrative appeals to her as a university teacher of modern English literature, she dwells on the intriguing emotional relationship between the patient and her doctors, her own experience with her mother's illness and death creates a distinct feeling of ambivalence. She is not at all sure about her mother's actual responses to her treatment by the doctors or the staff at the hospice: "She was so polite that it was hard to tell" (130). Esther spells out her approval of Burney's scream, acknowledging it as a powerful emotional outlet, as a physical release against "false shame": "Esther to Fanny. I am glad that you screamed throughout the twenty minutes of your operation, except when you fainted. To restrain yourself might have seriously bad consequences, your doctors told you beforehand. What miracles of sense and feeling those men must have been!" (132). The short story employs the rarely used second person narrative voice in order to establish a dialogue with the historical other. By juxtaposing the historical letter with the narrator's own communication with her dying mother, the story also highlights the overdetermination of Burney's internal perspective. Burney provides a detailed analysis of the subject positions involved in her situation, she is explicit in her judgements and feelings. This communicative and emotional explicitness, or even excess, is welcomed by the narrator Esther, who encounters her mother's polite distance, the "unfeeling" surroundings of late twentieth-century medical institutions, the unmentioned "smell of death." Burney's excessively explicit language of feeling provides Dunmore's narrator with a second person for her dialogue of grief.

14 A very different use is made by Penelope Fitzgerald of this communicative excess, who acknowledges her indebtedness to Burney's letter for her "description of an operation without an anaesthetic" in her novel *The Blue Flower* (1995) about the Romantic poet Novalis's love for Sophie von Kühn. Von Kühn died in 1797, aged fifteen, after three operations failed to cure her of tuberculosis. After using Burney's letter for some of the details of the preparations for the operation, Fitzgerald closes the chapter by leaving the scream to the reader's imagination, carefully framing it through the nosey landlady's sensationalist precautions:

Frau Winkler had discussed the expected visit of Professor Stark with all her neighbours within a certain radius, "in order that there should be no misunderstanding, when screams and cries are heard. They might imagine some dispute [ . . . ]." "A lodger, perhaps, strangling a landlady," agreed the Mandelsloh. (191-192) Frau Winkler,



waiting below on the bottom stair, had been able to hear nothing, *but now her patience was rewarded*. (194; emphasis added)

Fitzgerald uses the suspense building up in Burney's narrative of the preparations for the operation as well as its detached stance and transforms them into the figure of the landlady as an eye-witness. By omitting the operation scene from narration, the reader is led closer to the patient's position, leaving the eye-witness position "below on the bottom stair." Fitzgerald's third person narrative moves closer to an understanding of the operation scene from the patient's perspective than Brown's first person witness narrative.

**Maria Edgeworth: *Belinda* (1801) — Lady Delacour and the Secrets of Illness Narrative: The Aristocratic Memoir in the Bourgeois Novel**

15 As I have shown, Burney's "mastectomy letter" is dialogic in many respects: as a letter to her sister, it is an intimate kind of female discourse that she opens up to other women in a similar situation. While establishing the gendered context in which the surgery itself takes place, she also opens up her narrative by including her husband, on the one hand through enacting control over the situation by pitying him, on the other hand by inserting his voice into her narrative. Moreover, due to the attention it has attracted amongst later writers, Burney's letter enables a transhistorical dialogue with rewritings of it in the late twentieth century. In its historical context, Burney's explicitness in addressing the moral, social and sexual issues raised by breast cancer situates her narrative between the secrecy for which Mary Astell was praised by her first biographer George Ballard in the mid-eighteenth century, and the silencing of Ailie in Brown's mid-nineteenth-century text. The philosopher Mary Astell died of breast cancer in 1731, after submitting to an operation at a very late stage (Perry 319). After emphasizing the heroic concealment and self-treatment of her illness, Ballard praises "her stoic patience, her lack of struggle or resistance, and her silent resignation in the face of pain" (Epstein, Pen 78).

16 Secrecy is also a central aspect of the representation of illness in Maria Edgeworth's novel *Belinda* (1801), in which Lady Delacour, a rakish society-woman, tells her history to *Belinda*, the novel's enlightened bourgeois heroine. In this way, the first-person of Lady Delacour's aristocratic memoir is incorporated into the third-person voice of the novel. This life-story culminates in a duel between herself and a hated social rival, in which Lady Delacour receives a wound to her breast. She refuses to have the wound examined by a doctor for fear that public knowledge of her "deformity" will undercut her celebrity. As Kathryn Kirkpatrick notes, "her diseased breast marks her disfigured domestic and maternal functions"

(xvi), thus imprinting a moral judgement on her body. The female duel, as a travesty of the male world and its ideas of honour, is presented as a ludicrous and comic event which is prevented from becoming deadly serious by the intervention of "an English mob." Again, public and private meaning of the event are in conflict, since the "comic duel ended tragically" (57) as it marks the beginning of Lady Delacour's illness. After having ignored her developing symptoms for two years, she misreads the painful inflammation of her breast as terminal: "it was in vain to doubt of the nature of my complaint" (*Belinda* 65). While her pain and her fears have assured her of the serious nature of her disease, she refuses to consult a physician. Instead, she takes her servant Marriott and Belinda into her confidence, burdening them with her secret. With the help of her devoted servant she has managed to address her energies to playing the role of the coquette, and to concealing her illness from the public as well as from her husband. She explains her refusal to have her body examined with her need for public admiration and her rejection of pity, analysing her own situation as that of a life of public performance and private emptiness:

"I never will consult a physician — I would not for the universe have my situation known. You stare — you cannot enter into my feelings. Why, my dear, if I lose admiration, what have I left? Would you have me live upon pity? Consider, what a dreadful thing it must be to me, who have no friends, no family, to be confined to a sick room — a sick bed [. . .]." (Edgeworth 65)

17 Secrecy as a dominant motif of the novel in its connection with illness and the failure to communicate is examined in the chapter "The Mysterious Boudoir," which provides a turning point in the story of Lady Delacour's recovery as moral reform. When Lady Delacour becomes the victim of a carriage accident, the permanent pain in her breast gives the event additional seriousness. Her reaction to pain is described as an unnatural consequence of her attempt to keep her illness secret: "It was the constraint which she had put upon herself, by endeavouring not to scream, which threw her into convulsions" (127). Her attempts at ignoring the body and keeping pain secret are dismissed in the novel's moral subtext as the weakness of a society woman who lives only for her public image. Her mode of story-telling is not the autobiographical confessional, popularised by the rising middle classes in the eighteenth century, but the self-reflexive display of the public persona in the aristocratic memoir. Lady Delacour's "heroic" silencing of her pain is the counter-image of Burney's scream in the autobiographical narrative. The "mysterious boudoir" episode is also significant in showing the extent to which Lady Delacour's secrecy encourages misunderstandings. She locks up all the signs of her illness in her boudoir, like the laudanum she takes against her pain, while her husband mistakes the meaning of the locked closet for the sign of a concealed

lover. Belinda, however, takes the gentleman-physician Dr X into her confidence, and opens the boudoir door for him to let him see "that this cabinet was the retirement of disease, not of pleasure" (133). When Lady Delacour is finally convinced of the positive effects of opening the door of the "mysterious boudoir" to her husband, his reaction is not one of disgusted rejection, as assumed by her, but one of grief and love. The reconciliation with her estranged husband and daughter explicates one of the moral functions of illness in the novel, which links it to a privacy "diseased" due to secrecy and misunderstandings.<sup>8</sup>

