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TERATOLOGIES

A cultural study of cancer

Jackie Stacey

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TERATOLOGIES

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For Dr H.

MONSTERS

The figurative speculations in this chapter have gestured towards the possible source of that bodily chill evoked by cancer, that physical shudder already so familiar to me: the L word had laid the emotional traces some years before. I thus found myself both strangely prepared for, and yet painfully shocked by, the horrors of the C word.

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BODIES

The final pages are handwritten by quill pen. The ink is bright red blood. A sense of achievement fills the air. It is complete. The years of anguish are over. The release has a calming effect; it is done, I can let go. The end of the thesis. The flesh of the argument and of my body simultaneously knit together. The surgical binding closes the bisected abdominal wall as the conclusions of the project settle into place. The loose threads of the thesis and of the operation are tied up. The completed work of surgeon and academic harmonise: as the two walls touch, the wound begins to heal; as the finishing touches are applied, the ideas cohere on the page. Cells proliferate, tissues enmesh; concepts connect, resolution is achieved. A new beginning born out of a pleasing ending. Total satisfaction.

I awoke from the anaesthetic still in the throes of this dream. Amidst the postoperative nausea, I had the distinct feeling of completion. I could still see the red words on the page to prove it. I had done it. In the memory of this dream the processes of my mind and my body are fused. Under anaesthetic vivid imaginative narratives had played across the screen in which my body had provided the writing material – blood – which enabled the final words of an intellectual project to be written. The abdominal walls and the argument became analogous, providing interchangeable metaphors for processes of closure and completion. The work on the body and the work on the mind, instead of being in competition or conflict, were no longer distinguishable, but were operating together in harmony. The dream thus offered the classic Freudian wish-fulfilment on both counts: a completed PhD and successful surgery.

In addition to the lingering feelings entangled in the memory of this dream, another sensation pervaded. On waking from surgery I felt as if I had actually witnessed the operation; I had watched my body cut open and then stitched together. The clear sense of my internal body occupied my mind and, indeed, remained with me for several months. I felt sure I had seen inside myself and thus had an awareness of my body as 'flesh and blood' in a more literal way that was quite new. On leaving hospital, I began to see everyone through this physiological lens. This imagined iconography of the landscape of organs was incongruous with my sense of people's lives, including my own. It seemed impossible to reconcile the overwhelming feeling that we are just 'a bunch of cells and tissue' which might go wrong at any time, as mine had just

done, with the knowledge of the 'personalities', what we think of as the uniqueness of the people themselves. I began to see everyone through these new X-ray eyes: the woman in front of me in the supermarket queue suddenly comprised skin, intestine, bladder, liver, lungs and kidneys.

WHAT IS REMEMBERED IN THE BODY IS REMEMBERED WELL

(Scarry, 1985:110)

When the body has been through trauma, our memory of it has a physical presence for weeks, months or even years after. Of course sometimes this is because of its lasting physical effects (for example, new limits to the body and its capacities). But there is something more than this: the somatic presence of the memory that reaches beyond the physical symptom. Like the kinaesthetic sense of which we are barely conscious and yet without which we struggle to function in the world, these 'bodily memories' are an invisible, yet tangible, presence (Scarry, 1985:110).¹ In such cases, remembrance may take a physical form in advance of any intellectual recognition of an association with the past.

Much writing on the subject of trauma and memory investigates the ways in which the shock of the trauma means that the experience of 'the events' can often not be fully held in the memory (see Caruth, 1995). As I discussed in Chapter 1, this produces both the desire repeatedly to retell the story, and the impossibility of ever achieving a satisfactory sense of having been witnessed. The traumatised person may find themselves rehearsing the impact of the shock through the reaction of another, yet needing to keep retelling new witnesses because their own shock continues to circulate within their emotional repertoire. There is often an ambivalent sense of both wanting to 'relive' and 'recapture' traumatic events, and yet there is psychic resistance to such a return. This is partly because the person wishes to forget and escape the trauma and partly because they may have absented themselves in some way from the traumatic event at the time as a way of coping with the physical and psychic pain. Hence, in the retrospective reconstruction of the narrative, the subject of the trauma may defer to another person who was present, if there was one, as a witness to the traumatic event at which they themselves were partially absent.²

My own memory of the time I was ill is full of gaps, condensations and substitutions: not only do I get confused about the time-scale and sequence of events, but I have no memory whatsoever of some events which others have since related to me. This may be a result of the mechanisms of denial which protect the subject from the full emotional impact of extreme distress; or it may be part of the latency period of delayed shock (see Chapter 1). The memory loss one might expect about

a period of physical trauma is compounded by the effect of some chemotherapy drugs. I now experience intermittent interference in my everyday memory function; like a faulty television, my memory sometimes goes blank for a minute or two, in relation to names, events and conversations.

What is just as striking as the loss of memory associated with trauma is the endurance and sensation of the consequent 'bodily memories'. There is a transformation of bodily perception that persists after the immediate trauma of the illness has passed. The desire to forget cannot overcome the stubborn presence of bodily memory. This is the physical dimension of what Cathy Caruth refers to as the 'return of the event against the will of the one it inhabits' (Caruth, 1995:5). Those suffering from 'post-traumatic stress syndrome' (PTSD), suggests Caruth, are haunted by memories of particular events: 'to be traumatized is precisely to be possessed by an image or event' (Caruth, 1995:4-5). While people with cancer have not usually been considered within the PTSD category, there are parallels in the structure of memory and the patterns of its insistent repetition. For at least eighteen months after the treatments I was aware of 'bodily memories' as a constant presence. The memory of the surgery and its aftermath made me acutely aware of the internality of my body, a sense that seemed to separate me from others and from my previous sense of embodied subjectivity. Although this imagined bodily interior has now receded, it can instantly be recalled several years later, through an associative image, smell, sound or dream.

But in what sense is this a *memory*, if it is to some extent based upon my absence from the events in question? How can I remember something I did not consciously experience? After all, during surgery I was anaesthetised. In fact my memory of this event is based on a phantasmatic witnessing. Unless we explain my feelings through the idea of an 'out of body' experience in the more spiritual sense, then my feeling of having seen myself 'cut open' during surgery is either a memory of a dream, or an imagined omnipotence, or both. As Annette Kuhn illustrates so eloquently in her own 'memory work' on a very different topic, 'remembering appears to make no insistence on the presence of the rememberer at the original scene of the recollected event. Remembering is clearly an activity that takes place *for*, as much as in, the present' (Kuhn, 1995:108). As Kuhn goes on to demonstrate, we may have memories of events which are historically located before we were born.³ Thus, my memory of seeing my own bodily interior, and the consequent somatic sensitivities that informed my sense of presence in the world, are not entirely incongruous with my anaesthetised state at the 'event' in question.

Chemotherapy left traces of bodily memory in a rather different way. The sustained confrontation with the abject during chemotherapy

discussed in Chapter 3 made an intense bodily impression. Long after I had adjusted to the 'side-effects' on a physical level, my body would 'remember' the traumas of the treatment. The trigger may have been an association of somatic sensation with place, taste or sound. Music listened to during chemotherapy became unbearable and favourite food from that time inedible. For several years after the chemotherapy, I would find myself suddenly (and for no apparent reason) overcome by nausea. It always took me some time to realise that the dates coincided with those of the chemotherapy. It was not that I looked at the date in my diary and then felt nauseous, but rather that the memory was always generated by bodily sensation, or, at least, that's how it felt.

These 'bodily memories' gradually fade but they never disappear entirely. They return unexpectedly, uninvited.⁴ Such a transformation of the body in turn transforms self-perception. I have found it impossible ever fully to return to the more predictable and familiar (and external) relationship to bodily states that previously comforted my psyche, although I have become increasingly familiar with (though nevertheless always surprised by) the apparently inexplicable waves of nausea, or the sudden image of the abdomen's internal organs. These remembrances are the somatic forms of what Annette Kuhn has called 'the phantasmogoria of memory' (Kuhn, 1995:105). 'Phantasmogoria' here refers to 'a shifting series or succession of phantasms or imaginary figures, as seen in a dream or fevered condition, as called up by the imagination, or as created by literary description' (*Oxford English Dictionary*, quoted in Kuhn, 1995:105). Haunting icons of past trauma, they surface in the present repeatedly, if irregularly. But unlike the memories in Kuhn's account, the sense of place so crucial to memory formation is *internal* rather than external (Kuhn, 1995:114). It is the body's interior space that provides the substance and the staging of these memories: a 'bodily uncanny' that houses these strange sensations within the most familiar of places (see Donald, 1989; Chisholm, 1992).

For me these bodily memories are the lingering spectres of the trauma of having cancer, surgery and chemotherapy. The opposite of the nostalgic desire to regain the lost object of a better past, or the mournful desire to bring to life an absent love, these are the unwelcome memories which the subject would willingly exchange for oblivion. But the desire for forgetfulness is sabotaged by their menacing return. The intellectual will to forget is thwarted by the bodily presence of the past. Here, it is not the remembering that is the object of desire, but the forgetting. There is no term to connote the direct opposite of 'nostalgia': the desire to flee, rather than to return. Bodily memories linger long after their departure is required. Like the scars that become permanent reminders of the tissues below the skin, these bodily memories mediate against a complete forgetting.

But is there not a nostalgia at work here too, a nostalgia for the time when my body had a less obtrusive presence in my consciousness? Am I yearning for the familiar comfort of a separation between 'mind' and 'body', despite all the claims of its undesirability?⁵ Is this not a desire to return to the golden age when my body was expected to look after itself, when the workings of its interior rarely came to mind? For the 'bodily presence' following cancer has brought with it not only the internal iconography of horror, but the terror of imminent death. This constant awareness of physicality is accompanied by the knowledge of its fragility. Thoughts of mortality send regular shock waves down the spine with a force that was previously kept at bay. A constant companion that I would willingly forego. This nostalgia is for the paradisaical time I now imagine before the diagnosis when the intense physicality of bodily interiors was seldom contemplated and when death was less easily imaginable. In the narratives I tell myself (and that I relate here) I have constructed a mythic past for which I yearn: an age of innocence and immortality.

BODIES OF KNOWLEDGE

When I described the strange sensation of having seen my bodily interior to a friend she told me I had internalised the 'medical gaze'. Many Foucauldians would agree with her (see Chapter 2). The medical gaze refers to the construction of the body as an object of visual scrutiny within medical science which Foucault, and many others since, have documented.⁶ According to these arguments, the development of modern science has meant that human bodies have become increasingly defined as the space in which 'organs and eyes meet', as Foucault describes it. The medical expert has defined his authority to diagnose and to treat through an ability to isolate symptoms, to attach them to organs and tissues and to see disease as an exclusively physical manifestation in one individual. In this context patients have come to be seen, and to see themselves, as *objects* of medical investigation. Foucault characterises this relationship between the doctor and the patient, 'this unique dialogue' (1973:xiv), as a 'simple, unconceptualized confrontation of a gaze and a face, or a glance and a silent body; a sort of contact . . . by which two living individuals are "trapped" in a common, but non-reciprocal situation' (Foucault, 1973:xv). Thus, one is not only aware of one's status as 'object', as the patient's bed becomes a field of 'scientific investigation' (Foucault, 1973:xv), but, also, one is simultaneously the subject of this biomedical discourse, objectifying oneself.

