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Therapeutic Narrative
Illness writing and the quest for healing

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Abstract

This thesis examines how narratives of illness become therapeutic narratives. The method is to engage closely with (mainly Australian) texts – literary accounts of illness – in order to identify key elements that effect a healing function (healing is distinguished from cure). Textual analysis is placed in the frame of medical information about the relevant conditions, and theoretical perspectives that provide a cultural and historical setting for illness writing.

Bio-medical discourse foregrounds the clinical process of diagnosis, investigation and treatment and relegates the personal meanings of illness to secondary place. The thesis explores ways in which the patient's account provides an alternative discourse that supplements – and at times challenges – the medical discourse. Illness foregrounds the body, and illness narratives confront the reality of embodied experience. Illness that is chronic or incurable, ageing, physical and mental decline, and the inescapable prospect of death confront the patient with the need to find meaning in experience.

Narratives of illness may serve as ventilation, diversion or escape for the patient. They may provide practical help, information and consolation to family and carers, and others who suffer with the condition. These are valuable functions, but I argue that illness writing may embody more powerful therapeutic elements that transform and give meaning to the illness as part of the individual's life story.

Key therapeutic functions identified are perversity, empowerment and transformation. Healing can begin with the empowerment of telling one's story. Illness stories may challenge the stigma and the subordination associated with disease. They can affirm a sense of belonging and community where illness intersects with other forms of marginalization. Powerful illness narratives are often characterised by perversity, overturning the assumptions of dominant cultural discourses – including those that place authority with the medical practitioner and demand acquiescence from the patient. The most powerful therapeutic narratives transform the story of illness into a new story.

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Presentation and Referencing Convention

This thesis follows the MLA Handbook 6th edition for matters of presentation, using parenthetical documentation.

References cited in the text appear in the Bibliography.

Chapter 1 Introduction: the narrative context

Streaking through the jungle on a gaudy leopard, cape billowing out behind me as if I were aflame, I have on my head (my greying pate) – and this is vital – a hat, a black, gargantuan fedora with a drooping brim, and streaming from one side of it is a cassowary feather (of all things). (Dessaix Night Letters 3)

The narrator of Night Letters confronts an incurable illness and the prospect of death. The wild cat that prowls his dreams after he has been given the diagnosis seems to trap him between two equally terrible choices: between fleeing or fighting – and either way being torn to pieces ‘limb from bloody limb’ (80). Riding the leopard represents the possibility of an entirely new way of confronting illness and fear. The hat (the hat is ‘vital’ stresses the writer) – comical and defiant – signals the perversity of transformation. Prey astride the predator enacts a reversal: the victim has seized, if not control, at least a share in the beast’s wild power, and turned terror to exultation.

It is the possibility of therapeutic transformation that I seek in this exploration of illness writing. How does a personal account of illness become a healing story? When patients resist the authoritative discourse of medicine to tell their stories in their own voices, do these narratives of illness incorporate a sense of the therapy of narrative? What are key elements that transform the account of illness into a healing story? This thesis looks at the turning point where writing that arises out of illness and encounter with the world of Medicine becomes therapeutic narrative: where the leopard’s prey, flinging on a feathered hat, streaks into the jungle mounted on the beast.

Interest in the patient’s narrative of illness arises in the context of a shift in the medical paradigm, and of broader social and cultural changes. The twentieth century was characterised by the breakdown of master narratives that implied a fixed point of reference, a coherent and centred view of the world and the promise of grand solutions, whether religious, political or scientific. In Medicine, shifts in the scientific paradigm and awareness of the limitations of biopositivist science as the sole foundation of medical

understanding have challenged medical authority and the position of the doctor as expert. Such broad changes can be enabling for personal narratives of illness. Challenge to privileged positioning and unsettling of expert discourses have opened a space for the individual voice. The individual's story of illness foregrounds the subjectivity of illness in two senses: the patient as subject, central character in the story; and illness as a subjective experience: the personal and emotive meaning of illness. I will argue that patients' stories of illness can pose a counter discourse to dominant cultural 'narratives', particularly the discourse of medical authority. Resisting subordination to dominant discourses is one way in which an illness story may become therapeutic narrative.

Narrative has two necessary components: story and discourse (Chatman 19). The story consists of the events, organised into a structure or plot, and the 'existents' (characters, settings) which make up the content of the narrative. The discourse is the mode of expression, the means by which the content is communicated. Narrative presupposes a narrator and an audience: the viewpoints of both shape meaning from the elements of the story. Discourse as a form of expression includes the perspective or point of view that is explicit or implied in the narrative, and this reflects the cultural and historical context. The concept of narrative thus incorporates cultural context. Narratives exist within a social and historical setting, they rest on a body of assumptions and understandings, some overt, others hidden.

Postmodern understanding has unsettled the notion of fixed frames of reference, neutral vantage points. In the latter half of the twentieth century, there was a fundamental shift in the social sciences with the 'understanding that human beings live within and embody socially constructed narratives' (Donald 17). While literature has traditionally studied (fictitious) narratives, 'stories that are untrue and highly respected', a widely held contemporary view is that disciplines such as history, theology, anthropology and psychiatry 'are all concerned with narratives in one way or another' (Martin 23). Fiction creates a coherent and meaningful narrative from imaginary events; history constructs a coherent and meaningful narrative from the events of the past.

Narratives are the means by which we make sense of experience. 'Master narratives' are broad organising frames of knowledge that have traditionally been privileged as central and authoritative. The shift away from privileging 'expert' positions and the recognition that there is no 'neutral' position has opened a place for personal narrative in many academic disciplines, including health sciences, as the following excerpt illustrates:

[this book looks at] links between the individual lived experience of disability and the macro-social context in which disabled lives are played out. The use of life story narratives helps us to understand how lives are embedded within societies, and influenced by periods of social change. Using narrative, oral histories and autobiography can help to reveal 'lost' stories of disability, redressing the historical absence of marginalised groups...people may also be able to empower themselves, and others, through the telling of life stories in their own voices. (Priestly 245-6)

Within the broad social context, unsettling of master narratives is associated with changing attitudes to previously marginalised, stigmatised or 'invisible' groups. Post-colonialism incorporates a challenge to the grand narratives of racial and cultural superiority that were used to justify Empire: the political, economic and religious colonisation of the nineteenth and early twentieth centuries. Similarly the theories and political activism associated with feminism, gay liberation and queer theory assert the cultural construction of sexual identity and gender norms. Questioning normative assumptions about gender, race and sexuality is part of a broader recognition of the cultural construction of the body. Cultural assumptions about ageing and disability are also inscribed on the body.

Science and Medicine are among the master narratives that have claimed a neutral perspective but they too lie within a cultural context (Rachman 123; Fluet 5). Thomas Kuhn argues that scientific knowledge and discovery exist within a paradigm, a framework that shapes the way data is processed and interpreted. In The Cosmic Blueprint Paul Davies discusses the paradigm shift that has occurred over recent decades in scientific ways of understanding:

important new discoveries are dramatically altering the *scientists'* perspective of the nature of the universe. For three centuries science has been dominated by the Newtonian and thermodynamic paradigms...Now there is a new

paradigm of the creative universe, which recognizes the progressive, innovative character of physical processes. The new paradigm emphasizes the collective, cooperative and organizational aspects of nature; its perspective is synthetic and holistic, rather than analytic and reductionist. (Paul Davies The Cosmic Blueprint 2)

Davies suggests that recent insights such as chaos theory and quantum uncertainty have unsettled traditional scientific explanations. The paradigm he presents emphasises the complexity of the universe, the tendency for natural systems at all levels from sub-atomic particles to biological, ecological and social systems to be self-organising and to develop greater complexity in what often appear to be sudden step changes. In Medicine, paradigm shift is characterised by movement away from a narrowly biopositivist model of health towards a more holistic model, from emphasis on technology to inclusion of a wider psychosocial perspective, and from focus on the disease towards seeing the individual with the illness as the central concern of Medicine (Little 160). Medical practice has become more open and receptive towards a diversity of alternative health practices, outside the tradition of 'scientific' Medicine. Some of the key elements in this paradigm change are: more attention to the meaning of illness for a patient; greater concern with quality of life; a more holistic understanding of wellness; and empowerment of patients with emphasis on patients' rights, autonomy and involvement in medical decision making.

One way in which the medical paradigm is changing is in the move towards involving patients in decision making about treatment options. The doctor has an obligation to provide education and explanation, working with the patient towards a collaborative decision about treatment. 'Expert' knowledge is a source and marker of power (Fluet 10) and by sharing expert knowledge the doctor empowers the patient. Miles Little places respect for individuals and their quest for autonomy, together with the imperative to improve quality of life, at the centre of medical concern. Autonomy is the 'freedom to make realistic choices against a background of good physical and mental health', 'the potential to do anything that a human being can do' (76). Little not only emphasises the rights of the patient, but also recognises that

illness is part of a wider life narrative. His analysis underlines the need, as a crucial part of therapy, to empower patients in controlling their story of illness.

Over the past century there have been changes in Western patterns of illness and medical practice, with control of many types of acute illness such as infections, and increases in longevity and in the numbers of people living with chronic illness. These changes have put greater emphasis on the role of medical therapy in improving quality of life. Miles Little argues that since the limits to life expectancy have been reached in Western society, doctors 'must learn to ...express modern achievements in terms of improvement of quality of life' (12). The more holistic understanding of wellness that Little identifies, quality of life beyond absence of disease, has in the past been associated more closely with psychotherapy than with general medicine. Joanne Trautman suggests that the psychodynamic model of therapy, epitomised by Freud and the Psychoanalytic school, is in some ways closer to religion than to medicine, in that the goal of therapy is self-improvement and self-fulfilment whereas the medical model offers only diagnosis and treatment (28). John Launer, discussing the narrative approach to mental health in general practice, expresses a similar idea: 'Psychiatry lies in an uncomfortable no man's land between conventional medical science and the search for meaning' (117). In stories of illness and in the broader stories of our lives, narrative represents the quest for meaning.

One indication of the changing medical paradigm is the growth of Medical Humanities as a field of research and medical education. Studies in this field signal a shift from the biopositivist view of Medicine, towards recognition of the contextual and hermeneutic aspects of medical practice. Lisa Fluet distinguishes two roles played by the humanities in medical education: one is a humanising role, the repersonalising of 'unfeeling, highly technical applied science' (3); the other involves an exploration and explication of the narrative basis of medicine itself, based on a theorised 'perception of the permeation of narratives into all aspects of life – including medical practice' (4). Steven Rachman makes a similar distinction with respect to the uses of literature in medicine (123). The move to incorporate the

humanities, including literature, into medical education is one response to dissatisfaction with medical practice, especially its perceived depersonalisation and failures of communication between doctor and patient. The aim of medical humanities from this perspective is to shift focus back to the personal, human aspect of the medical consultation and to enhance the doctor's skills in listening, interpreting and communicating. Rachman, argues that the study of literature in medicine goes beyond a 'humanising' role to reveal 'the cultural frame of illness' (123). Rachman and Fluet both emphasise that the scientific paradigm of medicine rests on a language, or a discourse, that aspires to be 'neutral' (objective and transparent), but this claim to neutrality disguises the inevitable historical and cultural frame within which medical knowledge exists.

Narrative based medicine

Narrative ways of conceptualising the medical consultation, as identified by Fluet and Rachman, are the subject matter of narrative based medicine. The work of pioneers in literature and medicine (including Howard Brody, Rita Charon, Arthur Frank, Kathryn Montgomery Hunter and Arthur Kleinman) demonstrated the narrative basis of medical knowledge and the function of narrative in therapy (Rachman 124-5). Narrative based medicine draws attention to the patient's experience of illness as part of (and disruption to) her life story, and to the narratives constructed by patient and doctor for the medical interaction. Healing is seen as a process by which the experience of illness is given meaning, and the disrupted self and life story of the ill person are restored, through narrative:

A narrative view of medicine emphasises the constructedness of the case history that is shaped in the medical interview. Such attention to the patient-physician interaction is part of an attitude toward the ill person that is healing in itself... It grants that other human beings may be finally unknowable...It asks instead to know the other person's story. (Hunter 141)

Narrative based medicine rests on the postulate that becoming sick, the process of diagnosis and treatment, and coping with illness 'can all be thought of as enacted narratives within the wider narratives (stories) of people's lives' (Greenhalgh & Hurwitz 48). The doctor's hearing and interpretation of the

patient's story is crucial in the diagnostic and therapeutic project of medicine. Listening to a narrative is an interpretive act; discernment of meaning and medical interpretation of a patient's story has 'great power for healing' (Hunter 124): it gives legitimacy to the patient's experience and places it in a social context (the world of medicine). The provision of a diagnosis, or clarification of the problem, contributes to relief of suffering because naming can bestow a form of control, as well as providing guidance for therapy. While practical forms of treatment such as surgery and medication are an essential, the patient's story of illness incorporates the broader experience of suffering:

narratives offer a method for addressing existential qualities such as inner hurt, despair, hope, grief and moral pain which frequently accompany, and may even constitute, people's illnesses. (Greenhalgh & Hurwitz 48)

Patients' problems are often complex and multi-faceted, with organic, psychological and social factors interwoven in the story of dysfunction and distress. Respecting the patient's narrative may help doctors avoid the limitations of diagnosis. John Launer recognises that diagnostic labels are helpful in the ways suggested by Hunter (giving mastery and guiding therapy) but may also be counter therapeutic. Labels 'can become a tool for fending off the doctor's anxiety' especially where problems are complex or where the doctor has little 'medical' help to offer (119). Categorisation may distract attention from the parts of the narrative that do not fit: 'Narratives are not necessarily about categorisation; they may be about lack of boundaries'(119). It is just where the illness story is hybrid, encompassing multifaceted organic breakdown and psycho-social disruption, that the narrative of illness, validated in the patient's telling and the doctor's witnessing, is most crucial for healing.

Narrative therapy in psychotherapy

The narrative approach to medicine conceptualises the therapeutic process as a retelling or reconstructing of the story of illness, a collaborative endeavour by doctor and patient. This approach has been used productively in psychological and psychiatric therapies. Psychiatric medicine is an area where the border between impairment ('mental illness') and deviance from prevailing cultural norms ('difference') becomes blurred. There is an ill-defined

boundary too between the concerns of Psychiatry and the existential dilemmas of the human condition – the search for meaning. Psychiatric theory and therapy go beyond diagnostic labels and specific ‘cures’ for clearly defined disorders, to encompass a more holistic view of well-being. John Launer writes:

clinicians from many different therapeutic schools are moving away from a search for a normative explanation of someone's problems and towards the search for an appropriate new story for each patient. This change has its origins in modern and ‘postmodern’ intellectual movements, including cybernetics and structuralism.’ (117)

Narrative psychotherapy exemplifies this changing approach to psychotherapy, the search for a ‘new story’ for the individual.

Elements of narrative therapy have been used by therapists from a range of theoretical traditions. While Narrative Psychotherapy, expounded by David Epston and Michael White, represents a distinct theoretical and therapeutic project, there are other more eclectic and pragmatic approaches that incorporate elements of narrative therapy into diverse therapeutic practices. One example is Alida Gersie’s use of narrative in her work of ‘therapeutic storymaking’. She uses traditional tales, fairy stories and myths, patients’ personal reminiscence and new fictions in the setting of group therapy with people who have wide range of mental disturbances (Gersie 1997). She uses storymaking in bereavement work (1991) and in helping elderly people deal with the despair and marginalisation associated with confinement in a Nursing Home. Therapeutic storymaking enables women involved in domestic violence to gain a greater sense of worth and skills in assertion. Gersie’s work demonstrates the power of narrative to bring about change across a spectrum of psychosocial disturbances.

Amongst therapists from the Freudian Psychoanalytic school who incorporate elements of narrative therapy are Ellen Siegelman, Barbara and Richard Almond and James Phillips. Ellen Siegelman, whose work is outlined in Chapter 3, has written a detailed analysis of the use of metaphor by patient and therapist in her Psychoanalytic practice, and places the therapeutic use of metaphor in a narrative frame. Barbara and Richard Almond, who have a

background of Psychoanalytic clinical practice, present an interpretation of several works of fiction (including Pride and Prejudice and The Secret Garden) in Psychoanalytic terms – unpicking the central character’s story in a way that might occur in a psychoanalytic session. They ‘read’ the literary texts as narratives of psychosexual dynamics and therapeutic journeys of conflict resolution and psychological growth. James Phillips presents a narrative interpretation of the psychoanalytic tradition, moving from the narrative basis of Freud’s originating work to the ‘Narrative Therapy’ of David Epston and Michael White.¹ Phillips identifies ‘weak’ and ‘strong’ positions on narrative and identity. The weak position sees narrative as ‘a dimension of human identity, perhaps even an important dimension, but not the *defining* dimension of human identity’ (44). Phillips suggests that most workers from the more traditional and therapy oriented areas of Psychiatry, such as the Psychoanalytic school, represent the ‘weak’ position. The strong position implies ‘that narrative is at the core of human identity, that the terms narrative identity and personal identity become almost interchangeable’ (44). The ‘strong’ position is represented by the therapeutic work of Epston and White, whose approach is based on ‘strong sense of narrative as the structuring core of a person’s life and as the primary focus of therapeutic work’ (Phillips 46).

Family therapist Alan Parry describes in ‘A Universe of Stories’ the postmodern theoretical basis of narrative therapy in the ‘strong’ sense and outlines the narrative paradigm as it is used in therapy with disturbed individuals and families. Narrative therapy starts from the notion that we use story to make sense and meaning of our experiences – our lives and our identities reside in the stories we make. The crux of Narrative Therapy is that a person can change constricting and damaging beliefs they hold about themselves, and open new possibilities for their life, by retelling the story (43). A postmodern position underlies this approach. Postmodern understanding recognises the loss of fixed, central ‘truths’ and the ‘absence of transcendent values’: knowledge and interpretation of meaning is contextual – it is shaped by the historical and cultural frame: there is ‘no privileged position or neutral

¹ The practice of Narrative Therapy and its theoretical bases are particularly well covered in the collection of essays edited by Gerald Monk et al.

vantage point' (39), and 'expert' knowledges such as those of religious, political or scientific authorities must be seen as narratives amongst others, rather than as privileged. This lack of overarching authority is seen by narrative therapists as providing liberating opportunities – 'opportunity for remaking ourselves', 'for choosing and inventing who and how we shall be' (39). Parry argues that 'the goal of therapy, understood as "restorying," would be to facilitate a process in which a person finds her own voice to tell a story of *her* descriptions of *her* experiences. In so doing she becomes . . . a poet' (44). This process is one of empowerment, validation of the person's experience and selfhood, 'she takes charge of her own story' and 'she experiences herself in effective charge of her own life' (44). Narrative allows connection, the therapeutic function of placing our own story in the wider context of a community. We can transcend our limited individual view through imagination and curiosity, sharing other people's experience through hearing their stories, and 'connect ourselves to . . . those larger epic stories of our communities, our cultures, our humanity' (53).

Parry emphasises the playful, imaginative, 'poetic' aspect of narrative making. In 'telling our stories with the inventive power of new language, and fresh metaphors' (39) and in finding our own voice for our experiences we become 'poets'. Story gives room for imagination, inventiveness and play. Play frees the person to discover new and less constraining ways of being and living their life. Play allows mischief, irreverence for the master narratives that can dominate and disempower the individual. One of the potent strategies of narrative therapists is subversion of 'received texts', the normative, constricting beliefs and assumptions about who we are and how we must live, that are part of our cultural and political world. Parry suggests a place for the perverse and transgressive – 'the received text or life-story in its constraining role' is challenged and undermined by 'alternate stories, unexpected interpretations . . . "anti-mythic," paradoxical stories' (52).

Narrative Psychotherapy thus conceptualises therapeutic change as changing the life narrative. From the theoretical perspective that we make sense of experience through the stories we tell, it sees the individual who seeks

help for mental and emotional distress as trapped in a life story that is ‘problem-drenched’ and constricting. Re-telling the life story can break its ‘shackling’ constraints, allowing alternative constructions of the self and opening new possibilities for the future. The person can identify the capacity to live differently (to perform as a different self) by discovering in the old story what Michael White calls ‘sparkling moments’ – moments of autonomy, of resistance to dominant and disempowering scripts.

Elements of therapy

Shifts in the discourse of Medicine, and in the wider culture, such as those discussed have opened a place for personal narratives of illness and therapy in the field of literary studies. Thomas Couser’s study, The Value of Body Stories, consists of a detailed analysis of many examples of biographical and autobiographical accounts of illness. Couser develops the thesis that illness narratives serve as a counter discourse to powerful cultural discourses, including the discourse of medical authority. In setting up a counter discourse, illness narratives perform a healing function. Writing does not ‘cure’ illness, but part of the suffering of illness is caused by the prejudicial discourse that surrounds it – the myths, the ignorance, the stigmatisation: ‘It is this gratuitous collateral damage . . . that counterdiscourse in the form of illness narratives can address and perhaps alleviate’ (289).

The therapeutic functions that Couser identifies in illness writing include validating the experience of illness and discovering meaning in the disruption it makes in the life narrative. Amongst the disruptions of illness is separation from the social network: illness narratives may serve to reconnect the person to the family or wider community. Illness writing can seek or affirm belonging: for example Couser identifies a strong sense of belonging and solidarity within the gay community in (North American) narratives of AIDS. Another function of autopathography that Couser regards as significant is the foregrounding of embodiment as a basic condition of our humanity: illness narratives serve as a ‘reality check . . . remind[ing] us of the vulnerabilities of embodiment’ (295).

Autopathography challenges normative discourses. Couser argues that illness and disability, with ageing and bodily decay, belong to subordinate (invisible or stigmatised) categories according to 'dominant cultural constructions'. Youth, beauty and health are 'normal' and illness is a deviance from the norm. The therapeutic function of illness writing as counter discourse lies in its power to challenge the positioning of the ill person as 'pathetic victim' (291), to contest stigma and restore agency to the ill person. Illness narratives demystify the taboo subjects of embodiment and disease and in this way contest stigmatisation and alienation of sick people. They can 'reclaim bodies from medical colonization' (295), contesting the depersonalising aspects of biomedical technologies and setting up a counter to the master discourse of Medicine. In Couser's words, illness narratives may seek to 'recover variously dysfunctional bodies from domination by others' authority and discourse, to convert the passive object into active subject' (291). The narrative of illness can restore the damaged self, by resisting disempowering master discourses and asserting personal agency.

Narratives of therapy – of illness and cure – are not necessarily therapeutic narratives. Couser argues that a story which narrates medical cure may foreground the triumph of medical science over disease. In such a story medicine is the hero and the patient can be placed in the background as passive victim of disease, and grateful object of medical authority. Such a narrative re-inscribes Medical hegemony and the disempowerment of the patient. On the other hand, therapeutic narratives may not tell of recovery or cure; they often deal with chronic impairment, progressive physical decline or terminal illness. The healing power of narrative does not equate to cure.

Illness narrative is sometimes perceived, within literary studies, as fostering writing that is pedestrian, boring and of little aesthetic interest (290). This perception rests on the idea that the subject matter – illness, disability and death – deserves special indulgence, and is an excuse for poor writing. The texts examined in this thesis demonstrate that illness writing need not be mediocre, and may indeed be entertaining, innovative and aesthetically significant. However the preconception of mediocrity does point towards the

possibilities for 'bad' writing in accounts of illness and therapy. Narratives of illness may slip into a victim positioning, they may embody self-pity and whine, along with resentment or blame towards others who have caused the suffering or failed to alleviate it. Victim narratives reinscribe a disempowering and marginalising construction of illness. Alternatively the narrative may present a false story – one that either overdramatises and romanticises illness or disembodies and trivialises it. The reality of a diseased and disabled body can be betrayed by a sentimental or sanitised account.

Illness writing can fall short of its potential to pose a counter discourse and may reinscribe medical and cultural master narratives. Couser points to the narrative of medical cure as one example of this; another is the 'conversion' narrative where illness is seen as a result of moral deviance and the ill person is restored (morally and spiritually) through confession, rejecting a sinful lifestyle, and embracing religion – a plot that Couser identifies in some AIDS narratives. Narratives that seek to normalise the ill person or demonstrate that s/he is 'no different' from those without disability can also entrench marginalising and stigmatic discourses of illness; stories such as that of the wheelchair bound 'supercrip' who does anything an able-bodied person can do and more, and distances himself from others with disability. Such narratives attest the human ability to triumph over the odds; they can make good stories but they are not therapeutic narratives in the sense that they sidestep or reinscribe rather than transform illness.

Thesis and choice of texts

The foregoing discussion has indicated that narrative can be a powerful means by which meaning is made and healing enacted. The focus of this thesis is on how a narrative of illness becomes a therapeutic narrative. I will examine a range of texts, aiming to identify the elements that transform narratives of illness into therapeutic narratives. Whereas Couser's study focuses on 'auto/biographies' of illness, I have chosen texts from a range of literary genres that include but are not limited to life-writing. Texts examined in the thesis reflect sampling rather than systematic survey of the vast field of illness

narratives: writing that deals in some way or another with illness, therapy and experiences of the Medical world.

The texts that I have chosen to discuss grapple with the experiences of illness and impairment in ways that perform, or at least attempt, a therapeutic effect. I have also tried to include writing that covers a variety of medical illnesses and problems, and that illuminates a range of different therapeutic strategies. Autobiographical influence is another factor I have considered in choosing texts. Life-writing is represented, amongst other genres including fiction, poetry and some drama and film. Blurring of the boundaries between genres – the recognition of autobiographical components in much fiction and other writing (as well as the fictive aspect of autobiography) – makes these distinctions less clearcut. However I have selected work in which the writer appears to draw upon personal experience of illness and suffering. In many instances the author has shown a clear therapeutic intention in writing; where this is not apparent, a healing function can be demonstrated in the text's story of illness.

My thesis has a pragmatic bent in the context of the academic discipline of Medical Humanities, and Medicine and Literature in particular. I have sought texts that are illustrative and entertaining, and have avoided overly theorising narrative. I have chosen, with a few exceptions, texts by Australian authors, partly as a way of limiting the field, partly to increase the relevance of this work for medical practice and the teaching of Medical Humanities in Australia.

Narrative's power to transform

Telling the story of illness may be a diversion for the writer, allowing a temporary escape from the body and the lived reality of suffering. Telling can ventilate and diminish feelings of fear, anger or shame associated with illness; it can comfort and console. The narrator of illness may seek to gain the understanding and sympathy of others. Telling is a way of confronting something that is difficult to accommodate: the reality of illness and a

disrupted life. Naming illness through telling is a means of gaining control over what threatens the self. Telling the story of illness is a means of validating and authenticating experience. These elements commonly play a part in illness narrative and contribute to its healing effect. Ventilation, diversion, comfort and validation could be classed as weaker therapeutic functions: they alleviate but do not transform the story of illness. They do not make a new story. The strong therapeutic function of narrative lies in its power to remake the story of illness.

I had another dream, and what I meant to say to you when I spoke of jungle cats and cassowary plumes was that, in this dream, I neither faced the lion nor kept on running – I leapt onto its back, stuck a hat on my head and rode off on it. I rode it. Yes, it's true, with my heart in my mouth, but also with true exultation.
(Dessaix Night Letters 272)

The closing lines of Night Letters return to the image with which the narrative began. The novel has worked the transformation prefigured at the start. My focus of particular interest in exploring narratives of illness is to uncover their transformative possibilities: how narrative might enable the teller to leap onto the back of the lion. I will show where narratives of illness become empowering narratives, asserting agency and contesting dominant discourses. Far from being dreary or sentimental, marked by blame or self-pity, such narratives are often mischievous and transgressive: the rider on the wild cat wears a flamboyant hat. They are subversive stories, unsettling master narratives and refusing subordination. They are perverse: stigma becomes an honorific mark and marginalisation a badge of belonging. They are playful, bringing wit and irony, metaphor and myth to transform the story of illness into a new story.

Chapter 2 Inside stories: narratives of medical writers

Catherine Hamlin The Hospital by the River – a medical ideal

Catherine Hamlin's narrative opens with the story of a 'fistula patient':

By now the mother may have been in labour for five or six days, but her misery is only beginning. The pressure of the baby has cut off the blood supply to her bladder, and the tissue has died. The poor woman is left with a hole, or fistula, between the bladder and the vagina. In some cases there is also a hole in the rectum. The contents of the bladder and bowel leak continuously through the vagina. Because of her offensiveness, she is usually deserted by her husband and ostracised by the village. She is condemned to a life of loneliness and shame. (9)

The fistula hospital set up in Ethiopia by Australian obstetricians Catherine and Reg Hamlin provides hope for such women – hope of cure and a new life:

Most likely she spends the rest of her life in misery. But occasionally her story ends with joy. Somehow she hears about the hospital. . . .

The hospital is quiet and clean, set amongst flowers. People treat her with kindness. . . . the miracle she has hardly dared to believe in happens. After a time she returns home, cured, to begin life anew. (x)

When Catherine and her husband began working in Addis Ababa in 1959, neither had seen an obstetric fistula, an 'academic rarity' in affluent countries like Australia (9). They learnt that this form of birth injury is common in Ethiopia, due to a combination of cultural and geographical factors – early marriage and pregnancy ('child brides' whose bodies are often too immature for childbirth), geographical remoteness and lack of medical care for women in pregnancy and delivery.

The two doctors were deeply moved by the suffering of these women. What began as a three-year contract became a lifetime devoted to treating fistula patients. The Hamlins developed surgical skills and procedures capable of curing all but a small percentage of the cases and became leaders in this specialised medical field. Eventually they set up a hospital dedicated to the treatment of fistula patients. The hospital represents a standard of excellence in care and treatment. It is a base for community outreach to find and treat the ostracised women in remote villages. It has become a centre for specialised medical training, a focus for community education on the risks of childbearing

at too young an age and a source of political lobbying for accessible obstetric care in remote areas.

Catherine Hamlin's account of their work epitomises the ideal of the medical grand narrative. Women suffering terrible injury to their bodies are treated with compassionate care and technological expertise. The patient is cured and given a renewed life. Medicine is the 'hero' of the narrative. Powerful doctors, charged with the knowledge and skills of scientific medicine and driven by humane impulse, repair a damaged body. The patient is acted upon: her role is that of a passive recipient of care and cure.

Other hegemonic scripts are woven into the history of the fistula hospital. Catherine Hamlin, who was born in 1924 and grew up in a middle class Christian household in pre-war Sydney, takes for granted the centrality of family, monarchy and church, and hints at a nostalgic regret for Empire. She sees healing as a central part of Christian ministry and witness – placing her life work firmly within the master narrative of Christianity. She values royal patronage of the fistula hospital, recounting in detail visits from members of the British royal family and emphasizing personal friendship with Emperor Haile Selassie and his kin. Catherine Hamlin accepts family life based on marriage and heterosexuality as the norm. She views with disfavour the cultural movements of the seventies towards greater sexual freedom and recognition of diversity. The underpinning certainties of early twentieth century western society form a context for Hamlin's narrative.

Framed by these master narratives, the story of the fistula hospital attests a particular medical paradigm – authority, expert knowledge and technological mastery, beneficently deployed for the good of humanity. In suggesting this I do not intend to detract from the Hamlins' remarkable humanitarian achievement nor from their personal compassion, humility, and dedication. Nor do I mean to belittle the achievements of the biomedical ideal, the enormous benefits it confers upon suffering humanity. But it is an ideal – and one that has been subject to critique.

I began by reading Catherine Hamlin's story into the heroic medical paradigm. Such a reading does not do justice to the complexity of the account. In many ways Hamlin's narrative unsettles the dominant medical discourse. For someone so seemingly 'conventional' Hamlin is a perverse figure. In the traditional medical model doctors are typically men. Here the author is a woman doctor, and moreover a specialist in the overwhelmingly male-dominated field of Obstetrics and Gynaecology. At the time when Catherine Hamlin qualified in Australia (1946) female doctors were rare, and even now only a small proportion of Obstetric specialists are women. Hamlin's professional role in itself represents a counter to the 'patriarchal' character of Medicine.² While Hamlin herself stands in contrast to the normative image of male doctor, she also portrays patients who shift into the doctors' territory, blurring the dichotomy between 'powerful active doctor' and 'passive grateful patient'. Some of the women treated by the Hamlins, often women whose injuries could not be fully cured, remained at the fistula hospital as carers and nurses. Many acquired clinical and administrative skills and expertise. The story of one outstanding woman is told in detail. At the age of sixteen, Mamitu almost died from the complications of obstructed labour. After extensive surgery for internal injuries, she was left with some residual incontinence. Abandoned by her husband, she stayed on to work at the hospital. Having become fluent in English and skilled in nursing, she learned the surgical techniques of fistula repair and gradually took on a large role, not merely performing fistula surgery but teaching doctors from other countries. The (black female 'native') patient who becomes a surgeon and instructs (white male 'western') doctors, is a figure of reversal on many dimensions. Mamitu is one person, but she, like Hamlin herself, stands as symbol for a broader challenge to the assumptions of the medical discourse.

Hamlin's story of the fistula hospital shows authority and control passing gradually from 'expert' Western doctors to local Ethiopian people – doctors, nurses and patients. The hospital now has an Ethiopian woman doctor as medical director. Local people, often women and others from marginalised

² Patriarchal aspects of Medicine are discussed in Chapter 5.

groups such as patients and the disabled, are taking agency in community outreach, education and political reform as well as in running the hospital and in the care of afflicted women. Perhaps it is not surprising that Hamlin's narrative contains insistent elements of counterdiscourse despite its conservative assumptions. The Christian teaching that impels Hamlin is often allied with conservative political and social values but it carries a radical message. A theme of reversal pervades the core of the Christian master narrative and is demonstrated in the writing of another doctor-author – Luke the Physician.

Luke: counter discourse in the physician's gospel

The gospel accounts of teaching and healing by Jesus are part of the script on which the master narrative of Christianity is based. One of the gospel authors, Luke, was probably a physician and was particularly interested in the stories of the sick people whom Jesus healed. Luke has been identified as the 'beloved physician' referred to in Col. 4:14, a member of the early church some seventy years after the death of Jesus. Evidence includes textual analysis of Luke's gospel, highlighting his interest in medical detail and his use of medical terminology (Knight 9-10). In the gospels, cure of illness is often associated with repentance and submission to divine will. However the gospel of Luke the physician can be read as giving another viewpoint on Jesus' healing. Luke incorporates a theme of reversal and healing is linked to this reversal.

Luke presents himself as a careful historical investigator and seeks to establish the factual authenticity of his account, but he also selects and modifies his source material to construct a narrative that emphasises particular themes (Tuckett 23). Reversal is one theme that underpins the gospel. Tuckett argues that Luke the author is aware of the need for adaptation of the gospel teachings to differing times and situations. Writing from a cultural and historical context removed from the time of Jesus, Luke does not interpret the narrated events, especially the teachings of Jesus, in a fixed and didactic way. He allows ambiguity and the possibility of diverse interpretations within the

frame of a reader's world (115). Luke's gospel narrative can be seen as subversive. It foregrounds the disregarded or despised – the poor, sick and insane; lepers, prostitutes and tax-collectors. It challenges and deflates political and religious authority figures and lifts up the powerless – children, women and social outcasts. Luke is often seen as commending mercy and social justice: his is a 'social gospel, with a bias towards the poor' (Tuckett 95). This theme is emphasised in material that is unique to Luke's gospel – such as the parable of the rich man and Lazarus, the Magnificat, the infancy narrative where the humble and insignificant are chosen for the leading roles. Accepted hierarchies of honour and shame are overturned.

This reading of Luke aligns healing with radical reversal – uplifting of the humble and outcast. Resistance to subordination and stigma emerges in many narratives of illness as a crucial therapeutic element. Embodied in Luke's gospel this theme resides at the centre of the master narrative of Christianity. Medical writers from the very different cultural context of twentieth century western society may also demonstrate the unsettling and perverse possibilities of narrative.

Medical writers and the medical paradigm

The discourse of western Medicine is grounded in science and technology. A knowledge base that includes anatomy, cell biology, physiology and biochemistry is allied with sophisticated technologies for probing, diagnosing and manipulating the body – healthy or diseased. This techno-scientific discourse has other assumptions and expectations embedded in it. Confidence and authority are its hallmarks. Medicine can solve problems, diagnose and cure disease, fix damaged bodies. Doctors and medical scientists are invested with power and authority as a result of their expert knowledge and technological mastery. Patients are passive, as the subjects of investigation and as the recipients of treatment. Bio-medical discourse carries a mystique that rests in privileged access to specialized knowledge and skills and confers authority on its practitioners.

This chapter examines what a medical background – study of medicine, medical knowledge, clinical practice and the experience of caring for patients – might contribute to creative writing. Medicine in the twentieth century has been influenced by paradigm shifts not only in scientific thought but also in cultural and intellectual perspectives. Such changes are mirrored in the work of creative writers who are part of the medical world. Furthermore, literature from within Medicine not only reflects cultural change but also contributes to it. Such literature may destabilise fixed assumptions, undermine established authority, anticipate new ways of practising health care and imply new ways of thinking about disease and therapy.

The following discussion is not intended to be an exhaustive survey or a history of medical writers (that would provide subject matter for a book in itself). I have made a selection from the work of writers who depict the medical world or draw on medical discourse in the process of creating narratives. The selection of medical fiction below ranges over (roughly) the first half of the twentieth century, a time during which Medicine stood clearly within the paradigm of modern Science, sharing its aura of authority and achievement. I have chosen novels that illustrate differing perspectives on the medical discourse. While the main body of the thesis deals with narratives of illness and therapy, the narrative of personal illness is not the focus of this section. However, several of these selected works do have both autobiographical and therapeutic aspects. Medical writers do not just reflect and contribute to shifts in the medical discourse – making the medical world more accessible, enabling patients to tell their stories – but in the process may sometimes construct healing narratives for themselves.

Arthur Conan Doyle (1859 – 1930)

Sherlock Holmes stories and medical tales

The Sherlock Holmes stories seem to epitomise the triumph of rationalism. Shrewd analytical reasoning, deductive logic and attention to the detail of factual evidence lead to the discovery of the ‘truth’ behind a confusion of false trails, deception and error. Doyle turns the scientific method of medicine to innovative and surprising uses and in the process often unsettles and even subverts traditional medical discourse.

Arthur Conan Doyle drew on a traditional medical background in his writing . He studied medicine at Edinburgh University and practised for ten years before leaving his work as a physician for a fulltime writing career (Hodgson 3). Doyle based the methods used by Holmes on the paradigm method of medical diagnosis. The model for Holmes was Dr. Joseph Bell, a surgeon at the Edinburgh Infirmary, ‘famous among the Edinburgh students for his wonderful ability to discover almost instantaneously not only the medical complaints but also the occupations and backgrounds of his clinic’s outpatients’ (Hodgson 4). Conan Doyle became Bell’s outpatient clerk (the job of a trainee doctor) where as he wrote later ‘I had ample chance of studying his methods and of noticing that he often learned more of the patient by a few quick glances than I had done by my questions’ (Hodgson 4). Doyle developed Dr. Bell’s method, close observation and inference from the cues offered by the body, into the celebrated paradigm of Sherlock Holmes’ deductive reasoning.

Just as the Sherlock Holmes stories are anchored in the certainties of scientific method and logic, so too they rest within and seem to take for granted the moral and cultural certainties of the time. These include a patriarchal social and family structure, capitalist economic values and work ethic, colonialism and Empire, and the authoritarian and sexist assumptions of Medicine. Yet it can be argued that Doyle’s writing unsettles the assumptions and certainties of his society and of the medical discourse.

Alastair Fowler contends that the later Sherlock Holmes stories are concerned with the inadequacy of the paradigm scientific method. Fowler argues in an essay on 'The Dancing Men' that Holmes' method of deciphering the cryptogram (the dancing men) represents the larger process of rational deduction that forms the basis of Holmes' method. Each Sherlock Holmes story begins with an exemplary demonstration of his deductive skills, a demonstration that serves to establish his credentials to the client (or new reader). However, Fowler suggests, the methods actually used by Holmes – in solving the cryptogram and in his investigations generally – are not predominantly deductive: the deciphering 'is a multifaceted process, combining inference, intuition, inspiration, chance, mistake and recourse to external knowledge' (358) and equally multifaceted is the actual process of Holmes' investigations. Holmes' famous methods extend beyond a rigid deductive paradigm to a more holistic intellectual process that includes 'intuition', 'inspiration' and wider knowledge.

Sherlock Holmes himself is an eccentric and problematic figure. Taking logical reasoning and the application of scientific knowledge to its limits he paradoxically approaches the exotic and mystical. This is illustrated in the familiar image of Holmes sitting on cushions like an Eastern mystic, in haze of tobacco smoke. He uses intravenous cocaine and morphine to 'clear' and sharpen his mind, despite Watson's remonstrances. A conventional man of medicine, Watson is duller and more pedestrian. Watson stands for worthy middle-class norms as well as providing an audience for Holmes' logical (and intuitive) feats and foil for his brilliance. Watson's commonsense observations and plodding reason are shown to be limited (often simply wrong) and his 'taken-for-granted' moral certainties, grounded in middle-class respectability, are unsettled by the perverse possibilities of bohemian freedom.

Holmes' detections reveal interdependencies and interconnections between the 'moral' middle-class society and its darker side of crime, poverty, begging and drug taking. In 'The Case of the Great Detective' Stephen Knight argues that crimes of greed (theft, dishonest monetary gain) represent the 'dark side' of the Victorian ethic of hard work, thrift and material acquisition, while

crimes that threaten the respectable structure of the bourgeois family reflect male sexual anxiety and the threat of female sexuality to patriarchal power. The prevailing patriarchal economy, in which men controlled property, and women were themselves property rather than owners, is reflected in the tales of Sherlock Holmes – reflected but also unsettled. Ambivalences, inconsistencies and injustice in the social position of women and property rights form a subtext in stories such as ‘The Speckled Band’.³

Women are often stereotyped in the Sherlock Holmes stories. The women who seek Holmes’ help are typically beautiful and helpless. Vulnerable and emotional, they are driven by passions – love or jealousy – rather than reason (for example the Premier’s wife in ‘Second Stain’). Possible prototypes of the ideal woman for ‘manly’ men like Holmes and Watson are Watson’s wife, remarkable for her complaisant absence, and Holmes’ efficient but almost invisible housekeeper. The world of the Sherlock Holmes stories is one where the heroes are men. Yet Doyle at times counters stereotypical images of women (and of men). He portrays men who behind a conventional masculine façade (tough and unemotional) are driven by tender feelings. The young husband in ‘The Curse of Eve’ is desperately anxious as his wife undergoes a difficult labour; the old man in ‘Sweethearts’ is bound to his wife by deep affection. Women can outsmart rational men – even Holmes. Irene Adler (‘A Scandal in Bohemia’) outwits Sherlock Holmes and represents a direct challenge to the superior positioning of (male) rationality. Verrinder Smith (‘The Doctors of Hoyland’) is a woman doctor⁴ who without fuss outdoes the male, Ripley, at every turn: in professional skill, surgical expertise, intellect and wit. Furthermore, with all her coolheaded efficiency she is compassionate and gentle.

The body is a significant focus of Conan Doyle’s interest. The body and bodily manifestations of disease, often gruesome, disgusting or pitiable,

³ A detailed analysis of the economic context of ‘The Speckled Band’ and critique of the story from this perspective is given in an essay by Rosemary Hennessy and Rajeswari Mohan (Hodgson 389-401).