18 Lady Delacour's self-diagnosis of a terminal illness is finally revealed as a "misreading" that is due to two moral "errors": errors of the body, and errors of the mind. Her illness turns out to be, at least partly, self-inflicted. Significantly, her reform is achieved when she submits her body to the male authority of the gentleman-physician, Dr X, while her mind is cured of religious excesses by an Anglican minister. Her cure is based on the rational balance of her mental and physical "diseases." Even though this cure as character reform is mediated through the figure of the rational heroine Belinda, who serves as female friend and confidante, as listener, model, and preacher, it becomes clear that Edgeworth's ideal of enlightened, non-sentimental womanhood is in tune with her acceptance of rational male authority. Lady Delacour's urge for independence, her attempts at staging her own public image, or her endeavours to stay in control of her body and her mind in defiance of public authority and the domestic authority of her husband, are all revealed as irrational whims which even prove harmful to her health. Her scope for agency is more and more diminished in the process of her reform when even her mistaken assumptions about her illness are shown to originate in the manipulations of a quack doctor:

The surgeon and Dr X now explained to lord Delacour, that the unprincipled wretch to whom her ladyship had applied for assistance had persuaded her that she had a cancer, though in fact her complaint arose merely from the bruise which she had received. He knew too well how to make a wound hideous and painful, and so continue her delusion for his own advantage. Dr X observed, that if Lady Delacour would have permitted either the surgeon or him to have *examined* sooner into the real state of the case, it would have saved herself infinite pain, and them all anxiety. (Edgeworth 314)

19 A parallel reading of Burney's autobiographical account of her mastectomy with Maria Edgeworth's use of the threat of cancer for a moralist cure of the rakish Lady Delacour reveals a number of early nineteenth-century assumptions about illness and female agency. The strategies of information are gendered and indirect in both narratives. When Lady Delacour

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<sup>8</sup> In keeping with the novel's reception history, which has favoured the unconventional Lady Delacour over "that stick and stone Belinda," in Maria Edgeworth's own words (qtd. in Montwieler 347), her recovery of a domestic character remains related to her public image, and her domestication is never complete, she is allowed to stage the novel's ending and is given literally the last word.

submits to the operation and to the examination of her body by the physicians, she becomes the object of a male discourse: the symptoms of her body as well as her conduct become the subject of Dr X's explanations and observations to her husband, Lord Delacour. The consulted physician talks to the female patient's husband, rather than to her. This is also true of Burney's account: Dubois consults with Burney's husband, Alexandre d'Arblay, rather than with her, when he first examines her and gives the opinion that an operation will ultimately be necessary to save her life. The language, however, is much more indirect than in the case of the outspoken fictional physician Dr X, and Burney has to infer the meaning concealed by both her husband and her physician: "I had not, therefore, much difficulty in telling myself what he endeavoured not to tell me — that a small operation would be necessary to avert evil consequences!" (Burney 600). In Edgeworth's fictional account, information strategies are ideally transparent, while the doctor's strategy of communicating with the husband instead of the female patient is represented as the proper way of procedure. In contrast with Burney's account of her physician's procedure, the only secrecy involved in the mismanaged illness of the fictional narrative is Lady Delacour's own, which leads to a number of misunderstandings and conflicts.

20 Even though Lady Delacour's mistrust of Dr X's counsel is finally dismissed as irrational by the novel's moral subtext, her scepticism highlights her awareness that the new medical practices of examination and diagnosis prevent her from assuming responsibility for her own body and diminish her ability to act for herself. Lady Delacour's aristocratic disdain for being "managed" (178) leads her to reject Dr X's warnings against a secret operation that he has left in writing for Belinda. Lady Delacour regards this written document as a means of his own legal protection, which proves his prudence. She is also aware of the (legal) practice of involving the husband in the process of examination, diagnosis and operation observed by experienced surgeons and physicians (178-9). Lady Delacour's motivation for keeping from her husband both the knowledge of her illness and that of a possible operation is ambiguous: She hides her physical deformity from him in order to avert the dreaded reaction of disgust and pity. Her secrecy also serves the different, though related, purpose to make her husband jealous. On the level of the public staging of power games that defines her relationship to her husband, she seemingly assumes control over him. The manipulations rebound when Lady Delacour becomes the victim of her own suspicions, while her scope for agency is more and more diminished, until she becomes the object of the doctor's gaze and the subject of Dr X's consultation with her husband.

21 The open confrontation and disdain for male authority that characterizes the fictional female aristocrat is curbed as part of her reform and cure. Burney's account of her own consultations with friends, family, and surgeons in the context of her illness and operation highlights, by contrast, the scope for agency that she retains, while apparently submitting to male authority. She achieves this by domesticating the medical context and giving her doctors the roles of sentimental hero (Larrey) and villain (Dubois) respectively. While she has to submit, like the character in Edgeworth's novel, to the surgeons' practice of informing the husband rather than the patient of the diagnosis, by revealing and counteracting her surgeon's strategies of indirection Burney manages to assert her right to be informed. In contrast to the fictional Lady Delacour's arbitrary position towards her husband, Burney's narrative of domestic happiness and mutual regard strengthens her position: Even though her husband is part of the consultation process and of the preparations, Burney prevents his witnessing the operation. Her strategies of management are means of asserting her agency and control in a situation which tends to reduce her as an individual subject. In the detailed account of her illness and of her operation she draws attention to the physicians' strategies of objectification, while showing the limits and possibilities of reasserting her subjectivity as a patient. Both Edgeworth's narrative of Lady Delacour's misreading of cancer and Burney's autobiographical account demonstrate the consequences of the surgeon's "gaze," and represent the new medical practices of examination and observation emerging in the late eighteenth century. While Edgeworth's novel privileges male rationality over a disease that originates in female fancy, Burney's letter analyses, criticizes and sentimentalises the positions of the male surgeons and the female patient for her own purposes of gaining control.