Much as I may have yearned for a time when my ability to ignore the physicality of my bodily interior felt like a freedom, there are equally compelling arguments that designate this Cartesian construction of a separated mind and body as deeply problematic. Feminist scholars in

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particular have objected to this distinction and its gendered associations and to the ways in which women have been ascribed the position of 'body' within a hierarchical dualism. But perhaps my desire to escape the constant awareness of the physicality of my body might be read as a refusal of precisely the ascription of 'woman as body'. It is in the context of this ongoing debate about the significance of bodily subjectivity to ideas about gender that this chapter addresses the competing definitions of 'mind' and 'body' within biomedical and self-health discourses.

What Foucault failed to point out, as in so many of his accounts of the operations of power/knowledge relations in the contemporary professions (medicine, psychiatry, the penal system), was that this 'non-reciprocal' exchange between doctor and patient takes place within the context of other power imbalances, variously inscribed, if always contested, in cultural practices and processes: for example, inequalities of race, class or gender.⁷ The production of the basis for scientific knowledge about the body, for example, took place in eighteenth-century colonial Europe, and thus we might situate Foucault's account of the invasion of the 'dark' mysteries of the body by science in the context of an aggressive colonial desire to dominate and control not only the unknown territory of the human body, but also that of non-European cultures (Turner, 1984, 1987). The triumph of rational discourse, with its expression of 'man's' desire to control the so-called natural world, then, belongs to a larger Enlightenment project of White supremacy, accompanying the imposition of Western medicine on non-Western cultures (Picone, 1989). Similarly, the encoding and legitimisation of certain professional practices, such as those of medicine, are tied into the developments of industrial capitalism which enabled the middle classes to consolidate their authority in the public sphere. The specialization of certain kinds of knowledge and its concentration in the hands of a small elite took place in the context of the establishment of particular distinctions between different classes of people.⁸ The perpetuation of the exclusive ownership of these specialist knowledges and practices by middle-class minorities might be seen, then, to be integral to the development of biomedicine (Stacey, 1988).

Feminist readings of the history of biomedicine highlight the ways in which the clinical gaze, described by Foucault, are so typically those of the male professional whose object is the female body (Daly, 1979). Accounts of this history have documented the ways in which the development of some aspects of biomedicine meant a usurping of conventional female forms of knowledge, such as midwifery, by masculine, and often alienating, practices, such as those of obstetrics.⁹ These critiques have focused on the forms of medical knowledge produced, as well as the composition of the medical professions (Witz, 1992).

Thus, the masculinisation of medical knowledge refers to both the endowment of men with status and authority, but also the privileging of discourses of rationality, objectivity and progress within medicine. These have themselves been seen as central to the patriarchal project of controlling nature, and thus, according to its own construction, women. The Enlightenment project, at the heart of which has been the discourse of scientific discovery, progress and development, has been seen as a profoundly masculine, colonialist one. This overwhelming drive to see, to name and to know, which characterised the development of biomedicine, has been connected to a wider system of control and domination. Science and biomedicine have been criticised by feminists for the ways in which they legitimate masculine forms of knowledge about the female body through their claims to neutrality which ignore the power relations of medical practice (Ehrenreich and English, 1974; Dreifus, 1977; Graham, 1984; Keller, 1985; Birke, 1986; Turner, 1987; Oakley, 1993; Doyal, 1994).

Since the 1970s women's health movements have sought to engender confidence in women to develop a knowledge of their own bodies. Books such as *Our Bodies, Ourselves* (Phillips and Rakusen, 1978) represented an intervention which aimed to demystify biomedical knowledge, and to supplement it, or even replace it, with information culled from women's health groups. Medical interventions and interpretations have increasingly been viewed with scepticism and women have tried to refuse the medical gaze, making decisions about how to treat their illnesses based on a number of sources of information, only one of which might be that of the biomedical experts. As well as the challenge to the macrostructures of biomedicine, and to the forms of knowledge it produces, feminism has also facilitated intervention at the micro-level. The often humiliating and degrading examination procedures carried out by the mainly male medical profession and the patronising attitudes to patients have also been criticised. In particular, the women's health movement has encouraged female patients to develop a sense of entitlement to accessible information about their bodies, and to reclaim a sense of control over decision-making about procedures. Rather than obediently following the instructions of doctors and consultants, many female patients have been encouraged to ask questions, to find out more before accepting the doctor's recommendation, or to pursue alternative courses of treatment in preference to biomedical ones. Thus, doctors' diagnoses, prescriptions and recommended treatments have been viewed by some female patients as only one amongst many sources of advice, rather than as the definitive authority. This relativising politics has enabled many women to resist the passivity and alienation of the patient role, and to combat their

dependency on the masculine medical profession (Hepburn and Gutierrez, 1988; White, 1990; Hockey, 1993).

The impersonal and detached methods of communication employed within biomedicine have been criticised by feminists for the ways in which they reinforce the conventional notion of masculinity as 'rational' and femininity as 'emotional'. The procedures of communication are as much a part of the objectifying medical gaze as the forms of physical examination (Oakley, 1993; Gabe *et al.*, 1994).

THE DIAGNOSIS

After surgery for an ovarian cyst I keep vomiting for several days.

Why am I still being sick? Doesn't the anaesthetic usually wear off faster than this?

Eventually I am told they've taken a biopsy of the bowel.

As in all good narratives, each answer leads to a new question.

Why does a bowel biopsy produce continued vomiting?

The bowel is a very sensitive organ and stops working if it is interfered with. Vomiting is quite a common response.

And why have they taken a biopsy of the bowel?

To do some tests.

What tests, no one will say. I am baffled.

The director of the hospital pokes his head around the curtain which surrounds my bed on the surgical ward. Unannounced, he robs me of my fragile privacy. He is the one I most dread dealing with. I saw him on my first visit to the ward. Mobile phone in hand, exuding paternalistic pride and arrogance, he had sped through this ward full of women recovering from hysterectomies, calling out to them one by one at the top of his voice to ask if they had 'passed wind' yet (a crucial sign of recovery after such surgery, I was later informed).

I am throwing up as he enters. Ignoring this he announces casually:

You won't need further surgery but you may need further treatment. You've only got one child, haven't you? So we shall try and preserve your fertility in case you want another.

I don't have any children, I inform him.

Have one of mine, I've got too many.

And with this generous offer which amuses him enormously, he leaves.

I am puzzled. I am not aware that there is any possibility of needing further treatment. What could this piece of information mean? My head and my stomach spin. Waves of nausea are now accompanied by waves of panic and confusion.

Desperate to find out more, I ask for the doctor who performed the emergency surgery. Unlike her self-important boss, she sits down and at least pretends to have the time to talk to me. Though reluctant, she gradually lets slip a few more clues. I press her for an explanation. I may indeed need further treatment, she confirms.

What kind? I ask, genuinely – incredibly – ignorant.

She hesitates and resents being put on the spot.

Chemotherapy, she replies eventually.

There is a moment or so's pause while the name of the treatment connects to the disease in my mind. A sudden shudder passes through my body as the realisation hits me.

Do you mean I may have cancer?

We're testing to see if the cyst was benign or malignant. I'm sorry. We've had to take biopsies from various organs to check – bowel, the other ovary and so on. The cyst looked a bit nasty, but I can't tell you until the tests come back. You may need three months' chemotherapy. The test results will be back in a couple of days. She leaves.

I am left with the news. Alone, but surrounded by strangers. I don't think they planned it this way. I don't think they planned it at all. Perhaps that's the problem.

But the nurses are furious. They had plans. They had plans to keep it quiet until more definite news came. They are agitated. This unexpected revelation by a doctor has thrown them off course; they are left to deal with the fall-out. They mutter to one another under their breath.

I just make it down to the toilets; trailing the drip, hand on wound, surgical stockings on both legs. Away from those twenty or so strangers in front of whom I have just been given the worst news I could imagine. I look at myself in the mirror. Is this what a person with cancer looks like? Why do I expect a visible difference?

It's benign, it's malignant, it's benign. It must be benign. I am desperate to know more, but don't even know which questions to ask.

The next day I am still vomiting, so they decide to put a tube down my nose to suck up what is in my stomach. They push it down, I gag with each centimetre. I lie there waiting for them to bring it back up, but they tell me it will be left there for a few days. Surely not. My throat feels like I've swallowed a large chicken bone. Surely not. Not a few days! The temporary measure becomes a semi-permanent fixture.

I can't sleep because every time I swallow, I wake up. It's benign, it's malignant, it's benign. It must be benign.

The next day we all wait. And wait. At least I am not alone by this

time. I am prepared. Finally the doctor arrives. The results . . . won't be ready until tomorrow, she tells me. An endless deferral. The head of the hospital appears at the end of my bed and boasts of how many times he's had a tube like that inserted into his nose and stomach in demonstrations to medical students. We are all suitably impressed.

After two long days and nights of waiting, suddenly an entourage arrives unannounced. Where was the fanfare? They are all dressed up, dressed for a dinner party - bright colours, shiny materials, spruced hair-dos. There are about six or seven people round my bed all dressed in suits. At the back, the junior doctors; in front, the them, the two (women) surgeons who had performed the operation; in front, the consultant. He is wearing a bright red silk tie. I have never met him before as he's been away on holiday. He steps forward slightly from his team; surely he isn't going to tell me the results in front of this audience?

I'm sure you have a thousand questions, but it's best for you to wait and ask Dr M, he announces nervously, avoiding my eye. A pause. The team observes how the patient is taking it.

Are you telling me I have cancer? (By chance I know that Dr. M is the cancer specialist.)

Oh yes, it's malignant.

Their faces all stare down at me. How am I going to react? Am I going to burst into tears and precipitate their flurried exit? If there are tears, nurses can take over. Their tension shows through their sympathetic looks. What is the purpose of this bizarre gathering? Is it some kind of medical ritual? Have they all been invited to witness a 'cancer diagnosis'?

Aren't I a bit young to have cancer? I ask. This is all I could think to say.

No, 32 is quite a typical age for a teratoma.

After the dinner-party group leave, nurses rush in and tell me to think positively. What on earth might that mean under such circumstances? What it means is don't cry, don't get upset. Perhaps a quiet tear or two, but no sobbing please, it'll upset the other patients. And be heroic, be brave (be a man?).

I have to wait for four days to see the oncologist. Friends bring in as much literature on cancer as they can find. I have to be better prepared for the next encounter than for the last. 'Aren't I bit young?' really isn't good enough. I read and read. I feel as if I am taking an exam. Dr M, I am told, is an exceptional consultant and treats people like intelligent human beings. Does such a consultant exist, I wonder?