⁴ Conan Doyle himself supported the admission of women doctors, a contentious issue at the time, as well as supporting women’s rights in the area of divorce law reform (Rodin and Key 285).

are foregrounded in some of the medical stories from the collection Tales of Medical Humanism and Values: Round the Red Lamp. The body tells the 'truth'. In Medicine physical signs of illness are the clues that lead an astute physician to the diagnosis. In detection the body provides forensic detail – minutiae of appearance, skin markings, muscular development, scars and deformities, peculiarities of posture – 'diagnostic' evidence that Holmes uses as a basis for his brilliant deductions and inferences. Yet the body can also lie. Holmes subverts it in his disguises. Deceit and disguise are much used by Holmes as well as by those whom he pursues. Disguise brings identity – including sexuality and gender – into question, blurring the notion of a fixed and certain 'self'. The master criminal John Clay ('The Red-Headed League') is chameleon and ambiguous in appearance: the text demonstrates that he is tough but at the same time effeminate, and he has characteristics of both the educated aristocracy and the lower-class criminal underworld. The distinguishing features by which Holmes identifies him are not intrinsic to the body but imposed on it: he is clean-shaven, with 'a white splash of acid upon his forehead' and 'ears pierced for ear-rings' (Hodgson 64). In 'Sweethearts', (supposedly) irreversible physical signs of old age are remarkably altered as an old man's melancholy gives way to joy following reunion with his wife. 'The Adventure of the Dying Detective' illustrates the ultimate deceit of disguise in making the body and its 'truth' problematic. In this tale Holmes feigns fatal illness. He convinces the villain, his housekeeper and even Watson the doctor that he is close to death. He achieves this deception by setting up their expectations, manipulation of his own body (by deliberate dehydration and starvation), clever use of props and make-up, and masterly acting.

Thus the Sherlock Holmes stories and Doyle's medical tales reveal an ambiguous view of the body. It is the source of evidence that can lead to discovery of the 'truth' – in solving mysteries (detection) as in solving of medical presentations (diagnosis). Yet paradoxically, familiarity with the body allows the detective – or criminal – to manipulate it, using disguise, acting and mimicry to mislead the observer and to belie the body's 'truth'.

The Sherlock Holmes stories disturb Victorian certainties about rationality and ‘commonsense’, social norms, the body and identity. Similarly, Conan Doyle’s medical fiction represents but also unsettles the traditional medical model. The (male) doctor was a figure of authority with access to specialised knowledge, skill to diagnose disease and expertise to treat; the patient was generally a passive object of examination and treatment. Conan Doyle’s medical stories portray doctors who are caring and compassionate, and sometimes foolish. Doyle demonstrates self-deprecating irony aimed at himself as physician. The importance of human involvement and feeling in medical care is placed on the same level as scientific and technical expertise in stories such as ‘False Start’ and ‘Behind the Times’. Doyle satirises scientific positivism and reductionism in ‘A Physiologist’s Wife’. ‘The Doctors of Hoyland’ wittily depicts the superior ability of a woman medical practitioner and punctures the self-satisfaction of her male colleague.

In the essay on ‘The Dancing Men’ referred to above, Alastair Fowler refers to a ‘contention that Conan Doyle wrote from a conviction about the inhumanity of contemporary medical practice’ (355). Fowler argues that Doyle recognises an element of callousness in the ‘objectivity’ of criminal detective analysis, parallel to that in medical diagnosis. There is a tension in the text between Holmes’ (and the reader’s) pleasure in the purely intellectual problem-solving, and the real risks and suffering faced by the client – just as there may be tension between the physician’s interest in academic diagnosis and the patient’s human needs. Tension in the medical transaction is captured in ‘The Third Generation’, where a young man receives the devastating diagnosis of congenital syphilis. The doctor is compassionate and empathetic, but for a moment he is distracted by the sheer intellectual pleasure of discovering the classical clinical signs of the disease, forgetting what they signify for the patient:

... a glow of pleasure came over his large expressive face, a flush of such enthusiasm as the botanist feels when he packs the rare plant into his tin knapsack . . .

‘This is very typical – very typical indeed,’ he murmured, . . .

He had so forgotten the patient in his symptom that he had assumed an almost congratulatory air towards its possessor. . . .

The young baronet sank back in his chair and his chin fell forward upon his chest. (Round the Red Lamp 71-2)

Some of Conan Doyle's stories problematise simple-minded confidence in scientific progress. 'The Los Amigos Fiasco' is a farcical satire on misguided application of scientific technology. 'The Creeping Man' plays with the idea that medical science itself can be subverted in the name of 'progress'. Injections of monkey serum are used to rejuvenate the ageing Professor Presbury when he seeks to attract a much younger woman. The extract confers remarkable energy and vitality, but it also makes the professor 'brutish' – he not only climbs and 'creeps' like a monkey but becomes enraged and spiteful (cruelly tormenting his dog, for example). The story suggests the dangerous possibilities of scientific experimentation, especially if used for selfish or 'unnatural' ends. Doyle affirms a view of evolution as 'progress', the human a moral and spiritual being who has 'risen' beyond mere animal nature. He suggests that attempts to manipulate nature would cause degeneration to a more brutish state. Through the voice of Sherlock Holmes, Doyle puts the ironic view that evolution could become regression, with selection of the morally and spiritually inferior, if man took control of nature: "It would be survival of the least fit. What sort of cesspool may not our poor world become?" (Round the Red Lamp 419). The story anticipates bio-ethical dilemmas such as those associated with genetic engineering, and it embodies an understanding that advances in medical technology have social and moral implications.

Conan Doyle 'plays games' with the medical discourse. The stories in Round the Red Lamp place medical practice within a satirical and humanising perspective and form a critique of some assumptions underlying medical practice. In the Sherlock Holmes stories Doyle deploys elements of the medical discourse – of science, rationalism and the diagnostic process – for purposes of entertainment, in stories of mystery, puzzles and problem solving. He uses medical discourse in innovative and perverse ways and in the process sometimes unsettles and subverts the medical discourse itself.

W. Somerset Maugham (1874 – 1965)

Of Human Bondage (1915)

I began . . . to be obsessed by the teeming memories of my past life...they became such a burden to me, that I made up my mind there was only one way to be free of them and that was to write them all down on paper. . . . The book did for me what I wanted . . . I found myself free from the pains and unhappy recollections that had tormented me. . . .

[it is an] autobiographical novel; fact and fiction are inextricably mingled; the emotions are my own, but not all the incidents are related as they happened. (Of Human Bondage Foreword 6-7)

Somerset Maugham trained as a doctor (1892-97) but turned to a full-time career in writing and did not practise medicine. His ‘autobiographical novel’ Of Human Bondage is both a naturalistic portrayal of the medical world of the time – based on Maugham’s direct experience – and a therapeutic narrative for the writer. It includes an account of his experiences as a medical student and young doctor. The novel can be read as a generally uncritical presentation of the class system and sexist assumptions of his time and in particular of the patriarchal medical system under which he trained in England. However the text resists unquestioning acceptance of the cultural and medical norms. Maugham claims, in the excerpt above, that the novel was intended as a form of self-therapy and that it achieved this purpose. Philip Carey, the central character, is set apart from other men by his disability, a club foot. Philip’s gaze on his society and on the medical world from his marginalized position is one of critical appraisal. Moreover the club foot can be read as a coded symbol for Maugham’s homosexuality (Calder 68-9) and thus for his own experience of difference and exclusion. The therapeutic function of the novel for Maugham lies (at least in part) in coded ‘telling’ of his hidden sexuality and in covert questioning of cultural norms. It is the same perspective – one from the periphery rather than the mainstream of society – that promotes a critical slant on the medical discourse.

Philip’s sense of difference and vulnerability is represented by his club-foot. This disability, the club-foot, is a code for the hidden ‘disability’ of Maugham’s homosexuality. Homosexuality is a crucial although covert

subtext in the novel. Biographer Robert Calder surmises that Maugham was ‘haunted by the self-condemnation of one who truly believed in the narrow sexual morality of an earlier age’ (324). Homosexuality exists in the novel as in English society of time, denied and invisible. Ted Morgan (36-39) gives a summary of social attitudes to homosexuality in Victorian times. It was illegal and hidden, considered as an immoral and disgusting perversion or denigrated as an illness. The trial of Oscar Wilde in 1895 highlighted the negative social attitudes and the legal danger of identifying as a homosexual. In this cultural milieu homosexuality was associated with shame and often with denial or desperate efforts to be morally and psychologically ‘cured’. Maugham did his best to conceal his homosexuality and tried to minimise it even to himself: “‘I tried to persuade myself that I was three-quarters normal and that only a quarter of me was queer – whereas really it was the other way round’” (Calder 68). Although he had male lovers and a long-term relationship with his secretary, Gerald Haxton, the homosexual relationships remained hidden while Maugham openly claimed several heterosexual affairs, married and had a daughter. Homosexuality was absent or disguised in his writing as it was denied in his life. The subtext of the novel thus becomes a way in which Maugham ‘tells’ and works through the shame and conflicts, the ‘bondage’ of his sexuality. From this perspective the novel sets up a counter discourse and (as Maugham claims) enacts therapy. Philip is not ‘cured’ but does come to terms with his difference and overcomes his ‘morbid sensitivity’ and like his alter ego, Maugham was left with a sense of resolution and freedom when he had written the novel.

The social context of the novel incorporates the sexist, class-based social norms of Victorian England. Maugham’s attitude to the conventional medical world may be interpreted in the light of the novel’s depiction of cultural norms generally. The young Philip at the start of the novel accepts to a large extent the injustices and hypocrisy of his society – including his own positioning as crippled and insignificant. (In a similar way the young Maugham would have internalised the dominant culture’s stigmatising view of homosexuality.) The mature author sees from a broader perspective – he is aware of the oppressive effects of cultural norms not only for Philip as

'cripple' but for others: the socially ostracised, the poor, women. The author takes a more subversive view than did the young Philip; he exposes some of society's injustices, particularly those he saw in his medical work.

Maugham's attitude to women is ambiguous. He does little to challenge the subordinate position and restricted opportunities for women of his time, and is often considered misogynous for his contemptuous depiction of women, particularly Mildred Rogers and Fanny Price. Yet this novel contains sympathetic portraits of some female characters. Calder refers to Maugham's 'believable women' such as Aunt Louisa and Norah Nesbit (74-5). Aunt Louisa is generous in her undemanding, motherly affection for the orphaned Philip. The constraints and disappointments of her restricted life are recognised, as is her forbearance with her pompous, selfish husband. Norah is strong and resilient, capable of loving warmly but able to make her own way in life. Separated from her husband, she supports herself by her writing. Her financial independence parallels an emotional toughness that enables her to forgive Philip's exploitation and desertion of her and to avoid bitterness and get on with her life. Her success both in remaining independent, and later in finding contentment and security with the editor Kingsford, are represented as no more than she has earned for herself through her courage and generosity.

The text hints at the injustice and hypocrisy of patriarchal and sexist assumptions but it is a limited critique of women's subordinate position in the society. Even the sympathetically portrayed women are seen and valued in male terms – how they serve male needs. In reading Maugham's attitude to women, it is relevant that Mildred (the object of Philip's masochistic sexual desire) who is scathingly portrayed as shallow, coarse and manipulative actually stands for a 'youth' with whom Maugham was infatuated (Morgan 196). This interpretation casts a different light on Maugham's view of women, for it is Mildred who is most savagely dealt with in the novel. However the uninformed reader cannot know that Mildred's repulsive characteristics belong to a young man. By using a woman to carry loathsome qualities and to represent the object of his own shaming obsession, Maugham reinscribes both sexist and homophobic positions.

If Maugham's attitude to women and to their subordinate position remains ambivalent, the novel does critique other aspects of Victorian society. Religious hypocrisy is satirised in the depiction of Philip's uncle, the vicar William Carey, who is selfish and pompously self-righteous. Philip comes to see conventional religion as a sham, and his questioning of its dogma is reinforced by confrontation with human suffering and social injustice. Descriptions of Philip's medical work among the poor in the outpatient clinic at St Luke's hospital and in the slums of London reveal his growing awareness of their plight. Philip feels an empathy with the patients he sees, and senses a responding trust:

Philip found that he was less shy with these people than he had ever been with others . . . he felt at home with them. He found that he was able to put them at their ease . . . it seemed to him that the patient delivered himself into his hands with a peculiar confidence. (399)

Philip's deformity, his sense of difference and vulnerability, sharpen his awareness of the human plight and make him feel 'at home' with the clinic's stream of patients, 'humanity in the rough' (399). Ironically, it is his disability that enables Philip to experience power, as the patients confidently deliver themselves into his hands.

Carey's club-foot, as indicated, can be read as a code for Maugham's homosexuality. At the same time the novel's characterisation of Philip as a 'cripple' suffering the constraints and pain of physical handicap provides a realistic and physically grounded representation of embodiment. Maugham foreshadows the view that disability is (in part) culturally constructed. It is the attitude of Philip's peers and others rather than the physical deformity itself that determines the degree to which it restricts his life and relationships – he may disregard his limp as irrelevant, but others do not allow him this choice. He can walk and play tennis well although he does not dance – it is other people's view of him as 'deformed' and his own 'morbid' self-consciousness that constitute his disability rather than the bodily fact. He can run to catch a train ('abled') – but appears awkward and clumsy ('disabled'). Fanny Price makes him very angry by implying that they are alike and both set apart for this reason – she is ugly and awkward, he is deformed – whereas the other art

students do not treat him as disabled. In contrast to shaming and disabling attitudes is the matter-of-fact acceptance Philip observes in a child with a club-foot at the Surgical out patient clinic. He is not self-conscious, and is interested in his 'deformity' rather than ashamed:

He was a jolly boy, not at all shy, but talkative and with a cheekiness which his father reproved. He was much interested in his foot . . . Philip . . . could not understand why the boy felt none of the humiliation which always oppressed himself. (411)

Maugham inverts humiliating constructions of disability through his satire, using the club-foot to illuminate characters in the novel. Norah is matter-of-fact, she is not bothered by it and suggests to Philip that 'people don't think about it nearly as much as you do' (318). Fanny however uses it in an attempt to align Philip with herself as an outsider (216). Philip recognises weakness in himself when he exploits his limp to gain Mildred's sympathy (297). Other people can use it as a way of hurting him:

Philip knew by now that whenever anyone was angry with him his first thought was to say something about his club-foot. His estimate of the human race was determined by the fact that scarcely anyone failed to resist the temptation. (255)

Mildred's coarseness and spite are fully revealed (after Philip has rejected her sexual advances, now repugnant to him) in the final insult she spits at him: "Cripple!" (480). Ironically, the club-foot exposes the moral 'disability' of those who use it to wound and humiliate Philip.

The account of Philip's medical training and his encounters with patients is based on Maugham's own experiences. In general it is a factual and realistic portrayal: the description of Philip's work as a student of anatomy in the dissecting room (262), for example, could illustrate a history of medical education. Yet Maugham emphasises the human rather than the scientific face of medicine. Philip's fellow student Griffiths possesses a healing power that is distinct from technical mastery. Griffiths is 'an awful fool at books' and is 'ploughed in his examinations time after time' (328), but his kindness and genuine humanity make him a good doctor. When Philip is very ill and bedridden with influenza Griffiths nurses him, even washing his body 'with charming tenderness' (327-8). His mere touch, a 'large cool, dry hand' on

Philip's forehead, suggests healing (326). The 'feminine tenderness of this strong young man' (328), the homosexual innuendo of the scene, and the intuitive quality of Griffiths' care, all contest dominant discourses of 'masculine' biomedicine.

The novel provides little detail of Philip's pre-clinical medical training. This reflects his relative lack of interest in the techno-scientific basis of medicine. When he comes to work as clerk in the outpatients' clinic, Philip is seized by the human meaning of what he sees. The account emphasises his interest in people with illnesses rather than 'cases':

To the others men and women were only cases, good if they were complicated, tiresome if obvious; they heard murmurs and were astonished at abnormal livers; an unexpected sound in the lungs gave them something to talk about. But to Philip there was much more. . . . You saw in that room human nature taken by surprise, and often the mask of custom was torn off rudely, showing you the soul all raw. (399-400)

Philip listens to the patients tell how illness has affected their lives. Their stories evoke his compassion and respect for the individuals who are objectified as 'interesting cases' by other medical students. This episode does more than place the conventional medical discourse against a more humanised view: it conveys a sense of the narrative basis of the medical encounter.

Philip's obstetric work in the London slums focuses interest on the narratives of peoples' lives. It also reveals an awareness of social inequities, poverty and hardship. The novel makes the link between the harsh lives and powerlessness of the women and their experience of illness:

The people who dwelt here lived from hand to mouth. Babies were unwelcome, the man received them with surly anger, the woman with despair . . . Philip often discerned the wish that the child might be born dead . . .

The great difficulty was to keep the mothers in bed for ten days . . . no one would see to the children without payment, and the husband grumbled because his tea was not right when he came home tired from his work (559-60)

Philip is sensitive to the human drama of his obstetric 'cases': childbirth and its risks, unwanted pregnancies, the death of a baby or a mother. At the last confinement he attends during his training, the sixteen year old mother dies

from haemorrhage that cannot be stopped. He reflects afterwards on the life that would have been ahead for her:

It was cruel that a stupid chance should have cut off her life . . . but in the very moment of saying this to himself, Philip thought of the life which had been in store for her, the bearing of children, the dreary fight with poverty, the youth broken by toil and deprivation into a slatternly middle age . . . (567)

A 'narrative' depiction of medicine such as Maugham gives in this novel runs counter to the assumptions of his training – assumptions of scientific medicine as supreme, and patients as cases whose human feelings are ignored. The novel contests the dehumanising tendency of medicine. A theme of compassion pervades the factual record of medical experience. The novel also has a therapeutic subplot, in the motif of Philip's club foot as a code for homosexuality. Therapy for Maugham lies in the covert admission of homosexuality and in resisting conventional norms of sexual identity. The link between these two elements is their perversity, their unsettling of dominant discourses. Narrated from the perspective of the misfit the account contests the writer's marginalisation and gives recognition to others who are subordinated.

A. J. Cronin (1896 – 1981)

The Citadel (1937)

The Citadel was made into a Hollywood movie in 1938, indicating the great popular appeal of the medical model that it embodies: an idealised view of scientific medicine with the doctor as hero. The film version increased the novel's accessibility to the general public and dramatised the heroic medical model for a wider audience. Popularisation of the novel continued with its adaptation as a BBC series in 1983 (Salawak 60) which promoted more widely still Cronin's idealised vision.

A. J. Cronin practised Medicine for ten years before turning to full time writing. His novels, The Citadel in particular, reflect his experiences as a doctor, and his faith in the 'master narratives' of his time. His writing has strong religious and humanist underpinnings. It reflects his commitment to social justice and to democratic egalitarian ideals, his belief in progress and his

confidence in the ability of science, especially biomedicine, to improve the human lot. The popularity of his writing in the United States perhaps indicates that he struck a sympathetic note there with his scientific, moral and democratic convictions. Cronin critiques medical practice of his day for its shortfall from such standards. He condemns the failure of medical practitioners to apply the findings of scientific research and their use of outmoded and unproven treatments, and he satirises doctors who prostitute their medical expertise and authority for wealth and social status. These concerns are given voice by Doctor Andrew Manson, hero of The Citadel, in impassioned outbursts:

‘It’s the jackals who give all these unnecessary injections, whip out tonsils and appendices that aren’t doing any harm, play ball amongst one another with their patients, split fees, perform abortions, back up pseudo-scientific remedies, chase the guineas all the time.’ (389)

‘There ought to be a great attempt to bring science into the front line, to do away with the old bottle-of-medicine idea, give every practitioner a chance to study, to co-operate in research. And what about commercialism? – the useless guinea-chasing treatments, the unnecessary operations . . . The whole profession is far too intolerant and smug.’ (442)

Cronin’s political stand is reformist within progressive democratic models of his time. He does not critique the assumptions of scientific biomedicine, but rather the social constraints and conservatism that restrict its progress.

Some of the convictions that imbue Cronin’s writing may be traced to his early experiences, outlined in Dale Salwak’s study. Cronin’s childhood was marked by loneliness and a sense of being an ‘outsider’. His mother, who came from a Scottish protestant family, converted to Catholicism to marry a Catholic. However when the boy was seven his father died and his mother returned to her parents. As a child Cronin felt isolated by the family’s poverty and by religious bigotry: he was brought up as a Catholic in a sternly Protestant community. From these experiences he was left with ‘an almost inordinate affection for the underdog’ (Salwak 5). He was also left with a determination to ‘rise above misfortune and justify himself’ through hard work. He chose the medical profession for its promise of financial security: he wanted to be a writer, but felt he must choose a career that was ‘sensible . . . safe and practical’ (6). Cronin’s medical training at Glasgow University

included a three-month course in obstetrics, attending cases in the slums of Dublin. Here for the first time he became sharply aware of the harsh conditions and privations of the very poor. He practised medicine from 1921 until 1930, when he took up writing as a full time career. Many of his own clinical experiences are portrayed in The Citadel. These include gruelling work in Welsh mining towns, research into lung disease resulting from coal dust inhalation, and fashionable London practice with its ‘useless guinea-chasing treatments’ and shady ethics. The accounts of Andrew Manson’s work carry the conviction of an authentic record of medical practice at the time.

Grounded in realistic detail of medical practice, The Citadel presents an idealised and heroic portrayal of medical achievements. On one occasion, Doctor Manson saves the life of a baby born to a previously infertile middle-aged couple (83-86). After a difficult delivery the baby is apparently stillborn. The doctor first resuscitates the collapsed mother then works on the baby, performing a crude form of external cardiac massage, and against all hope succeeds in reviving the child. The incident is portrayed in dramatic images, the language is emotive, and religious references imbue Medicine with divine associations:

The sense of life, springing beneath his fingers after all that unavailing striving was so exquisite it almost made him faint. He redoubled his efforts feverishly. The child was gasping now . . .
‘Dear Father in Heaven,’ the nurse sobbed hysterically. It’s come . . . it’s come alive.’ (86)

Later Manson returns to the house and sees ‘the mother, her plain middle-aged face gazing in dumb happiness towards him, the babe sucking quiet and warm at her full breast.’ The midwife reminds her that “‘you wouldn’t never have another at your age. It was this time or *never*...” and the old grandmother interrupts, “‘We know we do owe everything here to *doctor*” (88). The heroic status of the doctor is emphasised by the trust and gratitude of the humble family.

In another incident that constructs the doctor as hero Manson amputates the arm of a man who has been trapped in a mine collapse. Working under desperately difficult conditions (no anaesthetic, no assistance, poor

light, dripping water) and in constant danger of a further cave-in, Manson frees the miner and saves his life. The episode is based directly on an experience from Cronin's time in the Welsh mining community of Rhondda (Salwak 11). Cronin depicts the crude surgical procedure with authentic detail that underscores the drama. The incident epitomises the heroic model of Medicine with the doctor at its centre, saving life through his skill and courage in a crisis.

The romantic, rugged Medical world held up in The Citadel is a patriarchal model. Cronin takes for granted the gender norms of contemporary Medicine and his wider society. There is a warm glow around the traditional family, motherhood and the domestic role of women (as in the childbirth episode above). Men carry out manly functions – mining, scientific research, Medicine. The typical doctor is a man: his role demands masculine qualities such as courage and strength as well as a propensity for decisive action and objective rationality. While the doctor is depicted as male, robust and dominant, nurses (female) are inferior and subservient, patients passive and grateful, and a loyal little wife at home cares for the doctor's needs and provides emotional nurture.

In general, female characters in the novel are stereotypes. They include a vamp (Frances), a 'good woman' (Frau Schmidt) and an innocent young girl succumbing to tuberculosis (Mary). Women remain subordinate and are defined in relation to men and how they serve men's needs. There are suggestions of a critique but this is not followed through. Doctor Manson's wife Christine is shown to be better educated and more insightful than he is. She argues for clear standards: a work ethic of professional and scientific integrity against 'guinea-chasing'. She stands for simplicity and asceticism against materialism, true friendship against associations motivated by snobbery, and rural life and nature against industrial urban squalor. Her symbolic significance is captured in an episode where Manson has reached a low point of shoddiness in his medical practice, has become preoccupied with wealth and social status and is unfaithful in his marriage. He enters his home to find Christine reading the gospel of Luke the physician – the gospel

characterised by themes of reversal, mercy and humility. Manson is scornful, deriding her as a ‘neurotic woman’ (354-5). Christine’s role remains passive – she cannot force her husband to change or even hear her point of view. She resists his corruption and anger by quietly holding true to her principles. The novel eventually makes her the sacrifice for Manson’s regeneration: *her* death is *his* punishment for self-deceit and the betrayal of ethical and professional standards, and is the instrument of his moral and professional renewal.

A significant source of the doctor’s authority in The Citadel is his power over the body. In the novel the body represents an unambiguous ‘truth’. The physical signs of disease can be accurately read by those trained to do so. In his research into lung disease caused by silica, Manson examines miners:

his clinical skill was now quite brilliant. There, in the changing room the men stood before him, stripped to the waist, and with his fingers, his stethoscope, he plumbed uncannily the hidden pathology of those living lungs: a fibroid spot here, the next an emphysema, then a chronic bronchitis. . . . Carefully he localised the lesions upon the diagrams printed on the back of every card. (211)

Here the body is presented as being an objective physical truth, and at the same time intimate and vulnerable. The imagery suggests the doctor’s power, his gaze and touch penetrating the secrets of the exposed body. There is no question of Manson’s benign, even altruistic, purpose in performing his examinations and research. The point is that Cronin’s writing expresses unquestioning confidence in the ‘truth’ of the physical body, and in the power of medical skill and science to discover its secrets. Clues provided by the body reveal much about the person, to a discerning gaze. For Cronin as for Doyle (and his mentor Bell) the body’s truth extends to the signs that it carries of a man’s emotional and even moral state. In The Citadel Manson’s physical state reflects his moral journey. His hectic energy and restlessness in the whirl of pursuing money and social status, his sickness and loss of appetite following Vidler’s disastrous death under the surgeon’s knife, and his physical disintegration after Christine’s death are contrasted to his surges of physical strength and well-being when he is tackling worthwhile tasks of medical practice and reform. Unlike Conan Doyle, who intrudes unsettling motifs of disguise and deceit, Cronin consistently assumes the body’s unambiguous truth. Medicine holds power through expert knowledge of the body.

Another underpinning certainty of modern Medicine is faith in the ability of techno-science to solve problems. This is a frequently recurring motif in Cronin's novel. The theme is exemplified in the account of Manson's research into anthracite based lung disease (silicosis). Details of the research process are described as Manson uncovers the chain of chemical cause (silica dust), its pathological effects on lung tissue, and the clinical pulmonary disease in miners (217). Manson goes further, noting the social and political implications of his research:

He thought of the vast numbers of underground workers in the great anthracite mines, the looseness of the legislation upon the disabilities from which they suffered, the enormous social importance of this line of investigation. (210)

Cronin emphatically endorses confidence in 'progress' that is based on the co-operative advance of science and social reform. According to this optimistic model, scientific research yields knowledge that can then be applied through better occupational and social conditions to progressively improve the lot of mankind.

Cronin holds up standards of good doctoring, professional integrity and medical ethics as part of the medical discourse that he espouses, and measures the failures of Medicine and of the wider society against these standards. He does not question the underlying techno-scientific and patriarchal assumptions of medical discourse. Of the two writers to be discussed next, Monica Dickens resembles Cronin in her broad concurrence with the medical discourse, whereas Mary Renault presents a far more radical critique of medical as well as cultural norms.

Monica Dickens (1915-1992) and Mary Renault (1905-1983)

Mary Renault and Monica Dickens trained and worked as nurses in the same social context, England during World War Two. Yet Dickens' One Pair of Feet (1942) and Thursday Afternoons (1945), both based on her hospital experience, largely reinforce the medical and cultural discourses of her time, while Renault's early novels, particularly the hospital-based Purposes of Love (1939) and The Charioteer (1953), contest and undermine the normative

assumptions of medical patriarchy and challenge dominant social discourses of gender, heterosexuality and military authority.

The differences between the two writers' work reflect their personal positioning in mid-century English society. Monica Dickens' upper class background is depicted in the autobiographical novel One Pair of Hands. The great-granddaughter of Charles Dickens, she was educated at St Paul's School for Girls, travelled abroad before continuing her education at a theatre school, and was presented at Court as a debutante. Although she worked in various jobs including cook-general, she was not driven (as Renault was) by the need to support herself. Her children's stories (the Follyfoot Farm series) attest to her lifelong interest in horseriding, another marker of upper-class status. In 1956 she married an American naval commander and continued in a family life of respectable affluence in the United States. Mary Renault by contrast was marginalised in several ways, as Sweetmann's biography reveals. Growing up in a conflict-ridden family, she experienced emotional rejection by her parents, poverty and invalidism (she was bedridden with rheumatic fever for a full year as a young woman). She was a lesbian at a time when this identity was denied or derided by mainstream society. She struggled to support herself by gruelling work as a nurse in her early years of writing, and later moved to South Africa with her lifelong partner, fellow nurse Julie Mullard, to work full-time as a writer. The difference in the two women's respective 'fit' with the norms of their society is reflected in the way dominant cultural assumptions are presented in their writing. Further, while Renault's writing can be argued to have therapeutic functions, there is little transformative therapeutic effect in Dickens' novels.

Monica Dickens One Pair of Feet (1942) and Thursday Afternoons (1945)

Monica Dickens has published more than thirty novels, autobiographical accounts and children's stories. There have been television and film adaptations of many of her books, indicating the popularity and accessibility of Dickens' work in the public arena. One Pair of Feet and Thursday Afternoons give irreverent accounts of the medical world, serving to

undo its mystique and poke fun at its pretensions and hypocrisies. Yet despite this, Dickens' representation of the hospital world generally works within the medical discourse, accepting its assumptions rather than posing a critique.

One Pair of Feet is based on Monica Dickens' training as a nurse during the first year of WWII and Thursday Afternoons, although not autobiographical, also draws upon her inside knowledge of the hospital world. Both accounts reflect the broader social assumptions and prejudices of the time. Working-class people, homosexuals and Jews, as well as pacifists and Germans, are often represented in Dickens' novels by negative stereotypes – ridiculous or contemptible. Much of the comedy derives from parody of lower-class patients, stereotyped as ill-educated and thick-skinned. No uncertainty troubles her patriotism: One Pair of Feet wholeheartedly endorses the British war effort, the usual position at the time (Renault's ambivalent and ironic insights into war and pacifism are remarkable by comparison). In one episode, two German airmen, injured when their plane is shot down, are admitted to the surgical ward. Dickens is unequivocal in her judgement:

Naturally, they both hated being here as much as we hated having them. They both had fractures and were difficult to move, and anything one had to do for them, like bathing them or making their bed, took a long time. I suppose if I had been a good nurse I should not have grudged this time, but I did. (189)

Whereas Dickens clearly places the German servicemen as Other, Renault's attitude is one of troubled but inclusive compassion. In a contrasting scene in The Charioteer, an air battle takes place near the hospital. Nurses and patients (wounded servicemen) cheer and laugh as a German plane is shot down nearby, exploding in midair – but Laurie is struck by the reaction of Dave, one of the conscientious objectors. Dave's expression registers a profound compassion that encompasses 'enemy' equally with friend:

on the outskirts of the group he saw Dave. At first his face seemed almost expressionless, till one looked at his eyes. They looked as if they were trying to remember what the first sharp impact of the world's grief had been. (70)

Dickens' depiction of an elderly Jewish man, evacuated from a London infirmary due to the blitz, is derogatory and stereotypical; even his hatred of the German prisoners is sinister where hers is patriotic:

Judas Iscariot, of course, nursed as big a grievance as anybody. He would lie with his glinting eyes trained on the screens, muttering Hebraic imprecations and complaining to the nurses that there was a bad smell in the ward. If anyone smelt, it was he himself. We told him so. It didn't matter what you said to him; he was ununsultable. That was the creepy part about him. (190)

Homosexuality is also a target for Dickens' mockery. She depicts the homosexual as a deviant marked by deceit and pettiness. Mark Stainer, for example, the manipulative publisher in Thursday Afternoons is placed as a homosexual by denigratory signals: effeminacy, personal vanity, fussiness, hypochondria and petulance. His 'deviant' sexuality is by implication linked to his questionable business ethics and weakness of character.

Aligned with Dickens' uncritical reflection of cultural norms and assumptions about social class, race, patriotism, gender and sexuality is her broad acceptance of the patriarchal system of authority in the hospital world and wider society. The representation of nurses in One Pair of Feet often reinscribes popular stereotypes such as man-haters and frustrated old maids. Marriage is taken for granted as preferable to a career in nursing, if the choice is given. One sister hesitates about whether to accept a marriage proposal – she does not want to leave nursing: “I love this work so much, I don't know that I should be happy without it. If I could marry him and still stay on here – but I couldn't” (159). Nurse Dickens' reaction typifies sexist assumptions of the time:

Even if he had not been so nice, there seemed to me to be no question between getting married and withering away your womanhood in a hospital.
. . . If he had any sense he would just sweep her off to church before she could get her breath.
It wasn't my place to tell her that I thought she was daft as a brush. (159)

Dickens largely accepts the gender hierarchy of the hospital world, which is savagely critiqued by Renault. Dickens does not question the dominant position of (mostly male) doctors although she satirises individual doctors. Like Cronin, she highlights the heroic stature of doctors. Their work is dramatic: they cure diseases, perform surgical feats, save lives. In the following example, the imagery links male power with other discourses of power: science, class and religion ('*scientific drama*', *Sir Curtis*, 'miraculous'). The simile of cleaning a pipe underscores the masculinity of surgery:

I loved working on the Theatre. Operations were enthralling, each one a scientific drama. . . . When I saw Sir Curtis Rowntree removing clots from a femoral artery as easily as he would clean his pipe, I thought that nothing could be more miraculous until I saw Mr Vavasour do a Caesarean. (170)

Nurse Dickens stands humbly at the fringe, waiting to be called to fetch and carry for the surgeon, otherwise ignored, but revelling in the drama and acquiescent in her subordination:

the fumes of ether and the necessity of standing motionless for two hours or more, makes you feel slightly dizzy. You dare not lean against a wall, so you stand on, feeling noble, a swaying figure in the shadows outside the cone of light which throws up the dramatic grouping of the concentrated figures. (171)

Thursday Afternoons also reinforces contemporaneous discourses of the medical world and wider society. The humour in both novels often resides in stigmatic caricature. Nurses are commonly denigrated, shown as intellectually inferior and professionally subservient to doctors. They may be young and silly, fawning on the heroic doctor, old-maidish, or ‘motherly’. Dickens largely ignores the possibility of authentic identity for nurses, for example as competent professionals. Nurse Lake is plain and ‘frustrated’. Her infatuation with the charming Doctor Sheppard is pathetic. The narrative underscores her foolishness but suggests no critique of the social system that has moulded her aspirations and restricted her opportunities.

Monica Dickens’s representation of the medical world endorses its assumptions and its discourse of power. Although her writing is irreverent and satirical, the humour largely targets stock ‘types’ – garrulous, ungrammatical patients, Sisters who are dragons or eccentric spinsters. Medicine remains the hero. Dickens uses scenarios that highlight the successes or the heroic failures of medical science, as does Cronin. In One Pair of Feet Mrs Colley returns from surgery collapsed and near death when Nurse Dickens is working on night duty. A young doctor and two nurses save her life with an injection of a cardiac stimulant and an infusion of intravenous fluids. In another episode, a man with severe burns, Jack Roper, is admitted along with twenty other badly injured men following a factory explosion. The man is described in a way that emphasises his youth and vulnerability:

He was unconscious, but breathing, his face waxy and an ominous blue shadow round his nose and lips. I could just feel his pulse. . . . I couldn't undress him; his overalls were burnt into his skin in places. . . . he was quite young, with a fine straight nose and curly mouth and brown, soft boy's hair. (53)

The scenes of frantic activity on the ward and in the operating theatre are depicted with authentic detail. There is a sense of drama as doctors and nurses work desperately to save the men. The surgeon, exhausted but grimly battling against death, is an heroic figure:

Mr Briant was examining my man sketchily when I got back. 'None of them are fit to go to Theatre,' he muttered, 'but I daren't leave them.' His long chin was dark with a stubble of beard and his eyes bloodshot. I remembered that the night nurse on Maternity had told me he had been up all the night before with a Caesarian. 'Get him up as soon as you can,' he said. 'He's got a chance.' (53)

Although four men die, already beyond help when admitted, Roper is successfully resuscitated and makes a gradual recovery. Dickens has 'an oddly possessive feeling' for him: 'Jack must not die. It was a kind of conflict between myself and the evil force that destroys youth' (57). After about a week Roper seems out of danger. Dickens is off duty when she hears that he has collapsed. The episode ends abruptly here, with the implication that Roper dies. Despite his death the episode works to valorise Medicine in a manner reminiscent of the scene in which Manson amputates the arm of the trapped miner in The Citadel. Although not always successful, doctors and nurses are engaged in a noble struggle against 'the evil force that destroys youth', playing their parts in the grand narrative of Medical science.

Mary Renault Purposes of Love (1939) and The Charioteer (1953)

Writing from her background as a hospital nurse Mary Renault challenged many of the assumptions of her time: the hegemony of techno-scientific medicine, the medical patriarchy, the subordinate position of nurses, normative heterosexuality, the inferior status of women, the family unit, institutionalised religion, war and nationalism, and attitudes to the body.

Embodiment is a significant theme in Mary Renault's fiction. For her earlier novels she draws on details of hospital nursing, injuries, sickness and death; and in later writing the harsh realities of the ancient world – battles,

wounding, barbaric cruelty, starvation, the vulnerability of women and boys to assault and rape. The body is used for satirical or subversive comment on assumptions about beauty, gender, sexuality and identity. The body is also metaphor: Renault presents embodiment directly and concretely to convey abstract notions about what it is to be human, she uses the body as a 'voice', a way of telling the human condition.

Purposes of Love, Renault's first published novel, is set in a provincial English hospital of the 1930s. The story is anchored in the daily business of the ward and hospital routine. In the opening scene, Vivian sorts soiled linen and makes the laundry list while a child is dying:

The child who presently would wear the shroud was lying with a pinched, waxy face, breathing jerkily through a half-open mouth. An apparatus of glass and rubber tubing was running salt and water into her veins to eke out the exhausted blood. It was all that could now be done. (1)

Events are played out against a backdrop of the nurse's intimate contact with human bodies – washing, dressing wounds, cleaning vomit and excrement, laying out the dead, holding down men delirious after anaesthetic. While the plot centres on the relationships between Vivian, her lover Mic, a hospital pathologist, and her brother Jan, the subtext provides an unsettling perspective on the medical world and the broader society of the time.

Mic suggests to Vivian at one point: ““We are people first, and belong to our sexes rather incidentally”” (79). The sexuality of the central figures is ambivalent. Vivian, tall and lean, 'beautiful in a clean hammered way' (48), looks very like her older brother Jan (even their names suggest ambiguous sexuality). Vivian has another nurse as lover when she meets Mic; Mic was Jan's lover before he met Vivian. Purposes of Love, like Renault's later work, counters normative assumption of gender and sexuality. Through its portrayal of the hospital world it unsettles other dominant discourses, and in particular that of medical authority.

In an episode early in the novel Vivian is on duty in a surgical ward that has received an intake of men badly injured in a power station explosion.

In the midst of frantic activity, she accompanies one man to the operating theatre:

a young man, tall and finely proportioned . . . but waxy pale from haemorrhage, for one of his legs had been torn off in ribbons at the thigh. . . .

The trimming and suturing were hopeless from the first, and everyone knew it. (81)

The young labourer's death overwhelms Vivian with a sense of waste and she gains insight into her own feelings from the experience. As subtext the episode has further significance: it represents the limitations of biomedicine. Firstly, surgery cannot save the young man's life. Secondly, given that technical shortfall, the hospital fails to care for the humanity of the dying man. His body is the object of futile surgery and blood transfusion, the meek girlfriend who provides his true comfort (ice, a cigarette and quiet company as he awaits death) is pushed aside by officious hospital protocol and the authority of the surgeon. When her young man dies, she screams in one cry of loss and despair, and runs out of the ward. The reaction of the nurses suggests the dehumanising effect of hospital routine:

The nurses came running to her, thinking, from long habit and discipline, of the decencies first of all. . . . The Sister stood staring after her: such a thing was unheard-of, and a great inconvenience, for there were several things needing to be asked about the funeral and the disposal of his money and clothes. (82)

The scene is paralleled near the end of the novel in Jan's death where the shortfall of medical power and the dehumanising effect of futile attempts to prolong life are more sharply satirised. Details of Jan's death reflect back to the earlier scene. His massive and fatal injuries, 'fractured spine, crushed pelvis and ruptured right kidney', are set against a splendid physique ('skin tanned like thick brown silk, over sleek hard curves of muscle'); a useless attempt at surgery and a blood transfusion serve only to prolong dying (306). Dark humour underscores the way in which the hospital sanitises death, hedging it with euphemism and protocol. Jan ironically resists the process by which he is denied ownership of his dying – and states his determination to face death squarely:

'I'm sure you'll understand that I don't want to make this a needlessly long business. It takes up your time. . . . Besides, I think it's – probably an experience you should come to with your perceptions still awake. . . .'

The Night Sister clicked her tongue against her upper plate; a gently reproving, encouraging sound.

‘Now, you don’t want to *worry*. We’re all out to get you better just as quick as ever we can. And the way you can help us best is by lying quiet and doing just what nurse here tells you . . .’ (316)

Jan’s honesty exposes the patronising denial implicit in the Night Sister’s platitudes.

“‘I used to think sickness only meant pain, dirt’” Jan says, but discovers that it can also mean loss of autonomy: “‘It’s not belonging to yourself’” (327). The scene finds a subversive resolution. Jan refuses subordination to medical authority and hospital routine. Knowing that the slightest movement of his pelvis will cause fatal internal bleeding, he uses his unhurt arms to thrust his lower body out of the supporting arrangement of sandbags, bringing about rapid death. The towel and sandbags that represented the constraint imposed by medical authority become symbols of Jan’s defiant assertion of self:

The linen towel that had fixed his waist, loosened from its sandbags, lay crumpled under his left hand. Against his right arm, the mattress was still dented with the thrust of his elbow. (329-30)

Nurses may domineer over patients but are themselves subordinate in the hierarchy of medical authority. Renault critiques the patriarchal basis of medicine as well as its disempowerment of patients. The position of nurses is symbolised by their uniforms:

Her apron-strings held back her shoulders, her high round collar kept up her chin, like a scold’s bridle; her cap, rigidly pleated, circumscribed the movements of her head. A white stiffened belt whose constriction she could feel whenever she tried to breathe deeply, gripped her waist . . . (100)

This ugly, constricting uniform tends to hinder rather than facilitate the work of nursing, its real purpose being subordination, ‘a reminder of obedience and renunciation’ (100). Nurses are dehumanised as much as patients. Their personal lives are rigidly disciplined, their sexuality repressed. Duty and obedience – subservience to the medical hierarchy – must inform their nursing duties while compassion and individuality are suppressed: Vivian receives ‘a severe reprimand from Sister for breaking off her dusting to address an envelope for a girl with a broken arm’ (28).

The surgeon Scot-Hallard personifies Mary Renault's critique of the patriarchal medical world. He stands for the doctor as heroic figure, competent and authoritative. Although comparable in this respect to Andrew Manson in The Citadel, Scot-Hallard lacks Manson's human warmth and his reformist vision, and is merely arrogant and egotistical. He is an excellent surgeon but indifferent to the patient as a person. Vivian describes him as a 'first-class operating machine', and contrasts his surgical skill with the 'long fiddling operations' of Sir Bethel, 'the oldest and gentlest of the honorary staff', yet on the wards she has seen patients 'warmed and made hopeful by the old man's loving courtesy, while Scot-Hallard would have run them over like an index file' (39-40). To Scot-Hallard, nurses are handmaidens, invisible except when doing his bidding. If not handed the correct surgical instrument by the theatre Sister, he will fling the tray of sterilised instruments to the floor. His attitude to other hospital staff is patronising. He appropriates Mic, the best qualified of the hospital's pathology assistants, to do extra work for his personal research. His sexuality is equally exploitative, his blunt masculinity expressed in a series of loveless affairs. In portraying the surgeon's affair with Vivian, Renault makes it plain that his sexual arrogance parallels professional egotism.