### **Susan Sontag: *Illness as Metaphor* — Essay-Writing "Against Illness"**

22 The two narratives compared so far approach the topic of illness not only from different perspectives and different genres, they also differ in the degree of centrality they give it. While Lady Delacour's illness narrative is a subordinate part of Edgeworth's first English society novel, a novel of development that participates in the less radical versions of the tradition of enlightenment feminism, and is part of Edgeworth's didactic concern with female education, Burney's autobiographical account of her mastectomy participates in the sentimental tradition of self-analysis, and is, to a certain extent, a medical case history. They share the historical moment of a shift in illness attitudes and in the technologies of medical diagnosis. Susan Sontag's essay, *Illness as Metaphor* (1978), differs in perspective, genre as well as in the historical moment, but it shares with Edgeworth's novel the moral concern and

with Burney's narrative the autobiographical motivation. While Edgeworth's novel can be read as a moralist and rationalist intervention against illness and secrecy, Sontag's essay, similarly, has a moralist and political agenda. It is written against twentieth-century attempts to psychologize cancer, more specifically against theories of a "cancer personality" developed by American psychotherapists in the 1960s (Olson 166-67).

23 Sontag analyses the new kind of blame attached to the patient's character as well as to his or her behaviour as part of American consumer culture which promotes a secular return to Christianity's moralizing of illness as a deserved punishment. In the nineteenth century, the "closer fit between disease and 'victim'" (*Illness* 43) that is associated with Christian notions of illness resulted in a shift from the notion of illness as punishment to an "expression of the inner self," which is even more punitive and destructive for the patient: "With the modern diseases (once TB, now cancer), the romantic idea that the disease expresses character is invariably extended to assert that the character causes the disease — because it has not expressed itself" (*Illness* 46). Sontag writes against these mystifying connections between illness and patient: In drawing attention to the uses made of illness as a metaphor, she distinguishes the "most truthful way of regarding illness" as "one most purified of, most resistant to, metaphoric thinking" (3). She regards the resistance to normative notions of illness which the form of the analytic essay can provide as more effective than a personal narrative, dismissing the individualist approach to story-telling as strategically less useful for counteracting the stigma of illness in contemporary Western European culture:

I didn't think it would be useful — and I wanted to be useful — to tell yet one more story in the first person of how someone learned that she or he had cancer, wept, struggled, was comforted, suffered, took courage [. . .] though mine was also that story. A narrative, it seemed to me, would be less useful than an idea. (*AIDS* 101)

With her analysis of metaphorical thinking about illness, Sontag attempts to relocate the individualised "guilt- and victim-approach" to the more specific historical frame of nineteenth- and twentieth-century fantasies about illness. While Sontag's essay has been most effective in challenging modern conceptions of illness, it remains within the "health/illness binary characteristic of modern medicine" (Diedrich 56). *Illness as Metaphor* has opened up a critical dialogue in disability theory as well as influenced personal narratives of breast cancer (Couser, *Recovering Bodies* 49). Her radical, but also strategic, dismissal of metaphor has been criticized by Anne Hunsaker Hawkins, who charges her with aligning herself with the medical ideal of a language fully purged of mythical and metaphorical thinking, while Hawkins herself distinguishes between enabling and disabling illness metaphors (Hawkins

22-23).<sup>9</sup> Sontag's own elaborate geographical metaphor with which she opens her essay "in mock exorcism of the seductiveness of metaphorical thinking" (Sontag, *AIDS* 93), has proved productive:

Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the 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 citizen of that other place. (Sontag, *Illness* 3)

In describing the postmodern illness experience as opposed to the modern sense of a binary opposition between illness and health, Arthur Frank adapts Sontag's notion of dual citizenship. He describes the "remission society" as one in which chronic illness has become survivable due to the progress of technological medicine, opening up a realm of "inbetween-ness": "To adapt Sontag's metaphor, members of the remission society do not use one passport or the other. Instead they are on permanent visa status, that visa requiring periodic renewal" (9).

24 Sontag's essay has proved dialogic in terms of the critical readings and rewritings it has provoked. It may also be placed in a transhistorical dialogue with Burney's letter and Edgeworth's novel. While Sontag eschews the closure of story-telling, and the metaphorical aspects of "success" or "failure" implied in the closure of autobiographical illness narratives, there are some interesting parallels between Sontag's approach and Burney's. The semi-public letter tells a story of "success," of survival and recovery, but it is also a "doleful ditty," a detached account of a painful operation bordering on a medical case history that is objective and lacks euphemism. In its performative use of sentimental discourse and military metaphors for shaping the relationship between (female) patient and (male) physicians it actively controls or asserts meaning rather than submitting to the illness metaphors' stigmatising force. Neither Burney's nor Edgeworth's texts fit neatly with Sontag's analysis of the "punitive or sentimental fantasies" about illness that turn into individual character studies in the nineteenth century. Burney's letter transcends the individual approach of the autobiographical patient's narrative by objectifying her pain, and by analysing the patient-physician relationship in her critical awareness of communicative strategies. Edgeworth's narrative of Lady Delacour's illness moralizes it and turns it into a character study, but it attempts a kind of demystification similar to the one that Sontag intends with her essay: The irrational connection

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<sup>9</sup> Sontag concedes these distinctions in her rereading of *Illness as Metaphor* at the beginning of *AIDS and its Metaphors*: "Of course, one cannot think without metaphors. But that does not mean there aren't some metaphors we might well abstain from or try to retire. As, of course, all thinking is interpretation. But that does not mean it isn't sometimes correct to be 'against' interpretation" (93).

between secrecy and illness is criticized in Lady Delacour's narrative and revealed in its destructive effect in *Belinda*. The attitudes of illness expressed in these early nineteenth-century texts combine individual survival strategies and the desire for successful stories rather than "doleful ditties" with an appropriation of illness metaphors and with a disdain for secrecy. Sontag's late twentieth-century polemic against the harmful meaning of illness metaphors leads her, on the other hand, to a surprising trust in medical progress as a rational (male) activity which counterbalances her mistrust of narrative.

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**Concept and Organisation of the Master's Degree Program "Health and Society: International Gender Studies Berlin" at the Charité-Universitätsmedizin Berlin, a joint facility of the Humboldt University and the Free University Berlin in co-operation with the Berlin School of Public Health**

By Gabriele Kaczmarczyk, Charité Berlin, Germany

"Health care is vital to all of us *some of the time*, but public health is vital to all of us *all of the time*" (C.E. Koop)

1 The master's program "Health and Society: International Gender Studies Berlin" has been developed and is offered by the Charité Universitätsmedizin Berlin, a joint facility of the Humboldt University and the Free University Berlin.

2 The "Health and Society" master's program offers continuing education along with an academic degree to women and men aiming to become professional leaders in their home countries or in international organisations, businesses, projects or universities. The program is designed to address globally relevant health and social problems and will be offered in co-operation with scholars from the medical, health, social and cultural sciences. The program will be guided by transnational, intercultural, interdisciplinary principles and a gender-aware perspective. The use of problem-centred teaching and research will serve to enrich the learning experience. Part of the courses on offer are supplemented by online resources. This allow for new forms of teaching and learning.

3 Students will be enabled to recognise the gender-dimensions of science and society, to detect social, gender, ethnic and cultural discrimination, and to develop strategies to counteract these phenomena.