MECHANISED BODIES

The story of my diagnosis is retold here to exemplify some of the limits of biomedicine. In particular, it highlights the insensitivity of biomedical practices to the needs of the patient, other than those of the physical body. In these exchanges my emotional response to the

diagnosis of cancer is so deeply feared, and anticipated as so inappropriate to the hospital context, that the consultant blocked out the feelings of the patient in favour of his own emotional needs. These chosen forms of communication demonstrate clearly that the patient is viewed simply as a body with a disease. Why didn't one doctor sit down and explain the situation to me? Why didn't the consultant come alone to convey the bad news? Safety in numbers? Why had it been impossible for any of the medical staff to utter the name of the disease I had? In such a context, the patient often suffers because of the medical profession's inability to process their own emotions; in the case of the female patient and the male doctor, women are once again obliged to facilitate, to cover for, men's emotional ineptitude:

Biomedicine was founded on a Cartesian division of man into a soulless mortal machine capable of mechanistic explanation and manipulation, and a bodyless soul, immortal, immaterial, and properly subject to religious authority, but largely unnecessary to account for physical disease and healing.

(Kirmayer, 1988:57)

In conventional medicine, illness is understood as an exclusively bodily process and the body is typically constructed as 'a biochemical machine' (Kirmayer, 1988:57). Following Descartes, this model separates not only the body from the mind, but also the 'body from its environment' (Stacey, 1988:163). As Andrew Ross argues:

The professionals' bad attitude is often caricatured in the following way: biomedicine sees and treats the body as a functional machine that occasionally breaks down, and for whose dysfunctions a physical cause and remedy can always be found by the repairman, the doctor.

(Ross, 1991:50)

As has been argued in medical anthropology (Taussig, 1980; Scheper-Hughes and Lock, 1986; DiGiacomo, 1992), the 'reification of illness as organic disease' in biomedicine can be criticised for its dehumanising effect on the patient (DiGiacomo, 1992:120). Doctors' metonymic references to patients as their illnesses ('this is the teratoma I told you about') reduces the patient's identity to a set of physical symptoms and alienates them from the medical process. Such an approach to patients exemplifies the extent of the biomedical belief in the autonomy of the body: a 'singular premise guiding Western science and clinical medicine . . . is its commitment to a fundamental opposition between spirit and matter, mind and body, and (underlying this) real and unreal'

(Scheper-Hughes and Lock, 1987:8). Furthermore, this philosophy derives from an essentialist 'atomism' which extracts parts from the whole and, decontextualised, ascribes them meaning as things in themselves. Patients are left behind in this process in which their physical symptoms replace them and become the sum of their identities (Gordon, 1988:26) (see Figures 4.1 and 4.2). Processes of biomedical 'reification' read biological signs as having no cultural meaning, and furthermore, according to Taussig (1980), reinforce the ideological needs of the social order.

It is against these myopias of biomedicine that many alternative and self-health therapies have defined themselves. Above all, they have offered the patient the possibility of being regarded as more than just a set of bodily parts and symptoms. Indeed, when I visited the Bristol Cancer Help Clinic, it was with the most profound sense of relief that I responded to the doctor's request to tell her 'the whole story of the illness, including how [I] had felt at each stage'. In this and other such narrativisations, I found the possibility of bridging the gulf between body and emotion which had been established in the biomedical context. In general, alternative and self-health medicines have developed techniques and practices which attempt to rewrite the story of illnesses according to a different set of conventions from those employed within biomedicine. Most patients, like me, come to these alternative medicines having experienced the objectifying medical gaze and its alienating effects. Many of these approaches to health and healing claim to overcome the mind/body dualism which lies at the heart of Western medicine and, in their view, is one of the central causes of its limited effects. Biomedicine has yet to find a cure for cancer, it is claimed, precisely because it treats the body in isolation from other aspects of the self which are seen as equally important in the production of disease.

In this respect, these challenges coincide with feminist criticisms of the separation of the body from the emotions in Western biomedicine. The privileging of the concrete, the observable, the quantifiable is seen to be integral to a hierarchical value system in which the feminine has been defined as opposite, and inferior, to these qualities. Furthermore, these belief systems have been criticised for producing degrading and depersonalised doctor/patient exchanges, and medical practices in general. In this respect feminist interventions and alternative medicine share the common goal of redressing the imbalance created by patriarchal biomedicine. As Ross highlights:

in recent years, the legitimacy of medical professionals has been further eroded, as popular consciousness absorbs the more general social critique of biomedicine's 'inhumanity' and lack of

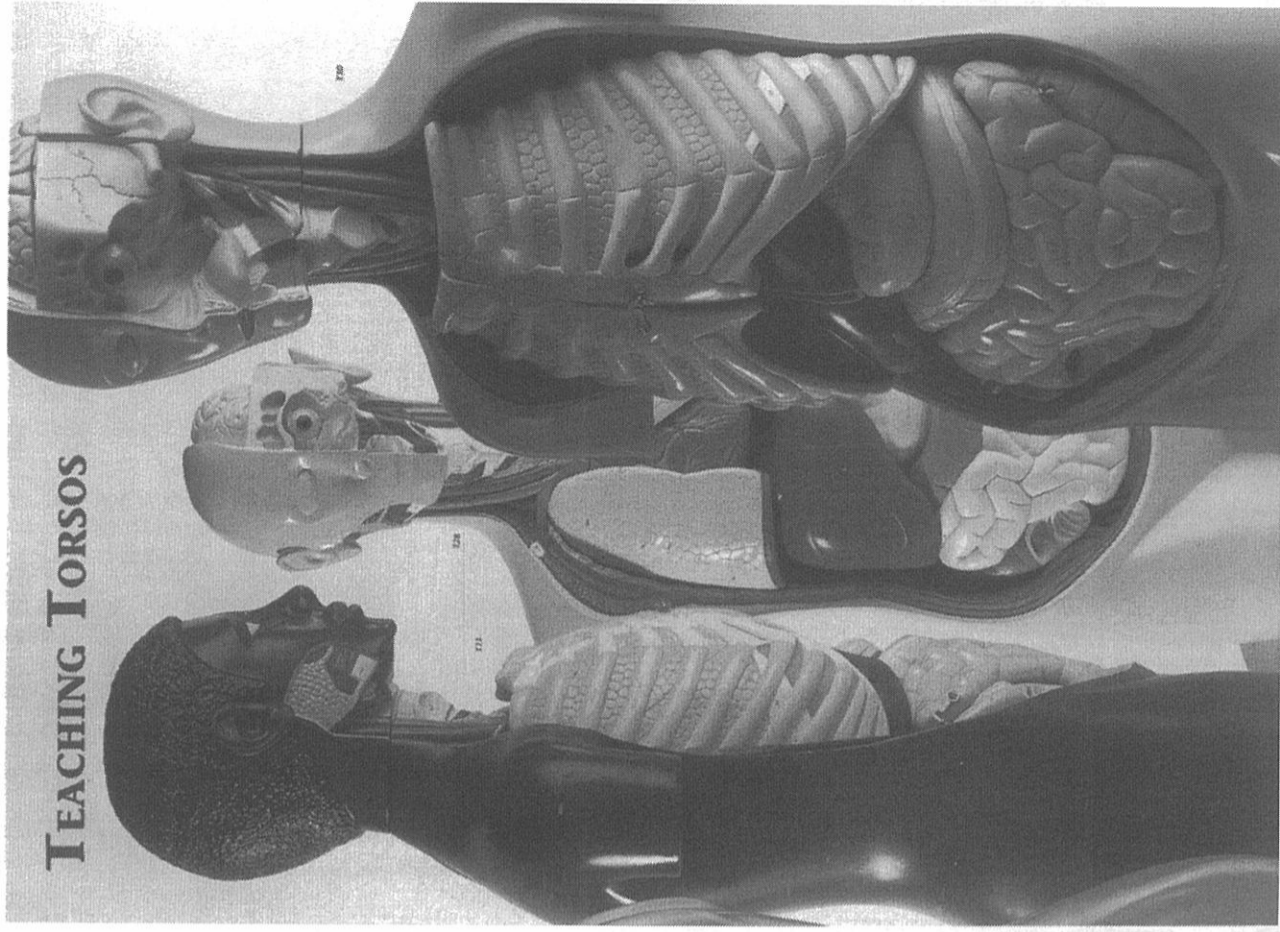


Figure 4.1 *Sharing the Knowledge Medical Teaching Catalogue*
Source: Denoyer Geppert International, 1995/6:9



Figure 4.2 *Sharing the Knowledge Medical Teaching Catalogue*
 Source: Denoyer Geppert International, 1995/6:11

caring for the patient. In a profession where the orthodox faith in the (large) technology fix has often led to consequences 'worse than the disease', the multitude of alternative health therapies (the women's alternative healthcare movement, for example) has made big inroads.

(Ross, 1991:50)

Many of the 'cure yourself of cancer' books depend heavily on certain aspects of alternative health philosophy. The self-health literature on cancer advocates a wider embrace, a more humanistic approach to cancer care, and an acknowledgement of 'the person inside the body'. But to what extent do these alternative and self-health practices overcome the mind/body dualism of biomedicine? And, furthermore, how compatible are they with the goals of feminism?

MINDFUL BODIES

As I emphasised in Chapter 1, there are numerous dimensions to alternative medicine, and enormous diversity and disagreements between the many different practices included in such a general category. These tend to get lost in blanket charges levelled against them, such as their individualism, essentialism or complicity with New Right discourses of personal responsibility (see Chapter 7, this volume; Coward, 1989; Wilkinson and Kitzing, 1994). In what follows I am not suggesting that all forms of alternative therapy depend upon the same premises in their treatment of cancer; however, certain discourses about the mind/body relationship repeatedly recur in the self-health literature on cancer which do not overcome the dualisms of Western medicine in the way they claim to. For example, many alternative approaches to cancer evoke a rhetoric of 'Eastern' belief systems, such as traditional Chinese medicine; but they nevertheless continue to rely on the conventional mind/body dualism in their notions of causality (the mind causes bodily decline), whereas in the original Chinese conceptualisation, the body was understood quite differently from the mechanical Western model (see Elvin, 1989).

Many alternatives to biomedicine shift the emphasis away from medical technology as the solution to the disease and towards the internal self as the source of healing:

Natural/Alternative/Complementary Therapy covers an endless range of techniques, all of which help to remove the cause of 'dis/ease'. They affect the whole person, mind, body, spirit, stimulating a person's intrinsic ability to heal themselves.

(Editorial, *The Well Newsletter*, 1993:2)

Thus, rather than being the passive recipient of medical technologies, the patient is encouraged to participate in her/his own healing. Based on this 'amateurist principle' (Ross, 1991), these therapies supposedly demystify the powers of the professional and democratise the processes of healing. It is with the operations of these 'psychotechnologies' (Ross, 1991) in relation to cancer that I am particularly concerned. This term refers to the shift away from the conventional technologies of biomedicine towards a view of the self (especially the psychological self) as a 'technology' of healing. My examples in the following section are drawn from an early, formative text on self-health (Simonton *et al.*, 1978). Although this is clearly not the most up-to-date example, I return to this work as it informs so many other more recent publications on cancer that I came across during my illness, and its models continue to inform many alternative and self-health practices which I encountered during that time (Brohn, 1987a, 1987b; Charles, 1990).¹⁰

It is no longer possible to see the body as an object waiting for replacement parts from the factory. Instead we now view the mind and body as an integrated system.