Scot-Hallard's identification with dominant patriarchal discourses is further revealed in his attitude to the looming war. For him it means an opportunity for the fullest expression of his drive for self-assertion: 'he would assume his rightful place: making decisions of which other people were afraid, enduring things under which they broke: using himself to the limit' (226). He is experimenting in methods of bacterial and chemical warfare, and is callously indifferent to the human cost of war. In the person of Scott-Hallard, Mary Renault aligns aggressive masculinity with medical and military authority. Through the subtext of Purposes of Love positions of entrenched authority are unsettled. A similar critique characterises The Charioteer.

The Charioteer is based directly on Renault's experience of nursing injured soldiers during World War Two. The central character, Laurie Odell, has been wounded at the Dunkirk evacuation, a massive gunshot injury shattering his knee. Laurie's leg injury is a significant motif in the novel. It

serves as a grounding in the body, established through factual descriptions of surgical, nursing and rehabilitation procedures, and of Laurie's day to day life as a patient on the ward – a setting where the body is always the focus of concern. Medical characterisation of the injury is balanced against the patient's experience – pain, reduced mobility, humiliation and nuisance. Laurie's injury is shown to mean multiple losses and limitations for his future life: mobility and independence, athletic prowess, employment possibilities, sexual power and 'masculinity'. The injury also exists as social construction, perceived in different ways by other people: for example, Laurie is varyingly seen by other characters as romantic hero, 'dear wounded boy' (Mrs Chivers), pathetic cripple (Mr Straike) and interesting surgical case (Major Ferguson).

Laurie's wound also functions in the satire and subversion of Medical authority, and is used to indicate the possibility of alternative healings. Renault does not underplay the crucial value of standard medical and surgical treatments in their ability to repair injury and treat disease. Ralph, who saw Laurie's smashed knee at the time of the evacuation from Dunkirk, comments on seeing it again after multiple surgical procedures, "It's bloody wonderful. I can't think how they did this" (219). However the story of Laurie's wound shows up the limitations of biomedicine – both in the shortfall of actual repair achieved by surgery, and in the gap between technical repair and 'healing'. The account of Laurie's treatment in the military hospital also links medical and military discourses and further connects these with normative assumptions about gender and sexuality.

During a surgical ward round, the military surgeon discusses Laurie's case with a visiting surgeon, at the bedside, observed by a crowd of medical students:

The Sister . . . lifted the dressing off with forceps. Major Ferguson peered down with simple pleasure, like a gardener at a choice rose . . .
". . . and comminuted patella," Major Ferguson was saying. "The fractured ends of the femur were extensively exposed and penetrated with gravel and so on. The osteomyelitis responded remarkably well to sulphonamides, but as you see, we had to open four times in all to remove various sequestra, and about a month ago we began to feel he'd probably be better off without it. However the callus started to look more promising, and the question then was

whether amputation would be justified by the increased mobility he'd get from an artificial limb."

"The knee's completely ankylosed, is it?" The brigadier sounded like an intelligent player discussing a chess problem.

"No, Sir, we managed to give him a flexion of about twenty degrees . . . we've reduced the shortening to just about an inch . . ."

Laurie sat at attention, eyes front. After the blow had reached him through the swathes of technical jargon, he . . . stiffened his pride, which the two specialists had made to seem nugatory, a trivial reflex like a knee-jerk. (46-7)

The Frenchman Charlot, in the next bed, asks Laurie what is wrong:

If he could tell just one person it was all he wanted. He said in French, "It's only something the doctor has just said about my leg – that it will always be stiff, and shorter than the other, and that all my life I shall be lame." (49)

The fact that Laurie is speaking in French to Charlot is an ironic comment on the obscurity of medical jargon, a 'foreign language' to patients. The 'swathes of technical jargon' contrast with the stark simplicity of his 'translation' of their words into personal meaning. The doctors' treatment of Laurie as an object, their indifference to his feelings and his pride, is highlighted by his craving for the comfort of ordinary human contact.

Medical expertise is limited in how far it can repair Laurie's injury, but beyond this it fails to provide adequate rehabilitation and relief of pain. It is not a doctor but a physiotherapist who recognises that Laurie's surgical boot exacerbates his pain and disability, and arranges for a boot that provides proper support. And in another key scene Ralph massages Laurie's knee with a healing touch that suggests the power of primitive therapies, relying on intuition rather than technology:

Ralph undid the bandage, and with an intent grave gentleness manipulated the joint. It was evident that he had some experience and knew what he was looking for. Laurie, who was used to the detached curiosity of doctors, felt something different here: Miss Haliburton had it, but in her it was overlaid with a complex technique, and in becoming mechanically perfect lost something of its nature. In Ralph it was direct and human, as it used to be in the old country bone-setters who came to their trade with nothing but an instinct in their hands of tactile sympathy with pain. (218-9)

The therapeutic power of Ralph's touch is captured in a telling phrase: as Laurie rebandages his knee he has, for the first time since his injury, 'a feeling of assimilating it to himself' (221). His sense of renewed wholeness is healing of a different order than mechanical repair. In this episode, Mary

Renault writes ‘through the body’ to challenge the monolithic authority of biomedicine.

Another aspect of this episode is the homosexual subtext in Ralph’s tenderness and the way Laurie abandons himself to it: with ‘passive trust . . . [he] lay in an irresponsible peace while Ralph undid the bandage’ (218). Homosexuality is central in this novel. Here, however, Renault implies links between subordinate discourses – homosexual identity challenges the dominant heterosexuality just as alternative ways of healing challenge the shortfall and inhumanity of the medical establishment.

Laurie’s wound gives him a sharp awareness of vulnerability, a sense of common humanity with others – fellow soldiers and injured men, overworked nurses, his weak, foolish mother. (Heightened compassion linked to physical impairment recalls Philip’s sensibility of the human lot in Maugham’s Of Human Bondage.) The wound is more particularly a bond with Ralph who ‘had half his hand blown off’ when the Merchant ship under his command was sunk at Dunkirk. The two men are marked by a common human vulnerability. Their wounds take on another meaning, indicating their marginalised position in society. It is plain from the novel overall that homosexuality itself is not seen as a flaw. Alienation for Renault’s characters arises from the meaning that society gives to difference. This is symbolised by the social meaning of Ralph’s injury. He has lost two and a half fingers, and according to the official ruling, this means that he is ‘disabled’, unfit to resume command of a ship. Loss of his rigorous and testing occupation is an immense blow for Ralph:

“It was rather bad luck, his getting beached. Especially as it was a matter of inches, literally. He lost just half a finger too many. Two and a half instead of two. With two he’d probably have got back on the active list again.” (161)

Ralph is fully able – he can drive and light a cigarette, for example, and is fit and hard. The arbitrary demarcation, with its power to wreck a life, is an ironic comment on social constructions of illness, disability and difference.

Finally, Mary Renault uses the wounds in a metaphysical way, to speak of the human condition. Here she foreshadows themes that are more fully explored in her later novels set in the ancient world. It is her use of embodiment to express a compassionate and ironical sense of what it means to be human that gives Renault's writing much of its power:

Laurie took his hands from his face and looked up: at the room, the blackout-curtains fastened with safety pins; at the padded fingers of the glove lying on Ralph's knee; he could feel in his lame leg the pull of the cobbled muscles...Life is cruel, he thought: leaving out war and all that wholesale stuff, human life is essentially cruel. Sometimes you can feel a smile. The Greeks felt it. Apollo Loxias at Delphi smiling in the smoke behind the oracle, and saying, "But I don't mean what you mean." (269)

Mary Renault's use of bodily and medical detail reveals several ways in which she challenges the assumptions of her society. At the time The Charioteer was published homosexuals in Britain were stigmatised, regarded as sick or criminal. Writing from her own marginalised position (lesbian, female, nurse) Renault does not merely represent perverse sexuality as part of the spectrum of human relationships but places it in the foreground. Many of her central characters are homosexual or bisexual. They see themselves as human first, defined only secondarily by gender and sexual preference: 'normal plus, not minus' (The Charioteer 214). Renault posits the fluidity of the body and identity in ways that recall the ambiguities posed by Conan Doyle. She foreshadows the understanding that gender roles and sexuality are mutable and dependent on cultural constructions, a view represented in theories of the body such as queer theory. Mary Renault's writing had a ground-breaking effect in setting up a reverse discourse on sexuality and 'normalising' perverse sexuality.

In regard to militarism and pacifism, Renault was writing with the perspective of a nurse who had cared for injured soldiers in England during the war. She worked alongside Quaker conscientious objectors who performed menial duties in the military hospital. She presents sympathetically the positions both of men in the armed forces, wounded and disabled in defence of their country, and of pacifists. She questions the whole structure of (patriarchal) military aggression, and the hypocrisy of those who embrace it

unquestioningly in a frame of Christian values. The conscientious objectors in The Charioteer are sympathetically presented, showing courage and integrity – as well as compassion and humour. Even the army men injured in service that the ‘conchies’ have avoided come to respect them. The hypocrisy of establishment religion, by contrast, is satirised in the hypocritical clergyman Straike. From a position of personal safety and comfort he glorifies war and sneers at the pacifists as cowards and traitors.

These examples serve to illustrate the way in which overlapping discourses of power are linked, grounded in Renault’s direct experience of wartime nursing. By throwing into doubt one set of assumptions – for example those surrounding war and pacifism – Renault unsettles other discourses of power in the society of her time. Her representation of the medical world, with its assumptions of authority, its hierarchies of power and its dehumanisation, stands in the context of a broader counter discourse.

Conclusion – perverse discourse

In this chapter a theme has begun to appear: a tendency for the perverse, the transgressive - elements of a ‘reverse discourse’ - to emerge from *within* narratives that seemingly embody and applaud the dominant. Moreover, a reverse discourse along one dimension commonly interconnects with others. Writing that destabilises (for example) sexist or heterosexual norms and polarities is also more likely to query other dominant paradigms – medical patriarchy, scientific rationalism, militarism, class structure. Conan Doyle intrudes disturbing questions about the social order, scientific medicine and the fixed truth of the body into stories that celebrate reason and deductive logic. Mary Renault shows the unsettling effect of pacifists in a military hospital, and of perverse sexuality in a normatively heterosexual world. She places disability against heroic masculinity, and a more holistic view of healing against patriarchal medicine. Maugham incorporates his critique of social inequity and his humane perspective on medical practice into a personal therapeutic narrative that deals at different levels with the shame of disability

and homosexuality. Writing from a marginalised position, as Renault and Maugham do, seems to foster an unsettling gaze.

In the following chapters the discussion moves from works by medical writers to illness narratives from the broader arena of literature. Reverse discourse will emerge as a central theme, a key strategy by which narratives of therapy become therapeutic narratives. Unsettling of one dominant discourse or form of marginalisation is frequently associated with challenge to other dimensions of subordination such as class, gender and homosexuality or militarism and pacifism in my discussion of medical narratives. Subversion of disempowering discourses, including the discourse of Medicine itself, and finding alternative ways of speaking, is crucial in the therapeutic function of many of these narratives.

Chapter 3 The patient speaks

It's the day for writing that letter, if one is able,
And so the striped institutional shirt is wedged
Between this holy holy chair and table.
He has purloined paper, he has begged and cadged
The bent institutional pen,
The ink.

. . . the moron's painstaking fingers – so painstaking.
His vestments our giddy yarns of the firmament,
Women, gods, electric trains, and our remaking
Of all known worlds – but not yet
Has our giddy alphabet
Perplexed his priestcraft and spilled the cruet of innocence.

Because the wise world has forever and ever rejected
Him and because your children would scream at the sight
Of his mongol mouth stained with food, he has resurrected
The spontaneous thought retarded and infantile Light.
Transfigured with him we stand
Among walls of the no-man's-land

(Francis Webb 'Harry' 217-8)

At the time of writing this poem Francis Webb was a long-term patient in Parramatta Psychiatric Centre, with a diagnosis of chronic paranoid schizophrenia. The poem depicts Harry (mentally retarded with Down syndrome) trying to write a letter. Harry inhabits a place beyond language and his effort to write enacts the poet's – and the patient's – quest to find words for the inexpressible. In this poem Webb grapples with the paradox that working through words he is always seeking an innocence that rests in the silence beyond language ('An imbecile makes his confession, /is filled with the Word unwritten'). Webb uses religious imagery to transform 'pudgy', food-stained Harry into a priestly and even Christ-like figure of redemption. Webb and the other inmates, all alike incarcerated and stigmatised ('we stand/ Among walls of no-man's land'), are 'transfigured' with Harry himself through his 'holy' writing. Despite the inadequacy of language (the 'bent' pen and 'giddy alphabet') the patient must find a way of telling his liminal experience.

Webb's poem 'Harry', centred on the paradox of voice and silence, introduces the theme of this chapter: seeking healing, patients must find a

language for their stories.⁵ The discourse of conventional Medicine foregrounds a process of diagnosis based on clinical signs and technical investigation, and treatment with medication, surgery and physical therapies. Bio-medical discourse relegates the personal meanings of illness for the individual to secondary place. In this chapter I will begin to explore ways in which the patient's voice provides an alternative discourse that supplements – and at times challenges – the medical discourse. In telling the story of illness, the patient seeks a language for liminal experiences – pain, madness, the threat of personal disintegration and annihilation. Narratives of illness often speak through metaphor, which can encompass meanings beyond those foregrounded by 'objective' and 'neutral' medical discourse. Further, illness stories may challenge the stigma and the subordination associated with disease. The illness narrative is often characterised by perversity – overturning the assumptions that place authority with the medical practitioner and demand passivity and gratitude of the patient. Healing can begin with the empowerment of telling one's story.

Two theorists who discuss the use of metaphor as a means of expressing the inexpressible are Ellen Siegelman, a Psychoanalyst who has explored the patient's use of metaphor in therapy, and Marilyn Chandler, a critic who has studied the healing function of self-narrative. Chandler uses the word 'symbol' but the meaning she gives the term overlaps broadly with Siegelman's use of 'metaphor'.⁶ Both writers refer to an image that is used to represent something else; usually a relatively concrete image stands for a more abstract idea or emotional state. Both writers emphasise that part of the power of metaphor (or symbol) for expressing liminal experience lies in its hybrid and multilayered associations.

⁵ The healing space that poetry provided for Francis Webb is discussed below.

⁶ There is considerable overlap in scholarly usage of the terms. The Australian Oxford Dictionary (1999) gives 'symbol' as one meaning for 'metaphor'. The Cambridge Guide to English Literature (1983) states in the entry on 'symbol' that 'The symbol may be thought of as a metaphor that purports to be more than "merely metaphorical". In practice this means that metaphors apparently having a number of referents and an indefinite reverberation of suggestions tend to be distinguished as symbols.'

In 'A Healing Art: Therapeutic Dimensions of Autobiography', Chandler proposes that 'to be healed we seem to need to find a way to tell our stories' (4). She argues for the therapeutic function of narrative, and of autobiography in particular. Healing is linked with story-telling historically, and across many cultures. Many modern autobiographers have written as a form of self-therapy, and the 'writing cure' – writing one's own life narrative – has been used as a systematic form of psychotherapy (9). The therapeutic functions of self-narrative that Chandler identifies are catharsis, restoration, connectedness and transformation. *Catharsis* is the cleansing that comes from confession, from simply telling, giving voice to the story of suffering. Telling can serve the therapeutic function identified in Narrative Psychotherapy as externalising the problem, placing it outside oneself. Telling allows integration of chaotic experience into a meaningful pattern: *restoration* or return to wholeness. Wholeness is 'both inner coherence and connection with a community – ultimately with the cosmos' (13): thus self-narrative enables *connectedness* to the wider community. Finally self-narrative enacts *transformation* through symbol: it can 'make new stories out of old facts...provide direction and power and relief from paralysing entrapment' (11). The reconstruction and transformation entailed by healing self-narrative parallel 'retelling' in Narrative Psychotherapy: remaking the constraining 'problem-drenched narrative' into a new narrative that opens up fresh possibilities for the ongoing story.

Self-narrative does not invariably serve a therapeutic function. Chandler notes that counter-therapeutic 'pitfalls' include: creating a false story; telling a defensive, self-justifying story; and reinscribing the old, constricting story (13). A false or reductive story may show facile wholeness and unity that belie the 'fragmentation and dissonance' that characterise 'modern sensibility'. Self-justification through a defensive or apologetic story refuses the opportunity for self-discovery and growth. Reinscribing constricting stories and assumptions limits rather than opens up possibilities.

Chandler argues that crisis experience, including suffering and illness, represents a dilemma – it *must* be told but 'there is no available language to

describe an experience that has pushed one out to the margins of the tolerable' (4). This is the power of symbol, the concrete image. A symbol allows holistic representation of complex experience: it functions 'to bring together a complex of ideas and emotions in non-discursive fashion, making possible a more holistic comprehension of experience than is comprehensible in linear discourse' (12). Symbol provides a means of telling, 'a grounding point for description of experiences that seem to defy description'; it connects the 'creative unconscious with the ordering consciousness', the emotional with the rational and 'factual' (11). Symbol allows retelling, reinterpretation of experience, suggesting new patterns and meanings, new possibilities for the future.

The power of metaphor as a means of communicating liminal experience is developed by Ellen Siegelman in Metaphor and Meaning in Psychotherapy. She demonstrates a significant therapeutic value for metaphor in the process of Psychoanalytic therapy, and uses case studies to support and illustrate her thesis. Her arguments can be applied more widely – they suggest the power of metaphor to serve a healing function wherever the patient speaks – in the medical consultation, in self-narrative, in story, poetry or song: 'Although poets and patients are very different in the skill and deliberateness with which they use metaphors, the underlying imaginal processes are the same' (Preface x).

Metaphor can express what is difficult to tell in literal language, because it makes connections. It connects the conscious, the rational and the explained with the unconscious and the emotional, and so serves in the process of uncovering the client's hidden ('repressed') feelings and conflicts. In Psychoanalytic therapy this is 'insight' (42). Metaphor can convey meaning 'before it is understood' before it is 'interpreted' or spelt out in literal terms (55). 'Key' metaphors are vivid, fresh, charged with emotion and meaning; these are more powerful than faded, clichéd metaphors (46). Siegelman calls the most powerful metaphors 'crucial' metaphors – those that give strongest expression to the client's concerns and allow the greatest access to buried feelings, the greatest insight. Crucial metaphors have complex and multiple

meanings, they span the concrete and emotional, rational and non-rational, and they resist reductive interpretation (confinement to a single meaning). The body is a rich source of crucial metaphors. Bodily experience is 'primary' – preverbal and peremptory – it is the 'bedrock' of our sense of continuing identity – hence the body is the source of powerful metaphors, images charged with meaning and emotion (25-9).

In therapy the analyst may use the client's metaphors to help her understand, confront and deal with painful feelings and experiences. The therapist can do this by providing interpretation - a 'translation' of the metaphor. However the therapist may also 'stay within the metaphor', that is use (continue, elaborate) the client's metaphor rather than 'interpreting' it (55). This demonstrates empathy with the client's world, maintains the complexity and emotional charge of the metaphor, and allows 'space for play' (87). Siegelman emphasises the significance of 'play' in healing; an important therapeutic function of metaphor is the room that it allows for playfulness – fantasy and imagination, humour and mischief.

Siegelman argues that metaphor is not only a mode of telling, of gaining access to repressed emotions, it also has a determinative function. Crucial metaphors serve both as representations and determinants of our lives: 'Much of psychotherapy consists in identifying previously unconscious metaphors and discovering how we unwittingly live by them' (67). A large-scale or extended metaphor becomes a life narrative. Life-narratives give meaning and structure to our experience and impose order, predictability and safety on the world, but can become constricting. Therapy is a process whereby the client realises that the metaphor (or script) can be changed; a new metaphor can open up fresh and less shackling possibilities for living.

Amy Witting 'Breakdown'

In 'Breakdown' (Collected Poems 101-112) Amy Witting uses extended metaphor to tell a narrative of mental disturbance – and to change the script. Although the allegory can be read and understood without any

knowledge of the writer, biographical information provides support for the poem's therapeutic function. According to Amy Witting's biographer and critic, Yvonne Miels, the poem explicitly represents and reviews Witting's 'confrontation with near madness' and was written as a deliberate therapeutic endeavour (The Net Under the Straw 45). In 1953, Witting was diagnosed with tuberculosis and spent five months in Bodington Sanatorium, facing the possibility of death. She suffered a nervous breakdown, an experience that remained unexpressed for many years. In writing the poem she gained self-knowledge, and 'laid to rest this particular ghost' (45). The poem is not concerned with psychiatric labels ('depression', 'obsessive disorder') that serve to pathologise experience. It foregrounds the individual's power to take control against engulfing 'madness'. Metaphor provides a way of telling experience that is, in Siegelman's terms, 'hidden' and 'charged with emotion'. Metaphor allows 'space for play' and transformation into a new story.

Witting's use of metaphor is lucid and accessible. The narrative centres on the figure of a monkey in a cage. 'Monk' represents reason, the rational self. A flood of filth rising in his cage, 'the intimate, shameful/ debris of living,/...viscera, turd' threatens to drown him, yet also compels and entices with 'the voice of the mermaid,/ singing, "Oh, come./...Come drown."' Lurking in the tide of filth is the monster that generates it, the monster that is also part of self: "in this tide there is a living thing/ means harm to all, and it is one with me...This body is the prison that we share" cries Monk. The monster represents shameful, destructive feelings – rage and envy, obscene impulses, disgust and self-loathing – that threaten to engulf reason. Witting suggested in one interview with Miels that her sharp wit was a mask for dark feelings: self-doubt, rage and humiliation. The protective facade of wit is imaged in Monk playing the clown to hide his shame from the onlookers:

Monk becomes gymnastic,
leaping from one trouble spot to another. No sooner
does he place his small frame to conceal
a used condom floating or an anonymous letter
washing against the bars, than something quite horrible
surfaces elsewhere. . . .
He is the clown . . .
. . . And lips stretched in misery
can pass for a grin. (102-3)

The poem tells the story of how Monk confronts his monster and tames it. He identifies the power that drives the tide of filth as ‘Rage’ and names it ‘Piggy’ – naming and mocking (diminishing) the monster is a strategy of control. He refuses to feed Piggy any longer with the ‘titbits’ on which it has battered – ‘sweet pickled insults,/ delicate morsels of spite,/ matured grievances,/ high-flavoured humiliations,/ acid drops’. By facing and defying his monster-self, refusing to sustain it, Monk wins a qualified ascendancy, a limited freedom from entrapment:

Pig did not die, . . . Pig remained powerful,
Yet his habitat deserted him slowly. Shrunken now
he sulks in a puddle in daylight.
.....
Monk is the regent. Pig sometimes escapes his vigilance
to cause a disturbance, but cannot live long outside his puddle.
That offers some reassurance.
The voice of the mermaid drifts only rarely from a distant sea.
The cage is for the most part fit for public view. (111-2)

In this playful allegory, with its black humour and mischief, Amy Witting confronts and tames her monster. The shackling narrative of a ‘breakdown’ and ‘near-madness’ has become a new narrative of the restoration of reason and sanity, in the ‘space for play’ provided by metaphor.

Philip Hodgins

Coming to the wintry trees
I choose a metaphor.
.....
Crows always make you think of mortality.
Even as I walk they are ruining
this landscape.
.....
My bad luck is to write the same poem every time.
A sort of postcard poem
from the rookery.
(‘From County Down’ 44)⁷

Philip Hodgins was diagnosed with leukaemia in 1983, at the age of twenty four. At that time he understood that although chemotherapy could give temporary remissions there would be no definitive cure, and he might expect to die within a few years: ‘Three years spoken for/ by a specialist doing

⁷ All quotations of Hodgins’ poems are from the 1997 collection Selected Poems.

his job' ('The Deadline' 64). In the event he lived for twelve years, suffering a series of relapses following remissions with chemotherapy. During those years he lived with the probability of early death as well as with the debilitating symptoms of illness and side-effects of chemotherapy. The poem quoted above was written shortly after his initial diagnosis; the one below in the weeks before his death. They indicate his continuing quest to find in poetry a 'metaphor', words for death, and perhaps his recognition that death is in some way a failure of language, a loss of self-narrative:

The poem has cancer.
.....
They say it has something
to do with words
.....
a failure of communication,
an inability to form
the right words
(‘The Sick Poem’ 314)

Hodgins appears in his poetry as a young man who savagely resents illness, pain and the prospect of death exploding into his life: ‘to die/ in stages of bitterness and regret’ ('Leaving Hospital' 9). He laments the irretrievable loss of careless boyhood happiness on his father's farm, ‘not knowing you would have to write out/ variations on - / Why was death announced so soon?’ ('Question Time' 17). He accepts every thin hope for reprieve or palliation that mainstream medicine has to offer, imaged in the recurring motif of the needle: invasive diagnostic tests, transfusions, ‘celltrifuge’, ‘valium and pethidine’, chemotherapy. Even as he clutches at hope and accedes to medical invasions and indignities, he confronts death again and again, in grim, embodied representations of terminal illness and physical decay.

Poems written during his final illness depict the ‘bedrock’ bodily reality of disease and disintegration – pain, nausea and intractable vomiting, weakness and debility – in words that are deliberately confronting:

You stiffen and shake. You give yourself emphasis.
There are tears in your eyes. There's blood in your piss . . .

You vomit through surges of nausea and pain.
And when there's nothing left to vomit you vomit again.
(‘Cytotoxic Rigor’ 318)

Now there is no hope of improvement or survival. 'Cytotoxic Rigor' expresses outrage at meaningless bodily suffering and at the failure of the metanarratives Medicine and Religion, to alleviate his suffering:

The drugs they've added to tone down the shock
are as useless as the words from a prayer book.

The writer is unreconciled. He gives voice to fear and to outrage at loss and injustice. How can poetry of protest and lament enact a therapeutic function?

Context provides one therapeutic element in Hodgins' poetry. In his publications poems dealing with illness and death are embedded amongst many that celebrate life. Hodgins' writing has a base in rural life: there is humour and 'dailiness' in his yarns of dirt track, paddock and cattle-yard; he describes driving the cows from sleep to morning milking and finding mushrooms in the grass, and remembers the 'baby possums' and 'disappearing snakes' in the 'battlements' of a haystack that later became 'testing place for cigarettes and cans of beer'. Poems such as 'Snake in the Department Store' and 'Image of the Murray' epitomise the rural grounding, the playfulness and the sense of celebration that are unquenched in Hodgins' writing. These two poems were published in the 1995 collection, Things Happen, together with the bleakest poems, such as 'Wordy Wordy Numb Numb':

Death.
Now there's a word.
He wrote it down.
.....
Later on, when words had passed,
he backed it up
by dying. (320).

The darkly witty poems of illness and approaching death are read alongside light-hearted poems of the everyday. Through childhood memories, rural scenes and comical yarns, Hodgins celebrates life. In illness, images of rural life are turned to the purpose of exploring death:

My plans for growing crops have all
turned out to be impossible –
there's something lacking in the soil.

There's not much hay to feed the cows,
and all the eucalyptus trees
around the never-finished house
have got a terminal disease . . . ('The Secret' 59)

Illness and the damaged self are written onto landscape. In 'Leeches', the motif of the leech connects rural images – duck shooters in the swamp, cattle coming to milking from the dam, infested with blood-bloated slugs – with hospital technologies and with the blood-devouring illness of leukaemia. In many poems Hodgins explores the darker side of bush life with its manifold faces of disease, infestation and death. 'At the Sheep-parasite Field Day' (167) is a grotesque 'circus' of 'maggots', 'lice and pizzle strike'. 'A House in the Country' (286) depicts the poet's home invaded and eaten away from within by hordes of termites, whose eradication will require 'poisons, vile as chemotherapy'. Hodgins' identification with farm and bush, with rural community, creates the kind of 'wholeness' that Chandler identifies as one healing function of symbol: 'connection with a community – ultimately with the cosmos' (Chandler 1989, 13). Calves are stillborn, rabbits are shot and skinned, crops wither, gumtrees die, farms are sold up – and a boy from a dairy farm is dying of leukaemia. Paddocks and bush, farming communities and landscape, endure.

Rural grounding is one characteristic of Hodgins' writing. Another is delight in the craftsmanship of words. In Hodgins' poetry craftsmanship creates a 'space for play', a space where he can grapple with bodily decay, approaching death, the loss of self. Poetic technique, wordplay, pun, wit and irony, are conscripted into the project of finding a voice, a way to tell what must be told, the experience at the edge of language, the extinction of self:

And though this
sticking words like leeches
to the page
will make no difference
to what the cancer knows or does,
I had to tell you anyway.
(‘Leeches’ 60)

Hodgins' poetry becomes an assertion of self in the face of death, but it represents the biographical not the biological self. In 'Resurrection' (46), written early in his illness, Hodgins investigates with some irony the notion that he will 'live on' in words – the conversations of his friends, or his own writing: 'blood is making me write/ letters in verse./ . . . I half believe that it's

another way/ of coming back'. Despite the self-mockery his later poems stand as a defiant assertion of self, as he writes not simply *about* but *through* the bodily experience of illness.

'Haematopoietics' and 'The Sick Poem', written in his final relapse, explore the relationships between writer and poem, self and words. Illness in the speaker is identified with failure of language. Hodgins uses his craftsmanship to grapple with the prospect of loss of self and to forge a language for his experience. The key to the therapeutic process here is not 'cure' or even 'accommodation' (acceptance, reconciliation with fate), but the struggle for meaning continued right up to the limits of life. These poems create a 'space for play' at the edge of death:

A sheet of ruled paper before me
has turned into an unwritten surface
of sweating skin.
.....
And what is happening to me now?
Is this dark dot half-way up my arm
the full stop

at the end of a death sentence,
or is it only the sign of something
never written down,

something too painful even to say?
(*'Haematopoietics'* 313)

The writing has become the writer, the 'sheet of paper' his sweating skin, the blue lines his veins, and the ink his blood, all marked with the stigma of fatal disease. The self is uncertain and receding, existing in the gaps: the 'full stop at the end of the death sentence', the words 'never written down'.

'The Sick Poem' appropriates medical discourse to deal with the theme of language and its relationship to liminal experience (mortal illness). Leukaemia becomes a metaphor that identifies disintegration of the self with disintegration of language. Diseased words infiltrate and corrupt language like cancer cells, crowding out the 'right words' just as in leukaemia the cancerous line of explosively replicating leukocytes (which are functionally bankrupt) overwhelms life-sustaining blood cells:

The poem has cancer.
.....
They say it has something
to do with words
but no-one really understands
how it works.
A well-paid team of experts
Is looking through it,
A sample has been taken
And yes, words were there.
.....
clapped-out poeticisms
struggling across the page
through a damaged form.
(‘The Sick Poem’ 314)

Inversion of medical discourse critiques medical authority (the ineffectual ‘well-paid team of experts’) and questions ‘what goes on/ in all those hospitals’. The poem also undercuts the false hope offered by popular psychology: ‘There’s a theory/ if you ignore the thing/ then it will go away’. Hodgins is scornful of hollow consolations: ‘insights/ . . . like the hard wisdom/ suffering is supposed to give you/ but doesn’t really’. The mockery points up the failure of master narratives – the fumbling experts – to offer healing or even explanation. In the final lines, irony barely restrains the writer’s frustration:

I’m telling you straight:
to use a metaphor
at a time like this
would be obscene.

Using a metaphor ‘at a time like this’ would be obscene since language itself is eroded, infiltrated by disease – yet the writer can only speak through metaphor. The poem enacts the power of metaphor even as it problematises language; it creates a voice for the self even as the self recedes and crumbles.

Les Murray: confronting the black dog

Just as Philip Hodgins turns craftsmanship with words to the task of confronting leukaemia and death, so Les Murray uses his virtuosity with language to explore the roots of depression and to seek healing. Murray’s playfulness serves the therapeutic function of resisting heaviness of mood and expression. Metaphor and allegory provide a way of ‘retelling’ and transforming old hurts and their legacy of bitterness into a new story. Murray

can describe his feelings in lucid prose, as he does in the essay ‘Killing the Black Dog’ (KBD) which tells the poet’s story of depressive illness and recovery. It describes what it felt like to live in the ‘black hole’ and identifies causes in Murray’s family tragedy and his tormented boyhood. The essay does not enact a therapeutic process, it is a narrative of illness not a therapeutic narrative, but in it Murray claims that writing poetry was healing for him (12). The essay is published with a number of poems that Murray identifies as embodying the therapeutic process. He notes also that his epic poem, Fredy Neptune (FN), had a particular therapeutic significance for him: ‘[in] my fight against the disease . . . I also embarked on a long work of fiction in verse which I might never have essayed without the disease’ (12). Murray’s essay and the associated poems represent the telling and retelling of his ‘problem-drenched’ story. I will explore how the poems represent a therapeutic process, and what insight the essay gives into the therapeutic function of poetry for Murray.

Murray asserts that writing poetry served a healing purpose for him: ‘I’d disapproved of using poetry as personal therapy, but the Black Dog taught me better’ (KBD 19). Amongst the therapeutic uses of poetry he identifies escape, self-discipline, self-examination, retelling and transcending. Escape, or diversion, is the weakest form of therapy – the poet turns away from dark feelings and difficult issues rather than confronting them: ‘in the latter part of *Dog Fox Field* (1990), I turned the instrument of poetry away from all that . . . I gave my stupid self a rest’ (11). Using poetry as a discipline moves a step further, from escaping turmoil to resisting it, resisting the mental ‘confusion’ that depression meant for him: ‘Poetry does not only require discipline, it is a discipline, and resists turgidity and imbalance . . . when I was utterly depleted I concentrated my resources around my essential art form, poetry’ (8). Self-examination involves rediscovering and confronting the ‘old bad stuff’: ‘dredging all of this up from the ash-pit of memory’ (19). That is, poetry becomes the means of giving expression to what has been hidden; a way of telling experience that is at the margin of the tolerable. Finding a way of telling, through poetry, allows *retelling*: reworking or transcending. Murray indicates that Fredy Neptune would be an attempt to deal imaginatively,

through epic narrative, with what he identifies as a core problem for himself: 'I have always been fascinated by the question of how it is possible . . . to live with the darker aspects of human frightfulness. And that's Fred's problem too' (13).

Murray identifies poetry writing as therapeutic for himself, as the writer, and suggests that he was also able to speak for others. He used poetry to help his daughter Clare through a bad time of teasing and bullying at school. He wrote 'a series of poems that did us both good': poems such as 'Where Humans Can't Leave and Mustn't Complain', 'Rock Music' and 'Burning Want' which – with scornful irony – identify schoolyard tormenting and ostracism in terms of Murray's notion of 'sexual Nazism' (19). He asserts that writing can be therapeutic for a fellow sufferer, or for a community with whom the writer identifies. Murray's passionate identification with outcasts and loners is a motive force in Fredy Neptune.

Murray's analysis of the uses of poetry as 'personal therapy' also identifies some of the potential problems in illness writing: it can readily slip into 'confusion', 'obsession' or 'whine'. Style may reflect the inner turmoil, in writing that is 'congested, jammed', 'incoherent', 'over-concentrated and under-explained' (3). Murray notes that 'a few tentative tries at submitting the whole mass of pain to poetic examination . . . produced some knotted and unclear poems' (11). Such writing may be little more than 'whine': infiltrated with self-pity and blame, inscribing a victim position (10). There is the risk of creating narratives that entrench the problem, the 'old bad stuff', and reinscribe stigma, rather than resisting and transforming them.

The 'old bad stuff' that Murray outlines in 'Killing the Black Dog' provides an autobiographical background to the therapeutic project of his poetry. The key themes that emerge as Murray confronts depression are a childhood marked by 'poverty-shame', the death of his mother when he was twelve years old, the tormenting and ostracism he endured at Taree High School, his preoccupation with body image (being fat) and the erosion of his sexual morale.

Those years trapped in a middling cream town
Where full-grown children hold clear views
And can tell from his neck he's really barefoot

.....
He blusters shyly – poverty can't afford instincts.
Nothing protects him, and no one.
'A Torturer's Apprenticeship' (KBD 30)

From just on puberty, I lived in funeral:
Mother dead of miscarriage, father trying to be dead
'Burning Want' (KBD 41)

Murray grew up on his grandfather's dairy farm in circumstances that he epitomises as 'poverty-shame'. He describes his father as withdrawn and cold, and recalls 'the frequent harsh floggings I got for being a bad boy' (16). His mother's repeated miscarriages, culminating in her tragic death, and the secrecy and shame that surrounded them, left the boy with a burden of irrational guilt and a sense that sex was dangerous – literally fatal - as well as 'sinful' (17). He became convinced that his own birth – a difficult forceps delivery – had caused the damage that led to his mother's subsequent miscarriages, the last of which led to her death from haemorrhage and septicaemia. Murray's grief and sense of abandonment at his mother's death were compounded by the dark hints surrounding it. The trauma of such an experience for a young boy 'just on puberty' was increased by his father's 'sinking into broken-hearted grief' so that in their isolated life Les had to 'get through adolescence with little help' (16). He was left with a hidden 'burning rage' – at his mother for 'dying on me', at his father for leaving him emotionally adrift (16).

Another damaging influence was the 'sexual Nazism' of Taree High school: 'Sex is a Nazi. The students all knew/ this at your school' ('Rock Music' KBD 33). For two years he endured what he remembers as a sustained campaign of torment and ostracism:

... all my names were fat-names, at my new town school.
Between classes, kids did erocide: destruction of sexual morale.
Mass refusal of unasked love; that works. Boys cheered as seventeen-
year-old girls came on to me, then ran back whinnying ridicule.
'Burning Want')

This experience left lasting hurt and anger, which he attempts to deal with in several of the poems of ‘personal therapy’.

Murray was diagnosed with depression in middle-age (1988, aged fifty). He describes symptoms that included ‘helpless downers and panic attacks’, prostrating inertia, uncontrollable crying and rages, feelings of persecution, worthlessness and despair (KBD 6-12). He sees these symptoms as the surfacing of a hidden rage that was the legacy of his formative experiences. He suggests that sadistic and destructive behaviour in his childhood and adolescence (such as torturing animals and setting fires) may have been early pointers to chronic depression. Murray describes anger and violence continuing into his adult life, despite his devout Catholicism: thrashing his children, outbursts of irrational rage; misogyny; lack of forgiveness (of the former school fellows who had taunted him) and an uncompromising attitude to perceived ‘enemies’ (such as the ‘generation of 68’, the ‘militant feminists’ and the anti-Vietnam demonstrators of the 1960s). Terror, rage and despair are the engulfing emotions that Murray attempts to give voice to – and to gain mastery over – in his poetry of ‘personal therapy’.

‘Corniche’ is one poem that confronts the raw experience of depression. The therapeutic power of this poem lies in its ability to express the horror of the experience, through metaphor; to gain control over the experience through wit and irony; and to transfigure the ‘depression narrative’ into wider cultural narratives – literary and Christian traditions. The poem centres on the metaphor of the cliff edge, which becomes a darkly comic symbol of the writer’s plight:

The first time, I’d been coming apart all year,
weeping, incoherent; cigars had given me up;
any road round a cliff edge I’d whimper along in low gear
...
The brave die but once? I could go a hundred times a week,
clinging to my pulse with the world’s edge inches away.

Laugh, who never shrank around wizened genitals there
or killed themselves to stop dying
(‘Corniche’ KBD 34-5)

The irony of ‘killed themselves to stop dying’ underscores the speaker’s irrational terror – it is fearful anticipation, a panic attack, rather than objective

danger that reduces him to a quivering wreck. Self-deprecatory irony gives mastery over terror: ‘You gibber to Casualty,/ are checked, scorned, calmed. There’s nothing wrong with your heart’ (27-8). Irony at his own expense does not prevent Murray from questioning Medical authority, with its scornful and patronising dismissal of his fear.

‘Corniche’ echoes Gerard Manley Hopkins’ ‘No worst, there is none’, one of the ‘terrible sonnets’ (Gardner xx) in which the Jesuit priest expresses despair and a bitter sense of abandonment by God. Both poets use the symbol of the cliff edge as a metaphor for experience at the edge of reason and the edge of language. Language breaks down into the shriek, the ‘howling’ and ‘gibber’ of raw feeling beyond rational thought; the speaking human becomes a wordless, whimpering, creeping wretch. Murray’s tortured anticipation of death (‘you stew and welter in your death./ . . . The blow that never falls/ batters you stupid’) inverts Hopkins’ theme of ‘comfort’ in the prospect of death – or its imitator, sleep – as a release from the torment of depression:

creep,
 wretch, under a comfort serves in a whirlwind: all
 life death does end and each day dies with sleep.
 (Hopkins ‘No worst, there is none’ 106)

Hopkins struggles against the longing for death. In another of the ‘terrible sonnets’, ‘Carrion Comfort’, fractured syntax and double negatives reflect his desperate resistance against the attraction of death: ‘Not untwist – slack they may be – these last strands of man /In me . . . not choose not to be’ (2-4). Murray struggles with his terror of death, a terror that he recognises as irrational but that defies reassurance. As Hopkins’ despair challenged his faith: ‘my lament/ is cries countless, cries like dead letters sent/ to dearest him that lives alas! away’ (‘I wake and feel the fell of dark’ 109), so Murray felt in the worst of his black moods that he was ‘beneath’ God’s help: ‘despair is of the very grain of depression. You feel beneath help, beneath the reach even of Godhead’ (KBD 8). The effect of the allusions in ‘Corniche’ to Hopkins’ ‘terrible sonnets’ of despair is to place Murray’s private experience of depression within the larger narratives of literary and Christian traditions. This

therapeutic undertaking is developed in the ‘redemptive’ themes of Fredy Neptune.

Fatness and body image – the politics of size – are significant preoccupations in Murray’s poems of ‘personal therapy’. ‘Memories of the Height-to-Weight Ratio’ links ‘political correctness’ with the tyranny of culturally inscribed valuation of the body:

there was a line called Height-to-Weight
and a parallel line on Vietnam. When a tutor
in politics failed all who crossed that, and wasn’t
dismissed, scholarship was back to holy writ.
.....
Modernism’s not modern: it’s police and despair.
I wear it as fat, and it’s gnawed off my hair

Disturbances of eating (loss of appetite or overeating) and physical activity may be symptoms of depression. In ‘Killing the Black Dog’, Murray describes extreme inertia and episodes of uncontrolled eating, and his resistance to the encouragement of his doctor and his wife to exercise, modify his diet and lose weight.⁸ Fatness is a consequence of his depressive illness as well as a cause. Obesity is an area of Medicine in which the ‘neutral’ discourse of health science is inflected by cultural discourses of the body. The health risks associated with obesity are well-documented and form a major contribution to morbidity and mortality worldwide; they include cardiac disease, high blood pressure, diabetes, arthritis and reduced mobility, increased incidence of bowel and breast cancer, and shortened life expectancy. Doctors know the value of encouraging people to modify lifestyle in order to maintain a healthy weight. However, the medical discourse can be inflected by judgemental attitudes to the body. Cultural norms prescribe idealised standards of body size and shape and inscribe stigma onto those bodies that do not fit the ideal. Murray’s preoccupation is with the ‘ridicule’ that pursued him relentlessly for two years. Murray connects the bullying that he suffered at Taree High with mob brutality and victimisation of those who are different. He sees ‘schoolyard’ thuggery reflected in political factions, in wars and

⁸Their concern has a practical rather than a ‘judgemental’ basis. Murray suffers from diabetes, a condition in which control (and consequently life-expectancy) is markedly improved by moderate exercise and by weight loss/ maintaining weight in the healthy range.

atrocities, in the persecution of minorities – and aligns himself with the scapegoat and victim:

As I unearthed my buried troubles, I saw how closely bound up they were with features of modern society that I loathed, such as demonstrations, in which I always heard the echo of the schoolyard, or radicalisms which seemed to enlarge the schoolyard into a whole ideal world. In the chants of early militant feminism, I heard the accents of Taree High. (KBD 20)

Thus his poems that deal with the ‘fat-names’ and bullying shift the narrative of ‘fatness’ into a political narrative. Murray transforms personal hurt and resentment of the bullies who ostracised him into a broad identification with the outcast. He mocks ‘mob’ mentality that breeds bullies – on the world stage as in the schoolyard:

The beautiful Nazis, why are they so cruel?
Why, to castrate the aberrant, the original, the wounded
Who might change our species and make obsolete
The true race. Which is those who never leave school.
(‘Rock Music’)

Murray’s alignment with the despised and outcast is a healing impulse. However there can be a note of self-pity, an exaggerated sense of persecution, in the reiteration of past grievances. ‘Demo’ exploits the victim position to denounce demonstrators for a cause that the poet disagrees with:

No. Not from me. Never.
Not a step in your march.
.....
To your rigged fashions I’m pariah.
Nothing a mob does is clean,
.....
The first demos I saw,
before placards, were against me,
alone, for two years . . . (KBD 43)

‘On Home Beaches’ revisits (yet again) the themes of fatness and ridicule, entrenching a sense of grievance and suggesting ‘whine’ rather than transformation:

Back, in my fifties, fatter than I was then,
I step on the sand, belch down slight horror to walk
a wincing pit edge, waiting for the pistol shot
laughter.
.....
you peer at this age, but it’s still there, ridicule (KBD 36)

Lightness of touch, achieved by irony or playfulness, can prevent the faults that Murray admits to: 'accuse and whine' and being 'boring'. Lightness can shift the writing from reinscription of grievance to a counter discourse. 'Memories of the Height-to-Weight Ratio' recalls one response that gave a non-derogatory construction of size while offering the possibility of a healthier lifestyle:

the doctor I saw next had no schoolyard in him:
You're a natural weight-lifter! Come join my gym!