**Significance and aims of the Berlin course of study "Health and Society"**

4 Public health decisions in individual countries currently have consequences that go beyond national borders (for example, AIDS/HIV problems, health system adjustments of the former Eastern bloc countries). In order to secure appropriate health care for the world's population, knowledge and new findings have to be place in a broad international context. This process has to take place with attention to the process of globalisation and in consideration of gender aspects. Progressive globalisation increasingly demands career flexibility in the health services, requiring a large spectrum of competences and an ability for

transnational dialogue. The rich countries of the world are faced with the responsibility to further the global development and qualification needs, and to create possibilities for intercultural exchange.

5 Health is more than the medical concept of the absence of disease suggests. In a public health context, health is seen in relation to ecological, economic and psychosocial conditions. Health finds its resources in an ethical attitude of nonviolent politics and in the concept of a society in which the personal and social surroundings of women, children and men are shaped for their well being. In the context of the course of study "Health and Society: International Gender Studies Berlin," subjects will be taught in international comparison. Thus, comparisons between industrialised and developing nations will be undertaken, and resources indispensable for change will be outlined. The students will bring with them specific knowledge and valuable experience from their professional experiences in their own countries, on which their further learning during their studies will be based.

6 Women are scarcely involved in public health decision-making on the national level, or in globally active organisations which establish priorities in the health services and distribute or develop resources. Following the International Women's University (IFU) in 2000, a new concept for continuing the academic education of highly qualified women was developed. It is obvious that a gender-specific view of health/illness and individual/society can arrive at successful solutions to problems only if women are represented in the various positions and if the gender perspective is embedded in the decision-making processes. For the course of study "Health and Society," this means qualifying the students to develop and promote structures within the health and social systems of their native countries that will ensure just and need-oriented health care for women and men as well as for girls and boys.

7 For this reason, they have to be enabled to master the following challenges:

- To recognise lacks and deficits in the respective health systems, to analyse developing trends in the population's health situation and to be perceptive to the manner in which women and men, or differing social or ethnic groups, are affected differently by given health developments. Furthermore, students are expected to be aware of global trends and possible reactions to these by the health and social systems.
- To assess the social, economic, judicial and global conditions that lead to the promotion or impairment of health, wellness and the ability to act; to analyse to what degree and in what differing ways these conditions affect women and men and social/ethnic groups; to recognise problem areas in the various societies that contribute to discrimination and disadvantage.

- To develop guiding concepts on the levels of planning, management, general legal conditions and finance for public health services which will allow a socially just distribution of public health services; to develop models of health care which contribute to the elimination of social, gender-related, cultural and/or global discrimination.

### **Field of Study and Teaching Principles**

8 The course of study "Health and Society: International Gender Studies Berlin" is structured according to four principles: 1. Transnationality and interculturalism, which will be secured through the international composition of both learners and teachers. 2. Gender perspectives and the promotion of gender equality, guaranteed through the gender-related orientation of the study subjects 3. Interdisciplinary and problem-oriented teaching and research will be realised through the shaping of a curriculum in which small group seminars, project work and Internet supported self study have an appropriate place. With these principles in mind, the course of study will make a contribution to building a new culture of knowledge in the global context.

9 The program focuses on theoretical and methodical fields that are relevant to the maintenance of health and health care. Among these fields are:

- Gender research in the health sciences, medicine and social sciences
- Development of health systems through democratic dialogue; transparency and empowerment in the public health services
- Foundation of medical knowledge
- Epidemiology, biostatistics and health reportage as instruments for the evaluation of the population's health situation
- Health promotion and disease prevention
- Health systems research, evaluation of public health services
- Health care research from an interdisciplinary perspective (medicine, epidemiology, social sciences, health system research) and in an intercultural context
- Management of health facilities, organisational development
- Social and health science research methods (quantitative and qualitative)

### **Employment fields and need in the job market**

10 The course of study "Health and Society: International Gender Studies Berlin" is open to students of all ages coming from disciplines relevant to public health (medicine, biology,

sociology, public health, or related disciplines). The courses offered are intended to enable them to acquire a comprehensive and critical perspective on the interaction between health/disease and society/individual under gender-specific aspects, and to use this perspective for the benefit of society. The students will be qualified to develop and realise needs-oriented health care concepts and innovative research approaches in their native countries. The work and the international exchange in the course of study is intended to support the students after the conclusion of their studies; it is designed to prepare them for careers in health politics and health care in their home countries, or to realise projects, e.g. in the context of employment with international organisations, or through consultation with political decision makers. The education is aimed at the following professional areas:

- Planning, management, organisation of health and social systems in politics and administration
- Planning and management of health care structures and of models of public health service
- Development and implementation of strategies of health promotion and disease prevention as well as social management in and for organisations and businesses
- Management and support of advocacy groups, self-help in public health services
- Evaluation of public health services
- Health reportage, monitoring of health trends and health systems
- Teaching and training of public health employees
- Academic care

11 The international need for qualified personnel who are epidemiologically educated as well as in possession of planning and management competence is evident. Studies by the WHO and the World Bank show an immense world-wide need for action in regard to the control- and development problems of health systems. With the foundation of post-graduate courses of study in public health and epidemiology in Germany in the 1990s and internationally co-operating courses of study in international health, this need has already been met to some degree. 12 For the students of the course of study "Health and Society," work opportunities arise with international or internationally operating health organisations (WHO, UNESCO, Gesellschaft für Technische Zusammenarbeit (GTZ), etc.), in ministries of health and administrations, with health insurance companies, associations, businesses, NGOs (CARE, Medecins sans frontières, etc.), and interest groups.

## **Program outline**

13 The prerequisite for admission is an initial professional degree (Bachelor, Diplom, Approbation, etc.) in a discipline relevant to public health.

14 The course of study, including the writing of the Master's thesis, lasts 12 months. The language of instruction will be English. Within this period, three six-week modules, one three-months module as on-site study, and an internship will be completed. Three months will be reserved for the writing of the Master's thesis.

15 From ten up to a maximum of twenty participants at a time will be admitted to the course of study. The tuition fee amounts to 7,700 Euro for a full twelve-month program, the fee for immatriculation included.

16 The modules will be taught by one of the local (mostly German) teachers and one foreign teacher. Individual parts of a module will be designed by foreign and non-foreign teachers coming from the US, England, Belgium, South Africa, etc. who are sponsored by the German Academic Exchange Service (DAAD).

## **Didactics**

17 The theoretical and methodological basis for the subjects/modules mentioned will be taught at a high scientific level. The focal point of the method of instruction will be intercultural differences in health and health care systems, and the political, economic, social and cultural structures behind them. To ensure the integration of all students into the overall group, an emphasis will be placed on identifying differences and similarities between the students from various cultures and nations.

18 To realise these objectives, we will:

- employ teaching personnel from universities and fields of practice who can represent and convey the differing cultures and health systems;
- allow students plenty of room in which to bring in and reflect their own experiences in the context of theoretical training (a conjunction of theory and practice);
- carry out excursions and internships in public health service facilities and organisations;
- integrate e-learning into the curriculum

More conventional didactic approaches will also be used: Lectures, seminars, work groups, presentations, tests. In addition, students will have time to work on texts, presentations, project outlines, etc.