The real issue is no longer *whether* the mind and emotions affect the course of treatment; the question is rather *how* to direct them most effectively in support of it.

(Simonton *et al.*, 1978:31-2, 89)

This example demonstrates a classic slippage in the discourses of self-health in so far as the mind refers to the emotions rather than to the intellect. What is emphasised throughout such accounts of cancer is that certain feelings, and, more important, certain (inappropriate) ways of dealing with feelings, can contribute to the onset of cancer. Biomedicine is criticised for its privileging of the body at the expense of the mind. At the heart of the Simonton model, for example, is the inclusion of emotions in the health equation:

It is our central premise that an illness is not purely a physical problem but rather a problem of the whole person, that it includes not only body but mind and emotions. We believe that emotional and mental states play a significant role both in *susceptibility* to disease, including cancer, and in *recovery* from all disease.

(Simonton *et al.*, 1978:10)

What is referred to here as the 'mind' is actually the physiological processes through which emotions are processed in the body. In their model of cancer development, for example, feelings of despair, resulting from stress, are processed by 'the limbic system' (the visceral brain)

which records stress and its effects. This is then passed on by 'the hypothalamus' (an area of the brain which receives messages from the limbic system and passes them on to the pituitary gland and endocrine system), which triggers a hormonal imbalance in the body and suppresses the immune system, leaving the body susceptible to the growth of abnormal cells. This chain reaction of the physical effects of emotional states is summed up in Figure 4.3:

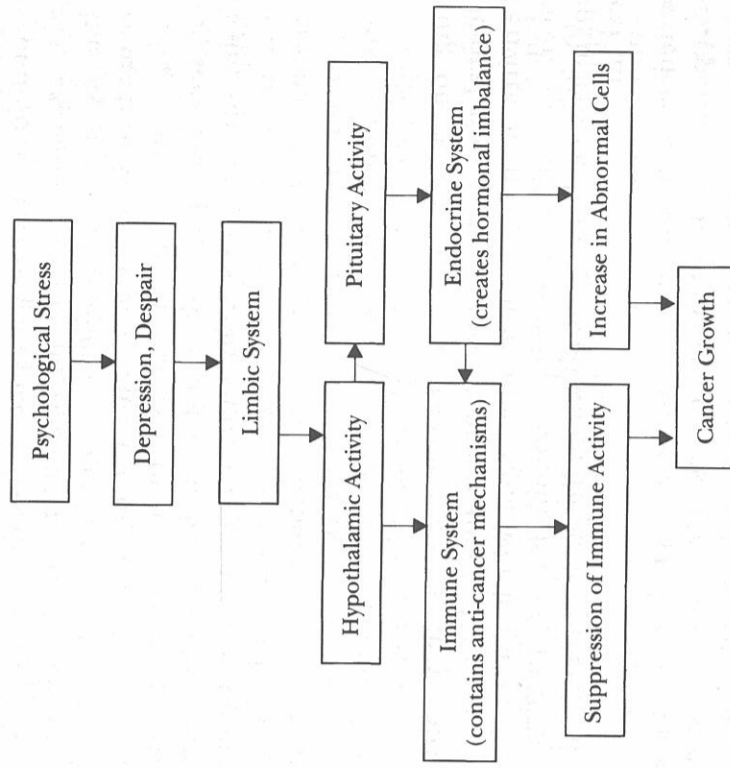


Figure 4.3 A mind/body model of cancer development
Source: Simonton *et al.*, 1978: 92

The Simontons rely heavily on previous medical studies of cancer (as well as on their own experience of treating patients at their clinic) to substantiate their claims. Hans Selye (1956), for example, is cited as a medical authority whose research proves the physical effects of stress on the body. He identified the damaging effects of the hormones produced by stress (often stimulated by our inability to follow what is called our fight-or-flee 'instinct' because of the 'unnatural' requirements of modern life). More importantly, according to the Simontons, he 'discovered that chronic stress suppresses the immune system which is responsible for engulfing and destroying cancerous cells or alien micro-organisms' (Simonton *et al.*, 1978:53). Bathrop (1977) is

cited for his claims that bereavement weakens the effectiveness of the immune system (Simonton *et al.*, 1978:53). J. H. Humphrey and associates (1977), they argue, have demonstrated that the body's immunity to TB can be affected by hypnotic suggestion. Finally, George Solomon is drawn upon to prove the empirical connection between the 'hypothalamus' and the immune system (Solomon, 1969). (All cited in Simonton *et al.*, 1978: 53-4.)

The supposed causative connection between emotional states and the physical conditions under which cancer cells can begin to proliferate is extended to explain why cancer might occur in some people and not in others. It is the individual's ability, or rather lack of it, to cope with the stresses of modern life which determine whether or not they will develop cancer. Thus cancer, it is argued, is actually a symptom (indeed a metaphor; see Chapter 2) of the problems which exist elsewhere in the patient's life; furthermore, certain kinds of reactions to stress are likely to result in the growth of a malignant tumour and particular types of people are more likely to produce such reactions. The cancer patient, according to this model, probably had a series of stresses between six and eighteen months prior to their illness and responded to these problems with 'a deep sense of hopelessness' (Simonton *et al.*, 1978:10).

Drawing on various studies of cancer patients, they construct a psychological profile of a typical cancer patient. A suitable psychological environment is produced, they argue, which, rather than causing cancer, 'permits' it to 'develop' (Simonton *et al.*, 1978:75). Their five steps in a psychological process which frequently precedes the onset of cancer include:

Experiences in childhood result in decisions to become a certain kind of person . . . the individual is rocked by a cluster of stressful life events . . . these stresses create a problem with which the individual does not know how to deal . . . the individual sees no way of changing the rules about how he or she must act and so feels trapped and helpless to resolve the problem . . . the individual puts distance between himself or herself and the problem, becoming static, unchanging, rigid.

(Simonton *et al.*, 1978:72-5)

The resulting 'deep sense of hopelessness', 'triggers a set of physiological responses that suppress the body's natural defences' and make it susceptible to the production of abnormal cells (Simonton *et al.*, 1978:10). Thus, a causative relationship is suggested between emotions and the physical ability to fight disease.

This connection between psychological types and cancer, the Simontons claim, is something which has been observed for centuries. 'Writing nearly two thousand years ago in the second century A. D., the

physician Galen observed that cheerful women were less prone to cancer than were women of a depressed nature' (Simonton *et al.*, 1978:57). Similarly, A. H. Schmale and H. Iker observed a 'sense of hopeless frustration surrounding a conflict for which there was no resolution' in their female cancer patients which led them to develop a 'helplessness-prone personality type' with which they achieved a 73 per cent accuracy rate in their prediction of the development of cancer (Simonton *et al.*, 1978:65-6). This personality type can be traced back to a past history in which the patient(s) had 'experienced a lack of closeness with their parents, seldom demonstrated strong emotions and were generally low gear' (Simonton *et al.*, 1978:65). Traumas, such as bereavements, are also seen to spark off this emotional chain reaction, especially if the emotions of loss or guilt are not expressed. Elida Evans, a Jungian psychoanalyst, for example, is cited for her conclusions that many cancer patients had lost an important emotional relationship before the onset of cancer:

[they] had invested their identity in one individual object or role (a person, a job, a home) rather than developing their own individuality. When the object or role was threatened or removed, such patients were thrown back on themselves, with few internal resources for coping.

(Simonton *et al.*, 1978:62)

The model of the cancer personality type is to be found either implicitly or explicitly in much of the self-health literature on cancer. In particular, the arguments of Lawrence LeShan (1966, 1977) form the basis for many of the hypotheses. His work is not only central to the Simonton analysis, but also to many other studies, such as Rachel Charles's *Mind, Body and Immunity* (1990). LeShan argued that 76 per cent of cancer patients (as opposed to only 10 per cent of the non-cancer control group) displayed the same four components in their life histories: isolated youth; significant relationship in early adulthood became the centre of their life; loss of this relationship; resulting despair which was kept 'bottled up'. People who are 'dutiful, sweet-natured, obliging on the surface with a secret desperation underneath' and who have a 'total inability to express anger' are seen as those most prone to cancer (Charles, 1990:46). Charles offers a series of magazine-style personality tests and charts against which readers can measure themselves in her chapter, 'How healthy is your personality?' What the cancer patient needs to counteract these negative patterns, according to Charles, is a holistic approach to healing:

this process involves you looking deep within yourself. It means considering your personality, your emotions, your values and your lifestyle, as well as the more practical aspects of diet and exercise.

It takes a great deal of courage to do this. There may be very good reasons why you need to be ill. If you become glowingly healthy, who will care for you then? It is a road towards self-acceptance, self-knowledge and yes, most especially self-love.

(Charles, 1990:5)

This prescription of love, laughter and self-realisation is again backed up with scientific evidence of the effect of emotional states on the immune system. Charles claims that 'laughter affects the immune system', using Norman Cousins (1981) as the example of the 'man who laughed his way back to health', and she offers the reader a chart to fill in to test their 'laughter quotient' (Charles, 1990:81-2). The healing quality of love is also appealed to. Even watching films about love is said to enhance the immune system; Charles also cites two Harvard psychologists, McClelland and Kirshuit, who discovered that people's immunoglobulin A could be raised in such a way (Charles, 1990:68). In addition to these external benefits, the patient also needs to develop through counselling in order to gain the confidence to become a person who is truer to themselves and less concerned about the needs of others. According to Charles, the effects of counselling have also been shown to improve immunity (Charles, 1990:69). Another holistic advocate, Ian Pearce, recommends deep relaxation, visualisation and counselling as the path away from helplessness and hopelessness towards self-healing (Pearce, 1983:9).

The consensus within these 'psychotechnologies' is thus that the cancer patient's mental attitude is crucial to understanding the onset of their illness and to the possibility of their recovery. Indeed, the patient's beliefs about her/himself are seen to play a formative role in the development of the disease. However, I should stress that not all self-health approaches assume that everyone 'who gets cancer is covering up some inner pain and suffering'; according to Penny Brohn (co-founder of the Bristol Cancer Help Clinic, and ex-cancer patient), 'mental and emotional stress is not an automatic precursor to the development of cancer' (Brohn, 1987b:85-6). Rather, she argues that if someone believes that their psychological state *has* contributed to their illness, then a holistic approach facilitates their exploration of this connection, whereas biomedicine does not. She cites the case of a female patient at Bristol who believed that her guilt and anxiety concerning her anorexic daughter 'was the reason behind her cancer'. Anticipating the usual criticism, Brohn insists: 'I shall repeat many times that the issue in such a case is not whether this woman was right about any of this, but that she *believed* she was right' (Brohn, 1987b:85).

These, then, are some of the central discourses of the relationship between the mind and the body that continue to inform self-health

cancer practices and literatures. Unlike biomedicine, these 'psychotechnologies' represent bodily modalities which incorporate feelings and emotional responses, both in terms of the cause and effect of the illness. According to several of these accounts, the fertile ground for the onset of cancer is provided by the destructive impact of stress, trauma and loss on the body of the patient. Similarly, the discharge of this distress, together with an exploration of its place in the patient's history and the impact of the illness on their life, are seen to aid recovery, as the new-found mental state impacts upon the damaged body. What is of particular concern is the effect of the build-up of unexpressed or unresolved emotions on the functioning of the immune system. In this 'hydrosomatic' representation of the body, the emotional pressure builds up and must be released to avoid bodily damage. Thus, cancer, and indeed illness in general, is seen as 'psychosomatic' in so far as the mind and the body are interconnecting systems, whose harmony depends upon the well-being of each.