However the 'victim' position reappears in this poem as the writer finds (imagines?) persecution everywhere and finally resigns from the organisation that intrudes on the personal domain of his health:

the Institute was after me
to lose seven teeth and five stone in weight
and pass their medical. Three years I dodged
...
When the Institute started afresh
To circle my job, we decamped to Europe

Poems such as this one, entrenching resentment and a sense of persecution, do not represent a strong therapeutic process. 'Demo' and 'On Home Beaches' discover ridicule everywhere. 'Rock Music' demonises Murray's tormenters. While the 'schoolyard' poems express continuing resentment towards childhood persecutors, Fredy Neptune gives voice to the crucial need to forgive in order to be healed.

In Fredy Neptune metaphor transforms the narrative of depression and self-pity into a narrative of healing. Fredy Neptune returns to the themes of the outsider and mob mentality. Peter Alexander suggests that Murray's identification with the 'loner-outcast' Fredy is a key impulse in this epic narrative (289). The poem embodies Murray's opposition to 'the spirit of mob persecution... whether it showed itself in playgrounds, literary coteries, political witch-hunts or in the gulags of totalitarianism: he would stand with the persecuted, the marginalised, the poor, the isolated and the oppressed wherever he recognised them' (289). Alexander suggests that Murray's own personal experiences become embodied and transcended in the wider human and visionary themes of the poem (292-3). Fredy Neptune avoids 'whine': with much comic play to lighten its tragic vision of 'human frightfulness' it

sees the ‘loner-outcast’ win through and achieve domestic contentment and bodily as well as spiritual healing; it transforms despair and rage in an allegory of redemption.

Fred Boettcher is Murray’s alter ego (Alexander 287-8).⁹ In Fredy, fatness is transfigured as strength, depression as numbness. Fredy’s superhuman strength is ironically the source of both respect and alienation. While it arouses admiration and marvel in those who witness his feats, it is also a mark of difference. Numbness too sets Fredy apart from his fellows. Fredy’s numbness can be read at one level as a metaphor for depression (Alexander suggests that Fredy’s bodily anaesthesia parallels Murray’s inner ‘numbness’ 288). Fredy’s numbness symbolises his response to cruelty and suffering. The onset of anaesthesia occurs after he has witnessed the horrific burning of Armenian women by Turks in 1915:

They were huddling, terrified, crying,
Crossing themselves, in the middle of men all yelling.
Their big loose dresses were sopping. Kerosene, you could smell it.
The men were prancing, feeling them, poking at them to dance –
then pouf! they were alight, the women, dark wicks to great orange flames,
whooping and shrieking. If we’d had rifles there
we’d have massacred those bastards. We had only fists and boots. (FN 15).

This scene becomes emblematic of Fredy’s confrontation with ‘human frightfulness’, multiplied throughout his epic journey in repeated encounters with brutality and injustice. Numbness represents his alienation: the dilemma of how to live with such knowledge. Although Fredy’s loss of sensation is ‘explained’ as a result of leprosy (macular anaesthesia) the anaesthesia does not fit any known clinical pattern. Murray shows Dr Cox’s bafflement with the bizarre pattern of clinical features, in a satirical play with medical discourse:

Meantime I was tapped and prodded and written up: Profound neuropathy:
Proprioception intact (see? read it) no gross motor deficit:
Agnosia frequent in darkness: slight allaesthesia: grossly flattened
Cutaneous percept ubiquitous (FN 34)

The pompous and obscure Latinate terminology disguises Cox’s inability to explain the symptoms or come to a diagnosis. Fredy’s anaesthesia defies

⁹ Among the many parallels that Alexander identifies between writer and hero, a particularly telling one is that Murray’s wife ‘responded to his sudden mood changes by calling him “Les” when he was cheerful, and “Fred” when the Black Dog had him’ (287).

explanation by the science of medicine and remains a mystery. It is associated with prodigious strength and endurance ('When effort doesn't reach pain you can take it much further' 35). These abnormal qualities are marks of Fredy's difference and isolation. Loss of sensation signifies his social estrangement (he is separated from his community and family as he travels the world, a German Australian belonging no-where) and his spiritual alienation. However anaesthesia and strength allow Fredy to perform superhuman feats. He employs his strange power in the service of fellow humans – often those who are humble or outcast. Fredy's stigmata of difference are transfigured into heroic marks, sacred stigmata that are the means of enacting compassion and rediscovering a place in human community.

Fredy's numbness serves as a multi-layered metaphor for Murray's depression, with medical, social and spiritual meanings. Murray's sense of being an outsider, his 'burning rage' and his despair are transcended in Fredy Neptune. The epic scope of Fredy's journey parallels a moral journey. Fredy recovers sensation – he is healed – when he is able to forgive. Murray saw Fredy's confrontation with the 'unbearable', his horror at the suffering of mankind in every time and place, and his ability to forgive – ultimately to 'forgive God' – as the redemptive themes of Fredy Neptune (Alexander 293). Grounded in historical and technical detail, of comic incident and verbal play, Fredy Neptune enacts a therapeutic allegory, transforming the narrative of depression into a healing narrative of personal and spiritual renewal.

Francis Webb

Of pain's amalgam with gold let some man sing
(Webb 'Pneumo-encephalogram' 216)

The healing power of song was crucial for Francis Webb, in whose life the 'gold' of artistic endeavour came to form an amalgam with the pain of chronic psychosis. On one occasion when he was receiving electroconvulsive therapy (ECT) for tormenting delusions Webb wrote: 'poetry was all to me, and, as with the man in terror of death and obliteration, I could just sense madness like the void with myself begging to write and unable to.' (Griffith

217). Craig Powell, a psychiatrist and a poet himself, admired Webb's poetry and knew him as a friend as well as being involved in his care. Powell suggests that for Webb poetry provided a healing space, between the fragile self of the schizophrenic and the engulfment threatened by the outer world (Powell 35-6). Powell comments that '[Webb] often told me that his life was chaos and horror but that he had tried to create order and beauty in his poems.' Powell claims that Webb's 'delusional preoccupations never intruded on his poetry' (31). This implies that for Webb poetry was an escape from mental illness. I will argue that Webb's poetry performs a stronger therapeutic function than that of escape: that it embodies a transformative power.

While the content of Webb's schizophrenic delusions is absent from his poetry, schizophrenia as existential experience and as mode of communication is present in the grain of his fractured and ambivalent writing (Ashcroft 74-6). An understanding of the condition and of the conceptual debate that has surrounded schizophrenia provides a background for exploring the healing function of poetry for Webb. I will place a biographical sketch of Webb's illness in the perspective of current understandings of schizophrenia, before turning to an examination of his poetry and its therapeutic achievement.

Webb's early life was marked by a series of losses which may have been linked to the later onset of schizophrenia. His mother died when he was two years old, and within six months his father suffered a mental breakdown and was admitted to a psychiatric hospital.¹⁰ He remained in psychiatric institutions until his death eighteen years later, having effectively no contact with his children. Webb and his sisters were cared for by their grandparents. Francis was strongly attached to his grandfather, who died when the boy was fourteen; Francis was the one to discover his grandfather's body. Powell comments: 'putting all these factors together we could certainly not say that the tragedy of his mental illness was inevitable. But it should not surprise us.' (28).

¹⁰Claude Webb-Wagg was diagnosed with what was then called 'melancholia' but as Craig Powell argues (28) was almost certainly schizophrenia, being associated with delusions and auditory hallucinations. Webb thus had a family history of schizophrenia, a strongly predisposing factor.

Webb's experience during the Second World War may also have been a trigger for psychosis. At the age of eighteen he trained in Canada as a Wireless Air Gunner. Although the war ended before he saw active service, it appears to have had a troubling impact on him. Bill Ashcroft refers to the notion, associated with the anti-psychiatry movement, of schizophrenia as a 'strategy for survival in a mad world' (59). Webb's biographer Michael Griffith postulates that social pressures outside the immediate family played a part in triggering Webb's illness. In particular, he suggests that Webb was deeply disturbed by the senseless destruction and cruelty of war and the holocaust:

Webb's response [to the horror of war and of the holocaust] was to feel personal guilt for global suffering. . . . his own innate cruelty and . . . moral cowardice in not having stood up to race hatred . . . were no different from the causes lying behind the tragedy of the war. (Griffith 107)

The Cold War and the breakdown of traditional values, morality and religion in post war society were further unsettling factors. Griffith records that Webb himself attributed his illness in part to alienation from a society marked by the erosion of moral and religious values that he saw as fundamental (287).

Webb was first hospitalised for mental disease at the age of twenty four. From that time he spent much of his life in psychiatric institutions in England and later in Australian hospitals including Callan Park and Parramatta Psychiatric Hospital. His illness was characterised by overwhelming rages and outbursts of aggressive violence. He was obsessed by delusions of persecution and conspiracy: Communists were taking over the churches and the mental hospitals, and the KGB had targeted him personally (Powell 30-2); he believed that his thoughts (particularly those of a destructive, envious or sexual nature) were broadcast and heard by those around him or were being controlled by outside forces (Griffith 217-9). The mainstay of his treatment was long term incarceration in mental hospitals, often against his will. Involuntary hospitalisation, with limited and difficult access to appeal processes, underscored his powerlessness as a 'mental patient' (Griffith 228-32, 267-72). At times when his behaviour was violent, Webb's management involved

physical restraint, including straitjackets and confinement in a padded cell (Griffith 214). He received frequent courses of ECT and at one time brain surgery was considered, a prospect Webb regarded as ‘monstrous’ (Griffith 268). Yet although his treatment was disempowering and often dehumanising, no-one who knew Webb, including his sisters, fellow poets and friends, denied its necessity or benefit. Webb himself recognised that drugs and ECT brought relief from the torment of delusions and uncontrollable rages, and mental hospitals provided the shelter and safety he needed to write (Powell 35).

‘Five Days Old’ illustrates the insights that biographical background can add to appreciation of the therapeutic functions of Webb’s poetry. This is one of Webb’s most lyrical and accessible poems. It can be read as a confident affirmation of Christian faith, an expression of humility and awe.

Christmas is in the air.
You are given into my hands
Out of the quietest, loneliest lands.

.....
The tiny, not the immense
Will teach our groping eyes.

.....
cloud-voice in war and trouble
Is at last Christ in the stable.

Now wonderingly engrossed
In your fearless delicacies,
I am launched upon sacred seas,
Humbly and utterly lost
In the mystery of creation (156)

At one level the healing power of this poem could be seen as simply the space it provides, a site of certainty and faith that for the time excludes delusions, terror and rage. While Webb’s deep Christian faith and relentless search for spiritual truth is widely known and permeates his poetry, the schizophrenic symptoms that possessed him are less well known and generally not apparent in his poetry. Webb later told Powell ““When I was holding that baby the main thought in my mind was dashing its brains out against the wall. What I wrote in the poem was how I *should* have felt””(32). The comment reveals Webb’s guilt and distress over his ‘painful preoccupation with the destruction of young children’ (31). Yet Webb’s admission does not negate the assertions of the poem. Rather, this insight illuminates how the poem works therapeutically, as

a defiance of Webb's monsters and a retelling of problematic experience. It transforms the 'illness' narrative of destructive feelings into wider narratives: the Christian story of the nativity with its promise of salvation balancing an awareness of sin; and the transcendent mystery of the created universe. An understanding of the poet's personal story (the aggressive feelings against children that were a symptom of his illness) brings added poignancy to the baby's frailty and innocence, but vulnerability is inverted as transcendent power. The poem's theme of redemption through the mystery of God's incarnation – as a tiny and helpless baby – takes on added meaning when read through the frame of Webb's schizophrenic experience.

A reading of 'Five Days Old' that saw only its lyrical sweetness would be oversimplified, and reinforce a notion of Webb's poetry as 'escape' from schizophrenic experience. The lyric is shot through with ambivalence and a sense of threat: the manger is surrounded by a dark wilderness of snow. Threat fragments the certainties that the poet wants to affirm. The poem does not abolish threat, it encompasses 'danger/ And fear' (31-2) but holds them in tension. Webb incorporates images that hint at his own alienation and guilt ('loneliest lands', 'groping eyes', 'war and trouble', 'utterly lost', 'shrive my thoughts', 'tempests of action') and subsumes these into faith and wonder. 'Utterly lost' becomes 'Humbly and utterly lost/ In the mystery of creation'; out of the 'loneliest lands' the baby is given, and the 'groping eyes' of the man will be taught through its perfections. Threat is subsumed into faith – but faith is troubled by a sense of threat. The poem balances rather than resolves its contending forces. It carries the experience of schizophrenia – not the particular delusions of the poet, but his fractured and ambivalent mode of being in the world.

Schizophrenia is a psychotic illness characterised by thought disorder, hallucinations and delusions, disorganised speech, and social withdrawal and isolation (Sadock). Delusions are often grandiose or persecutory (for example the person believes he is being targeted by sinister forces); hallucinations are most commonly auditory, for example voices that provide a commentary upon the person's behaviour or broadcast his secret thoughts aloud. Bizarre or

aggressive behaviour may result from the affected person acting upon delusional beliefs or following the dictates of voices: for example attacking someone whom he believes to be an agent of the persecutory forces arrayed against him. Thought disorder is characterised by loosening of logical connections, reflected in speech that is tangential, allusive or circumstantial.

The causes of schizophrenia have been the subject of controversy. It is now generally accepted that there is a strong genetic basis for the condition, and that it represents a disorder of brain biochemistry. It seems likely that environmental factors, such as social and interpersonal stress, act as triggers and strongly influence the course of the illness, its exacerbations and response to treatment (Sadock 105-6). Debate over schizophrenia has centred on different models, broadly the positivist medical model and interpretative, existentialist models. Interpretative models conceptualise schizophrenia as a strategy for survival in an alienating and inconsistent social environment (usually the family) that erodes the individual's sense of an autonomous self.¹¹ The medical model emphasises the genetic and biological basis of the condition, and the importance of physical modes of therapy, especially drug treatment, but also ECT, in controlling the symptoms and relieving distress. Historically the medical model has tended to be associated with the stigma and fear attached to a poorly understood condition, one often characterised by violent or bizarre behaviour. The medical model is also historically associated with harsh, inhumane treatments. Before the advent of potent anti-psychotic drugs, which calm the overwhelming rages, terrifying delusions and hallucinations, and occasional aggressive outbursts of the schizophrenic, these symptoms were often treated with equally violent and frightening forms of physical control including straitjackets, padded cells, isolation and more recently ECT and destructive brain surgery. However such treatments and attitudes are not necessary correlates of the medical model, and the medical model can be seen as complementary to rather than in confrontation with interpretative models.

¹¹ These models are associated with the anti-psychiatry movement, which critiques the medicalisation of social deviance and the role of Psychiatry as a means of social control.

Interpretative models emphasise the interpersonal and experiential aspects of schizophrenia. They stress the schizophrenic's fragile sense of self, the lack of clear demarcation between the self and the outer world. Social isolation and withdrawal from relationships with others is seen in this context. Intimacy may provoke anxiety because it impinges on the uncertain boundary between self and other, and threatens engulfment of the self. Craig Powell outlines a conceptualisation of the schizophrenic as one in whom the self is poorly demarcated from other, and whose experiences tend to be registered as 'totally good or totally bad without any gradations in between.' (27) The 'self-object' is sometimes experienced as 'happy, grateful self fused with loving object', sometimes as 'raging, envious self fused with an attacking or depriving object' (26).¹²

Such a person will find it difficult to live a separate, individual life because without the object he is nothing, a void. However he cannot achieve intimacy either because in any close relationship he is in danger of being absorbed and ceasing to exist. Any slight to his fragile esteem threatens him with fragmentation, and if he breaks down he will feel overwhelmed by his own destructive rage. Because he cannot tell what is inside and what is outside, this rage will seem to exist outside himself so that he will feel threatened by hostile voices that no-one else can hear, or will find himself the victim of malevolent plots hatched by obscure conspirators. (27)

In his study of Webb's poetry, Bill Ashcroft discusses at some length two interpretations of schizophrenia. 'Schizophrenia as ontological insecurity' (71-81) encompasses the schizophrenic's fragile and poorly demarcated sense of self, and focuses on schizophrenia as a mode of being in the world. 'Schizophrenia as metaphoric experience' (65-71) emphasises schizophrenia as a mode of communication that is highly metaphoric, and the schizophrenic experience a 'lived metaphor'. Ashcroft uses these concepts as a frame, showing how the existential insecurity and the multilayered metaphoric language that characterise schizophrenia inform Webb's poetry. Webb writes

¹² Powell suggests that the psychodynamics of Webb's delusional system were that the 'all-bad self-object constellation' was projected onto the Communists, and the 'all-good self-object constellation' onto the Virgin Mary, the Catholic Church, and the mental hospitals insofar as they provided essential shelter. This 'psychotic splitting' was a defence mechanism against the threat of engulfment by destructive forces – the outer world and his own unacceptable emotions and impulses. However it was 'a fragile solution, and the Communists were forever threatening to overwhelm the Church and the hospitals and plunge him into chaos.' (35)

not 'about' schizophrenia but through it: his poetry serves a therapeutic function, not by providing escape from schizophrenia, but by subsuming its experience and language into his artistic project.

In discussing schizophrenia as 'ontological insecurity' Ashcroft describes the vulnerability of the self as a fear of erosion and obliteration; of being disembodied, one object among objects in the world; a sense of being merged with the outer world or another person so that the separate self is lost. This is the schizophrenic's experience of lack of boundary between self and outer world, self and other, as discussed by Powell. One of the crucial healing functions of Webb's poetry is the resistance it poses to fragmentation and engulfment, loss of the self.

The model of schizophrenia as 'lived metaphor' implies that schizophrenics experience metaphor literally. Their speech does not distinguish literal and metaphoric levels of meaning: 'the peculiarity of the schizophrenic is not the use of metaphor, but of *unlabelled* metaphor' (Ashcroft 66). According to this interpretation, the schizophrenic responds to a social environment (usually the immediate family) characterised by ambiguous, emotionally-laden communications (the 'double-bind') by using metaphor: 'metaphors are not merely a way of avoiding confrontation, but a way of encompassing the interlacing dimensions of their own experience' (68). 'The consummate skill with which the schizophrenic uses language, forced as he is to negotiate an impossible life situation, leads to a multidimensional use of metaphor' (70). This model recalls textbook psychiatric descriptions of schizophrenic language and thought processes: eccentric and symbolic use of words, loosening of associations, concreteness and tangential connections (Waldinger 81-2; Sadock 100-103). There is a blurred boundary between schizophrenic use of language – allusive, making unusual and highly symbolic connections between words and ideas – and poetic language: 'Webb's 'so-called "schizophrenic" language is an intensification of the characteristics of "poetic" (that is, highly metaphoric) language itself' (Ashcroft 69).

‘Pneumo-encephalograph’ illustrates the metaphorical mode that is the hallmark of Webb’s poetry. In this poem Webb appropriates images from the medical world and uses them with multilayered metaphoric meaning. The writer pictures a fellow patient undergoing the painful diagnostic procedure in which a bubble of oxygen was passed up the spinal column into the brain, as a means of visualising the brain, and showing up abnormalities such as scars and tumours:¹³

Only come to this cabin of art:
Crack hardy, take off clothes and play your part.
Contraband enters your brain;
Puckered guerrilla faces patrol the vein;
The spore of oxygen passes
Skidding over old inclines and crevasses,
Hunting an ancient sore

The poem is grounded in concrete images: the ward at night, the anxious patient restlessly making a ‘tight scrimmage’ of his blankets, the delicate instruments used for the procedure, the ‘vigilant eyes’ and ‘mouths . . . almost mute’ of the doctor and his assistants as they perform the skilled procedure. The images of the poem have multiple associations beyond the simple descriptive level. The body is the site of warfare, with images of invasion, spying and insurrection: this suggests not just the battle between disease and healing but the necessity for painful intrusion in order to gain the knowledge of the inner self that brings healing. The procedure is linked to alchemy, the refinement of base material through mortification (suffering) into gold. In another layer of images the procedure becomes ‘art’ – using ‘instruments supple as the flute’ – suggesting that artistic endeavour demands suffering to achieve inner truth. The poet’s own quest for meaning parallels this ‘delicate’ and painful probing of the inner self, and it too is a quest for healing. Religious associations throughout the poem link the patient’s and the poet’s suffering to Christ’s ‘Passion’ (the crucifixion) with its meaning of healing – redemption through sacrificial suffering. In the opening stanza the poet protests the suffering of his fellow inmate: ‘May my every bone and vessel confess the power/ To loathe suffering in you.’ Through the progression of metaphorical

¹³ This procedure has been superseded by less invasive technologies such as computerised tomography and MRI scanning.

images in the poem he comes to 'confess' suffering as the means of finding inner truth and redemption. The 'contraband' oxygen has become the Holy Spirit:

What in you marshalled this improbable will:
Instruments supple as the flute,
Vigilant eyes, mouths that are almost mute . . . ?
.....
Only your suffering.
Of pain's amalgam with gold let some man sing
While pale, fluent and rare
As the Holy Spirit, travels the bubble of air.

The poem's translation of medical discourse into metaphorical meaning represents the patient taking control of the discourse. Webb has subsumed a 'schizophrenic' metaphoric mode of communication to his poetic endeavour, and he has subsumed medical discourse surrounding the invasive and dehumanising diagnostic procedure to his metaphor.

'Homosexual' illustrates another counter discourse that pervades Webb's writing. His poetry has an inversive element, unsettling assumptions that denigrate and stigmatise difference, that place the humble or the 'foolish' as outcast (Griffith 203-4). The poems of the 'Ward Two' sequence portray patients with chronic mental illness, amongst the most marginalised and neglected individuals in our society. Webb was a committed Catholic, writing from the 1940s; at this time and even in the 1960s when the 'Ward Two' sequence was written, homosexuality was regarded as moral deviance by the church and as sickness by some in the broader community (Griffith 264). In 'Homosexual' the cultural inscriptions of illness and sin are questioned and finally inverted as the man becomes an emblem of divine love and redemption.

Like 'Pneumo-encephalograph' this poem is grounded in realistic images: the real community of the ward and its watching inmates; the parents' reactions to their son's deviance ('his mother realises all./ Few questions, and a chaos of silence. Her thin eyes/ are emptied . . . Easier, the talk with his father, rowdy, brief/ thank God, and only the language of the gutter'); the man's inability to speak or hear, the suggestion that he has 'the pox'. This

levels. While this poem carries inversive meanings that unsettle cultural inscriptions of deviance, and that transfigure the outcast into the divine, the homosexual's dilemma can also be read as a metaphor for the schizophrenic experience of ontological insecurity. Bill Ashcroft proposes that the poem is 'not about a homosexual at all but about the schizophrenic consciousness' (74). While it is necessary to avoid a reductive interpretation (the poem is not *just* about schizophrenic consciousness any more than it is *just* about a homosexual) it is clear that this poem is built on images of existential anxiety. The 'lighted house, the security, the Beginning' represent the core of self. Sinister images show the lighted house invaded by booted storm troopers, the windows broken. Joy is transformed into terror by the invading footsteps: 'his grandest element/ Becomes his terror, because of the footsteps, us.' Any relatedness to the other, even being watched, threatens the vulnerable self with engulfment (Ashcroft 74):

To watch may be deadly. There is no judgement, compulsion,
And the object becomes ourselves. That is the terror
We have simply ceased and are not dead

The threat of non-being, merging into other and becoming object, refers both to the watching inmates and to the man they watch. The anxiety, the 'terror', generated in these opening lines pervades the poem and erodes the assertions of the final stanza with ambivalence and uncertainty: 'I am *tempted*.../to see in ugliness and agony a way to God'; He has dictated silence, a *kind of peace*'; '*almost* I can say with no answering scuffle of rejection,/ He is loving us now, he is loving all' (emphasis added). While the poem carries many levels of meaning – I have indicated only a few – it speaks through the experience and the metaphor of schizophrenia.

The final poem to be examined, 'The Yellowhammer', demonstrates how the schizophrenic consciousness informs Webb's poetry and is subsumed into his artistic purpose:

Fog overruns without thunder a taut shire.
.....
Colours grovel, the soused logos of the sun
Lips a last word from sallow wash and glimmer.
Cloud-structures of reason crumble without sound;
It is the song, the footfall of the yellowhammer
Will not give ground

To earth, sky, day, and night crouching as one.

.....
light dispersed and sucked up piecemeal, dumb,
This is the grey rat nibbling at the soul

.....
It is the song; the footfall of the yellowhammer,
Leaps of a sudden past the intellect. (140)

‘The Yellowhammer’ encapsulates the sense of existential vulnerability, the quest for an abiding and immutable principle in face of threat to self, and the overarching power of the poet’s song. This poem depicts English countryside in which fog silently creeps over and obliterates the landscape. All that stands clear in the uniform grey is the song of the little yellowhammer bird. Fog stands as image for loss of definition and boundary between self and world – reason crumbles and merges into the grey void. Light, one of Webb’s recurring images for the ‘indestructible centre’ (Ashcroft 72), is quenched. Only the song holds firm and centred against the representations of the fog – as anarchy, invasion desolation, madness and death – that overrun the poem. The song asserts renewal in images of life-blood ‘flooding the wizened limb’ and of sap bringing promise of green to the leafless tree shrouded in the ‘hostile nothing’ of fog. The song of the bird rings out sharp and clear, recalling the ‘hammer-heart of God’, the immutable and certain core of being. The precisely realised images of landscape in this poem straddle multiple layers of experience, from schizophrenic fear of non-being, to quest for an immutable and indestructible centre of being and assertion of the power of song.

‘Yellowhammer’ exemplifies the themes explored in this chapter.

It is the song; the footfall of the yellowhammer,
Leaps of a sudden past the intellect.

The poetry I have discussed illustrates the power of metaphor to make the leap ‘past the intellect’, to carry meaning at the limits of language, beyond the domain of the reasoning mind and at the edge of silence. ‘Song’, the poetic mode of communication through metaphor, provides one way of telling about illness, one way for the patient to speak.

Chapter 4 Stories coming apart: ageing and dementia

Old age has been a taboo subject for most of us living as I live. Are we all doomed to wheeze our way deathwards in foul-smelling loneliness in a flat somewhere, dropping dead on the way out with the garbage one night? Or will we be propped up in a brightly polished Home for aged gays, sung to by the gay choir every second Sunday, dragooned into croaking out old Barbara Streisand songs around the piano of an evening with people we have nothing in common with at all except something called ‘gayness’? (Robert Dessaix and so forth 369)

In this perverse representation of old age Dessaix plays games with two images of outsidership – ‘gayness’ and old age. Using the stereotypes to comment ironically upon one another he unsettles both. Shared anxiety about ageing, with its associations of decline and pathos, allows gay people to become part of the ‘mainstream’ while paradoxically the common human lot of old age is revealed as another form of marginalisation. Witty and inversive representations of ageing can expose and trouble our expectations and provide alternative perceptions. In this chapter I will explore some ways in which narratives of ageing and dementia unsettle and transform commonly held assumptions, to perform a therapeutic function.

Concepts of ageing

There is a growing interest in the study of ageing. In Sociology, research in ageing encompasses topics from ageism, elder abuse, health in later life and dementia, to the representation of the elderly in popular literature (Gearing vii). In medicine, Geriatrics has emerged as an important sub-specialty, with its own publications and journals. The inclusion of Geriatrics in basic medical education signals the growth of this field of practice. There is greater recognition in the medical discourse of the specific needs of one neglected and marginalised group, the elderly. Associated with increased research on ageing across many disciplines is a move to contest marginalizing constructions of older age, images that equate ageing with frailty, decline and illness. For this reason, to resist identifying ageing with illness, I propose in this chapter to discuss ageing *per se* as a broad theoretical frame. To illustrate ways in which fiction may counter stereotypes of ageing I will examine one

novel that speaks through the experience of older characters. For the purposes of exploring narratives that have a more direct therapeutic function, I will examine texts that confront a condition of incontestable decline – dementia.

Old age is both biological imperative and cultural construction. Human cells and tissues have a finite life span: that is the biological imperative. The experience of old age, however, depends largely upon its cultural construction, the attitudes and images that society builds around it. In Western society age incorporates many negative stereotypes such as feebleness, disability and mental decline. Images of Aging (Featherstone and Wernick) presents a range of cultural interpretations of ageing. The introduction (1-14) gives an overview of how old age is perceived. The elderly are often imaged as ugly, disgusting, incompetent or absurd – crotchety, childish or comical. Negative stereotypes are often related to lack of control and power. Thus incontinence, immobility, poor hygiene and self-neglect demonstrate lack of control of the body; loss of memory and sensory faculties, including failing vision and hearing, signal loss of mental power; and inability to work in paid employment or perform domestic tasks is associated with loss of authority in the family and the wider community.

In Western society, the cult of youth equates dignity, credibility and personal worth with attractive, youthful appearance, especially for women. Simone de Beauvoir in The Coming of Age provides strong support for her argument that for older women there is a double oppression – of being woman and being old. Denial of ageing takes many forms. It ranges from the segregation that retirement communities may entail to the absence of images of old people in advertising, the media and literature – or their appearance as demeaning stereotypes (Featherstone and Wernick). Even Western society's emphasis on slowing or reversing ageing, for instance by cosmetic surgery, is a form of denial. John Tulloch suggests that 'youthfulness as masquerade' – remodelling the ageing body to appear younger – is a denial of ageing analogous to incarceration in retirement villages, and in performing such masquerade, older people become complicit in their own degradation (271).

Insofar as old age is culturally constructed, changing the stereotypes can modify the experience of ageing. As the proportion of older people increases in affluent nations, there are moves to promote less demeaning images, that emphasise participation in the community and enjoyment of life in later years. Featherstone and Hepworth provide examples in 'A Case Study of *Retirement Choice Magazine*' (29-47). This U.S. publication portrays older people actively involved in life – travel, holidays, sports and community work. Such models for the elderly can enhance quality of life for individuals and help to overcome the social 'problem' (so perceived) of increased numbers of older people (seen as a parasitic burden on society). They will be more active, less dependent and less sidelined.

'Literary gerontology'

'Literary gerontology' is an emerging field of literary analysis focusing on works that are centrally concerned with the experience of ageing (Hepworth 4). Hepworth is a sociologist whose own work reflects interest in literature as a resource for Gerontology. In Stories of Ageing he examines a wide range of popular fiction: authors include Kingsley Amis, Agatha Christie, Doris Lessing and Oscar Wilde. Hepworth explores how ageing is represented in popular fiction and what role the imagination can play in making sense of growing older. He recognises literature as a 'human resource' that can help individuals as they grow older, but he goes further, attempting to show how the ideas and images popularised in fiction relate to the understandings of social gerontology. Specific topics that Hepworth examines include the representation of embodiment in fiction, isolation and loneliness, shifts in power in family relationships and the importance of places and possessions in representing and reflecting the self. He explores in detail ways in which fiction can attest the power of cultural stereotypes of ageing and proceed to undermine them. 'Disobedient' elderly characters, for example, may manipulate and exploit the masks of ageing for their own purposes (106-113), subverting restrictive cultural expectations and reasserting their selfhood.

In affirming the value of fiction for understanding the personal and social meanings that individuals give to ageing, Hepworth refers to the concept of 'narrative identity' (17). That is, individuals create a sense of self and of meaning through 'telling stories'. Fiction goes beyond mere representation of the subjective experience of ageing. Through fiction meanings are not only expressed but constructed. In revealing and contesting disempowering images of ageing, and in setting up alternative possibilities, fiction contributes to the cultural narrative of ageing.

Barbara Waxman's work also exemplifies the emergence of 'literary gerontology'. Waxman investigates how fiction and life writing that place the older person centrally can have an affirmative effect and resist dominant

cultural discourses of ageing. She argues that literature not only reflects current social attitudes to ageing but also contributes to the process of conceptual and social change. In From the Hearth to the Open Road: a feminist study of aging in contemporary literature Waxman describes the appearance in the USA, Canada and Britain since 1960, of what she calls the *Reifungsroman* or ‘novel of ripening’. This is a ‘whole new genre of fiction that rejects negative cultural stereotypes of the old woman and aging, seeking to change the society that created these stereotypes’ (2). Waxman addresses the ‘interlocking oppressions’ of sexism and ageism for older women (4) with her focus on female central characters. However her arguments apply to older men as well as women. She studies fiction that depicts opportunities – for exploration and adventure, new relationships, growth and self-knowledge – in later life. Such novels, placing older people centrally and emphasising their quests and individuality, challenge the stereotype that old people are ‘frail, dim-witted, and vegetating in nursing homes’ (5), and affirm much more spirited possibilities.

One of Barbara Waxman’s themes is the conceptualisation of ‘age as a continuum’ rather than a dichotomy between youth and old age (47). She discusses novels by Doris Lessing and Alice Adams that deal with middle age as a time ‘for discovery and new activities’, a time of ‘emotional and philosophical ripening’, instead of a time of ‘stagnation’ leading towards old age (46). Having established the possibility of middle age as a time of new explorations as well as growth and transition into later life, Waxman makes useful distinctions between different stages of old age:

the ‘young old,’ aged 60 to 74, frequently face crises and are required to make certain adjustments that the ‘middle old’ (75-85) or the ‘old old’ (over 85) would in all likelihood have already dealt with. (95)

The ‘young old’ adjust to transitions such as widowhood and retirement from work, often with ‘intense emotional turmoil’, but are ‘generally healthy and spirited’. The novels that Waxman examines in her chapters on the ‘young old’ and ‘middle old’ contest the myth of stagnation and portray heroines participating actively in life (96). In the final section of her analysis Waxman examines novels that are concerned with the ‘frail old’. She characterises the

traditional view of dependent old age as a time of ‘physical decay . . . mental confusion . . . dependency, anxiety and loss of identity . . . a dread of impending death’ (136). She argues that this view ‘is challenged by some angry heroines who struggle with their dependency, demand dignified treatment, crave beauty and love, and contemplate death as a natural ripening process.’ Novels that portray even the ‘frail old’ may embody a sense of ‘adventure’ and demonstrate ‘opportunity for growth’ (136). Waxman’s study supports the contention that fiction can form a counterdiscourse to negative and disempowering stereotypes of ageing.

Waxman and Hepworth demonstrate that one way in which fiction counters demeaning images of ageing is through the enactment of alternative roles – disobedient or mischievous elders. This strategy can be understood in terms of the concept of ‘performativity’ developed by Judith Butler. Butler suggests that cultural roles become entrenched through repeated performance. With particular reference to gender roles, she argues that individuals incorporate social expectations by reiterative enactment of their assigned identity: ‘identity is performatively constituted by the very “expressions” that are said to be its results’ (25). ‘Performativity’ is culturally determined and sanctioned rather than deliberate or volitional; the norms that are enacted are ‘given’ and generally taken for granted rather than chosen. The notion of ‘performativity’ can be applied to old age. Part of the cultural construction of ageing, as for gender, is through performance: the role of ‘elderly person’ is entrenched through doing what is expected of the elderly.

While performativity is a mechanism of social control, it carries a perverse option. Performances that counter the normative roles and assumptions – performances that are deliberately inverted, parodic or theatrical – subvert stereotypes and expectations.¹⁵ Stigmatic and constraining cultural norms of ageing (as of gender) may be subverted, in life and in literature, by transgressive performances. An old person may slyly exploit the stereotype for her own ends. The seemingly vacuous elderly lady who uses interest in gossip as a mask for criminal investigation is familiar in Agatha Christie’s Miss Marple and Dorothy Sayers’ Miss Climpson.

¹⁵ In regard to gender, Butler argues that parodic performance does not merely show that gender can be imitated, it ‘*implicitly reveals the imitative structure of gender itself*’ (137). A similar point could be made with respect to old age: that is, exaggerated, parodic and transgressive performance of the stereotypes of old age can demonstrate the culturally constructed aspect of age.

Disobedient or unconventional elders are popular in children's literature. Dianne Bates' character, 'grandma Cadbury' figures as a 'truckie' and leader of a 'bikie gang', and grannie in Nina Bawden's *Grannie the Pag* is also a 'bikie'. In Anna Fienberg's novel for young adults, *Borrowed Light*, which I discuss in Chapter 5, the grandmother is a Professor of Astronomy. Children, like old people, are relatively powerless, and enjoy inversive challenges to conventional hierarchies of strength and status. Naughty older characters can unsettle disempowering expectations – 'perform' a reverse discourse that may be empowering for child and elder alike.

Isolation of the elderly is one aspect of their marginalisation that studies such as those of Waxman, Hepworth, and Featherstone identify. Separation of older people can be either geographical (for example in retirement centres) or experiential – that is, old people even in the presence of others, including their own family, may be ignored or treated dismissively. Hepworth argues that loneliness is 'associated with social exclusion and isolation' more than with 'geographical isolation', it is 'lack of a sense that there is someone else who shares one's experience' (65). Diminishing interaction with others across age groups leads to lowering of self-esteem as well as loneliness. Remaking connection to other people, to the meaningful life of community and family, is therapeutic. Story telling is a relational activity. It draws together teller and listener. Personal narratives, family histories, tales of fiction, myths and legends – stories of all kinds emphasise the links between people across generations and within families, and strengthen continuities between past and present.

Literary depiction of perverse elders, accounts of quests for personal fulfilment, and the use of stories to connect older people into the wider community all counter the cultural discourse that denigrates and alienates older people. However these resistant strategies do not necessarily address the biological imperative of ageing, the inescapable condition of embodiment. Hepworth refers to the body as the 'bedrock' of the self, 'the fundamental fact of biological existence in which the symbolic elaboration of the self is grounded' (38). In his discussion of the 'dys-appearing' body Drew Leder argues that in the healthy adult the body is normally absent from awareness, but pain and dysfunction bring the body to the forefront of consciousness. Old age is one condition in which the body often intrudes unpleasantly on awareness due to deterioration in function and change in appearance, even when the elderly person is healthy (Leder 89).

The physiological changes of ageing provide the introduction to a standard medical textbook of Geriatrics (Kane 1-16). Kane distinguishes 'natural aging processes' from 'diseases' (which may be correctable) thus emphasising the inexorable aspect of ageing. Physiological changes include loss of lean body mass (bone and muscle), reduction in cardiac output and blood flow to organs such as the kidneys, thickening and fibrosis of blood vessels, reduction in lung capacity and elasticity, and slowing of intestinal motility. Sharpness of near and distant vision, colour sensitivity and depth perception decline. There is deterioration in high frequency hearing and pitch discrimination. The immune response declines and joints show degenerative change.

There is decrease in brain weight and number of brain cells, together with slowed psychomotor performance, decline in intellectual performance and complex learning, and reduction in hours and quality of sleep. The cause of ageing is multifactorial – both genetic make-up and environmental damage by agents such as free radicals contribute. Although there is no generally accepted theory that explains ageing, it is beyond doubt that the process is written into our being as cellular organisms.

The value of Medical treatment for the ageing and dysfunctional body is undisputed. Kane recognises the responsibility of Medicine to seek diagnosis and treat correctable conditions, but also acknowledges the limitations of Medicine:

No amount of rehabilitation, compassionate care, or environmental manipulation will compensate for missing a remediable diagnosis. However, diagnoses alone are usually insufficient. The elderly are repositories of chronic disease more often cared for than cured. (16)

Pain, disability and dysfunction can be minimised by the therapies available for cure, rehabilitation and palliation – but there remain discomforts and disabilities beyond the scope of Medical healing. What function can narrative have in confronting and comforting the *irreducible* discomforts and disabilities of the ageing body? I will suggest some answers to this question as I examine texts in detail; here I anticipate briefly some of the possibilities.

Honest ‘telling’ of the body’s condition, rejecting denial and euphemism, is the beginning of a therapeutic view. The texts that I will discuss depict embodied old age frankly, resisting sanitisation, but affirm dignity, courage and resilience in the face of bodily distress. Leder recognises that transcendence is a strategy by which people deal with pain and disability:

we seek to escape this hold of pain by focusing outward upon the world, or dwelling in our past or a hoped-for future. Yet even such a movement outward bears witness to the original constrictiveness of pain. The body is no longer a nullpoint but an active presence whose call we must resist. (76)

Forcibly returned to awareness of painful embodiment, people may make a deliberate effort to diminish the body’s tyranny over consciousness by projection back out into the world – through meditation, for example. Narrative and poetry can also be paths towards refocusing awareness in this way. Transcendence may be sought through the craftsmanship of writing a story or poem, through reconfiguring embodied experience or transforming it into part of a ‘larger narrative’ such as political satire, communal belonging or spiritual journey.

Amy Witting Maria’s War

Maria’s War illustrates several of the concerns of this chapter. Based on the friendship between two women in a retirement village and the stories they tell, the novel shows the significance of narrative, in particular an older person’s life narrative, in finding meaning. It places the older person in a network of relationships – family and others – and underlines the importance

of the links between generations. The stories of older people become part of the life narratives of their children and grandchildren. The novel has the effect of normalising old age, by placing the older person within this framework of ongoing life and shared story. By moving between different periods in the lives of the central characters it emphasises continuity rather than dichotomy between youth and old age. It is not so much *about* old age as told *through* old age: it is grounded in the embodiment and memories of older women, and embodiment and memory provide a basis for exploring meaning and the connections between people.

The central characters of Maria's War are older women: Maria in her late seventies, Erica a few years younger. Erica is 'able-bodied' ('young old' in Waxman's categorisation). She is fit and active, with a sharp and curious intellect. Maria is more obviously ageing, fleshy, slow moving and easily tired. As the viewpoint shifts between Erica and Maria the novel gives a clear depiction of the physical and social constraints associated with ageing but these are not the predominant concern. The lives and the stories of the older women are braided with those of Maria's children and grandchildren, and Erica's former pupil and friend, Margaret. Witting contests marginalising constructions of ageing (especially the ageing woman) by creating older characters who are perverse and spirited individuals, as much engaged in new challenges and on-going life as are the younger people around them.