## **Internship and Practice Orientation**



19 A 4 week internship will be take place during the course of study after the first three modules have been completed. The internship placements will be organised with the help of internationally operating institutions (e.g. GTZ, WHO), the co-operating colleges outside of the country, and through foreign teaching personnel. The internship is intended to be completed with an institution that represents a possible field of employment for the students. The co-operating universities and various international organisations offer internship placements.

### **Local Resources**

20 The Charité is excellently equipped for organising the master's program because it not only has ample local resources and the infrastructure of a large modern medical school at its disposal, but also, due to its integration into the Humboldt University and the Free University, has access to the resources of other schools, central institutes, libraries and institutions external to the universities. Our co-operation with the recently founded Berlin School of Public Health (postgraduate courses in health sciences/public health and a master's degree in epidemiology) allows us to draw on existing competences in teaching and multidisciplinary health research. Further synergies will develop with the Center for Transdisciplinary Gender Studies at Humboldt University, as well as with the master of science program in International Health, the European master's program in Nursing Science, and the master's program in Consumer Health Care at the Charité, and with the Center for Gender in Medicine (GIM) at the Charité.

### **Research**

21 Berlin is an outstanding location for research in health, medicine and biotechnology, especially by co-operation with the newly-founded Center for Gender in Medicine and the Berlin School of Public Health. Many public and private non-university institutions have been integrated into this network (the Robert Koch Institute, the Social Science Research Center Berlin, the DIW Berlin - German Institute for Economic Research, among many others). This Berlin research structure can be used for the integration of students into research projects.

22 The German and foreign teaching personnel are internationally renowned scholars and scientists. The foreign teaching personnel are generally professors at schools for public health or comparable university institutions and represent their respective research focuses. Teachers who are not professors at a university mainly come from institutions and organisations where they work in responsible leadership positions.

## **General Description of the Modules**

23 The teaching and learning material described within the following itemised modules will be conveyed through internationally renowned teachers, with whom discussion and exchange will be maintained throughout the whole course of study.

### **Core Module (three months): Health in diverse cultural contexts and gender-specific living conditions in different societies**

24 The core module will be concerned with the recognition and formulation of the central problems and tasks of health care, as well as with the development and management of health systems. It will proceed from the differing experiences of the participants in their home countries. The students will be expected to prepare examples prior to the beginning of the course and to present these in the first module. This approach aims at building the foundation for opportunities of exchange and mutual learning between differing societies and differing professions and disciplines. Common problem definitions will be developed and the differences in the conditions of the various countries will be worked out to facilitate discussions of the differences in health and health care in the students' native countries.

25 Theoretical starting points are the criteria for a health promoting general politics as laid down in the 1986 Ottawa Charter (empowerment, self-determination, health instead of illness, the elimination of social inequality, socio-ecological approaches, intersectoral cooperation and networking). The roles of women and men in the health care systems, their treatment and care within the public health system, as well as their possible disadvantages, care deficits or discrimination will be clarified on a descriptive level with examples.

26 After a phase of problem definition the participants discuss the problems introduced on an initial theoretical and scientific level, which means that they work out ideas in the following areas:

- Concepts of health and illness as expressions of cultural assessment and their historical (for example, religious) roots as points of departure for understanding the existing reality and possible changes;
- The importance and meaning of illness and health in the individual life plan and in the ideas of the collective welfare of a society or cultural regions;
- The reflection of the WHO declarations with regard to their validity and their relevance in different cultural regions (for example, health care justice, social inequality, health competence);
- Theoretical positioning of gender/women and health (in various societies);

- Health in the global context (international comparison of the spectrum of morbidity and mortality causes among the genders);
- Risks and resources for health and illness.

27 In addition, this module identifies the basic social conditions and causal factors for the health of a population. The analysis of the social positions of women and men in various societies and their connected risks and resources forms the starting point. Another aim of the module is to develop gender theories as a foundation to evaluate the living situations and the health of women and men.

- Women's work in job and family for the subsistence of the family in various societies;
- Health-related social, economic, and ecological risks of work in Third World countries; effects of globalisation on work and health;
- Social inequality and health (theories of inequality, social capital, etc.);
- Regional and global conflicts, crises, catastrophes and consequences for health and the management of health-related resources;
- The role of women in the health care of families (in various cultures);
- Sexuality, gender relationships, partnerships;
- Violence and trauma;
- Living conditions and their influence on health and illness: nutrition, hygiene, tobacco, etc. considering economic and ecological conditions;
- Selected groups, for example: prostitutes/sex workers, refugees, women in agriculture, women in health and social service jobs, women academics, women migrants;
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**Method Session:** Epidemiology I, Biostatistics, Social science research methods

## **Module 2: Diseases and Health Risks**

Exemplary models of disease and health risk constellations will be selected, each of which will be examined from perspectives relevant to public health. This will allow for several disease/risk constellations to be worked through in one module: heart diseases, frequently occurring cancers, AIDS/HIV, sexually transmitted diseases, infections (malaria, tuberculosis), environmental illnesses (water, ecological risks, radiation, etc.), psychological illnesses, handicaps/living with handicaps. Criteria for the selection of the health problem issues will be: a) Incidence of the health problem in the population; b) Seriousness of the corresponding course of illness, c) Special care or knowledge deficits with regard to gender aspects.

28 The public health cross-sectional dimensions under which these issues are to be considered will be:

- Epidemiology (incidence, distribution in various regions);
- Foundation of medical knowledge (pathophysiology, symptoms, course of illness);
- Social and medical risks for disease (tobacco, alcohol, nutrition, work, psychosocial risks); current knowledge and knowledge deficits, especially with regard to gender differences;
- Starting points and strategies for gender-sensitive prevention and early diagnosis;
- Care within the medical system (including over- and under-treatment, treatment errors; diagnosis, therapy, with a particular emphasis on the aspect of gender);
- Life with illness/handicap/risk;

**Method session: Epidemiology II**

### **Module 3: Reproductive Health and Gender Theory in the Health Sciences in an Intercultural Context**

29 Gender concepts and gender stereotypes in society and their reflections in medicine and health care will be studied in depth. Intercultural differences will be taken into consideration. The objective of this is also to demonstrate health care structures relevant for both genders and to work through the existing intercultural differences as well as health care deficits.