The popularisation of certain psychoanalytic concepts, such as 'psychosomatic', is part of an emergent common-sense discourse about health and illness in contemporary culture. Many of these concepts can be traced through a history of psychoanalytic thought which investigated the relationship between psyche and soma from Freud and Breuer (1893-5) onwards. More specifically, some of these accounts take their cues, and indeed, their evidence, from psychoanalytic writings about the meaning of modern illness. Psychoanalysts, like Groddeck (1923) and Reich (1975), have sought to investigate the cultural meaning of cancer, rather than accepting its 'organic' presentation as a purely biological phenomenon. Indeed, Reich sought to explain Freud's own cancer of the jaw, for example, in terms of 'his unhappy personal life and his repression of emotion' (Turner, 1984:238); he believed that Freud smoked heavily because 'he wanted to say something that never came out of his lips' (Reich, quoted in Turner, 1984:238). Thus, Freud's bitten-back emotions found an outlet in the cancer through which he 'chose' to express them, Reich argued. Groddeck also saw cancer as a symbol of repressed emotions and desires (Turner, 1984:238). In this context, the body is read as the cultural map of the psyche. Bodily memories are seen to threaten the health of the person by holding trauma or tension within the body. Thus disease is the bodily expression of the distress that could not be fully forgotten.

SOMATISED PSYCHES

Psychoanalysis is clearly a key source of ideas about the mind/body relationship in alternative approaches to cancer, but how closely do the discourses of these contemporary psychotechnologies resemble those

original *Studies in Hysteria* (1893-5), in which Freud and Breuer developed the basic theory of somatisation - the process whereby the psychic trauma manifests itself as a physical symptom? Although his work with Breuer is among some of Freud's earliest, and about which he changed his mind in later years, it nevertheless contains many of the central premises of psychoanalysis in their embryonic forms, later extended to explain other human neuroses. This work is particularly relevant here, since its concern centres upon the mental causes of some physical illnesses and returns us to the relationship between memory, trauma and disease with which I began the chapter.

Breuer and Freud claim that hysteria is prompted by external events.¹¹ While the symptoms are ostensibly spontaneous, their origin can be traced back to a precipitating trauma; while appearing idiopathic (primary, and not related to another disease), on closer examination, these symptoms prove to be connected to a previous, and unknown, event. They claim to have found a causal relation between psychic trauma and hysterical symptom, and they explain this through the mechanisms of repression and conversion. Repression is the process by which certain 'incompatible' or 'unacceptable' desires and wishes are forced out of the ego's consciousness and restricted to the unconscious region of the mind. In the case of hysteria the repressed memory of the trauma manifests itself in the physical symptom: 'the memory of the trauma . . . acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work' (Breuer and Freud, 1893-5:56-7). Hysteria is thus a method of defence through which 'excitation' is converted into 'a somatic innervation' (Breuer and Freud, 1893-5:187). Once the memory of the trauma is brought to consciousness and verbalised, through hypnosis or free association, the symptoms, it is claimed, disappear immediately (Breuer and Freud, 1893-5:57). Within the category of hysterical symptoms, they include neuralgias, anaesthesias, paralyses, epileptoid convulsions, chronic vomiting, anorexia, hallucinations, contractures and tics (Breuer and Freud, 1893-5:54). Thus, it could be argued that hysterics 'suffer mainly from reminiscences' (Breuer and Freud, 1893-5:58) as the affect of the trauma attaches to the memory and is repressed into the unconscious, thus remaining hidden from the patient. In particular, this mechanism is set into play when the immediate effect of the trauma is not expressed (for example, tears not shed, revenge not taken), which may be because of social convention and expectation, because the patient is not in a state where it is possible to react directly, because the loss is irreparable and simply unbearable, or a combination of these internal and external factors (Breuer and Freud, 1893-5:61). Thus, 'the ideas which have become pathological have persisted with such freshness and affective strength because they have been denied the normal

wearing-away processes by means of abreaction and reproduction in states of uninhibited association' (Breuer and Freud, 1893-5:62).

Common to all hysterics, though in different forms, is the splitting of consciousness and the emergence of what Freud and Breuer call 'abnormal' (or hypnotic) 'states of consciousness' in which ideas 'are very intense but are cut off from associative communication with the rest of the content of consciousness' (Breuer and Freud, 1893-5:63). Depending on the form of hysteria the patient displays different processes and sequences of split consciousness. In the case of 'dispositional hysteria', these hypnotic states are already present before the onset of the illness, in which case 'they provide the soil in which the affect plants the pathogenic memory with its consequent somatic phenomena'; in those patients with 'psychically acquired hysteria', on the other hand, 'a splitting-off of groups of ideas' results from the effects of a severe trauma or a 'laborious suppression' (Breuer and Freud, 1893-5:63). Thus, two psychic groups can be seen to be present in the same mind; after a hysterical attack the patient returns to normal life and the two states co-exist. Just as memories are aroused spontaneously, so the hysterical attack will occur in a patient; just as memories can be jogged in normal consciousness, so the hysteric can be provoked into an attack by associations. This can be aroused either 'by stimulation of the hysterogenic zone or by a new experience' which resembles the pathogenic one; 'in both a hyperaesthetic memory is touched on' (Breuer and Freud, 1893-5:68).

These general characteristics of hysteria seem at first to bear a strong resemblance to some of those said to contribute to the onset of cancer in the contemporary self-health literature. Cancer patients might be seen within these discourses as the modern hysterics whose repressed feelings have gathered over the years and manifested themselves in a tumour in a vulnerable (and highly symbolic) part of their bodies. Both sets of explanations share a belief in the damaging nature of unexpressed emotions; both assert the significance of early trauma on adult illness; and both ascribe pathogenic qualities to ideas and feelings. Finally, the possibility of recovery is asserted in each case with the correct work on the psyche with the help of a professional therapist (although in some alternative cancer literature you are invited to be your own therapist). In some senses, the hydraulic model of repressed feelings relentlessly seeking an outlet, which eventually manifests itself as physical disease, is common to both sets of practices. Even in the less mechanistic accounts where interpretative understanding replaces scientific explanation, they may seem to share a sort of hybrid 'bi hermeneutics' (Gellner, 1985), in which a patient's distress is seen in terms of 'the inexorable press of biological drives or the need for psychic energy to find an outlet' (Kirmayer, 1988:74).

However, these early psychoanalytic writings present contextuality, multi-causality and specificity rarely found in the self-health discourses on cancer. In their case studies Freud and Breuer demonstrate the circuitous route of their explanations of different patients' hysterical symptoms, and Freud suggests that 'it is not possible to assign the same origin to all the somatic symptoms of these patients' (Breuer and Freud, 1893-5:150-1). Furthermore, they do not claim that all physiological symptoms have a psychic origin. Even in relation to patients of hysteria, upon whom they base many of their theories of the psychosomatic character of some disease, there are some physiological symptoms. In the case of Frau Emmy von N., for example, Freud distinguishes emphatically between the psychosomatic symptoms and 'others of the patient's somatic symptoms' which 'were not of a hysterical nature at all ... but ... an organic disorder' (Breuer and Freud, 1893-5:156). In addition to the diversity of the origins of hysterical symptoms, and to the variation between psychosomatic and organic ones, Freud also adds the causal contributory influence of heredity (Breuer and Freud, 1893-5:163).

While insisting on the possibility of the somatic effect of a pathogenic idea which has been expelled from consciousness, Freud also warns against any assumption that there might be a *single* traumatic memory or a *single* pathogenic idea as its nucleus (Breuer and Freud, 1893-5:73). There are at least three different structures in which hysteria may present psychical material: a nucleus containing the memories of the trauma surrounded by a profusion of 'mnemonic material', 'groupings of similar memories' arranged in a linear sequence which share themes and are stratified concentrically around the nucleus, or an 'arrangement according to thought content, the linkage made by a logical thread which reaches as far as the nucleus and tends to take an irregular and twisting path, different in every case' (Freud, 1893-5:374-5).

Instead of the causal chain of relations between psyche and soma suggested in the model of Simonton *et al.* (1978), Charles (1990) and more extremely, Hay (1988, 1989) (see Chapter 2), Freud's case studies demonstrate the impossibility of interpreting symptoms as direct tropes of the mind. It is the presence and function of the mechanisms of repression and conversion which precisely prevent such a crude, metaphorical reading. It is the centrality of the unconscious to psychoanalytic theory that distinguishes it from models of illness which see the body as expressing a direct representation of psychic distress. Thus, what might begin as an act of volition ('I do not want to think about that') might have quite a different outcome from that desired by the subject. Freud argues that incompatible ideas are not annihilated by repudiation, as might be intended, but rather are forced into the unconscious and isolated psychically from the ego.

Thus, in their respective conclusions, Breuer and Freud state quite clearly:

[We do not believe] that they [hysterias] are all ideogenic, that is, determined by ideas. In this we differ from Moebius, who in 1888 proposed to define as hysterical all pathological phenomena that are caused by ideas.

(Breuer, 1893-5:260)

I should not like it to be wrongly thought that I do not wish to allow that hysteria is an independent neurotic affection, that I regard it merely as a psychical manifestation of anxiety neurosis and that I attribute to it 'ideogenic' symptoms only and am transferring the somatic symptoms (such as hysterogenic points and anaesthesias) to anxiety neurosis. Nothing of the sort.

(Freud, 1893-5:343)

What this excursion into late nineteenth-century theories of hysteria demonstrates, whatever is made of the theories and methods of these two doctors, is that the relationship between the mind and the body in the history of psychoanalytic thought problematises a simple, causal reading of physical symptoms as signs of psychic distress.¹² While highlighting the connections between the soma and psyche in categorising some diseases as 'ideogenic' and some ideas as 'pathogenic', Breuer and Freud both insist on the indirect and layered constitution of such relationships. Furthermore, through their focus on the role of memory and of the unconscious, they demonstrate the limits of the subject's conscious control and volition, emphasising instead the apparently 'irrational' and 'illogical' course of many illnesses:

In Freud, instincts had a goal and gave rise to much longer and more circumstantial accounts, as he pursued their migrations, their substitutions and the meshing of different aims or objects. It was now a complex circuit that had to be considered, and no longer a simple short shuttling between 'action' and 'reaction'.

(Starobinski, 1989:368)

THE BODY'S OTHER

Freud and Breuer's work can be located in a broader set of ongoing discourses about the meaning of the body and its relationship to other aspects of 'human existence'. If recent histories, or even 'fragments for histories', of the human body reveal anything, it is the extent to which the body has been so widely understood to signify something other than its material self (see Feher *et al.*, 1989, Parts One, Two and Three). The body has been read by historians and cultural theorists as a text of

political, moral, sexual, religious and aesthetic values and meanings in a multitude of fashions which cross-cut science and art, public and private.¹³ Histories of the body invariably represent histories of meaning systems in which the body is positioned through a shifting set of relationships, be it to the mind, the spirit, the soul, the personality, the psyche or the emotions. Thus, 'biohermeneutics' is not restricted to the psychoanalytic encounter, but rather permeates ancient, as well as contemporary, thought.