Leicester Gardens, the retirement village that Erica enters at the start of the novel consists of 'circles, like Dante's Inferno' writes Erica – independent villas, residential units, complete room service and the 'fourth circle is the nursing home. The fifth has no name and no place in the conversation' (35). Erica's place in this transitional world is a unit in the 'second circle'. Her dry wit both admits and ironically distances the inevitable spiral towards death. She wryly notes the evasions that surround the subject of death here. In a world of old bodies – 'surrounded by dewlaps, knotted veins, rheumy eyes and creaking joints' (33) – 'decline and death' are taboo subjects. When someone mentions a former resident who has cancer, Erica notes a marked silence amongst all present and reflects 'fear of death was strictly one's own affair'

(39). Erica's images of Leicester Gardens reflect her ambivalent and changing attitudes. Decline and death recede to the background and her initial 'prison mentality' (70) is consciously ironic, set against the residents' free movement between the village and wider community: shops, golf club, church. Formerly a schoolteacher, she draws parallels between her new home and stages of school life: 'this was like one's first week at school, and even at kindergarten. Saint Boniface's Preparatory School for the Aged' (40). A week or two later she comments to another resident that "'it's all very like boarding school, isn't it'" (113) and another time compares the 'pecking order' to that of 'any staffroom' (162). The school metaphor, with its implication of growth and development as well as youth, reflects ironically on the unspoken prospect of stagnation and decline. However the narrative is in fact one of growth for its central characters so that the school metaphor emerges as more than merely ironic. Despite the setting, the focus is not on the disabilities and constraints of old age. Interest centres on the individuals (who happen to be elderly) and on their engagement with an ongoing life.

One strategy that Witting uses in her presentation of older characters is perverse performance. As discussed above, part of the cultural construction of old age is through reiterative enactment – the older person is entrenched in the culturally ascribed role. Erica and Maria contest stereotypes of old age by enacting alternative possibilities. Erica's conversation is spiced with innuendo and ribald anecdotes (at the communal dinner table she tells the story of a young man who drank 'a quart of beer out of a chamber-pot' 14). She goes bushwalking, and pursues intellectual and academic interests. Her internal commentary is dry and witty: 'old age is like religion: it makes good people better and bad people worse' (162). Maria too is 'mischievous' and 'sardonic', her unexpected sharpness surprising Neil (her biographer): "'My personal god is the cockroach. Humble, persecuted, despised, and ineradicable'" (4). Maria and Erica can be catty, making sly fun of pretension and petty snobbery and 'offending' more narrow-minded fellow residents with their risqué stories (37-8, 65-69).

Another strategy for unsettling stereotypes of ageing is to subvert them to one's own advantage. In Maria's War stigmata of ageing are exploited by the residents of Leicester Gardens. Winifred makes use of her impaired sight when it suits her to have others serve attendance on her needs (130). Mrs Anstruther maintains aloofness and 'superiority' by refusing to wear her hearing aid except when her family visits. Erica plays the part of a gossiping bore to defuse Rosalie Barnes' anxious suspicion of her: 'Nobody fears a bore'

(128-9). Maria becomes deliberately vague to avoid revealing parts of her story to Neil, playing on his misinterpretation of her silences:

Maria could not speak to any man about Rosa. It was absurd to visit the guilt of a rapist on this gentle, intelligent young man . . . But he was a man, not immune from the furious rage which seized her . . .

Now she's gone again, thought Neil. He waited, wondering to what region her mind had wandered . . . (83)

Later Neil comes to understand her silences: 'the old woman's memories were being deliberately withheld' (86). He honours her need for privacy, and Maria no longer deploys the 'mask' of confusion as respect develops between them.

As well as demonstrating ways in which the mask of ageing may be subverted, Witting ridicules constraints which purportedly protect old people but in fact serve to diminish and marginalise them. Erica is 'vexed' to find that she will not be allowed to walk in the bushland reserve alone:

'Ah. We don't really care to have our guests go into the reserve alone. So easy, you know, to stumble and perhaps sprain an ankle.'

'I am perfectly able-bodied!'

'I'm sure. But you see, we do feel the responsibility. And you could be missing for some time before anyone noticed . . .' (24)

This exchange carries the ironic implication that over-protectiveness may be a self-fulfilling constraint, promoting the very physical frailty it takes as excuse. However, while the novel unsettles the cultural scripting of old age, it does not minimise the realities of embodied old age. Erica is 'perfectly able-bodied' but others are not. On her first night she watches the diners rise from the table and walk to the next room, 'slow, stiff and halting . . . Only two of them moved with ease' – and one of those two is blind (16). Although Winifred may exploit her blindness to suit herself, it is a real constraint (Erica tries to imagine the deprivation of being unable to read.) Catherine has arthritis so severe that standing up from her chair is a 'struggle' even with assistance and walking to the next room 'a very great effort' (20). Maria, little older than Erica, is notably more 'elderly' in body and behaviour. Neil sees her as a 'very old, fat, balding woman with the skin folded lizard-like over her eyes' (141). She has bunions, her gait is lumbering, she cannot climb stairs and is easily tired. In the background of the story the nursing home (the 'fourth circle') is a shadowy reminder of dependent old age, and offstage are other old people with cancer, dementia and Parkinson's disease. The novel depicts the embodiment of old age plainly, with flashes of sardonic humour but without denial. Calm acceptance of embodied ageing is the basis of a therapeutic view.

For Erica and Maria narrative has a healing function. When Erica meets her, Maria has started to lose interest in life. She has allowed herself to become fat and sedentary as a kind of withdrawal (120). However her lapse into the 'elderly' role is reversed when she begins to tell her stories. Maria's grandchildren want a memoir of her early life in Europe, and Neil is employed to record and write up her reminiscences. For Neil, listening and writing become part of his own recovery from humiliating rejection in love. He discovers his identity as a writer and the restorative power of work. Maria explores the story of her youth in Lithuania and Germany during World War II and in the post war refugee camps, of coming to Australia with her little daughter, and the new life she has built up: teaching, remarriage, children and

grandchildren. She tells Erica the parts of her wartime story that cannot be told to Neil: her encounter with the young woman Rosa who had just been raped, the breakdown of her first marriage and her disastrous love affair in the displaced persons' camp. At the outset of the journey into memory, Maria tells Neil that "Memory is the black sea" (2). She finds the process of reliving her past while trying to skirt around the dark memories emotionally exhausting, but when she has told Erica the 'black' secrets, Maria recognises that telling has brought about healing: 'Do you think it was worth it?' . . .

[Erica is referring to the scandalous love affair]

'One might as well ask, is it worthwhile to be hit by a train? And that is how it seems to me now, as I tell my life story – my childhood, my youth, our wanderings and our struggles – and I am thinking only, "Once, I was hit by a train", and after all these years, it is the first time I feel free of the memory. I suppose I had never really faced it before. . . .' (190)

Erica, feeling herself to be an outsider, always 'the misfit and the loner' (15) is the observer and listener. Only she can make the connection between Maria's story of Rosa, and Margaret's grandmother 'Oma', and solve the novel's mystery: Oma is Rosa, and her rape, seen by Margaret's mother as a terrified three-year-old child in Germany, is the family secret that has brought so much pain. Discovery brings understanding and healing for Margaret. Thus, telling her stories is empowering as well as cathartic for Maria. The value they hold for other people – her own grandchildren and Neil and Margaret – enhances Maria's sense of identity, reflected in her increasing physical activity and social involvement. She is less complicit with a constricting image of herself as 'old'. Story telling deepens her friendship with Erica: sharing secrets and unravelling a mystery draws them together and they discover that, strong minded and independent, they are both 'rebels' against the constraints of stereotyping.

Erica's own story also emerges. She has been a successful teacher, popular with her pupils, to some of whom (like Margaret) she has become a mother figure and confidante, but she feels a bitter sense of failure at not having attracted a husband and had children and grandchildren of her own:

The students who had seen her as a substitute mother had been for her indeed a substitute, and a reminder of her life's great failure – to inspire love, to marry and to achieve true motherhood. (33)

Maria helps Erica to 'retell' her story of 'failure' as one of achievement.

Perceiving the great confidence Margaret has in Erica, Maria exclaims, "How I wish I could have been such a teacher as you" (207). When Erica protests that having a student who is like a daughter "isn't the same" as being truly a mother, Maria insists "It can sometimes be better" (227). Erica's own therapeutic quest is to value what she has achieved and to go on with the continuing story – friendship with Maria, the challenge of finding new projects to occupy her 'vital and vigorous' mind and body in retirement at Leicester Gardens. For both women narrative is a quest for meaning as well as a connection linking them with the wider community. Narrative, the country of the imagination, transcends age, as Maria recognises:

'I have come to love Australia for many things, even at last for the landscape, but I have lived all my life in one country and longed for another. Now I can see that there is another country, where age does not matter and one does not care about gender or race or nation. You and I are lucky to belong to it.' (227)

Yvonne Miels, in her study of Witting's writing, asserts that 'Witting's intention is to reveal inner journeys in which characters seek meaning and a sense of purpose and self-definition' (The Net Under the Tightrope 46). She suggests that Witting's interest is directed beyond 'the constraints of conventional roles' such as gender and age, 'to a fuller exploration of what it means to be human' (175-6). For Witting's characters, old age is not a reason for withdrawal and stagnation, but instead highlights the quest for meaning 'in the full knowledge of death and life's transience' (133). In Maria's War Erica and Maria undertake 'inner journeys'. Their stories go beyond the particular concerns of ageing to explore 'what it means to be human'. Witting's representation of the embodiment and experience of older women serves to counter negative and marginalising discourses of ageing.

Dementia: theoretical perspectives

Narratives that deal with or speak through the experience of ageing may reflect the personal experience of the writer. Although Amy Witting is not directly telling her personal story in Maria's War, she constructs the narratives of older women through the lens of her own experience. The older person has a voice, has agency to speak. However a person who is affected by dementia is unable to tell her own story. A companion with the time and patience to listen may gain some window onto the experience of dementia but the demented person herself cannot thread the pieces of memory into a coherent and sustained narrative. At best someone else can draw on the fragments to speak on her behalf. With what authority can the narrator speak for another? How can accounts that depict dementia be considered therapeutic, and for whom? In Kate Jennings's Moral Hazard, Cath confronts these issues:

A bill arrived from the doctor, and in the space provided for the diagnosis was written *dementia*. . . . Other words and phrases came to mind: *gaga, away with the pixies, lost his marbles, nobody home*. Knowing next to nothing about Alzheimer's other than those cruel, dismissive tags, I . . . pulled out all the books on the disease . . .

I learned the obvious: Without memory we are nothing. . . . Bailey would lose not just his memory of events and people but all his skills, from the most sophisticated to the elementary – from language to control over his bodily functions. He would forget how to swallow, walk backward when he wanted to go forward, become sexually "inappropriate."
. . . Bailey would erode like a sandstone statue. (Jennings Moral Hazard 15-17)

Amongst the ‘books on the disease’ that Cath ‘pulled out’ could well have been a standard psychiatric text such as Kaplan and Sadock’s Synopsis of Psychiatry, from which I have drawn the following summary. Alzheimer’s disease is the most common form of dementia affecting older people.¹⁶ It is a degenerative condition in which there is progressive atrophy of brain tissue and deficiency of some neurotransmitters. Although the cause is uncertain, there is a known genetic component. People with Alzheimer’s dementia demonstrate progressive decline in memory and cognitive functioning. There is a gradual but relentless downward course, with average time from onset of symptoms to death of about ten years. Memory impairment is prominent and most marked for recent events (names of new acquaintances, events of the day); later there is severe impairment, with earliest learned information, such as childhood events, retained longest. The person has progressive difficulty in finding the right word (aphasia) reflected in earlier stages by stereotyped and circumlocutory speech, later by incoherence and eventual loss of language. The affected person is increasingly disoriented in time and space, becoming confused about dates and times and getting lost, initially in unfamiliar surroundings but later even in the neighbourhood and home. A person with Alzheimer’s disease has difficulty with novel and complex tasks initially, and becomes unable to perform everyday activities such as preparing food, bathing and dressing. Personality is affected: the early stages are often associated with marked anxiety; pre-existing personality traits may become exaggerated, or the person may become disinhibited, hostile or irritable. Hallucinations and delusions, often of a persecutory nature, occur commonly and may be associated with agitated or aggressive behaviour.

The biomedical model of dementia, represented by Kaplan’s text, is characterised by focus on the biochemical and pathophysiological changes in the brain and the clinical correlates of neurological deficit and problem behaviour. Malcolm Goldsmith, in his

¹⁶ The popular expression ‘senile dementia’ is a loose term, indicating dementia in an older person. Dementia occurs predominantly in older people but clearly it is neither an invariable aspect of ageing nor is it confined to the elderly. Approximately 5% of people over 65 have severe dementia and of those over 80, approximately 20% have severe dementia. Alzheimer’s disease accounts for about 50-60% of all people with dementia and although Alzheimer’s type dementia mainly affects the elderly, it does occur in younger people: in those under sixty it is termed ‘early onset dementia’.

study Hearing the Voice of People with Dementia,¹⁷ gives another perspective: ‘It is increasingly being argued that we should understand dementia as a complex interaction between personality, age, biography, ethnicity, health, gender, neurological impairment and the social psychology and web of relationships that a person has. This is to move away from an overemphasis upon a biomedical model’ (167). Interpreting dementia as ‘a set of deficits, damages and problem behaviours’ (the biomedical view) treats person as object. There has been a shift towards seeing the person as a whole and placing emphasis on previous and present relationships, personality and life history – ongoing personhood (24). This is a relational model – the person with dementia ‘needs the Other for personhood to be maintained . . . to hold the fragments together’ (27).

Goldsmith suggests that dementia is *interesting* because it poses problems about the nature of the self (33-4). Sensitive listening to people with dementia gives an entry into the experience of the fragmenting self. In the early stages people with dementia have variable degrees of insight and awareness of their condition. Insight prompts coping strategies such as list-making, diaries and reminder notes. Awareness of one’s mental disintegration may be associated with anxiety, guilt and sadness (32-3). In Moral Hazard Kate Jennings captures the responses of a man with early Alzheimer’s disease:

His perception of the world splintering, his horizons warping, he became frustrated, scared, angry. He raged, pounded walls, accused me of all kinds of perfidy. This, the most trusting and uxorious of men. (13)

. . . he took out large sheets of drawing paper and began, for the last time, remembering his generous, eventful life. Now, while he worked he cried. He cried for a year, his face bruising with sorrow. (21)

Goldsmith argues that ‘communication is possible’ (161). We may be able to communicate with most people with dementia by entering their world, understanding their sense of pace and time (165). Familiar surroundings provide cues and reminders, distractions increase confusion and distress. Methods that facilitate communication include non-verbal signals – touch, facial expression, gesture – and the use of metaphor and symbolism (163). Goldsmith’s approach in this study represents a shift from an objectifying medical view to one that honours the inner experience, the story, and the selfhood of the person with dementia.

Dementia and Story

Though memories were often regarded as careful files in a catalogue, Jonny now believed they could just as easily be wild stories, always in the process of being revised, updated, or having different endings written on to them . . . even if the entries faded into nothing almost at once. (Margaret Mahy Memory 170-1)

From a narrative perspective, the progressive loss of memory, language and identity that characterises dementia may be conceptualised as loss of story. People with dementia no longer live in a coherent or continuing story –

¹⁷ Goldsmith surveyed the needs of people with dementia and their carers for support and health services.

with loss of memory they must live suspended in the moment, with no connected self-narrative. This experience is often associated with great anxiety: incoherence and insecurity threaten to overwhelm the affected person.

Errollyn Bruce has written of the value of story for older people and in particular for people with dementia. She acknowledges that old age is often associated with multiple losses, denigration, powerlessness and lowered self-esteem. For any older person, retelling the past as a 'good story' can enhance identity, help cope with loss, allow resolution of old conflicts and affirm continuities between the past and the ongoing narrative of life now (183). Bruce is chiefly concerned with the healing possibilities of narrative for people with dementia. In early dementia especially, reminiscence and stories from the past can be a way of holding at bay the shrinkage of a world where memory and words are eroding (188). Bruce characterises dementia as 'loss of coherent internal narrative' that makes sense of experience (194). 'Restorying' present experience in terms of a more coherent past ('living in the past') can be seen as a way of coping with a present that is strange, without being overwhelmed by confusion and anxiety.

Bruce suggests that the demented person often behaves like a very young child, clinging and needing the constant presence of a known person. Like a child, she is unable to 'story' (make sense of) her experience, and needs closeness to another for a sense of safety and meaning (193). The carer thus faces the difficult task of providing reassurance as well as tending physical needs. The affected person has lost the shared memories and may eventually no longer even recognise a carer. This is 'a challenge to the validity of the carer's own narrative, and to the significance of their shared past' (195). Affected person and carer are bound together and yet isolated by loss of the shared story. In the early stages 'living in the past' can be a way in which the demented person makes sense of the bewildering events of the present. As dementia progresses, the new story must provide a self and a relationship that is continually being remade for the demented person, yet also give meaning to the carer's own ongoing life and identity.

Whereas the biomedical view of dementia, emphasising degenerative processes, diminishes personhood, the perspectives represented by Goldsmith and Bruce indicate some ways in which narratives of dementia may become therapeutic. A significant therapeutic function of narratives of dementia is to refuse the denials of euphemism and sentimentality, to confront the actuality of decline and affirm personhood nonetheless. Psychosocial and narrative models of dementia emphasise the person's life-story and relationships. Studies of dementia signal counterdiscursive possibilities: 'dementia is interesting', 'communication is possible', the demented person's story can be honoured even though she cannot tell it herself, and the carer's crucial role in constructing ongoing narrative is recognised. The texts that I will discuss work counter to discourses of stigma, depersonalisation and despair. They provide narratives that resist denial, portray the inner landscape of dementia, challenge stereotypes, take imaginative twists and move into larger cultural narratives.

John Bayley Iris

John Bayley's account of his life with Iris Murdoch begins in Oxford in the 1950s. The post war years were a time of rapid cultural and intellectual change, the shifting of old certainties. The book divides into 'Then' (Part I) and 'Now' (Part II) but the narrative shifts repeatedly between 'Then' – their meeting, courtship and early married life in Oxford – and the present where John cares for Iris who is affected with Alzheimer's dementia. 'Then' and 'Now' form one of a series of oppositions in which Bayley frames his narrative, oppositions that he proceeds to unsettle. By placing youth and age, intellect and dementia, in this context, the memoir unsettles these dichotomies also.

The opening pages describe a swim in the river 'now' – the couple pudgy and clumsy in their underwear and socks – placed against memories of their first swim in the same river forty five years ago – nude and vigorous. As the account moves between the two occasions, the dichotomy between youth and age is blurred. The sense of continuity between young and old self is captured visually in Eyre's film Iris where the scene cuts back and forth from the young to the elderly swimmers. Bayley continues to undermine dichotomies. He places the formality of academia and the scholarly Oxford dons against glimpses of a private life that was bohemian and sexually adventurous. Sexual polarity too is unsettled: Iris has men and women as

lovers and John sees her as androgenous, a 'little bull'. Contrary to the stereotype of masculinity Bayley gives a comical view of his own sexual naiveté contrasted to Iris's experience and forthright initiatives (47). Another contradiction that confounds expectations is the couple's unworldliness. Both are distinguished academics, Bayley a Professor and Iris a Philosophy lecturer and acclaimed author who became Dame of the British Empire, yet they have little concern with appearances or social status, dress shabbily and live in domestic squalor.

Dichotomies and expectations that are posed and unsettled create a narrative frame that challenges fixed ways of thinking. The idiosyncratic and offbeat are affirmed against normative images – including stereotypes of age and dementia. Bayley and Iris inhabit a space of perverse possibilities. This allows for an account in which a rigid, despairing view of dementia as (nothing but) decline, loss and absence is softened. It creates continuities between 'Then' and 'Now', between Iris the brilliant philosopher and novelist, and Iris as John knows her now. Bayley is able to suggest that their life always was eccentric, a little childlike, a little 'mad', and that they still share 'now' as they did 'then' a realm of playfulness, nonsense and story.

However Bayley does not offer a rose-tinted view of dementia or deny its bleak aspect. If his account is less grim than those of Kate Jennings and Jonathan Franzen (discussed below) this is largely due to Iris herself. She remains 'gentle' in her dementia, although often obstinate and exasperating:

Alzheimer sufferers are not always gentle: I know that. But Iris remains her old self in many ways. The power of concentration has gone, along with the ability to form coherent sentences, and to remember where she is . . . [but] She is always anxious to oblige. And the old gentleness remains. (34)

The baffling moments at which I cannot understand what Iris is saying . . . can produce tears and anxieties, though never, thank goodness, the raging frustration typical of many Alzheimer's sufferers . . . (44)

Ironically, it is Bayley who at times explodes in 'raging frustration'. He builds up a sense of what dementia means by depicting his own reactions. He is irritated by her insatiable questioning and demands for reassurance or her refusal to take off her trousers at bedtime. Travelling is 'agony' when Iris

panics on a bus: 'jumping up and down in agitation. Where are we going? Where is the bus taking us? She won't sit still'. She frets at the driver and grabs another passenger's handbag. John is embarrassed and angry: 'I get Iris into a seat and give her a violent surreptitious punch on the arm by which I am holding her' (176). He describes an occasion when Iris waters the pot plants so often that they are 'slopping over with stagnant water'. As he screams abuse at Iris, his rage reflects the breakdown of reason and order in their world:

. . . rage produces another person, who repels one, from whom one turns away in incredulous disgust . . . 'I told you not to! *I told you not to!*' . . . 'You're mad. You're dotty. You don't know anything, remember anything, care about anything.' . . . I find myself looking in a mirror at the man who has been speaking. A horrid face, plum colour. (175)

Iris shows the diffuse anxiety that is a common association of Alzheimer's. Her fear of separation recalls Errolyn Bruce's contention that the person with dementia needs close attachment to another for a sense of meaning where experience is incoherent:

This terror of being alone, of being cut off for even a few seconds from the familiar object, is a feature of Alzheimer's. If Iris could climb inside my skin now, or enter me as if I had a pouch like a kangaroo, she would do so. (92)

Bruce suggests that the carer can 'restory' the fragmented present for the person with dementia. Bayley uses 'story' to communicate with Iris, to soothe her 'terror' and to restore order to their shared life. One of the framing paradoxes he sets up is the opposition between the academic world of the serious intellect, and the playful world of fairy tales, jokes and rhymes. Their love began 'Then' with the discovery of 'childish chatter' and a private world of story:

We talked without stopping. . . . It was endless, childish chatter, putting our faces together as we talked. I think Iris was accustomed only to talk properly, as it were: considering, pausing, modifying, weighing her words. To talk like a philosopher and a teacher. Now she babbled like a child. So did I. (30)

'Now' Bayley uses their private language of 'childish chatter' – jokes, rhymes and nonsense – and the non-verbal language of gesture, 'horsing around' and 'live pantomime' (45), to make contact with Iris, to calm her 'anxiety and agitation'. 'Childish chatter' provides continuity rather than division between 'Then' and 'Now':

. . . communication had dwindled and faltered and all but ceased. No more letters, no more words. An Alzheimer sufferer begins many sentences, usually with an anxious repetitive query, but they remain unfinished . . . The continuity of joking can very often rescue such moments . . . snatches of doggerel, song, teasing nonsense rituals once lovingly exchanged, awake an abruptly happy response . . . At cheerful moments, over drinks or in the car, Iris sometimes twitters away incomprehensibly but self-confidently, happily convinced that an animated exchange is taking place. At such moments I find myself producing my own stream of consciousness, silly sentences or mashed-up quotations . . . At which she nods her head gravely and seems to act a conspiring smile . . . (43-4)

For Iris loss of words is a poignant irony. ‘Then’ as teacher, philosopher, novelist, she was master of words and they were her world. Bayley asks himself ‘has nothing replaced the play of her mind when she was writing, cogitating, living in her mind?’ (159). ‘Now’ she ‘twitters’ in a parody of ‘animated exchange’, and needs him to supply words for her ‘deadlocked’ sentences. Bayley attempts to enter the inner landscape of Alzheimer’s, to imagine what the loss of memory and of words might feel like for Iris:

most days are in fact for her a sort of despair, although despair suggests a conscious and positive state and this is a vacancy which frightens her by its lack of dimension. She mutters ‘I’m a fool’ or ‘Why didn’t I’ or ‘I must . . .’ (44)

Bayley’s joking often has an ironic edge:

The baffling moments, at which I cannot understand what Iris is saying . . . can sometimes be dispelled by embarking on a joky parody of helplessness, and trying to make it mutual. Both of us at a loss for words. (44)

Irony can have a healing function. It averts sentimentality and refuses denial but gives distance and control. It allows recognition of loss and at the same time accommodation – the wry shrug. At a cocktail party, Iris talks to another guest in a way that seems coherent but Bayley overhears her asking ‘What do you do?’ over and over, and listening to the same reply with animated interest. He suggests wryly: ‘Some people might actually find it more restful at a party to talk to someone more or less with Iris’s condition . . . less demanding and taxing than the conventional art of party intercourse’ (169). One of Bayley’s ironic devices is self-mocking identification with Alzheimer’s. He becomes flustered by Iris’s demands as they travel – tickets are lost, he frets and fumbles: ‘The elderly couple opposite look sympathetically at Iris. I am clearly the one who has become a problem’ (167). He shows himself as dithering, ‘at a loss for words’ or speaking to Iris ‘with her own degree of querulous repetition’ (166) – ‘Alzheimer’s obviously has me in its grip’ (167). Sharing Iris’s world, he blurs the divide between dementia and reason.

Yet Bayley is aware of the problem of agency when giving an account of dementia. He does not claim to speak for Iris. He refers to the fundamental unknowability of another person (104), and emphasises the separateness and privacy that always characterised their companionship (that their marriage combined closeness and ‘the joys of solitude’ (88) is another of the unsettling paradoxes that Bayley sets up initially). He never did attempt to penetrate her mind, and does not now: ‘so vast and rich and complex an inner world, which it used to give me immense pleasure *not* to know anything about’ (178). Her own philosophical writings and novels testify to that complex inner world.

Iris closes with a visit to the statue of Peter Pan in Kensington Gardens on Christmas day. The scene is described with a sensory immediacy, highlighting awareness of being present in the moment. Magic and fairy story, ritual and memories, the shared past and the narratives of the larger culture are all part of the ongoing story:

my mother assured me that if I looked hard enough over the railings . . . I might see fairies, perhaps even Peter Pan himself. I believed her. I could almost believe her now, with the tranquil sunshine in the Park making a

midwinter spring, full of the illusion of flowers and fairies as well as real birdsong.

Iris is listening, which she rarely does, and smiling too. There have been no anxious pleas this morning, no tears, none of those broken sentences

...

... I find myself thinking of the Christmas birth, and also of Wittgenstein's comment, once quoted to me by Iris, that death is not a human experience.

We are born to live only from day to day. (188-9)

Bayley places his and Iris's story within the wider culture – fairy tale, philosophy, religion – to create a sense of healing. The suspended moment holds anxiety and broken sentences at bay. For 'Now' at least, there is peace.

Iris is a private account of dementia, the narrative of a shared life. Moral Hazard and The Corrections are also derived from the authors' personal experiences of dementia in a partner or parent. Both spring partly from a healing impetus, acknowledged by the authors in interview. They explore the impact of dementia on close relationships, spouse and family. However these novels move beyond the private confrontation with dementia to a broader social critique. Satire in these novels serves a therapeutic function. The loss in Alzheimer's of memory, speech and cognition – those capacities that most characterise us as human – is set against dehumanised aspects of contemporary society. The corporate business world is greedy, brutal and self-deluding, its motive is profit and its values are 'synthetic' (Moral Hazard 11). Jennings makes an explicit parallel between the memory loss of Alzheimer's and corporate 'amnesia' of the banking world – its denials, cover-ups and deceptions. Franzen satirises the notion that modern science and big business together can find a 'Fix' for everything: the corporate world exploits people's fear of dementia, Parkinson's and old age itself, for profit. Both writers demonstrate the shortfall of the Medical world in dealing with problems of deterioration and degenerative disease for which there is no 'Fix'. These writers' inceptive use of dementia as a trope for scathing comment on society resists its dismissal or exploitation and incorporates it into larger cultural narratives.

Kate Jennings Moral Hazard

Kate Jennings has identified two major sources for Moral Hazard: the experience of seeing her husband deteriorate and die with Alzheimer's disease, and the time she spent working as a speechwriter for a Wall Street merchant bank.¹⁸ She was forty-five when her husband, twenty-five years older, was diagnosed with Alzheimer's. Jennings worked in the highly paid field of business finance to pay the costs of his care. Although she says the novel was not written as 'catharsis' for the experience of husband's illness, she did feel it needed writing: 'I just felt it would be all for nought if I didn't try to describe it.' These comments imply that there was a healing impetus for the writing of Moral Hazard, healing not for the affected person but for the partner.

The novel ridicules the American preoccupation with 'learning lessons' from suffering, the false optimism of a culture bent on certainties and 'fixes'. When Cath is leaving her job at the bank, a colleague Mike asks her, 'what did you learn in the last six years?' (170). He refers to her time on Wall Street, but she misinterprets him to mean Bailey's illness and death:

'We're rather keen in this country on learning lessons, as if everything were a test and not just life happening. No pain, no gain – all that bunkum. I could do without the pain, thank you.' . . .
' . . . What if you don't learn anything? What if you just put one foot in front of the other? Sure I've changed. I'm older. I'm on the other side of fifty, unable to see the point in anything, and lonely as all hell. Try tying that into a neat bow.'
(170)

Nevertheless, Jennings' frank depiction of what dementia entails for the affected person and for the partner performs a therapeutic function by its very refusal to sanitise the experience. The forthright account of Bailey's deterioration and Cath's reactions validate experiences that society prefers to ignore:

There were days when he seemed to say, in effect, screw sweetness, screw dignity. . . Days when neither Gwen nor I nor anyone at the home could go near him. . . . we shut the door and allowed him to remain filthy, unfed . . . he spat, swore, snarled. . . . he smeared excrement on the wall, played with it. . . . he was black with paranoia . . . he inhabited a dim cave where the regrets, frustrations, and sadnesses from his life flew in skirling circles . . . (108-9)

Cath's empathic witness allows a glimpse of what her husband might be experiencing. She describes his frustration and grief, and his efforts to compensate in the early stages of the disease when he can still undertake the art that has been his passion: 'he took out large sheets of drawing paper and

¹⁸ Kate Jennings has discussed her novel Moral Hazard in several public interviews. I have taken her comments about the novel from transcripts of interviews with Kerry O'Brien on ABC television's 7.30 Report (27.05.02) and with Ramona Koval on the ABC Radio National program Books and Writing (30.6.02).

began, for the last time, remembering his generous, eventful life. Now while he worked, he cried.’ (21). Later Bailey is subject to rage tantrums. Cath guesses at the baffled frustration that impels his rages, a body and mind that no longer obey:

he could no longer operate the CD player. I tried to show him. He flew at me, grabbing me around the throat, pressing his fingers into my windpipe. I pushed him away. Thwarted, still possessed, he ran shrieking into the bedroom. (58)

As his mental state declines Bailey has to be cared for in a Nursing Home. He becomes immobile and incontinent, his speech unintelligible. He recedes from Cath into delusion, rage and vacuity. The account traces her horror and helplessness at the relentless erosion of the person she loves. This narrative is bleak, but alongside the account of decline it retells Bailey’s ‘good story’. It honours the person he was – his artistic skill, his curious mind, his gentle and generous personality, his ebullience and optimism. The account thus combines the therapeutic strands of confronting the realities of Alzheimer’s, lamenting the partner’s loss, and retelling the narrative of the person and of their shared life.

The other therapeutic element is the novel’s achievement in incorporating the private story of illness into wider social commentary: ‘I was commuting, it seemed, between two forms of dementia, two circles of hell. Neither point nor meaning to Alzheimer’s, nor to corporate life’ (33). Moral Hazard exposes the ‘insanity of the corporate world with its twisted logic’ and in particular draws a parallel between Alzheimer’s and corporate ‘lack of memory’. Corporate amnesia allows financial deregulation to racket madly on, despite the crashes, despite the economic and social injustices that result. The vision that Jennings presents of corporate America is one of a world that is ‘craven’, ‘fascist’ secretive and ruthless (125). Its values are based in greed and competition; it is hollow at the centre. Cath sees the merchant bank Niedecker that she works for as: ‘a firm whose culture had been shaped by the kind of drive required to shave dimes off dollars without actually making something useful or entertaining, something that could be touched or enjoyed’ (11). The shady ethics of this world are underlined in Cath and Mike’s discussions of ‘hedge funds’, the unregulated ‘fiscal daredevilry’ of merchant banking, ‘not only opportunistic but antisocial, dependent on bad things

happening somewhere or forcing them to happen.’ (128-9) and by Niedecker’s financial crash that results from massive borrowing for speculative trading.

Bemused as she is by the brutality of the world of finance, Cath reflects wryly ‘the job was serving its purpose. There was money for the rent and to buy Cognex, the new Alzheimer’s drug’ (33). Ironically while the drug does little to mitigate Bailey’s remorseless deterioration, it delivers healthy profits to the drug company that markets it. Cath has to compromise her principles to make the money for Bailey’s care: working for a conservative finance corporation is at odds with her leftist, feminist ideals. The book contains many such ‘moral hazards’: dilemmas and betrayals large and small.

19

The novel presents euthanasia as a major ethical dilemma, especially problematic in dementia, where the affected person becomes unable to make his own decision. Exploration of euthanasia also opens up a critique of the Medical establishment. Jennings demonstrates parallels between the Medical and the corporate realms, in their arrogance, depersonalisation and alienation. In Cath’s story the medical world is conspicuous for its absences. The several specialist doctors whom Cath and Bailey consult provide little information or support. They give the diagnosis tersely; their explanations are abrupt and depersonalising. The medical profession is represented most prominently by the bills that compel Cath to take her Wall Street job. The central failure of the Medical establishment occurs when Bailey, in an advanced stage of dementia, haemorrhages and is resuscitated. Cath is outraged that her husband is not left to die in dignity, but her protests are ignored: she is ‘invisible’ as the Medical machine rolls on.²⁰

¹⁹ ‘Moral hazard’ is a banking term. It relates to the accepted practice that financial institutions that get into difficulties are bailed out for the good (stability) of the entire system and hence bankers don’t have to be so careful, can take risks. The moral hazard lies in the latitude that this code gives for irresponsible and unethical practices.

²⁰ The episode is taken directly from Kate Jennings’ own experience. She describes in an interview with Kerry O’Brien how (like Cath in the novel) she was completely ignored by the doctors, despite many attempts to protest against their intervention:

K O’B: ‘Were you as invisible as Cath was in the hospital when you tried to relate to the doctors and talk to them as this man’s partner?’

KJ: ‘Yes, and clearly I’m not an invisible person. I stood there and stood my ground – it did not make any difference at all.’

For the carer of a person with dementia, euthanasia raises the question of agency. Cath and Bailey have discussed euthanasia. Bailey's mother was a member of the Hemlock Society, and ended her life rather than submit to the dependency of advanced age. He had intended to do the same if he faced becoming incapable or demented, but when Cath tries to discover his wishes early in the disease, he is already beyond indicating a clear choice. She watches his descent into helplessness and mental vacuity over six years, before giving him a lethal dose of sleeping tablets – following what she knows was once his choice. Cath makes this decision with great difficulty and is filled with ambivalence and remorse after Bailey dies.

The moral dilemma of euthanasia in this situation is part of a wider question of agency with respect to a person with dementia – can another person speak on his behalf? Does Moral Hazard speak for Bailey (or for Jennings's own husband) or does it exploit their condition and powerlessness for the writer's purposes? The experience of dementia is a relational one – the journey, the suffering are just as much those of the partner as of the afflicted person – and the narrative 'belongs' as much to the one who is able to tell as to the one who is not. Jennings 'uses' her husband's dementia for literary purposes, social commentary and satire. Yet it is a shared experience, as much hers to tell as his to be respected. She honours his experience, his early anguish at the disintegration of his mental capacity, his anger and sadness; she honours the 'large curious mind' that was his. In portraying their shared journey, with all its bleakness, in recognising the ambivalence and dilemmas that it entailed, and in transforming the experience into a wider narrative of social critique, Kate Jennings has achieved a therapeutic effect in Moral Hazard.

Jonathan Franzen The Corrections

Alfred Lambert, the central figure of The Corrections is diagnosed with 'parkinsonism, dementia, depression, and neuropathy of the legs and urinary tract' (566). In an interview with Ramona Koval (Books and Writing), Franzen

explained that his exploration of dementia and Parkinson's disease was prompted by his father's affliction with these conditions: 'We in my family went through a hard time when my father was dying.' Franzen uses imaginative insight to reconstruct Alfred's experience of incipient dementia. One of his aims in writing was 'getting inside the head of the old demented man.' Years before his father's illness, Franzen was interested in the inward experience of ageing: 'even when I was a kid I had some weird sympathy with older people, particularly older men' (Books and Writing).

The central image of the novel remains that of Alfred's disintegration. Tall, 'full-lipped thick-haired well-muscled' (268) Alfred in his prime was a vigorous man. He remembers himself climbing the catwalk of the railway bridge over the Maumee river, forty feet above the water:

Maybe some of the women drivers crossing the Maumee . . . saw him perched there, flat of belly and broad of shoulder, the wind winding his cuffs around his ankles, and maybe they felt . . . that here was a man. . . . Alfred experienced from within what they saw from without . . . he felt like a man, and he showed this, you might even say flaunted it, by standing no-handedly on high, narrow ledges. (245)

He had a sharp, curious intellect. Besides working as an Engineer, he set up a home laboratory for research into electrochemical processes and read philosophy. By the close of the novel Alfred is in the Deepmire Home, 'restrained in a geri chair', incontinent and drooling, 'sunk deeply in a funk, his chin on his chest' or 'chatting amiably with . . . a potted plant', rambling about 'whatever demented scenario he inhabited' (567). Alfred's deterioration ends in death by self-starvation. The novel depicts a grim, inexorable process of decline. In what ways does such writing perform a therapeutic function?

A basic therapeutic function is honest telling. Franzen's black comedy foregrounds embodiment and the body's betrayal:

'Something to tide you while I get lunch,' Denise said.
. . . his clasped hands and lower arms began to bounce more freely . . .
His affliction offended his sense of ownership. These shaking hands belonged to nobody but him, and yet they refused to obey him.
. . . Alfred took pleasure in the imagination of chopping his hand off with a hatchet: of letting the transgressing limb know how deeply he was angry with it. (66-67)

A simple task becomes a frustrating and humiliating effort. Franzen captures the difficulty of an everyday activity like eating by describing it in minute steps: it takes

Alfred several pages to eat a snack, and he spills another on the floor. Betrayed by his body, he sits 'in a somehow penal posture, his knees high and his back a little hunched' as his daughter cleans up the oily mess (75).

Loss of language is another betrayal. In *Iris* John Bayley describes the anxiety that Iris shows as her speech erodes, and speculates at what this 'sailing into darkness' might mean for her, but he does not try to depict her inner consciousness. Franzen uses nightmare images to 'get inside' Alfred's experience of disintegrating language: every sentence became an adventure in the woods . . . hence the panic of a man betrayed deep in the woods whose darkness was the darkness of starlings blotting out the sunset or black ants storming a dead opossum . . . he discovered hitherto unguessed eternities in the space between one word and the next . . . he became trapped in that space between words . . . no longer knowing where he was or at what point he'd entered the woods of this sentence . . . (11)

In Alfred's grotesque half-waking nightmare about 'the turd' (284-8) black humour conveys failing control of body and mind:

His peripheral vision was alive with writhing stool now. He had to hold things together, hold things together. . . . Here he was, an American executive sitting in diapers on the floor of a floating bathroom under siege by a squadron of feces. A person got the strangest notions late at night. (288)

Jennings and Bayley give the onlooker's view of dementia; Franzen attempts to decode the inner experience from the outward signs of decay. The shifting point of view, between Alfred and the other central characters, gives entrance to the inner landscape of Alfred's 'crazy' behaviour as he slips in and out of dementia, hallucinations and bodily betrayals. The betrayals are darkly comic, but Franzen's humour encompasses sympathy with Alfred's frustration and bitterness.

Comic vision is one therapeutic aspect of Franzen's portrayal of decline. The novel's sharp sense of the ridiculous prevents it from becoming a 'tragic' account of ageing. Franzen's compassion for his characters comes out of (not in spite of) his recognition of their failings. Ramona Koval in her interview with Franzen comments on the 'black comedy of Alfred Lambert's struggle with Parkinson's syndrome dementia' and Franzen replies that 'real comedy – is usually growing out of some sort of sympathy' and, referring to the 'bad behaviour' of his characters, 'if you can really laugh at something, you're on your way to forgiving it' (Books and Writing).

Alfred as husband and father was a cold, stubborn man and harsh disciplinarian. In one episode from the past, he returns home after eleven days away inspecting rail track (242-283). He brushes aside his little boys' excited chatter, treats Enid with contempt, smashes garbage in a bitter rage and forces Chip to sit over an uneaten supper late into the night. However from Alfred's

confused inner wanderings a more complex character emerges – one who provokes pity, laughter and even respect. Much of Alfred’s harshness stems from philosophical pessimism. Bleak quotes from Schopenhauer are prominent in his internal monologues; he sees the human lot as a joyless struggle. Enid by contrast is a sentimentalist and her fatuous optimism inevitably provokes him. Alfred’s sour view of life is revealed with dark irony that brings both understanding and ‘forgiveness’:

. . . if the world refused to square with his version of reality then it was necessarily an uncaring world, a sour and sickening world, a penal colony, and he was doomed to be violently lonely in it.
He bowed his head at the thought of how much strength a man would need to survive an entire life so lonely. (275)

Late in the course of Alfred’s decline his stumbling efforts to speak to Chip parallel a complex inner experience: frustration at being betrayed and trapped by his helpless body, a longing for death and a trusting love for Chip (‘Here was a son whom he could trust to understand him as he understood himself’ 560). Chip is the only one to whom he can desperately cry for help:

‘Dad, Dad, Dad. What’s wrong?’
Alfred looked up at his son and into his eyes. He opened his mouth, but the only word he could produce was ‘I–’
I have made mistakes–
I am alone–
I am wet–
I want to die–
I am sorry–
I did my best–
I love my children–
I need your help–
I want to die–
‘I can’t be here,’ he said. (559)

Franzen shows meaning behind Alfred’s inarticulate struggles (rather than the inner ‘vacuum’ that Iris and Moral Hazard imply). Alfred’s unspoken admissions of regret, of need – and of love – suggest self-discovery reached through the inner journey of illness.

While Franzen’s interest in dementia and ageing is rooted in his father’s story, in the broader context of American society he sees ageing and degenerative conditions as ‘inevitably linked to a society that is both wealthy and healthy’ (Franzen Books and Writing). Franzen’s satire moves the examination of dementia from private experience into larger cultural narratives. He places illness in the context of contemporary American society

and its myths: the materialism, the cult of youth, the denial of mortality, the dream of a 'Fix'. 'Corrections' has many meanings in the novel: one is an ironic reference to 'the American ideology that you can fix what's wrong . . . with your body, with your head'. Franzen explained in the interview with Koval that The Corrections satirises the 'false dream – there's nothing that can't be fixed', and the way in which this ideology is manipulated by business to make profit out of people's fears of ageing and illness.