30 The following dimensions could be processed through a particular example (for example, reproductive health):

- Gender theories and medicine: gender related over-treatment, under-treatment, and treatment errors, intercultural differences (including high-tech medicine vs. under-treatment);
- Deficit-focused perspective and innovation potentials for sex and gender aspects in basic research, diagnosis, therapy;
- Primary health care and family health, especially under Third World conditions and with regard to public health service resources;
- Health care contributions that are carried out by women in the family or in their social surroundings;
- Reproductive health throughout the life cycle and related health care in intercultural comparison (menarche, contraception, pregnancy, miscarriage and abortion,

gynecological problems and illnesses, menopause, ageing, coping with death and dying;

- Priorities of health problems in various phases of life;
- Transculturalism and medicine, medical ethics in the intercultural discourse;
- Representations of health and disease in literature (examples from various cultures);

**Method session:** Evaluation and evidence-based medicine, Biostatistics

#### **Module 4: Health Care Systems and Services**

31 In all western nations, public health services are an important economic factor; this applies to an equal degree to investments in health in developing countries. In view of strongly expanding economical and technological developments, and in view of rising expectations concerning medical care, the question increasingly surfaces of how growing health care systems can be constructed taking into consideration economic employment politics and ethical aspects, and remain sufficiently under control. Answering this question represents an urgent task for health policy makers around the globe. In this context, gender aspects are of great importance; however, they have played a subordinate role in relation to the question of developing the macro-level of the systems.

32 The aim of the module is to develop theories of health systems that enable students to analyse and compare differing systems. Knowledge and understanding of the socially determined basic assumptions and prerequisites of a health care system will be conveyed, and students will be enabled to derive possible solutions for specific problem constellations. For this purpose, three dimensions relevant to defining a public health service will be developed and applied:

- Descriptive: A systematics will be developed and conveyed for characterising a health care system which will enable the various givens of the students' respective native countries to be analysed.
- Comparative: The development of indicators that enable a comparative evaluation of the health results and outcomes of a health care system, including aspects of medical effectiveness and economic efficiency.
- Explicative: Explanatory patterns for the various forms of systems with regard to the area of health in cultural contexts will be sought. This is important, for example, in order to arrive at a realistic evaluation of the chances of changing the health care systems in various societies.

33 Problems of various countries that demand a solution at the system level will be presented at the beginning of the module and, together with the students, solutions will be developed and tested to determine their chances of acceptance and their consequences.

34 Subject areas include:

**1. Conceptual conditions of a health system:**

- Foundation and objectives of health systems, including the aspects of equal health opportunities, solidarity, risk taking behaviour;
- Distribution of the responsibility for health between citizens and state;
- The human dimension, meaning the basic concept of the citizen, the insured, and the patient (e.g. responsible patients versus those needing protection and guidance);
- The position of the public health service in society (e.g. in regard to the extremes of welfare states following the European model of a state public health system, on the one hand, and public health service as a competition-driven economic growth industry on the other).

**2. Controlling elements of a public health service:**

- Financial coverage for health care costs, health insurance providers
- Placement and financing of the service providers
- Who takes over the health risks? (Health insurance companies, service providers, citizens)
- Professionalisation of the health professions
- Quality of medical care
- Goal-finding processes of health care services
- Participation by citizens, insured people and patients in decision- making on micro-, meso-, and macro-levels of the system.

**3. Structures and performance areas of a health care system:**

- Levels of care and degree of coverage of the population from primary care to highly technologised inpatient medicine
- Performance areas such as basic care, specialty care, emergency and intensive care
- Health advice, health promotion, prevention, rehabilitation
- Degree of co-operation and networking, integrative care approaches and the respective participating professions

**Method session:** Health reportage, health system research, health care research

**Frances Heidensohn, ed. *Gender and Justice: New Concepts and Approaches*.  
Portland, OR: Willan Publishing, 2006.**

By Andrea Quinlan, University of Calgary, Canada

1 Since the 1970s, feminists have engaged in criminological discussions, working to increase the visibility of women's issues within academic discourse. In the years following, feminist criminology has developed a voice of its own. *Gender and Justice: New Concepts and Approaches*, explores the ways in which feminist criminology has grown and is transforming in the face of cultural, political, and societal changes of the twenty-first century.

2 Frances Heidensohn, the editor of *Gender and Justice*, is a well-known feminist criminologist. Her work, since the late 1960s, has focused upon the complex intersection of gender and crime. In exploring the contemporary shifts within feminist criminology, *Gender and Justice* represents an extension of Heidensohn's academic project.

3 The text highlights the work of several authors from diverse backgrounds such as sociology, criminology, psychology, and law. Many of these researchers are currently working in the UK, and as a result much of the work represented in this text is regionally situated there. Heidensohn notes that many of the writers are young and developing academics. As such, the text illustrates current and developing trends in feminist criminology, through not only its coverage of developing substantive areas, but also by representing new voices within the field.

4 *Gender and Justice* might appeal to those working in any area of feminist criminology. The breadth of substantive topics renders this book an excellent resource for specific research areas, or for exploring broader, contemporary trends within feminist criminology. The substantial coverage of developing feminist methodologies and theories in the book makes a significant contribution to the more general category of feminist academic discourse.

5 Much of the work represented in *Gender and Justice* builds on previous feminist criminological work, expanding on substantive areas of inquiry and methodological approaches. Many articles explore developing areas within the field, such as Rachel Condry's investigation of female relatives of serious offenders and Kate Steward's examination of the impact of gender in remand decision-making. The data are all recent and situated within the political and cultural climates of the twenty-first century.

6 Other works within this edition engage in current theoretical and methodological debates within feminist criminology. The articles illustrate developing conceptualizations of

traditional feminist criminological themes, such as stigma (Condry) and double deviance (Phoenix). Others explore alternative methodologies, offering critiques and alternatives to previously used methodological approaches.

7 *Gender and Justice* does not claim to be an exhaustive source of the advancements in contemporary feminist criminology. At one time in its history, feminist criminology may have thought that an exhaustive collection was achievable. However, Heidensohn states "it is no longer possible to encompass the whole of this field in a single volume — it is too vast, diverse and complex" (8). *Gender and Justice* therefore seeks to represent some of the developing ideas within feminist criminology, by demonstrating the "strength, variety and vitality of what is being produced" (9).

8 The book is divided into three sections; "Gender and Offending Behaviour" (11), "Gender and the Criminal Justice System" (121), and "New Concepts and Approaches" (209). Heidensohn begins each section with an introduction, which connects each of the articles with their historical, theoretical and methodological roots. She illustrates the articles' inter-connections, and suggests what they can offer to the discipline.

9 The first section, "Gender and Offending Behaviour," presents the historical shifts in the theoretical understandings of gender and crime. As Heidensohn notes, the authors in this section draw upon traditional criminological concepts, to expand and in some cases, negate these contentions. Many of the articles in this section begin by tracing the ways in which feminist discourse has transformed within shifting political climates. This section progresses to a discussion of the current, and in some cases novel, usages of traditional concepts and theories in feminist criminology. Many of the articles highlight the need for further empirical and theoretical research in these developing areas of feminist criminology.

10 For example, Hansen's examination of the 'gender gap' in self-reported offending leads her to critique the way in which criminologists in the past have wrongly conceptualized women as a "homogenous group" (35). Instead, she proposes that feminist criminologists need to examine the differences within groups of women instead of between them.