The discourses mapping the relationship of the psyche to the soma are preceded by those which produce a relationship of the soma to the soul; these have been traced back, if rather unevenly, to classical cultures. Plato, for example, posited two models: both a 'soul of celestial origin imprisoned – or even entombed in the body' and 'a soul as the source of motion that dominates the body that it moves' (Alliez and Feher, 1989:48). In ancient thought between the first century BC and the second century AD, there was increasing concern about the 'soul's control over the body it inhabits' as the role of 'pathos' became more central: the superior soul, housed in the mortal body, was under threat from somatic afflictions against which 'every respectable individual spent his life struggling' (Alliez and Feher, 1989:54). Thus the desire to protect one's soul from the body resulted in 'the care of the self' explored by Foucault in his later work on the history of sexuality (Foucault, 1990). In other philosophical writings, the body is also seen as opposed to the soul: 'according to Socrates, body and soul are already irrevocably separated, just as are the visible and the invisible, that which is destined to lose its identity and that which keeps it forever, the dissoluble and the indissoluble, the mortal and the divine' (Loraux, 1989:15).

The belief that the soul is temporarily housed in the body is one which extends beyond classical antiquity. From early modern times the soul has been seen to be not simply *located* in the body, but to be *reflected* in its formation. The body was thus considered to be the mirror of the soul. According to Patrizia Magli, Western thought has been fascinated by the paradox that, on the one hand, as Lacan has pointed out, the face is the most elusive of objects which defies permanent or stable fixing, and, on the other, the face is infinitely classified according to cultural codes of recognition. Magli argues that 'confronted with an ever-changing appearance, ancient physiognomists focused their investigations on an attempt to capture an immanent and univocal essence, and they did this by establishing norms through which to penetrate the secret behind the countenance' (Magli, 1989:87). 'Physiognomics' emerged as a 'pseudo-science', closely related to medicine, which constructed a typology of faces and features said to reveal truths about the soul, dating back in origin to around the fifth century

BC and sharing 'signs described by ancient physicians' (Magli, 1989:89). Derivative of *phusis* (nature) and *gnomon* (interpretation), physiognomics was said to enable knowledge of 'particular passions of the soul from the particular shape of the body' (della Porta, quoted in Magli, 1989:87). Based on beliefs about the meanings of certain codified equivalents, physiognomics established conventions of reading characteristics in the facial features such as 'hooked nose = greed, fleshy lips = sensuality' (Magli, 1989:89). These correlations are recognisable within contemporary discourses of racial stereotyping through which White culture has classified and subordinated its racial 'others'.¹⁴

What is significantly different in contemporary accounts that rely on the discourse of body types is that 'the soul' has been replaced by the notion of 'the personality'.¹⁵ Indeed, as we saw in the psychotechnologies of cancer prevention, it is increasingly the cancer personality type which is to blame for the illness, not the person's soul. Although the soul has been reintroduced within holistic approaches to self-health (mind, body and spirit) this is very different from the classical idea of the 'soul', which is rarely located as the source of physical decline.

This connection between the psyche and the soul is not simply one of historical sequence in the history of bodily discourses. Their connection is also, of course, etymological. The term 'psyche' is now commonly used in its psychoanalytic rather than its spiritual sense. However, it continues to be defined as 'soul', 'mind', 'spirit', 'beyond or apparently beyond the physical' (*Chambers Dictionary*, 1972: 1085). In Greek mythology 'Psyche' was, in fact, the personification of the soul. Hence the *psychic life* of a person signifies two quite different things within religious and psychoanalytic discourse. This confusion may seem quite apposite given the widespread influence of Freudian thinking on Western thought. Psychoanalysis has been called *the* twentieth-century religion, not only because its followers have so venerated its founder, or because any objection to it can be incorporated into its own self-justification (conscious resistance to it only confirms one's need for it), but because the inexplicable or destructive elements in Western experience tend now to be located within the 'dark depths' of the unconscious mind instead of the evil soul and the wider forces which control it.¹⁶ Thus, the relationship of the mind and body has been refigured in so far as the psyche has come to represent the twentieth-century soul in a Western 'godless' culture.

BODILY SENSATIONS

The gradual replacement of the concept of the soul with that of personality in medical discourse is evidenced in the history of the idea

of 'cenaesthesia' (the internal perception of our own body).¹⁷ Originally used in 1794, the term 'cenaesthesia' referred to the 'process by means of which the soul is informed of the state of its body, which occurs by means of the nerves generally distributed throughout the body' (Reil, quoted in Starobinski, 1989:355). Drawing on Descartes's tripartite categorisation of perception elaborated in *The Passions of the Soul*, Reil classifies three different organic apparatuses: the first is cenaesthesia, the second, 'sensation' ('excited by the senses and represents the world to the soul'), and the third, 'the activities which originate and are carried out integrally within the organ of the soul . . . by means of these . . . imagination and judgement are formed; the soul receives the representation of its powers, its ideas and its concepts, and is thus rendered conscious of itself' (Reil, quoted in Starobinski, 1989:355). This model formed the basis for a 'pathogenic classification' in which idiopathic, as well as general, disorders were seen to cause changes in cenaesthesia. In other words, the disruption of the senses within a person could affect their mental life. The brain might be sent misleading messages about the body, due to disturbances in the senses. Ailments characterised by problems in bodily representations included pica, bulimia, polydipsia, nymphomania and a host of other complaints previously classified within melancholia and hypochondria.

This 'sensualist' conception of mental life opened the way for a kind of 'imperialism of cenesthesia', according to Starobinski (1989:356-7). By the nineteenth century, however, any notion of the soul seems to have largely disappeared and instead the debate is continued within the discourses of the 'personality' in which cenaesthesia is seen as 'the source of all psychic life' (Starobinski, 1989:356-7). Ribot's immensely influential *Diseases of the Personality* (fifteen editions of which were published between 1883 and 1914) suggested that 'if mental life was determined by sensory activity, and if all sensory activity was made up of derivatives of the cenesthesia, then one could finish by asserting . . . that our personality resided entirely in the messages, partially unconscious, that derived from bodily life' (Starobinski, 1989:357). The personality within this conceptualisation, then, is a 'kaleidoscope phenomenon' due to 'fluctuation in bodily states' (Starobinski, 1989:357). Thus, according to Ribot, states of the body produce sensations which in turn produce a 'physical personality' and 'the ego exists only on the condition of continually changing' (Ribot, quoted in Starobinski, 1989:357).

What is significant in this historical interrogation of the category of cenaesthesia is the indication it gives of broader transformations within medical discourse. It highlights the complexity of the interconnections between soma and psyche, which are so frequently superficially glossed as the mind/body dichotomy in the shorthand of debates about con-

temporary self-health cancer treatments. However, even more importantly for the purposes of my argument, Starobinski's scholarly investigation indexes the replacement of the soul with the psyche and now the personality, and the concomitant emergence of the notion of the responsible citizen who has a duty to be healthy (Starobinski, 1989:358, and see Chapter 7, this volume). In this shift from soul to psyche we can witness the *reversal of the directional causation* from feelings to bodies in which emotions are attributed a pathogenic potential. Furthermore, the emotional self now takes on a moral dimension as the psyche becomes overdetermined as a signifier of morality and duty. Illness, once again, though for different reasons, is constructed as a punishment (Picone, 1989:486). Individuals are thus increasingly under threat, not from their bodies as such, but rather from their emotions, especially from those designated negative which we store at our peril. As one publication puts it in its title, *You Can't Afford the Luxury of a Negative Thought* (Roger and McWilliams, 1991).

It is not that the somatic manifestations of emotional effects are particularly new: connections between the body and emotions have been theorised in many different ways in the past. Aristotle, for example, interpreted wrath as a desire for vengeance or as a 'boiling up of the blood around the heart' (Aristotle, quoted in Magli, 1989:88). In Galenic medicine it was principally 'by way of the humours, and not through the nervous information, that the body was capable of modifying the activity of the soul, and in turn, being modified by the soul' (Starobinski, 1989:354). Within this Galenic model 'the body was understood to be composed of four humours or fluids (blood, phlegm, black bile [or melancholia] and yellow bile [or choler]); the variant mixture of these determined people's characters' (Graham *et al.*, 1989:26). The imbalance of the humours was seen to produce emotions, such as too much yellow bile causing anger. Indeed, in *The Genesis of Cancer* (1978), Rather details the history of changing beliefs about the causes of cancer (humoral, tissue and cell theory) and offers examples of seventeenth-century theorists who saw certain emotions as a causative factor: 'Boerhaave [following Hoffman] includes among the precipitating causes of the cancerous change melancholy' (Rather, 1978:34).

However, in many of these previous accounts, the body affected the emotions rather than the other way around. It was not until Freud that this redirection of the causation became so pronounced; he hotly contested the primacy of cenaesthesia and attempted to desomatise the 'causal system commonly accepted by his predecessors' (Starobinski, 1989:365). Freud's model may have been a far cry from the more mechanistic and functional ones of self-health cancer literatures, but he did introduce the notion of dreams and instincts as having a psychic, not a somatic, origin. Before Freud the unconscious did exist as a term,

but it was conceptualised as the 'obscure murmurings of visceral functions - from which would emerge intermittently, conscious acts' (Starobinski, 1989:364).

Thus, although the mind and the body have been seen to affect each other since ancient Western thought, the typical direction of this influence before Freud was from the body to the mind. There is no doubt that although Freud and Breuer's path is a complex and circuitous one, it nevertheless reversed the direction of causality in this respect. To put it crudely, popular beliefs today are more likely to attribute physical symptoms to depression than they are melancholia to too much 'black bile'. Bodily sensations thus no longer threaten the soul's well-being and safety, but rather signify the individual's distress, or the somatised psyche. Replacing earlier moral concerns with the 'mind' in there has been an increasing preoccupation with the 'mind' in twentieth-century medical discourses. In the psychotechnologies of alternative and self-health cultures, what is meant by the mind in the notion of the somatic causes of illness such as cancer is not the intellect, but rather what has commonly been referred to as the psyche. Believing Western culture to have overvalued the intellect at the expense of the emotions, most alternative medical literature on cancer encourages patients to explore the possible causative factors in their emotional development. I have yet to find examples of beliefs about a lack of intellectual development causing disease. But are these beliefs about the psyche and the soma only to be found in the alternative accounts of cancer, or do they inform biomedicine, however indirectly? Has the increasing popularity of alternative and self-health therapies in cancer treatment had any significant impact on biomedical approaches?

BIOMEDICINE IN TRANSITION?