Coreck tall is Franzen's concrete image for the 'false dream' that 'there's nothing that can't be fixed' by technology and the free market economy. Coreck tall is aggressively promoted by its developer Axon as a cure for depression, ageing, dementia and even crime. Gary and Denise attend the 'road show promoting Axon's initial public offering' of shares in the development and marketing of the wonder drug (188-212). This episode links the profit-driven corporate world with techno-science, biomedicine and the myth of the 'Fix'. Franzen parodies technical and corporate hyperbole, to ridicule the false promises:

'Originally conceived as a therapy for sufferers of PD and AD and other degenerative neurological diseases,' Eberle said, 'Coreck tall has proved so powerful and versatile that its promise extends not only to therapy, but to an outright *cure*, and to a cure not only of these terrible degenerative afflictions but also of a host of ailments typically considered psychiatric . . . Simply put, Coreck tall offers for the first time the possibility of renewing and *improving* the hard wiring of the human brain.' (189)

Axon plays on the greed of investors as well as on consumers' anxiety about degenerative illness and willingness to believe in a 'Fix'. Seductive jargon cloaks half-truth and deceit:

Daffy Anderson . . . spoke of being *gratifyingly oversubscribed*. He compared the heat of this IPO to *Vindaloo curry* and *Dallas in July*. He refused to divulge the price that Hevy and Hodapp planned to ask for a share of Axon. He spoke of *pricing it fairly* and – wink, wink – *letting the market do its job*. (210)

As in Moral Hazard, the profit-driven business world itself appears mad. Behind Franzen's mockery is a sharp insight into the moral irresponsibility and downright corruption of the corporate ethos. The satire has a therapeutic function. It puts into context the denial of ageing, and degenerative diseases in particular, by a society that places a premium on youth. The Corrections uses the trope of dementia to contest disempowering cultural assumptions. In one scene Franzen describes Alfred in his basement workshop, disentangling an old string of Christmas lights. The muddle of electronic circuitry parallels Alfred's neurological decay: 'near the center of the spool was a patch of unlit bulbs – a substantia nigra deep inside the tangle.' As Alfred contemplates the

hopeless difficulty of pinpointing the breakdown and of repairing the string, he is aware that he no longer has the energy or the control over his body to ‘keep it all working, keep it all together.’ His own ‘mental hardware’ has become ‘obsolete’ (463). His despair at the encroachment of chaos encompasses his own plight: ‘Oh, the myths, the childish optimism, of the fix! The hope that an object might never have to wear out’ (464).

The novel’s message is uncompromising: there is no ‘fix’. The writer’s refusal to be manipulated by the false promise of a ‘fix’ parallels Alfred’s stubborn refusal to be dominated. When Alfred is lapsing towards death in the Nursing Home – bedridden, incontinent and unable to feed himself – Franzen shows him as still having enough awareness to long for release. He has begged Chip to help him die and has tried to kill himself. He finally determines his own death by refusing to eat. Thus Alfred wrests some measure of control in a situation where he has become powerless:

he stopped accepting food. . . . He moved for nothing and responded to nothing except to shake his head emphatically, once, if Enid tried to put an ice chip in his mouth. The one thing he never forgot was how to refuse. All of her correction had been for naught. He was as stubborn as the day she’d met him. (568)

The therapeutic element lies in refusal: in resistance to subordination, in perverse defiance even at the limit of coherent experience.

Dementia in Children’s Literature

Some of the most imaginative and antistereotypical writing on dementia occurs in novels written primarily for children or young adults. This seeming paradox highlights the importance of connectedness – to her own past, and to the wider community – for the older person, and especially for the person with dementia. First, it reflects the significance of her own childhood – her past story – for an older person in making a meaningful life narrative. Secondly, it indicates the importance of linking the stories of older people with other narratives – those of their children and grandchildren, and the wider community. Such books also show that children have much to gain from hearing older people’s stories. Not only can these stories provide insight into what it is like to be old, and help demystify dementia, they can also add to the

meaning and continuity in the child's own life story. Elders and grandparents may be represented as rebellious or perverse in children's literature: dementia can give licence for misbehaviour that challenges proprieties and cultural norms. For younger readers this can be empowering as well as entertaining. Children, like elderly people, are relatively powerless, and subject to strong pressures to conform to cultural expectations and a mischievous, eccentric or defiant old person can provide an assertive model. This view, that the stories of older people are valuable in helping children build meaning, connection and continuity in their own life narratives, works counter to the sidelining of older people.

Judith Clarke Friend of my Heart

'No one's touching my hair,' said Mrs Thredlow grimly. 'And that's final.'

Thora May Perlman drifted in from the corridor . . . and nodded across the room at her friend. "That's the spirit, dear" she called. . . . Her grave impartial gaze swept across Nurse Spooney and Monsieur André. 'All our lives," she declaimed . . . 'all our lives we're pushed from pillar to post, and then' – she flung out one arm in a brave dramatic gesture – 'when we decide to go our own way – they tell us we're *mad!*'

Mrs Thredlow chuckled delightedly. 'I don't know who you are, dear,' she said to Thora May Perlman. 'But you've certainly hit the nail on the head there!'(39)

Daz's granny, Sheila Thredlow, lives in Sunset Rest Home and has early dementia. She has no memory for present events, she does not recognise familiar people, she wanders and gets lost. She is preoccupied with an anxious search for the photo of her childhood friend Bonnie, 'the friend of my heart'. To outward appearance, Mrs Thredlow is a dishevelled, dotty old lady. The nurses are patronising, dismissing Mrs Thredlow's search as a delusional whim: 'nothing ever lasted long with the old dears, all the rages and tantrums and tears . . . In a few moments, Nurse Spooney knew, Mrs Thredlow would have forgotten all about whatever was bothering her'(61). Daz however tries to enter her grandmother's inner world, where old memories are imposed on bewildering present day experience. It is Daz – who at fourteen causes her mother to despair over 'dreadful boyfriends', ear studs, a 'convict' haircut and green nail polish –who tries to imagine what it might be like for her

grandmother, in a shrinking and puzzling world, to have lost the last link with her dearest friend (83). Daz decodes Sheila's 'ramblings', finds the photograph and solves the mystery of what happened to Bonnie. In the quest Daz and other teenagers in the story come to understand more about their own links with family, deal with their troubles, and form new friendships.

The novel presents dementia with a gentle touch, through episodes that imaginatively depict the inner world of the old lady. When Mrs Thredlow wanders for miles along a busy highway, she is reliving long-ago shopping trips with her sister-in-law. When she enters a timber yard she is again thirteen years old, skipping and tossing her ringlets, looking for her brother Viv who works here and for Bonnie who lives behind the yard; the workmen see 'an old lady in a funny sort of get-up . . . skipping like a child', giggling, and muttering. Judith Clarke enables young readers to discover human meaning in what the casual onlooker sees as the 'crazy' or pathetic behaviour of a confused old person. The old ladies are portrayed with a touch of mischief, as gutsy and resilient: the account affirms their personhood. The novel's insightful representation of Mrs Thredlow's narrative counters dehumanising constructions of dementia.

Margaret Mahy Memory

Memory goes beyond Friend of my Heart in its presentation of dementia. This novel for young adult readers does not merely give a sensitive depiction of Alzheimer's and of the relationship between a teenager and a demented old lady, although it does this well. Mahy uses the motif of memory, with its ambiguities and betrayals, in service of the novel's therapeutic narrative. She gives an imaginative twist to themes of dementia and story. Sophie, the old lady at the centre of the novel – demented and powerless – becomes the agent of healing, 'the angel of wisdom', for Jonny.

Jonny is tormented by ambiguous memories of his sister's death five years ago. Was it his fault that she fell from the cliff edge? Guilt and uncertainty paralyse his life now: he is unemployed, drinking too much and getting into brawls, always in trouble with the police and with his father. In a

mean part of the city late one night, drunk and sick, he stumbles upon Sophie, whose life is crumbling into squalor and self-neglect as she becomes more demented. Sophie weaves vivid memories into the jumble of the present. She identifies Jonny with her cousin Alva, whom she loved when she was young. Jonny is drawn into Sophie's world, playing along with her story as he gradually unravels it. He feels growing affection for Sophie and respects her valiant attempts to deal with a bewildering present. In the mingling and reworking of their stories past and present, both Jonny and Sophie gain a new story.

The novel is grounded in a realistic depiction of ageing and dementia. It shows plainly the isolated old lady's mental and physical deterioration. She is filthy and unkempt, her mattress is soaked with urine and she wears a suspender belt on top of her stained clothes. No longer able to prepare food, she lives on biscuits and is 'pinched and frail' (54). The breakdown of order in her house mirrors her disintegration – there is a block of cheese on the soap-dish, a dead blackbird in the fridge, mouldy biscuits in the knife drawer and 'dried orange peel and eggshells carefully saved in a screwtop jar' (55). Danger lurks – Jonny finds a burnt out iron and frayed electrical cord; Sophie leaves butter in a red-hot frying pan until it bursts into flames. The surreal comedy of Jonny's stay in this mad household intensifies the portrayal of dementia. Grasping at shreds of remembered hospitality, Sophie repeatedly offers him cups of tea and, unable to find tea in her disordered kitchen, pours hot water from the teapot – each time surprised to find the tea so weak. She bustles about, but her activity is fragmented: 'She had all the gestures of a busy person, but nothing was happening' (54). The pathos and vulnerability of Sophie's situation are heightened by these elements of the absurd but dark humour prevents sentimentality. Underlying Jonny's teasing is his recognition of Sophie's courage, of the valiant struggle she puts up to survive each day: 'Collapsing little by little in her collapsing house she still battled on with everything she had' (70).

Mahy's presentation of the ageing physical body sets up and then questions derogatory stereotypes. Seen through the eyes of a young man, Sophie's old body is at first pitiable and disgusting, but a changing perspective shows its peculiar beauty and hidden meaning:

Sophie scrambled like a dog down on all fours . . . naked except for her pot hat and unravelling singlet . . .

Over the last few years Jonny had seen many pictures of naked women . . . He had even seen one or two real live girls. He had believed that female nakedness could never embarrass him, but now he realised that it depended on the age of the woman. One mere glance at Sophie's bare bottom and he was outraged. (96)

Her hands, still grasping Jonny's, were very knobbly. He wondered if she had arthritis – if holding things actually hurt her – and looked with dismay at her forearm, so shrunken around its core of bone . . .

The closeness of her old skin and bone filled him with a repulsion that was not far from being fear, and which felt like an instinct, too natural to be denied, although he felt ashamed of feeling it. (98-99)

“Sophie,” Jonny said very gently, “don’t get cold.” The texture of her skin reminded him of the ferny patterns the sea sometimes printed on sand. It could have been beautiful. It was beautiful in its way, that fine print in which no one could read the account of a delicate progress towards an ending. (163)

Jonny’s repulsion at ‘old skin and bone’ shifts to a sense of beauty and mystery, captured in imagery of the natural world. This transformative view of the body is part of the novel’s broader challenge to stereotypes of ageing and dementia.

The depiction of Sophie moves between the realistic – dirty fingernails, false teeth, wet beds – and a magical, perverse vision. Wrinkled skin has a ferny delicate beauty. False teeth shift from being ludicrous and pathetic (‘smiling anxiously from a tumbler of clouded water’ 54) to fiercely powerful when Sophie saves Jonny from Nev’s attack:

In the very moment when he might have destroyed Jonny, Nev stepped back . . . [his] face twisted not only by pain, but by such horror, that Jonny turned involuntarily to see what had horrified him. . . .

Sophie . . . looked like an old, old spirit, her thin silver hair turned into a phosphorescent nest by the street light, her eyes nothing but two black holes under her high forehead, her mouth bursting with more teeth than any natural mouth could hold. Her lips were stretched thin trying to accommodate the impossible number of teeth . . .

. . . Jonny understood by now that she had simply jammed an extra top set of teeth over the ones she normally wore. (212-4)

Jonny’s attitude to Sophie changes from ‘superstition or pity or distaste’ (42) to affection and respect. Her plight calls up qualities obscured by the tough image he has cultivated:

Whether he liked it or not, something fair, even kind, in him made it difficult to walk off and leave her lost in her own kitchen. (57)

Over the past year and a half he had developed the reputation, among his parents’ friends, of being bad, mad, and dangerous to know, and though he was often surprised when people acted as if they believed it, he was flattered too. He did not want to turn into the sort of man who worried over wet mattresses, baths and breakfasts (105)

Jonny provides practical help for Sophie (he finds support through the aged People’s Welfare Council). At another level he provides healing through honouring her story. She identifies him with her cousin Alva, and he plays along. He pieces together the fragments of her memories and the clues in her house to discover the story of her love for Alva and her marriage to Errol West, ‘one of nature’s gentlemen’ (98). Through the unravelling of Sophie’s story Mahy creates an insightful picture of dementia. She demonstrates meanings that may underlie apparently senseless ramblings, the old person’s attempt to ‘re-story’ an incoherent present.

To Jonny, Sophie is both a vulnerable old lady with a ‘broken memory’ (63) and a possessor of mystical wisdom: ‘she perceived the world oddly. If she wasn’t a Pythoness, she was some other sort of oracle’ (70). At their first crazy meeting in the night city, Sophie cries, “‘I’m the angel of wisdom” and Jonny replies with deliberate sarcasm (and unwitting irony): “‘Gosh, I’m glad to meet you at last. You could be a big help to me””(29-30). Sophie does help Jonny as much as he helps her, by enabling him to retell his broken story. Jonny’s ambiguous memories of his sister’s death haunt him and impede his life now:

he might as well put his own name down on the new-memory list himself, for certainly part of his own past had been recorded falsely. Though memories were often regarded as careful files in a catalogue, Jonny now believed they could just as easily be wild stories, always in the process of being revised, updated, or having different endings written on to them . . . (170)

Sophie’s crazy world has a mystical healing power for him. There is a fairy tale aspect to Jonny’s experiences in Sophie’s house, that he recognises with self-deprecatory irony:

The only escape route. . . lay, for him at least, beyond this door. Saturated as he was with memory, it seemed he must make his way home through a memory-desert which might drain some of the burden from him. Jonny grimaced scornfully at this own speculations.

“It isn’t one of those great quests,” he told the door, as he unlocked it at last and went in. . . . in the end all paths led back to Sophie’s house, which had not finished with him yet. (126)

Through meeting Sophie with her fractured memory, through becoming a character in her story (as both cousin Alva and also as a rediscovered present day self – responsible, ‘kind and fair’) he is restored. He frees himself from the false memory of Janine’s death. Jonny helps to restore Sophie’s life story (and to make an ongoing one of being cared for) but Sophie is also a catalyst for the remaking of Jonny’s story. The demented old lady is both subject and *agent* of therapeutic change.

Memory represents the possibility of healing through a perverse and transforming view. Sophie’s vulnerability and oddities are also her saving and her power. At one level it is her realistic plight ‘lost in her own kitchen’ and her valiant battle that move Jonny to help her. At another level, in the realm of story and mystery, her mad world has a ‘truth’ and a mystical transforming power for Jonny in his own maze of overcharged and unreliable memory.

There is no cure for old age. Yet the texts I have discussed in this chapter all in varying ways present therapeutic perspectives on ageing and dementia. Refusing denial, they give frank, unsentimental accounts of physical and mental decline, but work unsettling shifts of perspective. They challenge stigmatic and constrictive narratives of age and dementia and affirm the personhood of their subjects. They create new narratives that encompass past

and present into the ongoing life story; they shift personal narrative of age and dementia into larger cultural and mythical narratives; they show possibilities that are surprising, perverse and transforming.

Chapter 5 Women's stories: illness and the female body

Inversive wit: women's poetry challenging myth and taboo

Kate Jennings, prefacing a collection of women's poetry, remarks sarcastically that in writing, as in their daily lives, 'women are stuck with childbirth, babies, menstruation.'²¹ Irreverent women writers may challenge such limitations not by ignoring the body, but by placing an exaggerated and subversive emphasis on it, representing sexuality and reproductive function in mischievous ways. Perverse perspectives can expose assumptions that denigrate woman's body as weak and sickly, or taboo – disgusting and dangerous. They can undermine the sentimentality that surrounds pregnancy, birth and motherhood. While the provocative wit of the following poems is not typical of women's illness writing in general, the excerpts illustrate transgressive elements that characterise the writing explored in this chapter.

Robyn Archer is frank in representing 'Menstruation Blues' as a disagreeable part of female embodiment:

**I can feel my life blood flowin', flowin' down the drain,
And the hardest damn thing to face is that next month it's all gonna happen
again**

**I got a pain in my guts and my head is spinnin' around
I feel like the lowest kind of animal crawlin' on the ground**

I can't chuck, I can't even fuck . . .

No one wants to mouth around that fishy old smell . . .

(The Oxford Book of Australian Women's Verse Lever 196)

²¹ Jennings' comment has an ironical edge, considering that few of the poems in Mother I'm Rooted: An Anthology of Australian Women Poets refer to 'childbirth, babies, menstruation'.

Archer challenges the taboo that forbids talking about menstruation except in discreet euphemisms – she uses deliberately coarse language to underscore the reality of being in a woman’s body.

‘It’ is another poem that flouts taboo. Susan Hampton gives a darkly comic depiction of the menstrual cycle with its wild hormonal mood swings:

**It grabs you from behind &
whomp! You’ve gone mad again tonight, despite Vitamin B
& the gynaecologist’s plan for sanity. It’s too much,
& worse, it’s predictable as a tea-cosy pattern,
those hot loins, those egg-shooting ovaries
a fortnight before, those lovely wet thighs –
but the debt collector’s at the door dear,
you grew up thinking blood money was a joke?
The mafia inside have wrapped their neat black gloves
around your glands, your hormones, & the chemicals
in your brain.**

**. . . we really want to kick the shit out of something
tonight, we’re violent . . .**

(The Sting in the Wattle Nielsen 217)

The colloquial language emphasises a down-to-earth perspective and contrasts with sanitised ‘neutral’ medical discourse (implied in the physiological references to ovaries, ovulation, glands and hormones). So the feisty voice that describes mid-cycle sexual urge (‘those hot loins, those egg-shooting ovaries/a fortnight before, those lovely wet thighs’) and pre-menstrual tension (‘kick the shit’) mocks dispassionate scientific description of the hormone cycle. Allowing the woman to speak directly of her experience, the poem also points up the failure of medical authority to alleviate the commonplace, ‘predictable as a tea-cosy pattern’, symptoms of menstruation. The imagery exploits and subverts

assumptions that link female physiology with Otherness – madness, crime and violence – undercutting the mystique of evil by placing it against the everyday (wet thighs and tea-cosies).

While menstruation is a topic most notable for its absence in polite conversation, motherhood stands at the opposite pole of acceptability. This is reflected in the use of ‘motherhood’ as an adjective in phrases such as ‘motherhood statement’ – defined by the Macquarie dictionary as ‘unquestionably worthy of support; unarguably meritorious and praiseworthy as in *motherhood* principles.’ The figure of the mother, giving birth and caring for children, is idealised, assumed ‘unarguably meritorious and praiseworthy.’ Pregnancy too is often surrounded by sentiment and its cruder physiological manifestations ignored. Women writers can unsettle sacrosanct ideals of motherhood by placing them under perverse scrutiny. In the following poems, Penelope Nelson and Edith Speers explode sentimental notions of pregnancy and childbearing. Nelson addresses her inversive account ‘To Leigh-Anne Who Got Obsessed With Motherhood At A Poetry Reading’:

Dear Leigh-Anne

I am writing to bring your attention

To some facts about having kids that Judith Wright doesn’t mention.

. . . your figure

Grows daily, relentlessly, bigger and bigger and bigger.

You find you’re thirty-eight round the bust and it goes to your head,

But you have to wear terrible bras and milk leaks all over the bed.

If you don’t want varicose veins you wear Supphose . . .

. . . They tell you childbirth’s a joy and leaves you ecstatic and shivery,

Omitting to mention the facts about forceps delivery. (Nielsen 191)

The deliberate ‘bad’ verse, doggerel, rhyming couplets and forced rhymes (bigger, figure; shivery, delivery) contribute to a comically perverse view that foregrounds crude bodily changes and mocks sanitised accounts of pregnancy.

In ‘Can’t They think of Anything Else to Do?’ Edith Speers gives a transgressive view of motherhood as boring, a ‘lifelong sacrifice to the commonplace.’ She represents ‘pointless propagation’ as a means of self-justification for women whose lives are uncreative. The poem’s insolent, idiomatic language serves to contest the sentimentality with which motherhood is invested:

**Do you really need all this proof
That you’re being routinely screwed?
Just who do you think you are,
Walking around with your bellies sticking out in front of you?
It is you who made baby into a dirty word for me . . .
(Nielsen 224-6)**

These four poems are deliberately provocative, exposing and resisting the constraints that sexist and medical discourses place on female bodies. The poems demonstrate the problematic border between normal physiology and illness that is represented in women’s bodies. The assumption that menstruation and pregnancy are aberrations (from masculine norms of body and health) is part of a broader view that conflates femininity with weakness and illness – a perspective that some feminists see as embedded in medical discourse. While these poems might seem abrasive, such counter discourse can have a healing function in narratives of women’s illness.

Women’s embodied experience

It can be argued that women come to illness writing, as to the experience of illness, already having a stronger awareness of their own embodiment than male writers. Drew Leder in his discussion of the ‘dys-appearing body’ (referred to in the previous chapter) suggests that for a healthy woman the body is generally more obtrusive than is the case for a man. He argues that in Western cultural understanding there ‘has been a tendency to identify the essential self with the incorporeal mind’ but that this view incorporates a hidden assumption of masculinity (69). Leder demonstrates that the ‘normal’ healthy body is absent from awareness for much of the time, but he contends that it is predominantly for ‘adult males in

the middle years of life' that health is a state in which the body is unobtrusive. Marked physiological shifts force the body into the foreground of awareness at puberty, in old age and in healthy adult women during the menstrual cycle and pregnancy: 'Cultural prejudices lead us to forget or devalue such changes' (89). Indeed, Leder points out, just as old age is equated with deterioration and abnormality, so female reproductive cycles, pregnancy and birth are 'subsumed into the medical paradigm as if they were dysfunctional states' (89). This tendency to conflate femininity with illness is one aspect of a feminist critique of Medicine. Whether or not it is construed as dysfunctional, the woman's body, especially in its reproductive capacity, lies in a zone between the 'absent' healthy body and the intrusive diseased body.

Women's embodiment has been the subject of extensive debate amongst late twentieth century feminists. Feminist insights into embodiment form part of the context within which women's therapeutic narratives can be read. Penelope Deutscher provides a concise overview of the significance of the body in theories and politics of gender in her essay 'The Body'. Historically, early feminists like Simone de Beauvoir identified and resisted biological essentialism, the equation of women with a female body, deemed inferior or defective (Deutscher 11). The definition of women in terms of their biological capacities was strongly contested by feminists because they saw biological reductionism being used to support notions that women were inferior to men in their psychological and social capacities, and to justify constraints placed on women and restriction of their rights (12). These feminists therefore shifted the focus away from the body and emphasised women's subjectivity as rational beings. However, late twentieth century feminist theorists of embodiment, including Jane Gallop, Luce Irigaray, Judith Butler and Elizabeth Grosz, re-emphasise the crucial significance of the body – seeing subjectivity as inexorably embodied. They emphasise 'the inseparability of . . . mind and body, reason and the passions, and nature and culture' (Deutscher 11). They demonstrate ways in which cultural norms and expectations are inscribed on the body, exploring the complex relationships between the 'bedrock' of embodied experience and the interaction between body and culture. A re-emphasis on embodiment serves to contest the neglect

or deprecation of the body by a (masculine) norm that foregrounds mind over body. At the same time, feminist theorists seek ways of representing female embodiment that do not take the male body as the point of reference.

Two significant issues for women's illness writing arise from the feminist debate over embodiment. The first is a directive to contest the neglect or deprecation of body implied by a normative (male) position that foregrounds mind over body. The second (and apparently contradictory) directive is to resist a biological reductionism that equates the woman with a (defective) female body. Meeting these challenges becomes part of the therapeutic function performed by women's illness writing.

Thomas Couser takes up some of the points raised in feminist theories of embodiment. In the article 'Autopathography: Women, Illness and Lifewriting' Couser suggests that as writers of illness narratives women are well placed to perform some of the healing functions of such narrative. Couser, like Leder and feminist writers, sees the 'privileging of mind over body' as being associated with masculine assumptions embedded within Western cultural discourses (68). He points out that women are 'more defined – and thus confined – by their anatomy, especially its reproductive capacities' than are men, and this is associated with the 'universal subordination' of women (68). For women, the denial and marginalisation that is associated with illness 'may echo and expose the marginalisation of gender'. Three healing functions identified by Couser in his exposition of illness narrative, Recovering Bodies, are particularly relevant for women writers. Illness narratives foreground embodiment as a basic condition of our humanity, serving as a 'reality check . . . reminding us of the vulnerabilities of embodiment' (295) – for women, awareness of embodiment is a more deeply entrenched part of their being. Illness writing demystifies taboo areas of embodiment and disease: for women, normal reproductive function is surrounded by taboo, silence and evasions. Illness writing resists the depersonalising effect of biomedical technologies, serving to 'reclaim bodies from medical colonization' (295): women resist the medicalisation of their bodies in health as well as in illness.

Women's experience and writing can unsettle the polarisation between embodiment in illness and the 'absent' body in health. Their writing can perform a therapeutic function in resisting the 'neglect or deprecation' of the body (Leder 69) and the medicalisation of the healthy female body. Women are, in Kate Jenning's phrase, 'stuck with childbirth, babies, menstruation'. Writing informed by these experiences – normal, healthy and yet irresistibly embodied – like writing that deals with ageing, forces recognition of embodiment as the bedrock of human existence.

The medical world as patriarchal . . .

As well as theorising embodiment and challenging phallogentric ways of defining and conceptualising the body, feminists have challenged 'patriarchal' hegemony in both the discourse of medicine and the provision of health services. Dorothy Broom provides an excellent overview in 'Masculine Medicine, Feminine Illness' and Rosemary Pringle presents a useful recapitulation of the main lines of current thinking in the introduction to Sex and Medicine (her study of the effect that women doctors are having on gendered power in the medical world).²² Feminist critique holds that Medicine – as a scientific intellectual discipline (a discourse) and as a system for delivering health care (a social institution) – embodies the patriarchy. That

²² Pringle's study is rooted in narrative although it is primarily an analysis of networks of medical power and shifts in power. Pringle tells the stories of the women doctors she interviewed, with insights into the barriers they encountered in their professional and personal lives. Their very difficulties seem often to have sharpened the impetus to heal for these women, and the narratives that Pringle tells carry a sense of empowerment, healing for self as well as others. The story of 'Dr Wade' (170-1) is one such healing narrative. This middle-aged GP was highly regarded by her patients: a feminist colleague of Pringle's 'who had reason to be hyper-critical of general practitioners . . . considered her to be the best GP she had ever consulted' (170). Yet Pringle discovered that the doctor's own story, far from being one of steady achievement and success, encompassed difficulty and personal illness: a troubled marriage and divorce, the struggle to continue working while raising young children alone, and episodes of heavy drinking. Battling to overcome her addiction had not only brought a sense of personal empowerment ('She stopped drinking and still regards this as her greatest achievement') but also inflected Dr Wade's approach to her patients with 'the kind of empathy that comes from shared experience.' The themes of this narrative echo those of many women's illness stories, linking the doctor's illness with the marginalisation of gender, and healing with assertion and autonomy. Dr Wade's professional story with its rewriting of the doctor's role, emphasising 'shared experience' rather than authority, unsettles the patriarchal assumptions of Medicine.

is, the world of medicine is one where power is gendered. Doctors are traditionally men, male doctors continue to predominate in numbers, and the professional habitus is male; men constitute the large majority of doctors in the more prestigious and powerful specialties and in administrative and policy making positions. Men retain overt political control of medical institutions and exert significant informal influence through covert 'old boy' networks.

The medical world is hierarchical: male doctors have authority, power and control over female nurses (including sexual power):

The primary division of labour in health represents a sexual division in its most blatant form, namely that between male medicine and female nursing. The symbolism of the family, doctor/father, nurse/mother, patient/child, has been used more explicitly in the definition of jobs and authority relations here than in any other industry. . . . in no other workplace are power relations as highly sexualised as they are in hospitals. (Game and Pringle 94)

Studies reported by Ann Game and Rosemary Pringle in Gender at Work and Anne Witz in Professions and Patriarchy are examples of research into gender and power in the health care professions that substantiates the perception of male power. The authors demonstrate that nursing is traditionally, and remains predominantly, female, and the rigid hierarchical structure of nursing puts emphasis on obedience and service, and on subservience to doctors. Men who enter nursing rise more rapidly to senior administrative positions and may be treated more as equals by doctors. The relatively low pay received by nurses compared to other health workers (especially doctors) despite the skilled nature of their work, is also an indication of traditionally low status. While change is gradually taking place, a gendered power relation still exists between doctors and nurses.

Authors such as Game, Pringle and Witz demonstrate gendered power relations between doctors and nurses. Other scholars have argued that the relationship between doctor and patient is also characteristically gendered, authoritarian and paternalistic. These arguments are summarised by Dorothy Broom and Peggy Foster. Broom contends that the power difference between a 'healthy, high status doctor' and 'an ailing, dependent patient who is probably also a social subordinate' is amplified when the doctor is male and the patient

female (104-5). Patients are in fact more frequently women: while men have a higher mortality and shorter life expectancy, women have more illnesses, visit doctors more often (even taking pregnancy and contraception into account), and take more medications (101). Normal physiological aspects of female function, and childbearing in particular, have been medicalised, and women denied control over their own bodies. Broom suggests that some medical interventions (especially gynaecological and psychiatric) do more harm than good to women patients (105). Peggy Foster has studied the impact of the health care industry on women. She claims that although women form the majority of patients, the health care system embodies patronising or blaming attitudes to female patients. She cites evidence that aspects of modern medicine may be ineffective or even harmful, especially to women, and that in particular there is unnecessary and potentially harmful intervention in normal childbirth. Some feminists have argued for more extreme views. Mary Daly in Gyn/Ecology holds that American doctors are damaging women, and that the medical literature and the actual practice of male doctors embody a sexist ideology. While the debate has been vigorous and often polarised, feminist critique in general sees Medicine as representing some degree of commercial exploitation, social control, denigration and disempowerment of women.

With respect to medicine as a discourse, unstated assumptions embedded in its language and concepts give normative status to what is male. Dale Spender, in Man Made Language, points to medical discourse as a good example of the assumption of masculinity as the norm. Medical teaching in anatomy and physiology traditionally takes the (adult) male body as the standard. Dorothy Broom argues that 'the norm of health is typically assumed to be male, and the female pattern construed as a deviation' (100). She contends that in numerous ways illness is feminised: concepts of illness and femininity overlap, and are partly mutually defining (106-109). Broom and Spender, like Leder in his discussion of the 'absent' healthy male body, emphasise that in traditional medical discourse, illness and femininity are both associated with passivity, weakness and deviance, whereas masculinity and health are normative, associated with strength, activity and vigour.

Medicine is masculine in ideology: it is based on the techno-scientific rationalist paradigm. Its orientation is towards active intervention, fighting and combating disease, utilising heroic measures (Broom 105). The idealisation of science and technology (and medicine as a representative of these) is an aspect of the 'modernist' view, which sees science as able to solve all of mankind's problems and as the pathway to unlimited 'progress' (Pringle 6). This view is critiqued by feminist writers, including those whose work I have cited, as linked to patriarchal ways of conceptualising the world. One of the significant therapeutic functions of women's illness narratives lies in the counter discourse they pose to gender assumptions embedded in medical discourse.

. . . and 'cracks' in the patriarchy

The authoritarian and patriarchal basis of medicine is under challenge. Rosemary Pringle is one scholar who argues that medicine is being forced to change:

What if it can be shown that, after a century of marginalisation and downright hostility, women [doctors] are having a major impact on medicine? It would then be difficult to go on conceptualising medicine as the linchpin of patriarchy . . . Rather than dwelling on the realities of male medical power I can point towards its vulnerabilities and cracks. (3)

Pringle details many 'cracks' and shifts in 'male medical power' within the health professions, and medicine in particular. She argues that the increasing number of women doctors has had a particularly destabilising effect on all aspects of masculine hegemony, both institutional and conceptual, within Medicine. The habitus and popularity of female doctors is one factor that is changing the ways in which medicine is being practised. Pringle suggests that the presence of more women doctors has influenced a changing style of medical practice, one that places more emphasis on 'skills in communication and understanding' (126).

Another challenge to the medical 'patriarchy' is represented by the women's health movement, which has sought to address the particular health needs of women while at the same time empowering women patients. Toni Schofield, reviewing health services for women in Australia, suggests that

women's health centres, set up in the early 1970s, 'are arguably the most visible sign of Australian feminist discourse and practice in the field of health' (123). The emergence of the women's health movement was closely connected to concerns about the medical mismanagement of women's health by traditional models, and the services placed priority on reproductive and gynaecological health, and on emotional and mental well-being. Community women's health centres provide health care that is based on principles of women's agency and responsibility for their own bodies. Their 'non-hierarchical, collectivist social relations and practices' challenged the hierarchical power structure of traditional models of health provision (125). By providing free care, an interpreter service, and outreach programs to workplaces and community groups, they attempted to make health care more accessible for groups of women marginalised or neglected by mainstream services – working class women, the poor, students, non-English speaking and migrant women (126-7).

Deborah Saltman argues that the women's health movement represents a more holistic attitude to health, placing more emphasis on preventive care and the promotion of wellness than does the traditional medical model. This holistic perspective has influenced the wider consumer health movement in its demands for greater attention to health promotion as well as greater empowerment of health consumers (217; 229). Saltman and Schofield both attest the importance of the women's health movement in achieving greater participation by consumers in public debate and decision-making about health services. Women's voices have had impact on the debate in areas of medical control of female reproduction (including childbirth, management of the menopause and contraceptive options) and mental health (Saltman 228; Schofield 127, 129). The women's health movement has 'provided a model which incorporates an ethos of representativeness and empowerment which has been adopted wholesale by the consumer health movement' (Saltman 217). The women's health movement not only represents increasing agency for women in controlling their own health, it also challenges conceptual assumptions of patriarchal medicine – assumptions about what constitutes the norm of health, what is good for patients and where authority rests.

The women's health movement embodies the understanding that patient empowerment is fundamental to healing, and especially so for those already in a position that is subordinated and denigrated. Empowerment encompasses practical issues such as control of health services, and also conceptual issues – who controls the discourse, whose voice is heard. The common element is agency: self-assertion and a sense of self-worth. Moira Stewart and her colleagues have provided evidence that empowerment of the patient is effective as a therapeutic strategy. Their publication Patient-Centered Medicine: Transforming the Clinical Method draws together the theoretical and research basis of a clinical approach that puts the patient's experience of illness rather than the doctor's 'case history' and diagnosis at the centre of the medical consultation. Patient-centred medicine represents a paradigm shift in clinical approach from the 'conventional biomedical approach' that 'ignores the person with the disease' to a model that 'includes the conventional biomedical approach but that also goes beyond it to include consideration of the patient as a person' (Stewart et al, xv). There is evidence of improved clinical outcomes with this approach. Areas where improved outcomes have been shown include patient satisfaction and adherence to treatment (188), symptom reduction and improved physiological status (xxiii), and health promotion and the prevention of disease (84). The patient-centred model demonstrates the therapeutic advantage of counteracting the doctor's traditional monopoly of control and authority by focusing on and empowering the patient.

Feminist critique of gendered medicine, along with the achievements of the women's health movement and evidence of the therapeutic effect of empowering patients, highlight the crucial role of agency in illness and healing. Assumptions that denigrate and disempower women are embedded within the discourse of medicine. Dorothy Broom concludes her overview by noting that the influence of gender in the experience of illness and medical care is generally 'obscured' and that these covert assumptions that obstruct healing are 'more powerful and more difficult to dismantle' than are openly recognised inequities (109). She suggests that the first step towards 'breaking

the nexus' between gender, illness and medicine must be to deconstruct the gendered basis of medical discourse (110). Narratives of women's illness and of their confrontations with a patriarchal medical world form one part of such an alternative discourse. Gaining control of discourses of the body and illness becomes a significant part of the healing function of women's illness narratives.

Margaret Coombs Regards to the Czar and The Best Man for This Sort of Thing

Margaret Coombs deals with themes of feminised 'illness' and embodiment such as childbirth and postnatal depression in ways that are consciously theorised. She deconstructs sentimental images of pregnancy and motherhood, giving an openly feminist and darkly comic perspective. Coombs' fiction is closely based on her own experience: in one interview she states '[my] work reads as, and to a large degree is, extremely autobiographical' (qtd. in Bartlett 205). Her writing is self-conscious and reflexive. Helen Ayling (nee Diamond), the central character of the novels and Coombs' alter ego, obsessively analyses her experiences, and her introspections are interpolated with quotations from many sources. The intertextual material represents and critiques numerous discourses that impose upon the female subject: medical texts, Dr Spock, Freud, works of literature, feminist theorists and pharmaceutical advertisements. These extracts invite critical reflection on the cultural construction of Helen's 'illnesses'. Coombs' writing employs the commentary of textual interpolation as a therapeutic tool, as a way of transforming personal distress and problematic embodiment into a wider narrative.

Coombs' representation of embodiment reflects her own experience: 'I've always in my life been acutely aware of being in my body, and for me it's been mostly really difficult, a nuisance.' (qtd. in Bartlett 207). In her fiction the body intrudes into awareness. Helen is overwhelmed by the sense of being trapped in an intransigent body. It betrays her (for example when she is constipated or wets the bed as a child), it is smelly, sweaty and lumpish.

When she is suffering post-natal depression her body has to be forced through the simplest acts of daily life:

Your body is more than you can cope with today: it feels like a sodden, shapeless mass, heavy and flaccid and dense as a fat old woman's breast
. . . You imagine yourself sitting up in bed. . . . You would have to lift your leaden flesh right up off the pillow, lean out from under the cover, expose your hot, bare, sweaty skin . . . (Regards to the Czar 146)

Coombs uses strong concrete images to emphasise the discomfort of embodiment. Like the poems on menstruation quoted above, this writing contests (masculine) assumptions that take the absent body as the norm, and asserts the (female) experience of embodiment. By foregrounding embodiment Margaret Coombs at once reveals and resists woman's experience of her body as alien and the site of shame.

Writing from this perspective, 'through the body', Margaret Coombs deals with the experiences of childbirth and post-natal depression in ways that expose and contest the association of femininity with illness. Pregnancy and post-natal depression can be seen as pathological, as 'medical problems', or they can be construed in alternative ways. Pregnancy and childbirth are normal physiological functions. Post natal depression might be the understandable reaction of a conscientious and compliant woman to the conflicting, often denigrating messages directed at mothers, and to the unrealistic expectations surrounding motherhood.²³ If a woman does not find that caring for her baby is intuitive and blissful, she may feel that she rather than the cultural stereotype is at fault; she may feel guilty and inadequate as well as disappointed and physically exhausted. This is Helen's experience of puerperal depression that Coombs portrays in The Best Man for This Sort of Thing.

The events leading up to Helen's depression (told in Regards to the Czar, 'Induced and Abandoned' 106-134) give a critical view of medical

²³ Post-natal depression is part of a wider debate about the impact of gender expectations on mental health. In making emotional and mental health a priority, women's health activism drew attention to and sought to counter what it 'saw as the medial pathologising of women's understandable emotional distress in the face of the struggles they encountered as women in a society with a gender hierarchy' (Schofield 129).

intrusion in childbirth. Helen's obstetrician decides to induce the delivery of her baby at a time to suit his Easter holiday plans, oblivious to Helen's wish for a 'natural' birth. The doctor's arrogant control medicalises an uncomplicated birth, but more destructively for Helen it obliterates her fragile sense of autonomy and worth and sets off overwhelming guilt and depression:

You'd tried to persuade yourself that if you unquestioningly agreed to have what Mr Rhys-Williams and you both *knew* but did not *say* was a medically unnecessary surgical induction . . . he in return would respect you for being *a rather special sort of woman* –

. . . you'd realised too late that you'd colluded in his mistreatment of you and your unborn baby for *nothing*: you and your baby weren't 'special' to him at all but just bodies, just objects . . . Forced to see this at last, you'd been too depressed to feel any pleasure at Jemima's birth . . . you'd compounded your sins by being guilty of the mortal sin of 'bonding failure'. You'd *become* just a body, just an object.

(The Best Man for This Sort of Thing 23-4)

Helen, angry and desolate, is oppressed by the weight of medical authority.

Other people – nurses, even her own husband – view her according to the labels imposed by powerful doctors:

'It's terribly unfortunate, all this,' he said. "Puerperal depression", we call it. As you probably know. It's just a . . . biochemical thing. . . .'

I was pretty sure that what was wrong with me was not 'biochemical' . . . but I was also sure I didn't have the guts to say so. Where I came from, women whose misery was not 'just biochemical' were either labelled 'looney', locked up and written off or else labelled 'self-indulgent'. . . . (The Best Man for This Sort of Thing 3)

The novel develops the argument indicated here in its opening lines. Misery is a reasonable response to Helen's situation (denied control of her body, patronised and denigrated) yet the gendered medical discourse positions her as sick ('a biochemical thing'), 'looney' or 'self-indulgent'. There is no space that allows her, as a distressed woman, to be a healthy and reasonable person.

Margaret Coombs gives a darkly satirical view of the medical world. She portrays doctors (male) as arrogant and invasive – inflicting themselves upon the passive, acquiescent (female) patient in ways that deny her the right of control over her body. They dictate 'treatments' such as unnecessary enemas, tonsillectomy and induction of labour. They perform intrusive actions on her body without explanation, override her questions and concerns, patronise and diminish her. One doctor who treats Helen this way is her father.

Doctor Diamond is affectionate enough towards his daughter, but when he acts on her as doctor (performing an enema) he becomes detached and cold, inflicting pain and humiliation with a depersonalising indifference:

But he was only the doctor now – as he bent over her body in his starched white coat and mechanically gripped her ankle as if it were a thing and observed the child with his empty eyes and saw only the hole that her poo came out of. . . . As impassive as if he were cleaning out the fish tank, he held the dull red rubber thing firmly in his rubber-gloved hand and she felt the cold hard end of it push into her while her gloating mother held her down and she screamed and screamed and his eyes refused to notice . . .

(Regards to the Czar 14)

Helen's subordinate position as patient is amplified by her unequal status as child to father, female to male. The childish language reinforces Helen's vulnerability, while the aggressive imagery depicts the 'treatment' as a violation. The doctors Helen confronts as a depressed young mother are also father figures, their authority as doctor to patient augmented by difference in age and gender. This positioning encourages a critique of the patriarchal basis of medical power, emphasising its destructive effect on patients – especially women patients. When Helen is 'treated' by the psychiatrist, Dr Argyle, medical power merges with sexual power:

The fingers that have been on the space between my armpit and my breast slide under the lace edge of my nightie and move gently up and down the rise of my breast. *Is this really happening?* Yes. . . .

I glance up at his face: it appears to have no idea what his hand is doing. . . . I must be MAD to feel the way I do! I must hide my feelings from him or God knows what will happen – He'll be angry, disgusted – I'll be humiliated, sent to a looney bin. . . . *perhaps I AM 'psychotic', 'depraved'!* . . . I am careful to keep my body as stiff and still as a plastic doll's.

'I never had a daughter,' he says wistfully.

(The Best Man for This Sort of Thing 37-8)

Helen endures in the stunned silence of disbelief. The experience so disrupts her expectations of a doctor that she is unable to protest. Coombs shows how a woman may interpret such a violation of trust as evidence of her own guilt or madness.

Postnatal depression is one experience that Coombs uses to deconstruct the mystique of motherhood. Episodes depicting Helen with her small children also show how the expectations surrounding motherhood can be damaging for

women. For Helen, being a mother, far from guaranteeing fulfilment, entails anxiety and guilt. She displays neglect and even cruelty at times:

The two of them look ridiculously picturesque, clutching each other and crying like the victims of some fairytale wicked stepmother or pre-Raphaelite painter. You feel accused and condemned. The damned-up rage comes rushing out of your mouth in a torrent.

. . . I'm sick to death of having to tramp everywhere after you little brats every day. Sick to bloody death of it! Go on, get out! Can't you see I'm sick? Oh I really hate you two sometimes! Really HATE you! Get out of this bloody house, you rotten little brats! . . .

These are your children, a voice remote and cool in the back of your head is telling you. *You love them. You know that.*

What will the neighbours think? your mother asks.

The children scuttle away, screaming . . . (Regards to the Czar 152)

Helen recognises how despicable her behaviour is but, trapped in depression, she cannot control herself. The black comedy underlines both Helen's insight and her sense of helplessness as she screams abuse at the children. References to the fairytale wicked stepmother and to the (imagined) critical gaze of mother and neighbours place the scene in the context of the wider culture.