11 Further to this, Condry's work on female relatives of serious offenders highlights an alternative understanding of 'stigma'. Condry suggests that traditional understandings of stigma within feminist criminology tend to confine and limit agency. Instead, she proposes a notion of stigma that allows more room for agency.

12 The second section of *Gender and Justice*, titled "Gender and the Criminal Justice System," looks specifically at historical debates in criminology and feminist criminology. The articles seek to redefine and re-articulate the terms of these debates. As Heidensohn states,



"authors in this section consider, develop and contradict these arguments" (122), within the context of the twenty-first century.

13 Steward, in her study of remand decision-making, challenges the criminological notion of 'chivalry', by suggesting that "gender's effect in remand decision-making does not operate across all cases alike" (142). She claims that the effect of gender is complex and therefore cannot be reduced to a simplistic conceptualization of homogeneity. Haymen examines the ways in which some feminist interventions in the Canadian penal system have had opposite effects to those that were desired. Using the P4W prison in Kingston, Ontario as a case example, she explores how feminist initiatives have in some ways inadvertently caused more "oppressive regimes for women prisoners" (188). These findings challenge traditional notions of feminist agendas guaranteeing progressive political change.

14 The third section of *Gender and Justice*, titled "New Concepts and Approaches," illustrates some of the developing methodological approaches, theoretical interpretations, and substantive areas of study within feminist criminology. The articles in this section map out some of the new directions that feminist criminology has the potential to take in the near future. Heidensohn writes that the authors in this section "propose new sets of tools, of ideas and approaches for use in twenty-first century criminology" (209).

15 Rafter, in her piece on feminist criminology during a "century of biology" (211), claims that it is crucial to recognize that both contemporary feminism and biology are evolving and changing. She believes that as the popularity of scientific thought grows, feminists need to engage more vigorously in these discussions. Rafter asserts that feminists need to look for ways in which biology and feminist theory can be thought of concurrently.

16 In another chapter in this section, Silvestri uniquely employs a human rights perspective in her examination of gender and the criminal justice system. Exploring the theme of "New Concepts and Approaches" and arguably *Gender and Justice* as a whole, Silvestri asserts that, "exploring new directions offers us the opportunity to restate the continuing significance of gender within criminology" (222).

17 As Heidensohn asserts, it is clear that "it can no longer be argued that gender is invisible or ignored within criminology" (3). The breadth of substantive areas, the intricacies of the theoretical and methodological debates, and the range of contemporary empirical data discussed in this book demonstrate the vitality and vibrancy of feminist criminology in the twenty-first century.

**Cara Carmichael Aitchison, ed. *Sport and Gender Identities: Masculinities, Femininities and Sexualities*. London: Routledge, 2007**

By Kate Zoellner, The University of Montana, Missoula, Montana, USA

1 Sport and Gender Identities: Masculinities, Femininities and Sexualities is an edited collection exploring and describing the complex interplay among sport, gender and sexual identity. The interdisciplinarity in this new sub-discipline in which the editor places the work, the sociology of sport, are evidenced by the selections chosen, and parallel the myriad connections in the formation of gender and sexual identities the book succeeds in making visible to readers. Researchers working in Australia, Canada, the United Kingdom and the United States present a range of disciplinary perspectives that inform this work, including anthropology, geography, philosophy, psychology, sociology and sport sciences. The research and post-structural critiques that comprise the text are developed for researchers and graduate-level students in these disciplines as well as those working in cultural studies, gender studies, media studies, queer and sexuality studies, social and cultural geography, and sociology.

2 Editor Aitchison, Professor of Human Geography, Director of the Centre for Leisure, Tourism and Society at the University of the West of England, and a leading researcher on identity and social justice related to leisure, sport and tourism, introduces the text in the opening chapter, "Gender, Sport and Identity: Introducing Discourses of Masculinities, Femininities and Sexualities." We find out that the book "explores and explains the complex ways in which both gender and sexuality, as significant aspects of individual identities, identity politics and identity relations, inform and are informed by sport" (Aitchison 1). Aitchison identifies the twofold aim of the empirical research and social analyses selected: to both problematise thinking on the possibilities and relations existing with the interplay of sport and gender and sexuality and also, "to question our policies, practices, rights and responsibilities in relation to developing a more inclusive sport studies within the academy and a more equitable sport management in practice" (4). Sport and Gender Identities succeeds in its goals by partnering theory, research, and practice to grow scholarship and to foster research-based change.

3 Following the introductory chapter, the book is organized into three parts that represent aspects of identity formation in sport: the social and media construction/performance of masculinities; contesting and reifying femininities in sport organizations and spaces; and sexuality performance. Part one, "Representing Masculinities in Sport" contains two chapters: Garry Whannel's "Mediating Masculinities: The Production of

Media Representations in Sport," and Eileen Kennedy's "Watching the Game: Theorising Masculinities in the Context of Mediated Tennis." Whannel provides an historical context to masculinity in Britain and its "relational construct" to femininity, emphasizing that masculinity — and in relation femininity — are, "always shaped in ways that have a social and historical specificity" (7). His essay focuses on representations of masculinities in media ranging from advertising, fiction and film to music, news and television programming. His analyses lead readers to question the ways in which masculinities have and are played out in sport and their abilities to challenge, change, or maintain hegemonic masculinities (17). Kennedy continues this conversation with a focus on recent (1990-present) gender and media theory. She brings to the forefront the need to consider class, nation and race; and through case study-like examinations of tennis championships at Wimbledon, deconstructs "the myth of the great, white, athletic Englishman" (25). Kennedy wants scholars to recognize and engage with the ways in which sport media images ask to be looked at and are viewed. Both scholars provide a strong foundation for the situational performance of "masculinities" (i.e., multiple/plural) in sport, particularly as these acts are shaped by and shape the dialogue among media and consumers.

4 Part two, "Transgressing Femininities in Sport," is comprised of three chapters. Tiffany Muller's "The Contested Terrain of the Women's National Basketball Association Arena," examines the public spaces of sport as an arena in which femininity/gender and lesbian identity/sexuality are challenged and constructed, for both athletes and fans. Through examples of power relations in the league's structure, game attendance and activities and the lack of acknowledgement of the Association's large lesbian fan base, Muller explores and argues that, "WNBA spaces are contested terrains that are implicated in both the elimination and reification of traditional heterosexual norms of femininity" (40). The following chapter by Amanda Jones and Cara Carmichael Aitchison, "Triathlon as a Space for Women's Technologies of the Self," presents feminist ethnographic research on triathletes. Through the theoretical work of Foucault, Jones and Aitchison analyze the female triathletes' life stories, specifically their controlled eating, training routines and the clothing and equipment they wear and use, and "suggest that triathlon practices both function as technologies of power and also operate transgressively as technologies of the self" (71). Sally Shaw's "Gender in Sport Management: A Contemporary Picture and Alternative Futures," concludes the second section of the book with practical guidance for creating change in the organizational structures of sport. Shaw discusses the need for examining the culture, history and policies that have shaped the gendered nature of sport organizations; and urges employees to use these lenses,

assessment and analyses of "deep structures" to "become more aware of their organization's gendered nature, and work towards alternative discourses," to gender equity (74, 82). The studies and theory presented in this section of the book offer broad perspectives on the presentation, social construction and contesting of femininity in public, corporate and organizational sport spaces.