The more traditional rejections of alternative approaches to cancer continue to be widely represented in biomedical debates. Several studies of biomedical practitioners' attitudes to these approaches in the 1980s reveal 'a certain degree of distrust, intolerance and misunderstanding' (Furnham and Bhagrath, 1993:238). The language of rationality and objectivity is used to question their validity and is rejected on the grounds of a lack of scientific evidence to prove their efficacy, as a quotation from a letter in the *British Medical Journal* exemplifies: 'Surely the economic limitations imposed on general practitioners and their primary health care team require managers to prefer treatments that work rather than appeal to irrational sensibilities' (Egan, 1992:1096). Using words such as 'unorthodox', 'unproven' and 'questionable' to describe alternative therapies, biomedical literature makes its ostensibly neutral objections clear. Drawing on scientific studies which 'prove

that there is no correlation between a number of psychosocial factors and the progression of cancer', one doctor writes, 'it is time to acknowledge that our belief in disease as a direct reflection of the mental state is largely folklore' (Angell, 1985:1571-2).

In medical textbooks on cancer, alternative approaches are rarely mentioned at all and where they are, they are, not surprisingly, evaluated according to biomedical criteria, rather than on their own terms. In *Cancer in Practice*, the authors present a summary of the available forms of treatment outside conventional oncology, but they nevertheless evaluate them within the discourses of biomedicine, focusing on the objectivity of the scientific method:

Most of the progress that has been made in the fight against cancer has been as a result of critical scientific evaluation. The characteristic feature of the scientific method is the preparedness to expose favoured hypotheses or beliefs to the hazard of refutation... 'Alternative' treatments are treatments which, almost by definition, are outside conventional or orthodox medical practice, and which have not been exposed to or have not withstood the rigours of scientific evaluation... Not only are alternative treatments for cancer of unproven value, they are very rarely objectively assessed by their proponents.

(Rees *et al.*, 1993:88)

Each of the therapies evaluated in their textbook are then presented within conventional evaluative criteria: 'special diets', for example, are referred to as having 'conceptual appeal' but readers are cautioned about the fact that 'there is no objective evidence that they can improve the long-term outlook for patients with cancer' (Rees *et al.*, 1993:89); a deficiency in beta-carotene is acknowledged to increase the risk of malignancy according to some epidemiological evidence, but again, no evidence is found that supplements 'improve the chance of a cure of cancer' (Rees *et al.*, 1993:90). Indeed, in the case of the controversial Laetrile, toxicity and a few incidences of death from overdose are reported.¹⁸

However, despite evidence of such hostilities in these respects, in evaluating the role of the patient's 'mind' in the progress of their disease, this biomedical account suggests that studies provide evidence which both confirms and contradicts the connection between loss, stress, personality, will to live and cancer prognosis. Many of the claims made about the impact of techniques of the mind (such as positive thinking, 'discharge' of emotional distress and a sense of hope) on the cause and cure of cancer are rejected as 'unproven' or 'unsubstantiated', but the authors nevertheless acknowledge the value of support groups for cancer patients and devote chapters of this other-

wise quite traditional textbook to subjects such as 'Quality of Life', 'Psychological Support' and 'Support for Patients with Cancer'.¹⁹

Much new research continues to confirm existing 'medical scepticism' about the use of alternative medical treatment. In the case of the study of the Bristol Cancer Help Centre, for example, the misleading claim that the Bristol Centre might harm cancer patients led to a general battle over the reputation of the Centre and resulted in headlines such as 'Death from Complementary Medicine' (Richards, 1990:510-11). Bagenal *et al.* (1990) published, and publicised, the results of their study of 334 women with breast cancer who attended Bristol and a control of 461 women with the same disease who did not. Their much criticised conclusions were that 'women with breast cancer attending the BCHC fare worse than those receiving conventional treatment only... For patients metastasis-free at entry, metastasis-free survival in the BCHC group was significantly poorer than in the controls... Survival in relapsed cases was significantly inferior to that in the control group' (Bagenal, 1990:609, 606). The many lines of defence against these allegations drew on both scientific discourses (the Bristol patients were younger and cancer grows faster in younger women, more conservative surgery tends to be carried out on younger women which might have affected their chances of survival, patients attending Bristol may have had more advanced malignancies before they went there) and those of alternative medicine (perhaps the Bristol women had lower hopes about the efficacy of conventional treatment and thus their survival, the Bristol patients may have had more cancer-prone personalities than those in the control group, failure to control for psychological factors invalidates the results of the research). Common-sense knowledge of health and illness was also appealed to: how could relaxation, counselling and an organic vegan diet be damaging to your health? (*The Lancet*, 1990:743-4).

Despite the attempt to defend the Centre's reputation and the numerous challenges to the research methodology and its conclusions by doctors, medical sociologists, Bristol patients and alternative practitioners, the work of the Centre has nevertheless suffered and services have been reduced. The counter-arguments successfully discredited the research on numerous grounds, but they did not have the scandal value of the findings, and received less media attention.²⁰

However, while it is a negative example of medical evaluations of alternative practices, this research belongs to the beginning of a more general reevaluation of this relationship. Despite such attacks on alternative medicine, it could be argued that in the call for tighter regulations there is nevertheless an acknowledgement of the role of such practices in Britain's medical future (Smith, 1983:307). The British Medical Association produced a report which argues that com-

plementary therapists should undergo some basic training in medical science and doctors should participate in such a programme. They also advocated a general register of members of each type of therapy, which only competent practitioners could join (Kingman, 1993:1713). While this may seem like an inappropriate intervention for those who argue that the existing British Register of Complementary Practitioners already fulfils such a function, and that basic medical knowledge such as anatomy is already part of such practitioners' training, the BMA's engagement with alternative medicine is nevertheless significant: it set up a working party on the extent of usage of such therapies in Britain and Europe and subsequently published a report on its findings (Kingman, 1993:1713). In addition, the referral of patients to alternative practitioners is no longer considered 'unethical' (Pietroni, 1992a:565). Recent changes in doctors' responses to alternative medicine have been widely documented in the medical journals. The deputy editor of the *British Medical Journal* informs readers of the increasing interest in alternative medicine among doctors. He cites one survey of general practitioner trainees in Britain which showed that '70 of the 86 general practitioner trainees in Britain which showed that '70 of the 86 wanted training in techniques such as hypnosis, acupuncture, manipulation, homoeopathy, and herbalism. Twelve of the doctors had referred their patients for treatment to non-medical practitioners - a step which a few years ago could have led to an appearance before the General Medical Council disciplinary committee' (Smith, 1983:307). Another study found 'a positive attitude towards complementary medicine in 86 out of 100 general practitioner trainees in 1982', and yet another that out of 200 general practitioners surveyed in the Avon district '38% had received some additional training in one form of complementary therapy' (Pietroni, 1992a:564-5).

The studies of Cassileth *et al.* (1984, 1985, 1991) and Cassileth (1989) clearly reject the claims that the patient's state of mind affects the development of cancer, but they demonstrate the perception of the need to examine claims of alternative and self-health claims about cancer. In a study of 359 patients with cancer, Cassileth *et al.* conclude: '[O]ur study of patients with advanced high-risk malignant disease suggests that the inherent biology of the disease alone determines the prognosis, overriding the potentially mitigating influence of psychosocial factors' (Cassileth *et al.*, 1985:1555). In another study of 'unproven' cancer therapy, the length of survival and quality of life in patients receiving 'unorthodox' in conjunction with conventional treatment is compared with patients just receiving the latter (Cassileth *et al.*, 1991:1180). This concluded that not only was there no difference in the survival rates of the two groups, but also that the quality of life in patients undergoing *conventional treatment only* scored higher. This obviously goes against the claims of many alternative cancer treatments

that they enhance quality, if not length, of life. However, it should also be noted that the 'quality of life' of patients of conventional treatment was also better at enrolment (Cassileth *et al.*, 1991:1184).

Despite their negative conclusions about alternative approaches to cancer care, both studies show an engagement with alternative beliefs and practices. To measure 'quality of life', for example, as well as survival rates, is to engage with a shift in medical discourse away from the purely mechanical model of the body, and to acknowledge the patients' need for emotional care. Furthermore, in their studies of cancer patients' use of alternative medicine, Cassileth *et al.* (1984) demonstrate its widespread popularity and impact upon cancer treatment. While defending the superiority of the scientific method of biomedicine against the appeal of these new unorthodox, unproven methods, Cassileth *et al.* nevertheless highlight the general dissatisfaction with conventional medical practice. They conclude: 'when patients turn toward alternative treatments, they are simultaneously moving away from perceived conventional care' (Cassileth *et al.*, 1984:112). This study also points to the increasing overlap between these two systems of biomedicine and alternative treatment in cancer care: 54 per cent of patients using conventional treatment, for example, were also using unorthodox therapies; and 60 per cent of the 138 unorthodox practitioners studied were also medically trained doctors (Cassileth *et al.*, 1984:105).

Indeed, as Cassileth (1989) goes on to argue, orthodox and unorthodox approaches to cancer may even share the influence of certain social and cultural changes. Contemporary beliefs in "metabolic" therapies', he argues, 'emphasising diet, self care, vitamins, and internal cleansing, along with "immune-enhancing" regimens . . . reflect underlying social trends and values, such as the belief in assuming personal responsibility for one's health, the importance of self care and physical fitness, patients' rights movements, dietary emphases' (Cassileth, 1989:1247; see also Chapter 7, this volume). These changes, it is suggested, are in part a result of new emphases encouraged by conventional as well as alternative medicine:

other features to which patients gravitate are available, *at least potentially*, within the conventional framework. These features include the opportunity for patients to participate actively in their own care; the inclusion of nutritional and dietary factors, which patients read about in their daily newspapers; and the opportunity for patients to develop a sustaining relationship with a primary physician whom they perceive to be caring and involved.

(Cassileth *et al.*, 1984:112, my emphasis)

Cassileth *et al.* suggest that conventional medicine might learn from

research on patients' disaffection with its alienating practices and begin to build some of the advantages of alternative medicine into their philosophy of treatment. Another study of the uses of alternative therapies by patients with terminal cancer in Australia advocates the need to understand this rising phenomenon within the conventional model of patient behaviour. Yates *et al.* argue that:

people who are ill engage in a range of strategies, in efforts to have their disease cured . . . From this point of view it is surprising that more people with terminal cancer don't adopt alternative therapies, once they realise that conventional treatments are not going to save their lives.

(Yates *et al.*, 1993:214)

Further evidence of changes in biomedical practices can be seen in the ways in which some oncology departments in hospitals have begun to include some alternative practices within their hospital programmes. At The Royal Marsden Hospital in London, for example, cancer patients are offered counselling and psychotherapy, art therapy and therapeutic massage in addition to surgery, chemotherapy and radiation treatments. Following visits to the Bristol Cancer Help Centre, oncologists from Hammersmith Hospital in London have begun to offer some forms of 'complementary treatments' to their cancer patients. Forty-four per cent of their patients expressed an interest in trying some form of complementary medicine, and 22 per cent had used them previously for other illnesses (Sikora, 1989:1285). Again, drawing attention to the criticisms of the autocratic and patronising approach to the patient which has characterised hospital practice in Britain for so long, the combination of conventional and complementary medicine in cancer care is favoured as a more democratic alternative. The policy at Hammersmith, for example, diffuses the centrality of the patient/oncologist encounter, and provides emotional, social and informational support, in addition to the physical treatment (Burke and Sikora, 1992:62-6). This report in *Nursing Times* reaches an audience who may be more sympathetic to the aims of alternative medicine than many consultants. Indeed, it has been suggested that the refocusing of biomedical treatment through a holistic lens might be best suited to begin with nursing practice which has traditionally been more concerned with overall patient care (psychological, as well as physical) (Montbriand and Laing, 1991:325).