Helen's entrapment as a mother struggling against depression is also juxtaposed with abusive experiences from her own childhood. Earlier episodes in Regards to the Czar show Helen's mother treating her coldly and sometimes brutally, sneering and humiliating the child and instilling a lasting sense of inadequacy and guilt. The novel's inversive representations of motherhood perform a therapeutic function in several ways. One therapeutic aspect is the open confrontation with unacceptable and yet explicable acts of child abuse. Coombs uses black humour, subverting the icon of motherhood by representing the mother figure as a monster, to underscore her point. Secondly, the writing goes beyond frank portrayal of aberrant mothering, to provide insight into the damaged mother and validation of her suffering as well as that of the child. Coombs shows that the roots of Helen's abusive behaviour lie in her own childhood – her role as victim and the destructive effect of denial and silence. In Helen's story Coombs recreates the inner world of the abused child and the mother she becomes.

Finally, the novels demonstrate the therapeutic power of breaking free of silence and complicity. Helen is repeatedly silenced by the overwhelming

authority of the doctors who treat her – psychiatrist and obstetrician – and by the imposed medical discourse. A letter that Helen writes to her psychiatrist indicates that his power to control the discourse equates with his failure to ‘cure’:

Dear Doctor,
When I came to you, I was a ventriloquist’s dummy . . .
You *did* inspire me to speak (at least in writing) with the voice I’d been afraid I didn’t have. . . .
When I spoke, you said: *Very nice – but not quite the ticket for a ventriloquist’s dummy . . . WE’LL see to the words*, you said. . . .
You said: take these drugs, have these treatments, let me charm you back into dummyhood, sweetheart.
You said: go back to speaking in other people’s voices. . . .
And so you left *me*
With nothing,
No voice at all . . . (The Best Man for This Sort of Thing 361-2)

The linked narrative of the novels represents a process of empowerment through finding a voice. At times Helen seems too much the helpless victim – surely no-one with her education and social status (she is a master’s graduate of Sydney University) would have been quite so spineless. However this is just the point that Coombs is emphasising. As a child given enemas by her doctor father and as an adult patient, Helen is unable to speak in protest. She has internalised the disabling cultural myths, seeing herself as worthless and impotent, and becoming complicit in her role as victim. The writing stands as Helen’s struggle to articulate her feelings and understandings, against the weight of medical (and especially psychiatric) discourse that positions her and denies the validity of her experience. The narrative is Helen’s protest, and the beginning of a new narrative of self.

Anna Fienberg Borrowed Light

Stars . . . make their own light!
Now take the life of a moon. It just follows a planet around, like a dog on a leash. . . . it catches light rays like bones thrown by stars.
I am a moon. (Borrowed Light 8)

Borrowed Light, written for young adults, is another body story centred on woman’s reproductive function, the account of a young girl’s unplanned pregnancy and abortion. Puberty, emerging sexuality and pregnancy are times when rapid changes in physiology compel heightened

awareness of embodiment for women. This narrative encompasses an evocation of Callisto's (often problematic) experience of her adolescent body. The novel demonstrates social expectations that mould a girl's attitude to her body – represented especially by the male gaze. Callisto's story at once affirms the bedrock of embodied experience and resists reduction of a woman to an inferior body. Callisto asserts control of her body and comes to value it in her own terms. Anna Fienberg uses the motif of astronomical bodies – stars, planets and moons – to convey Callisto's enlarged sense of personhood. The narrative performs a therapeutic function by telling a story of the body in a way that is transforming and empowering.

. . . Tim and his friends sitting on their towels, looking at girls in bikinis as they strolled past. I'd heard they rated the girls one to ten. Big breasts scored high. . . .
. . . What about my spiky hips, my disappointing breasts? . . . the hairiness of my arms, my scrawny legs . . . the shadow of a moustache?

But at Miranda Blair's party . . . Tim Cleary looked at me for thirty seconds. When he was finished, he still wanted to kiss me. I smiled so much my face ached. I was caught in his gaze, . . . I felt beautiful for the first time. (23-25)

Callisto at sixteen is intensely conscious of her body. She sees herself in terms of 'a judgement made by the world' (24), as object of the male gaze. Defining and valuing herself from the reference point of male needs, she 'works hard' at fitting the right image. She is anxious about her body's reproductive function as well as her sexual appeal (one reason she becomes pregnant is that she believes she is not fertile). Her menstrual cycle is irregular, she is thin and hairy and she worries about her 'estrogen deficiency' – her body does not 'keep time with the rhythm of the universe' (39). She is 'outside the circle' of other girls: 'they flowed together, damp with their animal nature, fertile and generous as wild moss growing in a cave. I was as dry as an old stick' (38-9).

Dryness is a recurring image for Callisto's sense of her body as alien and inadequate. Infrequent menstruation is one form of dryness, and dryness marks her first sexual encounter. The story, told bleakly through the body, is presented as painfully honest. It conveys, with wry humour, not just disillusion but an overwhelming impression of the girl's body as object:

It was a terrible disappointment, if you really want to know. . . .
. . . I smiled at him and sat down on the bed.

‘No, not there,’ he said.

He pointed to the polished timber floor, where there was today’s newspaper spread out. He took my hand and pulled me down. ‘It’s your first time,’ he explained kindly, ‘you might make a bit of a mess.’

... I felt like a puppy he’d decided to train.

... He put two fingers straight inside me. I hoped I didn’t smell down there. His nail scraped against me. I winced. I was so dry. ‘Sorry,’ I whispered. (63-65)

Despite Callisto’s complicity, her puppy-like willingness to please, this episode is marked by a sense of violation. Violation because her body is an object, and not least because it is denigrated in her own view – she sees and judges her body through the masculine gaze.

The central narrative of Callisto’s pregnancy and abortion shows her continuing to regard her body as object, troublesome and alien. She sits passive and silent as a doctor confirms her fear that she is pregnant; she lies for hours on her bed swamped in despair. When Tim enlists the help of a quack ‘herbal’ practitioner to bring on a miscarriage, Callisto obediently swallows a nauseating concoction despite knowing it will change nothing. Emotionally isolated – Tim disappears on a surfing trip to Byron Bay with his mates, her mother is remote, lost in her own troubles – Callie feels helpless: ‘The undertow was drowning me’ (127). She is trapped in a narrative that she is not ready for. Although she knows that some girls of sixteen are ready for motherhood, she cannot accept this as her story: ‘I only knew what *I* was like. And I wasn’t ready to have a baby’ (127). From this moment of insight Callie takes control of her body. She faces her fears and regrets, and overcomes the practical obstacles, to have an abortion. She meets Richard and finds an equality of give and take in shared scientific interests, playfulness and their private body language of sex. By the close of the novel she has gained a sense of agency and self-worth. She values her body and she is in charge of her life.

A brief overview of Borrowed Light cannot do justice to its subplots, but these form part of the therapeutic narrative. One example is the exploration of family and especially of motherhood. Fienberg unsettles the myth of the good mother who is intuitively nurturing, by portraying a range of possibilities and perversions. Callisto’s troubled family is not merely backdrop but integral to her difficulties. Her mother, Caroline, is consumed by the quest to ‘mop up

the sorrows of all the women in the world' (17) – an attempt to deal with unspoken sorrow over the death of her first baby. Walled in by secret grief she is unable to fill her children's need for understanding and help: 'she might ask questions, but she doesn't listen to the answers' (18). Grandma Ruth, Caroline's mother, is an Astronomer, intellectually brilliant but emotionally as distant as the stars. The novel's multiple realisations of motherhood are all far from the cultural ideal. At the heart of the narrative is abortion, apparently an inversion of motherhood, but paradoxically, for Callisto an affirmation of the importance of mothering. She grieves for the 'little fish' she carried but knows that she is not ready to be mother. She wants to have babies when she can give them the care they need – she must 'grow up first' (240). As it is, she struggles to make up the shortfall of mothering for her obsessively anxious little brother Jeremy. By unsettling myths of motherhood, Fienberg suggests the destructive potential of cultural expectations, and the guilt and denial they can entail. As family secrets emerge and hidden anger and sorrow are finally spoken, Borrowed Light enacts the healing power of telling the story. Telling brings the possibility of retelling – a new narrative of a family that can, despite its failures and its dissonance with the cultural ideal, give respect and nurture to its members.

Motherhood and family is one discourse that this novel explores. Other discourses that shape and control Callisto's life are threaded through the narrative. Science, medicine and alternative healing, mainstream religion and new age spirituality, global politics and stolen children narratives all impact on her efforts to define herself and to confront her pregnancy. For Callisto the discourse of science is empowering – she is at home with it and enchanted equally by the fact and the poetry of science: 'I'd whisper words from the language of the universe to myself, words like *isotropy*, or *inertia*, or *cosmic microwave background*. The words were a comfort.' (66). Callisto's use of imagery drawn from biology, geology and astronomy reveals her intellect, her thirst for knowledge about the natural world, and her creative ability to connect science and imagination. Science is a source of strength for her. Fienberg does not line up discourses of power and alternative discourses in expected ways: how each stands in the narrative depends on its capacity to

empower – or disempower. Caroline’s new age spiritualism is critiqued not because it is anti-scientific, but because it has become an escape from real problems and real emotions, a way for Caroline, however unwittingly, to exclude Callisto and Jeremy and deny their need for her. Mainstream religion can also disempower. When Callisto goes to the clinic, she has to run the gauntlet of ‘Right to Life’ picketers. “You’ll burn in Hell”, “You’re a murderer if you go in there” they shout as she pushes past the ‘clutching hands’ (201-2). Yet Callisto mourns the loss of her embryo baby: her feelings are far from the callous selfishness attributed by the protesters. The narrative contests their attempt to deny her not only choice, but more insidiously, the freedom to grieve: ‘When they’re waving placards and spitting at you, you can’t admit a moment of weakness. You can’t tell about the feeling afterwards, the sadness.’ (240).

In Borrowed Light, the discourse of medicine, mediated through the women’s clinic where Callisto has her termination, is enabling. The receptionist is helpful, the counsellor supports her in making her decision. The clinical procedures have a neutral and reassuring quality, countering the judgmental regard through which she has seen her body. Callisto returns to the imagery of science to convey her sense of comfort, in a scene that forms an obvious contrast with her ‘inspection’ by Tim:

The doctor was nice. When he put his gloved fingers inside me, he didn’t wrinkle his nose or shake his head or call me a naughty girl. He just poked about with an expression of detached curiosity. I felt like a quite ordinary flower being inspected by a kindly botanist. (211)

Above all she is allowed to talk about her feelings, and to cry. It is at this time when she accepts the sadness and confirms her decision to have a termination that Callisto realises how much she has allowed other people’s expectations to control her. ‘I . . . saw the girl that was me . . . She’d try anything to be liked. . . she’d lie down on newspaper and apologise, she’d swallow plants . . . It was shameful’ (208). She accepts that she can take responsibility for her body – for her self:

Who’d leave all this up to me? But then I felt a wave of certainty. As Rosa said, there was really no one else. . . .

For once, I was trying to do the best thing I could for myself. (210)

Callisto's retelling of her body story is a narrative of empowerment. By facing up to her pregnancy and taking the difficult course of having an abortion, she asserts control of her body. Identifying herself at the start as a moon, reflecting light from others, she comes to resist this subordination and to realise that her light is not 'borrowed'. At the close of the novel she states her new sense of self-respect and determination to keep growing. She must bear the sadness of her lost 'little fish' but she will not 'hold on to the sorrow' as her mother did (235). Callisto will 'see past the sorrow' and move forward:

If I get pregnant again it will be because I really want to. . . .
I wanted my second chance. I needed it like oxygen. I wanted to grow up first. Richard and I might have babies one day. . . . And I'll make sure our babies don't have to borrow their light. (239-40)

Amy Witting I for Isobel

The imperative to seek healing through 'telling' is a key theme in Amy Witting's I for Isobel. The final pages drive home the discovery that Isobel has been moving towards since childhood: writing will be her saving. The image of a baby put into the oven by its mother and rescued at the last moment (based on a story that Mrs Prendergast told Isobel) becomes the metaphor of her transforming insight:

There's a writer in there, Isobel; a naked infant greased and trussed in the baking dish with an apple jammed in its mouth. . . .
Too late. It must be too late. The poor little bugger in the baking dish; nobody came in time.
Suppose I tried? . . . The writer might come back.
. . . the poor little bugger trying to get out of the baking dish. (152-5).

The unformed writer in her, an infant that her mother jealously tried to destroy, is struggling to live. By accepting the challenge to write Isobel confronts and begins to triumph over her demons. Her revelation encapsulates a key theme of Amy Witting's fiction – the healing power of writing.

Writing had a therapeutic function for Amy Witting, as it did for her 'alter ego' Isobel Callaghan. Yvonne Miels argues that there is a significant autobiographical basis in Witting's writing.²⁴ Isobel on her Way to the Corner Store is based on Witting's five-month confinement in Bodington Sanatorium

²⁴ Other critics who support this view include Margaret Connelly and Peter Craven.

with tuberculosis (Miels 'Gold out of Straw' 45). I for Isobel also 'draws on personal experience', in this instance 'the powerful material of childhood.' While Amy Witting was 'reluctant to discuss the links with her own past' she admitted in an interview with Miels that 'it is not possible to write a novel like I for Isobel "except from personal experience"' ('Gold out of Straw' 39-40). The 'personal experience' behind this novel appears to have been dark:

'I thought I could make my life into a room and choose what came into it. . . .
. . . life isn't like that. It's more like swimming in a sea, with currents
and undertows carrying you where you don't want to go.'

The currents and undertows were mysterious evil passions, rage and
envy; most of all an unconquerable sadness – no matter how willingly they
accepted her – at being somehow disqualified, never to be truly one of them.
(I for Isobel 90-1)

I for Isobel follows Isobel from childhood as she struggles against the 'rage and envy' and 'unconquerable sadness' entrenched by her emotionally destructive family. It portrays her sense of isolation from others, the self-loathing and anger that burst out in spiteful acts such as obscene phone calls, and in degrading sexual encounters. Miels demonstrates that in Witting's early, unpublished stories there are recurring portrayals of a family that is fully drawn in I for Isobel – the family, Miels implies, in which Amy Witting grew up ('Gold out of Straw' 40-1). This 'factionalised' family consists of a beautiful sister who is favoured, an ineffectual or absent father and a mother 'trapped in a world of neuroses destructively vented on others'. There is another child, often depicted as the 'victim' of this situation – 'confused by the physical and mental deprivation that is part of home life', 'unusually perceptive and feisty', a child 'with an independent mind and daring spirit', a reader with a 'rich inner world', who is a 'natural survivor'. This child becomes Isobel Callaghan.

A key therapeutic function of I for Isobel lies in its subversion of the iconic good mother. The novel challenges a cultural assumption of motherhood as 'unarguably worthy'. Mrs Callaghan is 'the most devastating portrait in our literature of a "bad" mother' (Craven 35). So devastating indeed that I for Isobel was initially rejected for publication, on the grounds that it attacked the sacrosanct institution of motherhood, the editor Beatrice Davis

reportedly saying ‘No mother has ever behaved so badly to her own child’ (Connelly 35). Mrs Callaghan is a monster – neurotic, spiteful and vindictive toward one daughter (Isobel) while favouring the other (Margaret). She arbitrarily inflicts punishments, jibes and humiliations. Isobel’s suffering is compounded by the absence of cultural validation for her experience – as Beatrice Davis’s remark implies, such a mother could not exist.

The significance of cultural expectations of mothering is illustrated in the first episode of I for Isobel, ‘The Birthday Present.’ Each year Isobel hopes that she will get a birthday present and each year her mother takes twisted pleasure in crushing her hopes then taunting her daughter for sulking. Isobel’s disappointment is compounded by anticipation – against experience – that this time her mother will do as mothers are *supposed* to. The guests at the boarding house where Isobel and her family are staying represent normal cultural expectations. Their astonishment and disapproval at Mrs Callaghan’s behaviour (having insisted that Isobel not tell anyone it is her birthday, she is openly furious when one of the guests gives Isobel a present) highlight the conflict for Isobel. There is no place in the cultural narrative of motherhood for *her* reality, her mother’s hatred, as symbolised in the ritual birthday travesty. When another child tells Isobel “‘Birthdays aren’t secrets. Not ever’” she can only reply, “‘Well, mine is’” (6). The contradictions undermine Isobel’s confidence in her own perceptions and her sense of self. Her mother hates her, therefore she must be wicked, worthless and unlovable. The cultural myth of motherhood denies the authenticity of Isobel’s experience. Retelling the story of her childhood and building a sense of her own worth requires deconstruction of the motherhood icon.

However Amy Witting does more than testify to the child’s experience of a perverted mother. Isobel comes to glimpse the torment that underlies Mrs Callaghan’s savagery, even to have some pity and fellow-feeling for her: ‘all the grown ups were turning on her mother the same glare of indignation, . . . Isobel felt an ache of sympathy, knowing how it felt to be the last to be chosen, or even left out’ (12). Witting states in an interview that Mrs Callaghan is ‘a harridan’, but although she is a monster, women like her are

‘much to be pitied.’ Driven by suffering she ‘has to take it out on others.’ Witting saw such women as the ‘victims of sexism’; they are women ‘in a trap’ (Bookshow).²⁵ I for Isobel demonstrates the roots of the mother’s cruelty in her private torment, and shows how the child Isobel gains the beginning of freedom through insight into her mother’s suffering:

‘Tell me.’ Her mother’s voice, which had been rising to a scream, turned calm and gracious again. . . . Isobel looked up and saw that her eyes were frantic bright. She doesn’t want me to tell her, she wants me to scream. I do something for her when I scream.

Then she saw that her mother’s anger was a live animal tormenting her, that she Isobel was an outlet that gave some relief and she was torturing her by withholding it. (29)

Isobel is driven by the same torment when she vents her ‘black passions’ in obscene phone calls and outbursts of rage at well-meaning friends. One theme of the novel is Isobel’s escape from the trap that held her mother.

Deconstruction of the myth of motherhood – insight into Mrs Callaghan’s suffering and Isobel’s own role as victim – is therapeutic for Isobel.

Even so, insight alone is not enough. Isobel continues to be possessed by ‘rage and envy’ and ‘unconquerable sadness’. As well as uncovering the source of her pain in the unthinkable ‘bad mother’, Isobel must ‘retell’ her damaged story as a new story. The narrative of I for Isobel is a retelling in which Isobel discovers her strengths and gains self-esteem. She is a survivor despite it all. She has intelligence, a sharp wit, a love of ideas and reading – a ‘rich inner world’. Progressively, Isobel reinterprets the negative images that she holds of herself. The child’s conviction that she is wicked and worthless is born of her mother’s destructive hatred. In the episodes ‘False Idols . . .’ and ‘The Grace of God . . .’ Isobel is castigated by her mother as an incorrigible liar and wrong-doer; retelling from a mature perspective shows a child with a passion for truth, who struggles after goodness. Her intelligence and love of reading make her an outsider at school, the butt of teasing and bullying by other children when teachers single her out for praise. Retelling affirms the

²⁵ In the interview, Witting likens this trap to the ‘little ease’, a cage of such dimensions that the prisoner ‘could neither sit nor stand nor lie’. She uses the same image of the ‘little ease’ cage to describe her own inner life as a young woman (Miels ‘Gold out of Straw’ 43). This link suggests that Amy Witting, like Isobel, escaped becoming a tormented ‘harridan’ - a Mrs Callaghan - through the healing power of writing. Witting’s explanation for choosing her pseudonym supports this view. The name is ‘symbolic of a private but powerful directive that she made to herself . . . she would never be “an unwitting monster”’ (Miels ‘Gold out of Straw’ 39).

value of the 'rich inner world' of the mind. Equally, the young woman Isobel's view of herself as unattractive, not a real woman, is based on constraining social expectations. Her wit and intelligence make her an object of suspicion to conventional young men: Norman's 'gaze', 'fixed on her, tense and dull with hatred' because she has outwitted him, drives this home to Isobel (68). Workmate Frank,²⁶ friendly and perceptive, spells it out: "'you're not out to please the boys, or you wouldn't be pulling that nice little face around making funny remarks'" (76). It is Frank, one of the few who values Isobel's intelligence, who recognises and encourages the potential writer in her. Frank's insight is placed against the mostly denigratory and constraining images that crush Isobel. In the novel's therapeutic retelling it is Frank's view of Isobel that is foregrounded, countering the damaging story of her as a failure and outsider. For Isobel, retelling is a healing process, restoring her self-worth and overcoming depression and rage.

Retelling Isobel's damaged story as a healing narrative, the novel moves towards her transforming discovery – 'I am a writer' (155). This realisation carries a new sense of agency: Isobel can build for herself a valued identity against the constricting images that others impose on her – wicked child, unfeminine intellectual, promiscuous 'tramp', outsider. Writing represents a creative drive that will counter the negations of self and self worth and transform the raw material, the 'straw' of destructive, humiliating experiences into the 'gold' of stories and poems. For Isobel, discovery that she is a writer is the beginning of healing: 'she knew she could choose to be a writer . . . that was the end of the crying' (155).

Amy Witting Isobel on the Way to the Corner Shop

Taking up where I for Isobel ends, the sequel tells the story of Isobel's illness with tuberculosis and her treatment in a sanatorium. At the opening of the novel Isobel is making a tentative start as a writer (she has had two short

²⁶ The names suggest the men's contrasting symbolic roles: Frank represents benign insight and plain-spoken honesty; Norman, commonplace and dull, represents normative views of the sexes – to him, women are 'peaches, dishes and little bits of fluff waiting to be picked up' as Isobel sharply notes (66).

stories published). The novel demonstrates the healing power of narrative for Isobel – reading and discussing literature with others, and above all writing, are significant ways in which she regains agency in the depersonalising experience of illness and hospitalisation. Beyond this, the narrative performs therapeutic functions by foregrounding embodied experience, by exposing and resisting the hidden assumptions of medical power, particularly the dehumanising medical gaze and its positioning of the patient's body as object, and by placing agency and control of her body with the patient.

Witting places high value on mind, the life of the intellect and the imagination. Isobel is intellectually curious, she analyses her experiences in a constant process of ironical reflection, and she is an avid reader of literature, especially poetry, as well as a writer. Yet without devaluing mind Witting foregrounds Isobel's embodied subjectivity in this novel. Thought, emotion and connection with other people are mediated through an imperious and constraining body. Isobel's embodiment is established in strong physical images, even before she knows that she is ill. Severe hunger makes her 'fretful' with a kindly critic who is discussing her writing and the body overwhelms her attention: 'the word pie brought cold sweat to her forehead. . . she leaned against the window, breathing deeply' (32). In the episode leading up to Isobel's hospital admission, debilitation and delirium are established with graphic physicality. The 'very careful operation' of emptying a chamberpot, 'a cloth over her mouth and nose against the ammoniac stench', dragging herself up and down flights of stairs with the heavy bucket of urine, is described in minute detail to recreate the experience of overpowering weakness (49-50). In a picture theatre she drifts in and out of consciousness, racked with stabbing pain under her shoulder blade, sweats and rigors: 'shudders were running down her body, . . . she had to bite on her sleeve to keep her teeth from chattering' (54). A few hours later delirium and weakness overcome her struggle to retain control of her body: 'She took a few steps away from the lighted doorway, yielded to the invitation of the pavement and lay down' (57-8). Isobel's illness exaggerates her sense of alienation from her body, an alienation shown earlier in bleak sexual encounters, lacking as much in 'physical pleasure' as in 'friendly feelings' (4-5). The marked lassitude

associated with tuberculosis emphasises her sense of being trapped in a passive, alien body: 'How odd to be inhabiting this flaccid body. It sprawled limp on the bed' (81).

Isobel's treatment as a patient increases her sense of entrapment in a denigrated body. To the medical world, her body is an object: 'One had to remember that one was a parcel. Parcels can have no pride.' (61). She is prodded, percussed, auscultated with a 'beastly cold' stethoscope (60), washed, hoisted onto bedpans, carted on trolleys and wheelchairs and manhandled in and out of beds and ambulances. She is ordered 'strip to the waist' so often that she labels this phrase the 'new mantra'. Routine procedures such as X-rays and blood tests are intrusions performed without apologies; on the contrary, she is criticised if her body fails to perform:

In the laboratory she struck trouble. A young man trying to draw blood from her fingertip grew irritable.

"Shake your hand about a bit, will you? This is like trying to get milk from an old dry cow."

"Sorry!"

She shook and massaged, feeling shame at her incompetence (139)

The attitude of hospital staff is infantilising as well. Coaxed to eat ("That's a good girl. Nice clean plate") Isobel does 'not resent this return to childhood. . . . any word of approval was welcome' (133). However she rebels at a huge 'china shoe' bedpan: 'She could go back so far to infancy but no further. Being sat on a potty was too much' (136). Isobel's subversive irony is the beginning of a therapeutic counter discourse that defends her sense of self against the demeaning positioning as patient. The image of patient as parcel becomes a private code for her ironic resistance.

The humiliation of being reduced to an inferior body is increased for Isobel by the stigma associated with her disease: 'One was not only a parcel. One was a toxic, undesirable parcel' (71). In the setting of the novel, tuberculosis is seen as a contamination, associated with poverty and unsavoury lifestyles. The Sanatorium itself, where many staff members are tubercular subjects, shares in the stigma: 'it was us against the world at Mornington' (141). When Isobel is admitted as an emergency to the city hospital (St

Ursula's) she is put in isolation and the nurses and orderlies who care for her must wear face masks to protect them from her disease. She is issued with her own set of china and when she coughs her tissues must be disposed of in a special lidded receptacle. In short, she is made to feel dirty and dangerous. At Mornington, she is 'among friends' but even here the 'humiliating ceremony' of daily injections into one's 'naked posterior' regularly reminds the patient of her body's denigration: 'Pulling down pyjama pants . . . established forever one's social status, which was humble' (142).

Isobel's experience of her body is imperious and constraining – her subjectivity is compellingly embodied – and this is underscored by the medical view of body as object, but she resists *reduction* to a denigrated body. Even at her weakest, delirious with fever, when first admitted to hospital after collapsing in the street, Isobel contests the treatment of her body as an object:

Someone was tapping most annoyingly on the bones of her ribcage, one after the other. It was too much. Then somebody rolled her over and the tapping began again on her back. She uttered a sharp protest . . .

'What's she mumbling about?'

'Says she isn't a bloody xylophone, sir.' (60)

Isobel's experiences are mediated through her writer's vision, with sharp insight and humour that expose and counter the dehumanising medical discourse.

Alienation from the body is also countered through healing touch. Mrs Delaney, a hospital volunteer at St Ursula's, and Dr Wang at Mornington both communicate friendship and care for Isobel through the body, through touch. Mrs Delaney comforts Isobel when she is overcome by panic before her transfer to Mornington:

Isobel muttered, 'I'm frightened. Plain bloody terrified. Sorry.'

Mrs Delaney put her arms around her and gathered her into an embrace. . .

. . . Isobel thought, with surprise, that it was the first time anyone had ever touched her in kindness. It was a new sensation, remarkably steady. (106-7)

When Dr Wang examines her, like the other doctors 'tapping, listening, prodding and noting' Isobel recognises in 'the touch of hands: skill, confidence and a kind of courtesy' (140). Dr Wang's humanity – his

acknowledgement of her as a person, not just a body – shown in the ‘courtesy’ of his touch is reinforced by the cryptic conversation that follows. Isobel learns that he too has been afflicted with the ostracising disease: ““You too?” “Oh, yes. I am a member of the world’s least exclusive club””. He offers the alliance of shared stigma. The healing that is common to the touch of Wang and Mrs Delaney lies in their recognition of fellow humanity: their touch communicates respect and caring. Isobel discovers more about the importance of embodied communication in her dealing with the annoying youth Lance, who is dying from his disease. She pities him, but when he kisses her she can hardly control her disgust:

She was paralysed by a conflict of emotion; the disgust she felt as his thin lips climbed her cheek like a small rodent was inhibited by the pity she felt for the fever smouldering in his flesh. (243)

Isobel cannot understand her disgust – the boy, seeking attention and affection, is not threatening, ‘nothing sexual about it’, merely pitiful. ‘Enlightenment’ comes from a ‘cheerful and careless hug’ by Dr Wang:

body talk . . . was good or bad, . . . In Wang, good. In Lance, bad.
Bad above all because it did not communicate. Wang’s hug spoke directly to her; Lance’s body talked to itself. (244)

Lance’s kiss is ‘bad’ because it treats Isobel’s body as object; Wang’s touch carries respect and care for her as another person. The power of ‘good’ touch to communicate, to heal, stands in the novel as a counter to the medical discourse of body as object.

The image of the body as object is one motif through which this novel explores and resists medical authority; another is the gaze. The gaze can be used to dominate and depersonalise its object. Amy Witting establishes the power of gaze from the start of the novel:

Mr Lynch . . . would come out of his room to watch her pass. The bathroom was a flight further down; even if she got past before he came out, he would wait, patiently, for her return. He did not speak. . . .

He was a small, pastel-coloured man with silver hair and pink-rimmed pale blue eyes. His gaze was steady; his mouth on the other hand moved with the shiftiness one expects of eyes.

He frightened Isobel very much. (13-14)

In this depiction of ‘bad’ body language, Mr Lynch’s stare demonstrates the threatening power of the (male) gaze. Even where there is no apparent gaze however, Isobel imagines herself critically through the eyes of others:

Look at Isobel! Take a dekho at Isobel in that dress! Making a real effort! Poor old Isobel, pretending to be a girl.
The prison of other people’s eyes. No prison narrower. (21)

She experiences the gaze of other people as derogatory – it imposes a sense of inadequacy on her, as a person and especially as a woman.²⁷ The critical gaze that Isobel imagines here is placed in contrast to the benign regard of her friend Robbie: ‘When he looked at her, he saw a girl who lived in an attic and wrote – how romantic. How she would like to be the thing that Robbie saw’ (25). Robbie’s ‘romantic’ way of seeing, like Frank’s perceptive view in I for Isobel, allows Isobel a new narrative of self: it conveys recognition and validation of her as woman, as person and above all as writer. This vision is a key to the healing impetus of Isobel’s story.

The power of gaze to diminish and control is amplified in the scrutiny of medical authority. When Isobel becomes a patient, the medical gaze signifies threat and depersonalisation. She feels vulnerable and exposed. Her humiliation and the sexual overtones of the male medical gaze are captured by imagery of nakedness. She is undressed for examinations, her temperature taken ‘*per rectum*’, she is instructed to ‘strip to the waist’ for X-rays, her clothes are taken away and she is covered only by a gown open at the back. Having left her lodgings wearing no underwear (too weak to dress fully) and collapsed on the street, she is admitted to hospital ‘without knickers’, a ‘disgrace’ that is repeatedly driven home to her: ‘The best people wore knickers, even on a trip to the corner shop’ she broods (67).

Isobel counters the dehumanising power of the medical gaze by turning humorous regard back upon the doctors. When Dr Stannard, the medical

²⁷ Amy Witting was well aware of the degrading power of the male gaze, with its tendency to reduce women to their female body, and the corresponding devaluation of intellect in women, as this caustic remark to an interviewer indicates: [at Sydney University] ‘women were accepted only on the most humiliating terms . . . you were a dead failure if you were not somebody’s girlfriend and . . . as sexual bait, a logical mind was on a level with facial hair’ (Jefferis 35).

superintendent of Mornington Sanatorium, visits her in consultation at St Ursula's, he makes her inferior status plain. Introduced to Isobel, the doctor overlooks her polite nod and does not address her directly: he 'acknowledged the introduction by nodding to the X-ray' of her chest and 'studied Isobel's chart.' She is reduced to a 'problem' – a lesion on a chest X-ray, a fever, a body to be transported to Mornington. Isobel counters his negation of her with her own ironical stare:

a tall, broad-shouldered figure who was quite the handsomest man she had yet seen. Chieftain of the eagle tribe, she thought . . .

Lucky he took to tuberculosis, thought Isobel. You wouldn't want that one examining your haemorrhoids. (95)

At Mornington, Isobel's subversive scrutiny mocks the arrogance of another doctor:

a burly, dark-haired individual whose face seemed to be set in a permanent sneer. . . . Dr Hook despised all sufferers from tuberculosis. At worst they were doing it on purpose; at best they had only themselves to blame. . . . His abrupt manners and his brusque commands earned him great respect as a doctor. (138)

Wang is one doctor whose gaze does not diminish the patient. Wang is in some ways a subversive figure whose friendship with Isobel represents several of the therapeutic concerns of the novel: marginalisation, embodiment and the transforming power of narrative. He and Isobel share a sense of being outsiders: 'He was as lost among the medical staff of the hospital as Isabel was lost among the patients' (199). Like Isobel, he resists categorisation. He carries stigma that place him in an ill-defined border zone between the heroic figure of Doctor Stannard and poor, working class tubercular patients like Gladys and the Jewish youth Lance, neither of whom will recover from their disease. Isobel sees him as very young and 'vulnerable' (229). Wang, like the female patient, represents ways in which marginalisation can be inscribed on the body. He is taunted by Lance because he is Chinese. He is effeminate looking: Isobel recognises that his 'beauties' – a 'sprite-like cast of countenance', full red lips and skin of 'honey colour' – give him, to Western eyes, 'a disagreeable hint of the epicene' and she consciously draws attention to his wife and baby son to resist the implication of sexual ambiguity (230). He is tubercular (a 'wog' in the Mornington code for anyone infected with the bacillus) and therefore unlikely to find work in a more prestigious field of

medicine: “this has to be my work. A tubercular doctor has something special to give here, and little to give anywhere else.” It had not occurred to Isobel that Doctor Wang might have preferred some other specialist field’ (349). Thus Wang’s experience, like that of Isabel as patient, foregrounds embodied subjectivity.

The friendship between Isobel and Wang also picks up the theme of narrative and its healing power. Isobel’s return to physical strength is expressed in a returning hunger to read – no longer satisfied with escapist detective novels she craves the solid fare of poetry. She discovers that Wang shares her love of literature. Isobel helps him to make sense of English poets – Hopkins, Donne, Auden – and he brings appreciation of the Chinese poets Li Po and Tu Fu for her. Their poetry readings gradually draw other patients into what become regular group discussions. Delight in literature forms the basis of a new sense of belonging, a healing community. For Isobel however, the ‘poetry hour’ is not enough: ‘She wanted to write. The urge to write was beginning to torment her’ (231). Although it means hiding in the bathroom to write – an activity that aligns her with the ‘rule breaker[s] . . . the naughty ones, the smokers, the jokers, the truants’ – and sets back her recovery from tuberculosis (by detracting from the rest cure), it is a healing imperative for Isobel. Writing represents healing of the self, and this stands above healing of the body: ‘She must somehow find the opportunity to write. Not a novel, of course, but a poem. One poem wouldn’t wreck her health; it might save her reason’ (236).

When Wang discovers what she is doing, although he is duty bound to insist that she rest properly, he understands her compelling need to write: his first response is to ask if he can read her poems, and only then does he suggest that she must ‘give up the poetic excursions’ until her fever subsides (258). Later, when she is asked to share a room with an older woman who is dying, Wang encourages her by saying ‘remember that you are a writer’ (293). Being a writer, able to employ the transforming power of narrative, he implies, will enable her to confront illness, emotional pain and mortality – at Mornington, and in her larger life.

Isobel is cured of tuberculosis during her stay at Mornington Sanatorium, but the deeper healing that takes place in the novel is her new sense of self-worth and agency. Return to physical strength is a reflection of her healing as a person. Cured of tuberculosis, she refuses the offer of a job at Mornington, with its prospect of a stultifying ‘safety’ and turns to the challenge of ‘real life and its chances’, above all to the challenge of writing:

This is wog world, where . . . everything is a little askew. Everything is a substitute for something else; medical attention for love, doctors and sisters for parents, their approval a substitute for achievement, a hospital for a home and safety for real life and its chances. . . .

I am going, thought Isobel, to a rented room, to part-time jobs, chance encounters, rejection slips and maybe some successes. My typewriter will be my only security. (351-2)

Isobel on her Way to the Corner Shop ends with the symbol of the typewriter, a restatement of the saving power of writing for Isobel. The novel has used narrative to perform healing functions, validating the patient’s experience of illness, foregrounding embodiment yet resisting reduction to a denigrated body, and asserting the personhood and agency of the patient.

Amy Witting does not write from a consciously ‘feminist’ position, as does Margaret Coombs, for example. Witting is concerned with what it means to be human, rather than with ‘particular issues of gender’ (Miels The Net Under the Tightrope 175). Nevertheless her writing demonstrates many of the healing elements that I have identified as particularly characteristic of women’s narratives of illness. She foregrounds embodied subjectivity. She creates narratives of personal autonomy against the cultural discourses of gender, family and medical authority that entrap her characters. Women’s illness writing becomes therapeutic above all when it contests the hidden assumptions that link gender, power and illness. Healing takes place in the retelling of a constraining story as a transforming and empowering narrative.

Chapter 6 ‘Night stories’: AIDS writing

You don’t have to be too smart to figure out that a thirty-year-old man that winds up weighing sixty-two pounds and babbling, after being the most promising and beautiful of his generation, is tragic. But there’s much more to the story than that. It’s also about the survivor, the caregiver, and that community of caregiving . . . (Allan Gurganus qtd. in Canning Gay Fiction Speaks 245)

Among key elements that transform narratives about AIDS into therapeutic narratives, Allan Gurganus identifies grappling with embodiment and challenging normative social and moral assumptions about sexuality. In addition, literature that deals with HIV infection and AIDS evokes the therapeutic significance of belonging: it moves between the individual story and the communal experience and attempts to unite private grief and political action.²⁸ In the interview quoted, Gurganus goes on to identify the ‘courageous laughter’ and ‘camp bravery’ exemplified by ‘high-drag mask funerals’ as characterising a therapeutic response to the early AIDS epidemic (Canning 249). Camp bravery implies the use of recognised codes to signal communal solidarity and the therapeutic function of belonging; it implies also defiant humour. Farce, wit and irony perform a therapeutic function in AIDS writing. The texts that I explore in this chapter exemplify these elements and go beyond them. Timothy Conigrave’s autobiography foregrounds embodiment and also creates a sense of community and belonging. Bryce Courtenay’s account of his son’s illness serves as a forceful critique of medical authority. The writing of Armistead Maupin and Gary Dunne is characterised by ‘courageous laughter’ and a sense of community but is also broadly inclusive, unsettling polarising assumptions about ‘difference’. Robert Dessaix’s Night Letters incorporates a sense of threatened embodiment and an inversive wit, but also uses AIDS as a trope for a literary exploration of death, aesthetics and meaning.

Gary Dunne Shadows on the Dance Floor

One novel that confronts embodied disease and employs camp humour to evoke a sense of community is Gary Dunne’s Shadows on the Dance Floor. Witty and entertaining, it provides an engaging introduction to an examination of HIV/AIDS writing. In 1985 the narrator, Grace, tested negative to HIV while his friend and onetime lover, Mr Pointy Head, tested positive. Now (1991) Pointy Head has AIDS. In comic episodes over the period spanning two Gay Mardi Gras festivals prior to Pointy’s death, Gary Dunne gives an insider’s view of a community where illness and death are part of day to day living:

²⁸ HIV/AIDS is not a ‘gay disease’ and its narratives do not come only from the gay community. However I have used texts mostly from the gay male community for reasons outlined below, p.176.

Dear Grace,
 . . . I won't be there, in any practical capacity, for my own funeral.
You'll do fine but here's some advice anyway. . . .
 Dress me in my favourite green undies, 501's and the red Docs . . .
 Sell the left over morph to her up the road, usual rate, don't let her beat
you down . . . use the money . . . for a decent wake and spend what's left over on
your wardrobe. A needy charity, if ever there was one. . . .
We've got this far without sentimental bullshit so I won't start now . . . (93-4)

Dunne's caustic, camp humour undercuts pathos and 'sentimental bullshit' and highlights both the sordid facts of the disease and the resilience of the gay community in facing it.

Dunne does not evade the bodily ravages that AIDS causes. The progression of disease is captured in comic snapshots and offhand, even flippant, remarks: 'I used to worry about his consumption of booze. His doctor says it will kill him. Mr Pointy Head says it can join the queue'(4). For Pointy Head, thinning hair is an excuse to add to his collection of outrageous caps; housebound by deteriorating health he makes a 'hobby' of watching the 'cute' engineering students walk past in their tight shorts (39). He treats his illness with dismissive wit: 'it's only an illness, not a lifestyle and like . . . an unpleasant job he'll only devote energy to it when he has to' (40), but black humour reinforces the novel's portrayal of physical deterioration. Pointy is emphatically a body as well as an irrepressible personality. He returns from a trip 'north' looking like an old man: grey around the eyes, feeble and shrunken, and has to be nursed by Grace and other friends. Wasted to skin and bone, he amuses himself and his friends by using his liquid nutrition supplement (Ensure) to make tempting cocktails: 'Chocolate Ensure, Kahlua and dry white rum.' Dunne uses scenarios and images that confront embodied disease and at the same time assert a defiant queer identity. Pointy insists on attending the Gay and Lesbian Mardi Gras, only a few months before his death. Unable to walk, he refuses to go in a wheel chair and is given a ride with the Dykes on Bikes. He parties hard, boasting of his ride on the Ducati, gossiping and joking, sustained by alcohol. Drunk and vomiting he revives with the anti-emetic drug, Stemetil, injected into his "very bony arse" by a co-operative lesbian: "You can trust me. I'm not a doctor." (82). After the

party he ‘crumples’ and is carried into his flat and put to bed by Grace: ‘he was so thin, so light. Just skin over bones.’ (85).

Dying in the hospice, on palliative treatment with ‘his favourite morph syrup’ Pointy Head is weak and confused – ‘The virus has moved to his brain’ (87) – but still gallantly maintains his standards. He is ‘entertaining and charming, his social skills covering the gaps in his memory’, until overwhelmed by exhaustion. His death is signalled with bleak understatement: ‘I’m still sitting by the bed watching him breathe. The nurse rests his hand on my shoulder, “You’ll be staying here tonight? I think it’s advisable”’ (95). Pointy’s death is one of many in the novel. Grace notes almost as an aside, ‘Of the early eighties Balmain crowd . . . four or five had died’ (21). Funerals are so commonplace that, in ‘the early days’ of the epidemic, Pointy ‘was always complaining about the hidden cost of AIDS, the wardrobe maintenance’ for keeping up appearances in ‘full cremation drag’. They have had to become selective, attending only the funerals of their ‘best friends’ (28). One of these events is the picnic to scatter Chris’s ashes at Bondi. Chris’s partner Adrian, also infected and unwell, returns when Pointy is dying. His comment on hearing of Pointy’s condition captures the feeling of the times: ““Seems that’s all I’ve been hearing since I got back from up north . . . Greg and Steven both died while I was away. And Stuart of course. And now this”” (89).

The insistent presence of death throughout the novel, culminating in Mr Pointy’s death, creates a sense of a community under siege. Yet it is a community that confronts death with ‘camp bravery’ and defiant laughter. There are ashes, shadows, on the dance floor, but the party goes on. At a Mardi Gras celebration Grace sees Tim ‘show[ing] off a lot of firm fit flesh’ but dirty and gritty:

‘We were dancing. And John comes up with this container . . . we think it’s glitter . . . and hurl it all up into the lasers. And it isn’t glitter, it’s ashes. And we’re real sweaty and they stick to us. And John says Serge won’t mind. He wanted his ashes scattered on the dance floor. But all over us is near enough. . . .’ (83)

The predominant impression that this short novel gives is one of resilience. Pointy as central figure is a self-styled ‘positive role model’ – HIV positive,

perversely mischievous, exuberant. He takes wicked delight in confronting self-righteous respectability and outraging the priggish and the convention-bound. The story opens with him dressed in a silver lurex 'Tina Turner number', designer stubble and Docs accompanied by Grace in a 'tasteful yellow shift with big, bold flowers on it', 'shopping' (shoplifting) in Grace Bros, Broadway. While onlookers were 'too busy pretending not to notice the frocks to actually notice what he was up to' Pointy was hiding 'little luxuries' under the 'twelve pairs of assorted second hand' underpants in his bag.