5 "Performing Sexualities in Sport," is the final section of the work. In the opening chapter, Corey W. Johnson and Beth Kivel's "Gender, Sexuality and Queer Theory in Sport," introduces and advocates for the use of queer theory and "being queer" to expand the current thought on sexual identity as it relates to sport and leisure — to allow for multiplicities of categories/identities and to place sexuality at the center of critiques (93-94, 103). Johnson and Kivel present a series of useful queries to lead scholars through this process. Kate Russell's "'Queers Even in Netball?' Interpretations of the Lesbian Label Among Sportswomen," based on interview data, explores the experiences sportswomen have with the lesbian stereotype and/or being labeled a lesbian. Russell found that "women are regarded as lesbian purely on the basis of physical activity rather than as a consequence of participation in 'male' sports" (110). The third chapter in the section, Celia Brackenridge, Ian Rivers, Brendan Gough and Karen Llewellyn's "Driving Down Participation: Homophobic Bullying as a Deterrent to Doing Sport," looks at the use of gender, sexuality and sexual identity as tools to deter participation and enjoyment in sports. Specifically, the researchers address homophobic bullying by looking at previous studies conducted in school environments that provide data and context for their discussion of the same harassment in sport. Their analyses show that homophobic bullying influences female and male participation in sport in different ways, discouraging females and encouraging hypermasculinity in males. Caroline Symons's "Challenging Homophobia and Heterosexism in Sport: The Promise of the Gay Games," provides the context informing, and the history of, the Gay Games. Similar to the closing chapter in the previous section, Symon's analyses concludes this section and Sport and Gender Identities with practical guidance — specifically on the important role of policies, practices, and guiding principles in creating a space for diverse participation in the Gay Games — and, in turn, mainstream games/sports generally.

6 *Sport and Gender Identities* provides researchers with a thorough critique of gender and sexuality in sport, making the collection of importance to me as an academic librarian supporting researchers in the areas of health and human performance. As stated earlier, I think the work succeeds in accomplishing its dual aim of both problematising the relations among sport and gender and sexual identities, and leading scholars to query the traditional male and

masculinity-driven sport infrastructure still governing many sport policies, practices and spaces. A future compilation of the results of such querying (and queering) in informing and creating designs for equitability and inclusivity in all aspects of sport would be of interest to scholars.

**Kath Woodward. *Boxing, Masculinity and Identity: The 'I' of the Tiger*. New York: Routledge, 2007**

By Curtis Fogel, University of Calgary, Canada

1 In *Boxing, Masculinity and Identity*, Kath Woodward approaches the sport of male boxing, where traditional notions of masculinity appear to clash with fluid notions of gender. Woodward's project is to explore how male boxers establish and reestablish their masculinity and identity, both within and outside the boxing ring, with one foot in a world dominated by notions of heroic masculinity and the other in a society with ever-changing gender norms and expectations. More specifically, Woodward focuses on the role of the body, narratives, and film in forming masculine boxing identities. In her own words, the central task of the project is to investigate: "How do boxing masculinities work?" (37).

2 A senior lecturer of sociology at the Open University, Woodward has published extensively on the subject of identity, particularly as it relates to gender. In her monograph *Boxing, Masculinity and Identity* Woodward uses boxing to frame broader theoretical and sociological concerns. If on the one hand Woodward thus seeks to illuminate the topic of boxing with the help of social theory, on the other she employs boxing to examine social theory. For example, she uses Pierre Bourdieu's concept of *illusio*, or a shared understanding of the stakes of a particular game, to shed light on the possible internal experiences and rationales of being a boxer. In doing so, she reveals the importance of gender to the concept of *illusio* in Bourdieu's work, i.e. the fact that, in order to be successful in his field, a male boxer must invest in 'masculine' stakes. Although predominantly focusing on male boxing, the author makes some references to female boxing, too. This, however, is characterized in terms of a masculine coded space, which Woodward exemplifies by referring to *Million Dollar Baby*, arguing that the film revolves around the female boxer's male coach and trainer.

3 In analyzing the role of the body of the male boxer in relation to masculine identity formation, Woodward draws heavily on the work of Michel Foucault and Pierre Bourdieu. Thus she illustrates, how the body of the boxer is shaped and disciplined through regulatory practices such as weight training and dieting — to turn it into a strong, hard and agile weapon. This disciplined body, Woodward suggests, becomes a form of physical capital which can then be converted to economic or cultural capital in the form of a strong, masculine identity.

4 According to Woodward, the boxer's need and motivation to attain this strong, masculine body is rooted in the regulatory discourse of boxing narratives, which for her involve any discursive practices surrounding the sport such as personal stories, pictures,

various forms of news media, the Internet, locker room talk, and film: "Boxing identities are situated within particular narratives which have both a well-established tradition and enormous purchase at every level" (19). In these narratives, the heroic struggle to achieve the impossible is a recurrent theme: "Boxing deploys the language of legends and constructs its own mythological heroes" (100). Discursive renditions of this are the rags-to-riches story and stories appealing to traditional, breadwinning masculinity, evoked in many different ways via real-life examples or through film and other mediums, representing the boxer as a man down on his luck who must enter the ring, and win, in order to feed his family.

5 A further theme of boxing narratives examined by Woodward is the heroic battle between good and evil, exemplified by the 1964 fight between Mohammed Ali and Sonny Liston. At the time, Liston was known as the bad guy of boxing because of his involvement in the dark side of the trade including organized crime and his over-aggressive demeanor in the ring. Ali, on the other hand, was the hero, set on the mission to knock Liston down and out. Through these narratives, Woodward argues, boxing legends and heroes are born: "The masculinities that are implicated in the practice of boxing are about fantasy, mythology, and the invocation of legend" (102). Such legends can be born through a fight in front of millions of people such as the Ali versus Liston, or they can result from a fight in a local gym attended by only a handful of people, where the story nonetheless spreads from locker room to locker room until it achieves legendary status. For Woodward, the importance of this discourse of heroism is that it regulates how far boxers are willing to go in training and damaging their bodies, which ultimately contributes to the formation of their masculine identities.

6 She concludes that masculine identities are forged in the sport of boxing through training regimes that are discursively regulated by narratives of courage, honour and heroism. The resulting masculine identities are fixed according to ideas of the hegemonic male. Her analysis reveals that despite social changes allowing for increased gender fluidity there are still particular social institutions where gender identities appear to remain fixed and rigid, such as in the sport of boxing.

## List of Contributors

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