These calls for the integration of certain beliefs and practices which treat the patient as more than just a physical body extend beyond oncology into debates about general medical practice. Documenting the rapid growth in complementary medicines in Britain (approximately 50,000 practices of one sort or another in 1992 with a growth rate

of 10 per cent a year) in the *British Medical Journal*, a senior lecturer in general practice at St Mary's Hospital, London, advocates their integration into an expanded primary health care system:

My view is that although our roots may lie in medical schools and our current identity is that of general practice, our future lies as members and, at times, leaders, of an expanded primary health and community care team which, among others, must include selected complementary practitioners. (Pietroni, 1992a:566)

In the last ten years we have witnessed the beginning of what promises to be a fundamental shift in attitudes to alternative medicine. What is surprising, I think, is the amount of serious dialogue with alternative therapies to be found in contemporary biomedical journals. Even in the form of these critical exchanges, alternative medicine 'one of the few growth industries in contemporary Britain' (Smith, 1983:307) is making an impact on biomedical beliefs and practices. As the above examples illustrate in a number of different ways, alternative medicines are not only being used by patients with cancer and other diseases, but are also increasingly recognised by medical doctors and nurses as a potential source of knowledge in patient care and support. In my own experience, having concealed my vitamins and mineral supplements from the medical staff at the hospital for fear of having them confiscated (as rumour had it they might be), I later discovered that most of the staff I encountered on the chemotherapy ward were interested in, if not sympathetic to, alternative approaches to cancer care. Once I had 'come out' as a patient who used such methods, several of the chemotherapy nurses wanted to talk to me about my experiences for their research projects in their own medical training. Indeed, my oncologist took his patients' use of alternative methods very seriously; during one pre-treatment examination he warned me against mocking them myself when I rather self-consciously drew humorous attention to the acupuncture studs in my ears which had been inserted to counter the nausea caused by chemotherapy.

This debate has brought with it an open recognition of the power imbalances between doctor and patient and the negative effects of what has too often been a brief and humiliating encounter; cancer patients, not surprisingly, have expressed dissatisfaction at the average time for an oncology consultation being 13.4 minutes, with 24 per cent of patients having less than 5 minutes (Burke and Sikora, 1992:62). Connected to this change is the acknowledgement that patients will no longer accept being treated as just physical bodies with symptoms. Increasingly, there is some attempt to debate the ways in which patient care might extend beyond 'the physical' to 'the emotional'. However,

this gradual acceptance of the importance of what has been called 'the mind' in treating the effects of illness has not been extended to debates about its cause. Several advocates of the incorporation of alternative medicine into the conventional structures of cancer care continue to express caution about the dangers of the 'victim-blaming' condemnation of the patient as responsible for their own illness (and sometimes death) which characterise some of these 'psychotechnologies'. In tracing some of the changes in medical discourses of the mind/body relationship it is thus important to maintain a distinction between a more 'holistic' model which recognises the broader needs of the patient with cancer and one in which the patient's disease is merely considered to be the somatic manifestation of psychic 'dysfunction' (see Hay, 1988, 1989).

ALTERNATIVE SYSTEMS?

Having established the extent to which conventional medicine has been influenced by some of the 'mind/body' models of its alternative counterparts, this final section of the chapter takes a brief look at the question in reverse: in other words, it examines the question of how independent alternative and self-health approaches to cancer are from biomedical models of bodily knowledge. Some forms of alternative medicine are obviously based upon entirely different conceptual systems from Western medicine. Acupuncture, for example, is a practice of Chinese medicine which uses terms with no immediately recognisable Western counterpart. As Mark Elvin argues, the Chinese 'body' has quite a different meaning from Western understandings: *shen* might be translated as 'body person' and refers to ideas of 'person', 'self', 'life' or 'lifetime' (Elvin, 1989:275). It is thus difficult to 'translate' the philosophy of different Chinese acupuncture systems.²¹ Put crudely, acupuncture uses needles to release blocks in the flow of *Chi* energy. Stephen Fulder sums up Seven Principles acupuncture thus:

health is achieved through a balance between opposing forces represented by *yin* and *yang*. . . *Yin* is fire and *yang* is water: thus everything that is *yin* sinks like water and everything that is *yang* rises like fire. When either of these forces is out of balance, illness results.

(Fulder, 1984:122)²²

The other type of acupuncture, Five Elements, works through the belief that:

all things, including man [*sic*], are composed of five fundamental forms of energy: wood, fire, earth, metal and water. The relationship between these five transformations is subject to certain

laws that govern the flow between them. Because the organs of the body are associated with the five elements, these cyclical laws can be applied to the workings of the body, enabling the practitioner to treat disorders.

(Fulder, 1984:122)

Little of the above description accords with Western beliefs about disease and its causes and there are numerous other examples of medical belief systems which work outside Western models. However, many forms of alternative medicine work within a framework that is much more familiar to the Western model of the body. Assessing the relationship of 'holistic' and 'psychosomatic medicine' to biomedicine, Kirmayer (1988) argues that the former two fail to overcome the Cartesian mind/body dualism of the latter because of the way in which they are 'so deeply entrenched in Western experience' (Kirmayer, 1988:58). Indeed, he argues that this dualism is reinforced by approaches which simply reverse the hierarchy, positing the mind as controller of the body:

In the healing vision of psychosomatic medicine, mind and body are to be brought into harmony. Most often, however, this goal is described not as an equal marriage but as the reestablishment of the mind's dominance and control over the body and with it, of reason over emotion . . . invok[ing] the same values of rational control and distance from passion and bodily-felt meaning that are part of the mechanistic world view of biomedicine.

(Kirmayer, 1988:58)

In the same vein, Helman's study (1988) revealed 'important agreements between lay and biomedical explanatory models of psychosomatic disorders', particularly with respect to chronic illnesses which conventional medicine could not explain or cure. Interviews with patients showed the extent to which they had internalised a view of themselves as 'too "obsessive", "perfectionist", and "anal", or "sensitive", or as people who "hold too much in"; their personalities, emotions, lifestyle, or physical weaknesses are blamed for their failure to conform to . . . [certain] ideal social values' (Helman, 1988:117).

This overlap between alternative and conventional medical belief systems can be seen in slightly different ways in the context of cancer care. The most common alternative therapies used by cancer patients in one study, for example, were, in descending order: 'metabolic therapy, diet treatments, megavitamins, mental imagery applied for antitumour effect, spiritual or faith healing, and "immune" therapy' (Cassileth, 1989:1248). What is involved in the most popular of these approaches, 'metabolic therapy', is summed up thus:

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[It] rests on the notion that toxins and waste materials in the body interfere with metabolism and healing, and that cells lack the nutrients essential to health. Cancer and other chronic illnesses are viewed as the result of degeneration of the liver and pancreas, and of the immune and 'oxygenation' systems. Treatment is directed at cellular 'detoxification and restoration'.

(Cassileth, 1989:1248)

This 'alternative' approach to cancer differs from conventional medicine in some ways, but its vocabulary and conceptual system are clearly derived largely from scientific frameworks: the metabolism, the immune system, the cellular composition of the body.

Similarly, the language of the Simontons' model of disease, or Charles's explanation for her cancer, discussed earlier in this chapter, also employ highly Westernised, scientific language. Indeed, one might suggest that therein lies their credibility: perhaps their appeal is, in part, due to their common-sense use of relatively familiar models of the body, authorised through a scientific language. Simonton *et al.* (1978) utilise a combination of medical and psychological language (he has been a doctor, she a psychotherapist) to explain the development of malignant cells. Systems such as 'limbic', 'immune' and 'endocrine', and activities such as 'hypothalamic' and 'pituitary', form the basis for the connection between mind and body. Cancer growth is thus made possible because of the effects of emotions, such as depression and despair, on these physical systems and activities. According to Charles (1990), the 'immune system' responds directly to emotional stimulation, and thus again cancer might develop in a patient whose negative disposition allows her/him to be vulnerable to the disease.

Scientific theories of the immune system form the basis for many alternative and self-health approaches to cancer. It might seem ironic to some that a mainstream scientific discourse like immunology, which has become increasingly influential on scientific understandings of disease and its cure, should authorise 'alternatives' to it. In the last twenty years its impact has transformed the language of medicine, and, with the HIV and AIDS epidemic, it will no doubt continue to play a central role in the biomedicine of the future. Its cultural purchase can be seen from the way in which its concepts and knowledge successfully translate across the alternative/conventional medical divide, demonstrating the interconnection between mind and body, on the one hand, and the organic character of physical disease on the other.

The exchanges and influences between biomedical and alternative models of the mind and body in the treatment of cancer can thus be seen to flow in both directions. Conventional medicine, in its own defence, has become more reflexive and self-critical about some of the problems

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with its rigidity about its previous exclusive concentration upon the physical body. In alternative and self-health medicines, while some have drawn upon non-Western practices, many have relied heavily on developments in the biological sciences and have combined these new systematic models of 'the body' with their own psychological models of 'the mind'. It is the cultural significance of these new forms of medical knowledge and, in particular, their effect on visualising health, which is the subject of Chapter 5.

VISIONS

There is an inevitable slippage from the visible to the mirage of absolute transparency, as if the light of reason could extend into the deepest murkiest depths of the human organism. As if truth consisted simply in making something visible.

(Braidotti, 1994:67)

SEEING THE SIGNS: BEFORE AND AFTER

In the first photograph [see Figure 5.1] I am watering the geraniums outside the kitchen door. The old stone house is built into the abbey wall of a small French village. Here at the back there is a daily watering ritual to perform as the hot sun begins to die down for the day. The setting is idyllic; the house is the envy of passers-by who have come to visit the abbey. Here I can be seen in holiday mode: casual, relaxed, contented, taking pleasure in 'playing house' away from home. I look healthy and fit. The shorts show off tanned legs that have been well-exercised. I smile, do not look up, aware that the photograph is being taken, but not willing to pose further. A picture of happiness; a picture of health.

In the second photograph [see Figure 5.2] I am sitting at a table writing a letter. The accoutrements of a holiday in the sun surround me: beach mat, airmail letters, sunglasses. The white walls behind belong to the patio of the rented studio flat in Crete. The patio provides some shade from the heat of the sun and also offers a sense of privacy. I do not look at the camera, but continue writing as if unaware of its presence. I am not wearing a hat or scarf. My head bent over the letter, you can see clearly the new growth of hair. Have I been ill or is this a radical fashion gesture or even a political statement? Chemotherapy may come to the minds of some who see me.

The first photograph was taken in July 1991. I found out I had cancer two months later. The tumour must already have been growing inside in July. Looked at with this knowledge, the first photograph offers a less innocent story. The paradise holiday preceded the nightmare diagnosis; the healthy, tanned body concealed a large and potentially lethal tumour. The story the photograph tells is now one of deception. I