Camp humour is one way in which Dunne creates a sense of community and belonging. Matt has nursed his partner John through terminal AIDS and, infected himself, commits suicide. The grief of Matt's gay and lesbian friends at the discovery of his death and at his funeral contrasts with the denial and hypocrisy of his family (29-30). Matt's funeral illustrates the betrayal of personal identity that compounds the experience of disease for people suffering from AIDS:

There are two types of AIDS funerals, the ones where 'it' is mentioned and the rest. We knew this was going to be one of the second type and there wasn't much we could do about it. . . .
The service had a generic quality to it. It could have been anyone's. (29)

When a young cousin refers to AIDS, Matt's mother pointedly ignores him, to remark on the weather. The 'bland' respectable funeral is contrasted with the wake held by Matt's friends and hosted by 'a very demanding retired transvestite glamour star' and 'an equally demanding lipstick lesbian' (30). The wake resonates with feeling – grief and quirky humour – and serves as a genuine tribute to Matt. Grace and others spend a long day packing Matt's things and cleaning his flat, while his brothers (who had never visited him during his illness) come 'to collect the TV, the fridge, the heater and anything else of value' and nigger about giving old furniture to the 'HIV-pos kid' in the flat downstairs. The coldness of family and their refusal to accept Matt on his own terms highlight the solidarity of the gay and lesbian community. This episode illustrates one of the chief therapeutic functions that the novel performs: it asserts identity on behalf of those for whom diagnosis with AIDS entails stigma and denial of personhood by mainstream society.

The novel also asserts independence and individuality against medical authority. The benefits of medical technology and the support services provided by the health system are not denied. However the gay community resists medicalisation and transforms the medical discourse into its own terms. Nursed at home Pointy needs medication through a porta-cath in his chest. Grace performs the elaborate clinical ritual of sterilisation with a solemn

theatricality that blurs into parody: ‘I never realised until we started regularly hanging around hospitals and doctors, just how much modern medicine is based on theatrics’ (75). A ‘post modern drip stand’ welded from scrap metal by an artistic friend replaces the standard hospital pole to carry Pointy’s infusion bag and serves as symbol for his appropriation of the medical discourse. Throughout the novel medical authority is unsettled by its translation into the terms of queer. Prescription medications are combined with or swapped for street drugs. At the hospice the ‘only staff [Pointy] really trusts are a couple of lesbian nurses who know when to call his bluff’ (60), and Grace’s own ‘favourite nurse’ is ‘an angelic gay boy who isn’t burnt out despite three years in the front line.’ (92). The novel’s parodic and irreverent transformations of the medical process do not imply rejection of what medicine can offer in treatment and palliation, but refuse its hegemony. Dunne appropriates medical discourse with witty irreverence, subverting it to affirm the identity of his characters. Camp humour deflects sentimentality and self-pity, and serves as ironic affirmation of community. This novel introduces the subject of HIV/AIDS writing and its therapeutic possibilities. In the following section I will outline medical and epidemiological data and theoretical perspectives on AIDS as a background for the analysis of a selection of narratives dealing with HIV illness.

HIV/AIDS – medical and epidemiological overview

Since AIDS ‘crashed into public consciousness’ (Stewart 2) some twenty years ago, there have been major shifts in the clinical presentation, treatment and prognosis of this disease. In Managing HIV Graeme Stewart gives an excellent summary of the pathophysiology, epidemiology, clinical spectrum and treatment of HIV/AIDS and provides a broad social perspective. Infection with the human immunodeficiency virus, HIV, causes progressive suppression of the immune system. Lowered immune competence is defined and tracked in the laboratory by the falling count of T-lymphocytes, CD4 cells, and marked clinically by increasing susceptibility to unusual infections and cancers. Progression to AIDS is identified in terms of ‘AIDS defining illnesses’ such as *Pneumocystis carinii* pneumonia (PCP) and Kaposi’s

sarcoma, which emerge as the body's immune response is severely reduced. Dementia, psychological disorders, neurological deficits and profound wasting are commonly part of advanced AIDS. Death results from marked debilitation, malignancy or overwhelming infection. Suicide and assisted suicide are relatively common causes of death in people with AIDS (Stewart 161).

In the developed world, AIDS was first diagnosed in homosexual men, and the 'epidemic spread in the large gay communities of the major western cities' (Stewart 2). Initially AIDS was considered a disease that primarily occurred in Western countries and mainly affected gay men, drug users and prostitutes, but it is now recognised as a disease which predominantly affects the developing world, with heterosexual sex the most common mode of transmission (Carr 14). In sub-Saharan Africa, the Caribbean and large parts of Asia, HIV/AIDS is a disease of the general population and contracted most commonly by heterosexual intercourse and mother to child transmission during pregnancy. The epidemic in developing countries is associated with poverty, social disruption and population shift from rural to urban areas, and high levels of prostitution related to these cultural patterns.

In Western countries, AIDS quickly became 'supercharged' with moral and cultural meaning:

In the Western world, HIV was instantly associated with homosexuality, despite the fact that a heterosexual epidemic was already well established in Africa. It was also associated with promiscuity, illicit drug use and hence with socially "deviant" behaviour.

Rarely is a disease supercharged with such strong social significance. (Stewart 2)

Data from the Annual Surveillance Report 2003 of the National Centre in HIV Epidemiology and Clinical Research (NCHECR) shows that in Australia the proportion of people infected with HIV (67 per 100,000) is low on a global scale. There were 13,120 people living with HIV in Australia by the end of the year 2002 (5). Transmission continues to occur primarily through sexual contact between men: about 85% of cases surveyed were contracted through male homosexual contact (5). In Australia, HIV/AIDS continues to be associated predominantly with the gay male community, and secondarily with intravenous drug users.

Since the first cases of AIDS were identified in the USA in 1981, the clinical patterns and prognosis of the disease have shifted with the advent of antiretroviral drugs, as described in Hoy and Lewin's comprehensive manual HIV Management in Australasia. At the start of the epidemic cases were diagnosed at an advanced stage, when the infected person was already

afflicted with rare cancers or infections, and the disease was rapidly fatal. The virus responsible for the condition was identified in 1983 and tests to reveal whether a person was infected with HIV became available the following year. Epidemiological surveys mapping the progression and time course of infection gave an overall prognosis of ten to twelve years from contracting the virus to developing AIDS, and twelve to eighteen months from the onset of AIDS to death. The Annual Surveillance Report 2003 demonstrates that newer therapies have prolonged the average survival time from the onset of AIDS to about three years. More dramatically, treatment of an HIV infected person with a combination of anti-retroviral drugs can delay the progression from viral infection (HIV positive) to AIDS for thirty years, and perhaps indefinitely. These drugs are expensive, and have unpleasant and potentially serious side effects. The person on treatment must be constantly monitored. Antiretroviral treatment is available for most infected people in affluent countries including Australia, but not for the vast majority in poorer countries. Thus the implication of HIV infection has shifted, for the 'privileged', from a prospect of inexorable decline towards debilitating illness and death within about ten years, to a chronic infection, a state of relative clinical wellness at the cost of continuous medical surveillance and multi-drug treatment, with treatment and surveillance both providing a constant 'memento mori'.

In Australia, even before the advent of anti-retroviral drugs, efforts to limit the spread of HIV infection were effective and this has been attributed in large part to the commitment and solidarity of the gay community (Carr 17). This community was already organised through gay rights activism to combat prejudice and discrimination, and partnership between gay organisations, the medical profession and politicians was significant in controlling the epidemic (Stewart 2). Stewart argues that the HIV epidemic 'challenged the competence of medical science' and demonstrated to doctors 'the advantages of having patients empowered to make fully informed decisions' (2). There are clear parallels between Stewart's conclusions about the impact of AIDS on the politics of health, and therapeutic elements demonstrated in Shadows on the Dance Floor. He identifies destabilisation of medical authority, a shift in power between patient and doctor and a translation of medical discourse into

the terms of the gay community as significant consequences of the epidemic. He indicates the importance of affirming the autonomy of the patient against both social prejudice and medical hegemony, and underscores the value of community in confronting an illness that is associated with cultural stereotypes and moral judgements.

Annamarie Jagose argues that the AIDS epidemic and the increase in homophobia that it brought about generated an upsurge not only in radical gay activism but also in theorising about gender (Queer Theory 93-6). She identifies several ways in which AIDS has influenced understandings of identity, sexuality and power (94). There has been wider recognition of the importance of the discourse itself, unstated assumptions embedded in language, in determining the ways we depict and respond to HIV/AIDS. One effect of AIDS that demanded a change in thinking was the 'persistent misrecognition of AIDS as a gay disease and of homosexuality as a kind of fatality'. Another effect was a shift in emphasis – in safe sex campaigns for instance – from sexual identities to sexual practices. AIDS activism has drawn on coalition politics: AIDS activists include gay men, bisexuals and transsexuals, parents and friends of gays, sex workers and health workers. Coalition politics reconceptualizes identity in terms of affinity rather than essence. AIDS writing from within the queer community tends to resist dichotomised constructions of gender and sexuality, it blurs and reconfigures boundaries between gay and straight, and between gender identities. These shifts in the public discourse carry therapeutic potential by resisting stereotyping and stigma, and promoting inclusiveness.

Couser devotes one section of his study of auto/biographical narratives of illness, Recovering Bodies, to the analysis of AIDS stories. He explores how autopathography can challenge cultural stigmatisation of illness: with regard to AIDS, the identification of illness with moral depravity and 'deviant' behaviour. Autopathography can also resist depersonalisation and disempowerment of the patient by the dominant biomedical discourse. Couser argues that 'discourse theory grants to individuals – disabled or not – the ability to subject language – terms, tropes, conventional scripts – to scrutiny

and revision' (216). Disease and disability, along with other marginalised positionings, are 'prescribed' by the cultural norms, they 'can invoke . . . particular "master plots"'. Illness writing provides the possibility of 'rewriting the old scripts'. AIDS narratives may, for example, employ 'transgressive strategies that disrupt or reverse stigma' (216).

Although AIDS narratives can unsettle stereotypes, Couser demonstrates that they may reinscribe dominant scripts and perpetuate notions of blame and guilt surrounding illness and homosexuality, when affliction with AIDS is attributed to a personal flaw or deviant lifestyle. He argues that such accounts 'tend to perpetuate the mystification and moralization of illness' (113). These include 'conversion narratives' and 'reaffiliation narratives' (168-9). In the conversion narrative, HIV/AIDS diagnosis leads the person to enrol in some religious or spiritual 'master plot', either traditional Christian or 'new age' mysticism. The homosexual identity and lifestyle are repudiated as evil or misguided. Memoirs by a mother, sister or other close relative (family narratives) can be 'normalising' in so far as they position the homosexual person with AIDS in a 'normal' family relationship, but may at the same time deny his meaningful relationships in the gay community. Narratives that exempt the person with AIDS from blame and dissociate him (or her) from the stigmatised group (the 'innocent victim' such as the haemophiliac or unsuspecting wife of an infected man) may, intentionally or not, reinforce marginalizing and blame-ridden inscriptions. Couser argues strongly in support of his contention that all such narratives 'as illness discourse tend to be retrograde' (113).

By contrast, affirmative strategies in AIDS narratives contest these various marginalizing discourses. One strategy identified by Couser in Recovering Bodies is the representation of the gay community in its larger life. The community is not just a backdrop to illness but a site of collective engagement with the epidemic. Such accounts repudiate guilt and secrecy and take gay identity and lifestyle for granted, needing no apology (156). Metaphors may be used in ways that subvert the dominant: for example portraying a man with AIDS and his lover as romantic warrior heroes opposes

constructions of the homosexual with AIDS as a victim, passive and effeminate (158). Other accounts appropriate the biomedical discourse in order to demystify AIDS and place its cause with the virus rather than with personal 'flaw' or 'deviant' lifestyle (145).

Choice of texts: AIDS and homosexuality

One important qualification that Couser notes in his analysis of AIDS autopathography is the lack of typicality and representativeness in AIDS narratives. Issues of power, privilege and wealth influence whose story gets written and whose account is published. Many of the narratives available represent gay men, and published stories are especially unrepresentative of the poor and of intravenous drug users. They do not reflect the heterosexual pattern of the infection, with its marked correlates of race and poverty both in the USA and globally. The male homosexual writers of AIDS narratives are usually affluent and well-educated, often in positions of privilege and power in their own culture and even more so from a global perspective. Poor, illiterate African women who are HIV positive, for example, are in a position of marked powerlessness. Their stories are not represented in Couser's analysis.

My choice of texts is also selective, and does not attempt to be representative of the spectrum of AIDS as it affects populations worldwide. In the following section of this chapter I will examine a number of predominantly Australian texts that deal with HIV/AIDS. I have chosen to focus mainly on texts written about AIDS in gay men (April Fool's Day is the exception) for a number of reasons. In Australia, HIV/AIDS remains predominantly an infection of gay men, and the greatest literary response has been from gay writers. AIDS has had a marked impact on the cultural and literary community in Australia, through the illness and deaths of prominent writers, artists, performers and intellectuals (Altman 146). The HIV/AIDS epidemic has

impelled an artistic and cultural response from the gay community. Their response becomes a form of therapeutic endeavour, individual and communal.

The interplay between homosexuality and AIDS bears on the themes of illness and marginalisation, and the relationship between illness as a biological entity and the cultural and political meanings that are inscribed onto it. Homosexuality was removed from the American Psychiatric Association classification as a mental illness only a few years before AIDS appeared and was labelled 'the gay disease'. The popular conflation of AIDS with homosexuality is a continuation of the process of stigmatisation, of seeing homosexuality itself as 'a kind of fatality' (Jagose 94). The prevalence of homophobia in Australian society has strongly inflected cultural responses to HIV/AIDS, the experience of being infected, and AIDS narratives. Writing that deals with HIV/AIDS from the perspective of the gay community serves as a model for illness narratives as counter discourse. The gay community's response to the epidemic has challenged medical autonomy and shifted the balance of power towards the patient and community groups. In a similar way, therapeutic narratives of HIV/AIDS from within the gay community, while not representative of the global spectrum of the disease, do represent the therapeutic function of challenging disempowerment and stigma wherever the patient is positioned.

Bryce Courtenay April Fool's Day

Unknowingly, I was standing at...the beginning of twenty-four years of a great river of anger and frustration at the arrogance, the careless disregard for feelings and the patronising manner of the Australian medical profession. (40)

Bryce Courtenay's memoir is a forthright, journalistic account of his son Damon's illness with haemophilia and AIDS, and death from AIDS. One of the central motifs is an indictment of the medical world – individual doctors, the health care bureaucracy and the medical discourse – as authoritarian, arrogant and dehumanising. April Fool's Day exemplifies Couser's contention about whose story gets written and published. Bryce Courtenay was already a best-selling author when the memoir was published in 1993: he is in a relatively privileged position to have his voice heard as he tells his son's story. Yet throughout the account, Courtenay's helplessness in the face of medical arrogance is striking, not only when, as father of haemophiliac baby Damon in 1967, he was still an unknown advertising executive, but even twenty-four years later when he was a recognised writer with wealth and influential contacts. The

account forms a critique of medical hegemony, and the impotence of a man of Courtenay's status highlights the force of medical authority.

Damon's story is grounded in the body, the insistent presence of chronic disability:

by the age of seven his little body was pretty badly beaten up. His left leg was shorter than the right, badly atrophied and permanently damaged with the knee almost completely fused so that it gave him only very limited movement. His left arm was the same, permanently locked at the elbow. . . . From constant bleeding all his joints were damaged and arthritis was beginning to set in, bringing him a good deal of additional pain. (100)

The physical and mental deterioration of AIDS is bluntly depicted.

Courtenay's memoir opens with Damon's death, a vivid description of terminal bodily decay:

Celeste . . . dressed his bedsores, swabbed the thick yellow crusted thrush from his lips and the inside of his mouth and the pus from his conjunctive eyes. She . . . cleaned up when he was incontinent and dressed his shingles . . . (4)

The body is in the foreground of the account, from baby Damon's joint bleeds requiring intravenous Factor VIII infusions three or four times a week, to the end-stage of AIDS. At the same time the narrative attests Damon's resilience and lack of self-pity despite living in this frail and constraining body.

Courtenay avoids both denial and sentimentality; his matter of fact recognition of embodied disability serves a therapeutic function as it accommodates and demystifies chronic illness.

Damon's suffering and the distress of his family is compounded by the failures of the medical profession. April Fool's Day is an indictment of the shortcomings of medical authority, especially its disempowerment of the patient and his family. Damon's paediatrician, nicknamed by the family 'Sir Splutter Grunt', is patronising and arrogant. His dehumanising attitude is exemplified by the 'reassurance' he offers, having told Bryce and Benita of their son's diagnosis in an 'direct and no-nonsense manner':

'You may be assured I'll keep my eye on the boy. Haemophiliacs are not that common and a classic haemophiliac with virtually no clotting factor whatsoever, well, it's a bit of a find really. The pathology is damned interesting.' (42)

Courtenay concludes the account of Damon's childhood as a haemophiliac with the remark: 'it was becoming harder and harder not to see ourselves as the victims of an uncaring system' (101). After Damon was diagnosed with AIDS, the family encountered 'a new level of incompetence and . . . ignorance' in the medical profession. Courtenay criticises 'a bureaucratic and reactionary hospital system' and doctors who are 'socially inept . . . superior, careless in their human relations . . . stubborn old men who wield enormous and unreasonable power' (100-1). Damon was one of the first of the haemophiliacs in Australia to develop AIDS (he was diagnosed in 1984). At the time the health profession was 'on a learning curve' (353) and the family encountered ignorance and fear within the health system. In one instance, two male nurses come into Damon's room in hospital shortly after his diagnosis with full-blown AIDS:

gloved and gowned on the pretence of attending to him; then they simply stood by his bed and called him a 'fucking poofta' and 'turd burglar' whereupon they left. (351)

In a later episode, Damon's psychiatric scheduling with mania (a manifestation of AIDS) on Boxing Day 1989, although justified (his wild behaviour endangering himself) demonstrates the family's helplessness and frustration in the face of bureaucracy and of inept doctors. Despite all Courtenay's influence and efforts to have his son appropriately treated, Damon is shunted from one hospital department to another, roughly manhandled and finally incarcerated in a closed ward at Rozelle psychiatric hospital, alone and terrified.

April Fool's Day provides a strongly worded critique of medical hegemony. It exposes the disempowerment and depersonalisation that frequently characterise Damon's relationship with the medical world. The polemic is sometimes overstated, the account lacks distancing irony and does not have the light touch provided by Gary Dunne's playful wit. Even so Courtenay's bluntness has impact, and his direct, compelling style makes this an accessible narrative in the public arena. He concludes that his 'anger' in writing is directed at the 'callousness and complacency' of the medical bureaucracy towards AIDS. This attitude 'mirrored the ambivalent attitude

society immediately adopted towards this disease when it was stereotyped as a homosexual affliction' (598). April Fool's Day is an attempt to demystify AIDS and to counter prejudice and stigma as well as medical arrogance by presenting the human story of an individual, and his family, affected by AIDS.

Armistead Maupin Tales of the City

Maupin's Tales of the City sequence has a large following in the general community as well as the gay community. The six novels are international bestsellers, and have become the basis of three television miniseries. Maupin uses playful humour to unsettle rigid categorisations. He affirms queer identities and builds a sense of community and belonging, yet the world of the Tales is inclusive, embracing other marginalised groups and the 'mainstream' as both subject and audience. When AIDS appears in the narrative midway through the series, it is incorporated into Maupin's comic and inclusive perspective in a way that has powerful therapeutic impact as counter discourse.

The sequence is characterised by its comic vision and its project of inclusiveness. Maupin discusses these aspects of his fiction in an interview with Richard Canning (Canning Gay Fiction Speaks). He addresses the way in which the appearance of AIDS inflected his writing and problematised what was 'basically a comedic story.' He was 'determined' not to stop the sequence when 'AIDS came along midway through the series . . . because I didn't want to seem as if I was retreating from the epidemic. I certainly wasn't in my own life' (159). Canning suggests that humour in writing about AIDS may be legitimate (only) if the author is HIV-positive himself, provoking Maupin to ask 'You mean whether it's impertinent on my part to be funny about AIDS, when I myself am not antibody-positive?' (159). His response is that it is 'the job of the writer to be empathetic with others . . . Any writer who really wants to test the limits does not avoid writing about an experience that's not his own' (160). Maupin has faced the reality of AIDS through the illness and death of many of his friends, and his own partner is positive – so he is not standing on the outside. However the writing itself provides the strongest answer to this question – Maupin's comic vision and humour function not to trivialise AIDS but to seek a therapeutic response.

Maupin's perspective is broadly inclusive. In the interview with Canning he admits the tragedy of AIDS, and comments in particular that it took its greatest toll of the 'brightest, and finest' and the most defiant of the gay community, people 'who were sexually comfortable with themselves, and therefore more adventurous' (174). However he also recognises that 'to assume that we are the only people on the planet with problems is to let the drama queen in you take over too much' noting that, for example, 'There were women dying of breast cancer at the same time that men were dying of AIDS' (174). This viewpoint is characteristic: he insists that he stands not just as a gay man, but as 'an intelligent thinking person' (160) and his inclusive view permeates his writing. Canning suggests that some critics see as romantic and 'utopian' Maupin's narrative world, in which queer and 'mainstream' identities are equally accepted (163). However as Maupin proclaims, part of his project is to explore 'outsiderness' in a broad way, looking at gender, disability and racial identity as well as sexual identity (163). There are limits to his inclusiveness, but outside the boundaries are hypocrisy and predatory coldness, not difference (Maupin is, for example, harsh on 'pedophilic sexuality' and 'stylish closet cases' 174). As Canning suggests, the 'villains' are characterised by 'deceit and exploitation – the opposite of those qualities the Tales seem to uphold: openness, honesty, truthfulness' (174). One of the therapeutic aspects of the Tales is just this achievement of inclusiveness: the writing contests marginalisation and stigmatisation, celebrates difference and creates a sense of community based on shared values rather than shared sexual identity. AIDS is confronted within the 'democratic' and affirmative frame that Maupin has set up from the start of the sequence.

The series spans more than a decade, from 1975 to 1988. AIDS appears in the fourth novel, *Babycakes*, set in 1982. In the fictionalised San Francisco that is Maupin's 'city' the norms of mainstream America are inverted. Queer characters – gay, transsexual and bisexual – predominate. Maupin's comedy, with its elements of farce as well as verbal wit, builds a sense of the carefree, celebratory mood of the 1970s, when many gay people in America were proclaiming their sexuality with pride. Michael Tolliver is the character at the heart of the series and it is his experience, his 'dilemma' of

how to live as a gay man, that holds together the sequence, spanning the celebratory ‘before AIDS’ era and the stricken ‘after’. Michael’s sexual affinity is exclusively homosexual but his capacity for friendship is broadly embracing. He is an engaging man, raunchy, vulnerable and kind. In the early stories he cruises gay bars and dances in jocks on a bar counter, befriends the lonely newcomer Mary Ann, and ‘comes out’ to his parents in a moving plea for acceptance. After AIDS he confronts tragedy and risk with resilience, compassion and irrepressible gusto for living. While Michael is a somewhat idealised representative of Maupin’s ‘democratic’ vision of humanity, a host of other characters broaden the picture – including a minority who are straight. Characters not only shift between sexual affinities and even gender roles, but also unsettle stereotypes of class, social status and race. Mrs Madrigal, the motherly landlady who cares for her ‘family’ of young tenants, was once a man and is biological father, not mother, to Mona. Her transsexual status is not revealed in the first novel, so that her identity as a woman is strongly established, and her sexuality as an older woman (she is aged sixty-five in the last novel) is emphasised throughout the series. Wilfred, whom Michael meets while visiting London (Babycakes), is a streetwise gay sixteen-year old squatting in a shabby flat – and as it happens, an Aboriginal Australian. In the same story Michael is befriended by a midget who challenges notions of disability – witty and tough, she is a former actress, one-time nanny and now a manicurist (with the British monarch among her clients). Maupin creates a narrative world that revels in diversity and eccentricity, one where ‘outsiderness’ is a badge of membership.

In this setting AIDS appears in the narrative as it did in life – unanticipated, breaking into and transforming individual lives, the gay community and the discourse and politics of queer identity. Maupin incorporates HIV/AIDS into his tales from a perspective that takes the gay lifestyle for granted. Babycakes and the following two novels reflect the impact of the epidemic on the gay community: the initial ignorance and fear, the stigma, the beginnings of AIDS activism and the communal effort to overcome public apathy and hostility. Michael counsels on the AIDS hotline, comforts friends – gay and straight – in their perplexity and grief, nurses his lover Jon through the terminal stages of AIDS and faces his own diagnosis as HIV positive. Although the tone of the series darkens with AIDS, the zany comedy persists. Maupin uses ironic humour to create a sense of belonging through shared understanding. Condoms become a motif that signal responsibility and caring, but they are also intrusive reminders of the sex/death nexus. A group of gay men quip about changes in the meaning of condoms: before AIDS they were officially ‘for prevention of disease

only' but in practice were used for contraception. Now, superseded by more effective forms of contraception, they are indeed being used for prevention of disease – but in homosexual encounters: an ironic reversal in both respects. There is dark play on the word 'breeders' – a derisive term used by gays for heterosexuals. Condoms prevent 'breeding' (babies), but now gays are stigmatised as 'breeders' in another sense – breeders of disease (Babycakes 55-6).

Comical devices subvert stigma and hostility. In an episode in Sure of You, set in 1988 (when homophobic reaction to the 'gay disease' ran high), anti-gay vilification is neatly turned against the attackers. Two youths board a bus on which Thack and his friend Brian are riding, shouting provocative insults:

'You catch AIDS and you die like a fuckin' dog.' He was moving towards the back now, brandishing the acronym like a switchblade. 'Watcha think? Any *faggots* on this bus?' (Sure of You 95)

Thack, the ardent gay activist, raises his hand with 'bored assurance' – then a 'stout young black woman', then two 'older guys' raise their hands. One after another more passengers join in, until the young troublemakers ('slack-mouthed . . . at a loss') are humiliated by laughter 'rumbling from one end of the bus to the other.' Maupin's humour claims the possibility of a healing community. Gay and straight, young and old, black and white, the passengers are united in discomforting the attackers. While applauding openness and honesty, this scene admits the reality of homophobia in wider American society: it ends with Thack saying ruefully, "Don't try it in New Jersey" and Brian replies "New Jersey, hell. You could get killed doing that" (95).

Maupin places great value on the sense of belonging that the gay community can foster, but also demonstrates the importance of connection to the broader society and to family. One therapeutic response to HIV/AIDS is to show the possibility of understanding and reconciliation between a family and the son who has been rejected or become estranged as a result of his homosexuality. In Sure of You Michael renews contact with his mother, Alice. He is prompted to do this by his partner, Thack, who can see that Alice, despite her conservative outlook ("She's against everything you stand for," Michael tells him) is "trying her damndest to hook up" (35-6). Michael responds to his mother's overtures, but (in a letter to her) affirms that the gay

community is now his true family: ‘I . . . believe in families just as much as you do. I have one of my own and it means the world to me’ (271). In contrast to Alice, Eula, the mother of an HIV-positive man is a vivacious seventy-year-old who has moved from a small town to be near her son in San Francisco when he becomes sick with AIDS. She embraces the queer scene enthusiastically. She becomes an habitu  of gay theme bars (going alone when she can’t persuade her son to accompany her), dancing with lesbians and young gay men and whooping it up at Bare Chest Contests and gay Pageants – “‘She knows more queers than I do’” avers her son (Sure of You 75). Eula is a comical emblem for a redefinition of family ties in response to AIDS. A transgressive parent like Eula may be exceptional, part of Maupin’s ‘utopian’ dream, but Maupin asserts the possibility of forgiveness and reconciliation even where parent and son remain divided in their fundamental convictions as Michael and Alice do.

There are limitations in Maupin’s comic approach to AIDS. He does not confront physical illness directly as Courtenay and Dunne do: bodily deterioration and death occur ‘offstage’ and most central characters who are HIV positive, Michael in particular, remain well. The timespan of the sequence (roughly contiguous with the actual time of writing) moves from the early AIDS epidemic, when a diagnosis nearly always meant death within a few years, towards the advent of anti-retroviral treatment, when ‘living with HIV’ became a reality. In the interview with Richard Canning, Maupin reflects:

we have moved into another era. My own partner Terry Anderson thought he was going to die for ten years. When protease inhibitors came along he realized that he wasn’t going to die right away . . .
[Michael Tolliver] is not dead. He tested positive at the same time Terry did, and Terry’s still here. . . .
. . . some are living; some are dead – and you are in the midst of it. That’s what living with AIDS meant from the very beginning: turning to the moment.
(Canning 169)

One way in which Maupin maintains a comic structure in the sequence is by ‘turning to the moment’, a strategy that is the more effective in that it continues the sense of *joie de vivre* that informs the earlier novels. In Sure of You Michael (HIV positive but well) has a beeper to remind him to take his

preventive medication every four hours. The beeper represents living with disease: it stands both for the hope of remaining healthy and as reminder of mortality. It repeatedly brings attention back to the present moment – going off while Michael is walking the dog, watching television snuggled up with his lover, or working in his plant nursery. It symbolises living with the virus as against being defeated by it. It is also the focus of jokes and camaraderie in the face of communal threat. In one episode Michael is sitting in a gay bar, and his beeper goes off as his drink arrives. The bartender comments, ‘Another bionic man,’ and the man seated beside Michael says ‘I’m due to go off any second.’ Michael (washing his pills down with the beer) quips, ‘Last night at *Big Business*, there were enough to start a symphony’ (Sure of You 73). Like condoms in the early days of AIDS, the beeper becomes a sign of membership and community solidarity in confronting the epidemic.

Other United States novelists, including Edmund White (The Farewell Symphony) and Allan Gurganus (Plays Well with Others), also introduce HIV/AIDS in the context of a predominantly gay community. These writers, like Maupin, take gay lifestyle as a given, requiring neither explanation nor defence. They depict the qualities of the queer community – creative energy, eccentricity and self-reflective irony, solidarity and supportiveness – as the backdrop to the devastation of the AIDS epidemic. The depiction of a vital, cohesive community heightens the sense of tragic loss, but affirms identity and contests the stigmatisation of AIDS as the ‘gay disease’ and homosexuality itself as an affliction. Maupin’s writing exemplifies a body of writing that is ‘therapeutic’ by countering discourses that mark AIDS with guilt and shame.

Equally, many Australian writers dealing with AIDS convey the vigour and solidarity of the queer community. Anthologies of gay or queer writing such as the annual Outrage short story collection, communal rather than individual works, reflect co-operation as well as the diverse literary output from queer culture. Gay writers like Dunne demonstrate the possibility of broad inclusiveness in their writing and in their world, with central (and likeable) characters including women (lesbian or straight), older people and straight men. While foregrounding their own community and the significance

of belonging, they avoid reinscribing dominant/subordinate hierarchies. In terms of the 'reverse-discourse strategies' identified by Jonathan Dollimore these writers perform a 'transgressive subversion', they 'destabilise and displace the binary, to destroy at base the categories responsible for one's exclusion' (Sexual Dissidence 226). Writing that unsettles dichotomised categories allows the possibility of a radical challenge to marginalisation.

Dennis Altman The Comfort of Men

Dennis Altman is a political scientist and prominent gay activist. He writes analytically on the theory, history and politics of the gay subculture, and the impact of AIDS. His essay on cultural responses to HIV/AIDS (Gott 139-74), for example, is a balanced discussion of the effects of AIDS within the gay communities of the Western world in the perspective of the wider global epidemic. Altman's fiction reflects his academic background, the style often suggesting a work of political and cultural history. The Comfort of Men lacks the ironic distance and witty subversions that Dunne, Maupin and Dessaix (below) display. The novel has more similarities to Courtenay's account, with a focus on direct telling, and obvious polemical intent.

James is dying of AIDS while the narrator, his partner Steven, is HIV negative. The narrative is roughly framed as Steven telling James his life story. As AIDS writing this is oblique: the novel does not set out to be an account of illness. However it does have a therapeutic intention: Altman suggests that storytelling has the function of distancing illness, even – in the manner of Scheherezade – of deferring death:

As [James] grew sicker I took leave from work to spend time with him, and as he grew weaker he clung to the story of my life as if it were a lifeline keeping him afloat. (157)

The novel has elements of political satire – fictitious events such as Tasmania's secession from the Commonwealth are a commentary on the parochial and conservative socio-cultural milieu. Altman's account of growing up in the 1960s as a homosexual in Tasmania (the last state to decriminalise consensual sex between men) is grounded in the detail of time and place. It

recreates the social and political climate of post-war Australia, a time when the 'White Australia' immigration policy and allegiance to the British monarchy dominated foreign affairs, when the conservative Liberal party of Robert Menzies was entrenched in federal parliament, when indigenous Australians were outcasts on the fringes of white Australia, when women were encouraged to remain in the home, and homosexuality was a criminal offence. Steven tells how he broke free from this constricting background and from the guilt and shame that it fostered over his homosexual affinity. Steven's story becomes part of the upsurge of radical, humanist politics in the 1970s – the women's movement, Aboriginal rights and gay pride – as he is swept into political awareness and action.

The Comfort of Men performs a therapeutic function in that it embodies an affirmative sense of community. It shows the growth of solidarity and pride, and a gay activism that sought first to contest stigma and oppression. The gay community later used its basis of organisation and power to confront the AIDS epidemic. Altman's account works within its limits, but does not go beyond polemic. It lacks the playful twist, the irony that can transform the story of illness.

Timothy Conigrave Holding the Man

'It's Denise. I've just heard you guys . . . have AIDS . . .'

I heard her blow her nose. I thought she was crying. 'This is terrible. I love you guys.' She blew her nose again. 'I'm sorry.'

'Don't apologise. We're going to be all right.'

I rang Morna. 'When you tell people, could you ask them to fall apart elsewhere? I'm finding it too draining. I end up counselling them and I don't have the energy at the moment.' (217)

On coming home after being hospitalised with *Pneumocystis carinii* pneumonia, Tim not only has to face the fact that his HIV infection has progressed to AIDS but must also deal with the grief and shock of one friend

after another – ironically, it is he who comforts them. This episode exemplifies what Conigrave did through gay activism and his work as playwright and actor, and particularly in writing Holding the Man . While confronting his own illness he provided healing for others: those infected with HIV, for their lovers, families, and the wider community.

Timothy Conigrave and his partner John Caleo tested positive in 1985. John died in 1992 and Conigrave in 1994 at the age of thirty-five, a few weeks after completing Holding the Man . Conigrave writes as a member of a community reeling from the epidemic, infected himself, and caring for a lover through his final illness. One theme running through the memoir is the therapeutic power that narrative held for Conigrave himself. The account cites instances where films, plays or documentaries about AIDS enabled him and his friends to confront their dilemma, talk about their fear and grief, or tell family and friends of their HIV status:

John and I saw Alex Harding’s play *Blood and Honour*. Michael, a Chinese boy, watches his lover Colin, a newsreader, being crushed by AIDS but slowly growing to acceptance . . .

John was crying by the end, and I was choking back tears. We drove to Bondi Beach and walked along the damp sand . . .

Talking to him about my fears, my anger, was not easy . . . But the play had given me courage.

‘Do you think you are going to die from AIDS?’

‘Probably.’

‘How does it feel?’

‘Scary.’ (202-3)

Conigrave could be seen as representative of the gay community’s best response to AIDS. He is out and proud, athletic, good-looking and a successful actor, he maintains a lasting relationship with his boyhood lover and close links to his family and heterosexual friends. His individual story is darkened by the communal tragedy of AIDS. Conigrave threw himself into the campaign against the epidemic even as he and John became sicker. He worked on the AIDS hotline and with the AIDS Council Fun and Esteem group (a group for young gay men). As an actor and playwright Conigrave turned naturally to drama as one way of grappling with the impact of AIDS. He initiated the theatre project Soft Targets that aimed to raise awareness of the epidemic, resist shame and allow communal grieving. He wrote two plays that

deal with death and with homosexual identity, Thieving Boy and Like Stars in my Hands. His last work, Holding the Man was a bestseller throughout 1995 and a screen version is planned.²⁹ The book's popularity suggests that it struck a chord in a community already struggling against discrimination and now facing the tragedy of epidemic disease: that it carried a measure of healing, just as other narratives had done for its author.

Holding the Man places illness with AIDS in the context of larger, meaningful lives. The account validates the love as well as the lifestyle that Tim Conigrave and John Caleo shared, and questions master narratives (such as church and family) where they dismiss or condemn the lives of gay men. John's family surround his homosexuality, as well as AIDS, with secrecy and shame. Their attitude to his death and funeral recalls Dunne's 'two types of AIDS funerals, the ones where "it" is mentioned and the rest' (Shadows on the Dance Floor 29). Conigrave is distressed by the behaviour of John's father: "He treats me like I'm not there. It's like he's trying to reclaim John from the dirty poofter who corrupted him. All this stuff about not mentioning 'gay' or AIDS at the funeral" (274). Silence at the funeral is a recurring motif of denial in AIDS writing. The strongest healing function that Conigrave's narrative performs is its resistance to denial through assertion of gay identity.

The background that Conigrave creates unsettles discourses that place the heterosexual family centrally and denigrate other models. In his narrative homosexual lifestyle has a place in the wider community of church and family. The Jesuit priests at Xavier College (Conigrave's school) are tolerant. Some of the teachers are markedly supportive. Brenton in particular is frank about his own sexuality and choice to be celibate (88, 99). Brenton listens to Tim's concerns about his sexual preference, helps allay his parents' anxieties and shows respect for Tim's commitment to John. At John's funeral, another priest, Father Wood, pays tribute to Tim and John's other gay friends, in contrast to the antagonism that John's father displays (274, 283). Conigrave's depiction of Catholic priests like Brenton and Wood shows that, alongside

²⁹ An adaptation for screen is currently being written by Tony Ayres, screenwriter and editor, who was a friend of Conigrave and helped bring his plays to the stage posthumously.

condemnation of homosexuality, attitudes of broad inclusiveness exist within the Church. He draws on contradictions and ambivalences within the Catholic community and the Catholic discourse itself to disarm religious authority.

The depiction of the gay community and of Tim's own day to day life in Holding the Man has the effect of 'normalising' the lifestyle. Conigrave gives a multifaceted view that includes the commonplace of classroom, school sports, domestic life and workplace, as well as the theatre and political and social action groups. Tim and John are shown squabbling with brothers and sisters, camping in the bush, horsing around with friends, setting up house together. Tim describes his arduous training as an actor at NIDA , John sets up a small private business as a chiropracter.

Conigrave's forthright account also demystifies gay sexuality and brings it into a broader narrative. He reveals his own naïveté in the candid descriptions of his early sexual experiences, his first attempts at anal intercourse and casual encounters outside the relationship with John. In his work at the AIDS Council he is sometimes startled by the stories of addicts and sex workers. Tim's relationship with John is presented as a conventional love story, from its beginning in schoolboy awkwardness, to later episodes of separation and reconciliation, and committed care in terminal illness. The element of romantic innocence validates their love by bringing it into a wider cultural narrative. The narrative of romantic love resists shame ridden constructions of AIDS as the consequence of depravity.

Conigrave does not use romance to sanitise the reality of embodied disease. He gives detailed descriptions of the manifestations of AIDS, such as the sweats, racking cough and delirium of pneumonia, the headaches and visual impairment of cerebral toxoplasmosis; he depicts vividly John's terminal deterioration. He is candid about his disgust at the bodily evidence of disease. He recoils from the sight of John's wasted buttocks: '*His bum looks like two skin flaps. A rush of revulsion went up my spine*' (242) and deplores his own fat gain with corticosteroids: '*I caught sight of a chubby white body. Nice fat white bum? I was looking in the mirror*' (249). Embodiment,

foregrounded by illness and disability, impinges on fundamental meanings and puts to question the nature of love:

He started undressing me and kissing my hard-on. I undressed him, revealing his skeletal body, his skin hanging loose. I tried hard not to let him see that I was shocked. I hugged him and we rolled around the bed naked, his [naso-gastric] tube swinging and getting caught up in our bodies. (246)

At John's suggestion he and Tim have anal sex after John comes home from hospital, shortly before his death. Afterwards, Conigrave sees this as '*such a gift, giving of himself. I love him for it*' (247). Anal intercourse is a form of gay sex strongly associated with AIDS, but here it is transfigured into a symbol of John's generosity and love. Conigrave counters his dismay and disgust at bodily deterioration by direct confrontation, in physical caring as well as sexual closeness. He nurses and cleans his lover, finally washing and laying out John's body after death:

We pulled the blanket back, revealing his ravaged body. There was a small turd sitting between his legs. Peter picked it up in a tissue and threw it into a contaminated-waste bin. We started to bathe him, caressing his body with sponges. It was a chance to say goodbye. I had a strong desire to kiss his penis but was well aware that Bob was crashing around the room putting everything into plastic bags. (275-6)

The preoccupation with contamination shown by John's father (Bob) suggests hostility that encompasses John's homosexuality as well as AIDS. It has a depersonalising effect, in contrast to the tenderness of the other men. Their actions show acceptance of embodiment and give dignity to the dead man.

As well as confronting bodily decay, Conigrave appropriates and demystifies the medical discourse. Both he and John accept what conventional medicine can offer. John in particular is eager to take any chance of combating disease, including chemotherapy and radiotherapy with their severe side effects, and high-risk surgery on his lung. Conigrave gives details of investigations and medical treatments. He translates technical jargon into colloquial language, for example explaining that toxoplasmosis is a germ one gets from 'cat poo.' Explanations of procedures, such as the multiple attempts at pleurodesis of John's collapsed lung, are given in layman's terminology. Medical treatments are presented from the patient's perspective. John's experience of pleurodesis is painful and frustrating as one attempt after another fails. In several instances the account critiques Medicine for its

shortfalls, as when an anaesthetist gives John a brusque warning about the risk of death from an anaesthetic for lung surgery in his frail condition (240). Conigrave's account challenges the hegemony of Medicine by giving a place to alternative therapies, such as the anti-fungal diet and meditation class, which the men use in conjunction with standard medical treatments. John himself is a chiropractor, representing a skill at the fringe of conventional Medical practice. Conigrave draws alternative therapies into the broader field of medical care, and shows that Medicine itself is limited, unable to cure AIDS or do more finally than offer palliation and deferment of death. While not rejecting the medical discourse, the narrative unsettles its authority by revealing its limitations, 'translating' its jargon and technology into familiar words, and foregrounding the experience and story of the patient.

Robert Dessaix

The candour and 'innocent' romance of Conigrave's memoir form a contrast to the erudite wit, playfulness and ambiguities that characterise Robert Dessaix's writing. Dessaix himself blurs boundaries and resists categorisation. On one hand, he is a respected and influential academic (he taught Russian at the Australian National University for many years), critic and broadcaster with the ABC. He is a well-known author. As a white, male intellectual, he is in a position of privilege and authority in contemporary Australian society. In other respects, he stands in positions of marginality and stigma: illegitimacy, homosexuality and HIV positive status. In the autobiographical account of his quest to find his birth mother, *A Mother's Disgrace*, Dessaix begins by showing how his 'voice' as a writer is identified with a sense of vulnerability and shame. In the first chapter he tells the story of 'finding a voice' after his abduction and threat with murder by sinister youths in Cairo. Following this experience of humiliation and abject terror – 'who'd ever have thought, that I'd end up naked and shit-smear'd on a Cairo rubbish dump?' (6) – he at once began to write. The resulting account resonates with ambivalence: the 'disgrace' implied by secrecy troubles Dessaix's record of reunion with his mother and personal success.

As an AIDS writer, Dessaix represents an intersection between the elitism of the 'Academy' (as former University academic, and critic) and the accessibility reflected in his radio broadcasting and speaking in the public domain. The 'voice' in his fiction and critical writings shifts between an engaging intimacy and frankness on one hand, and formality and 'literariness' on the other. As a literary critic Dessaix has written extensively on politico-cultural themes (including marginality), gay writing and AIDS writing. He comes to the writing of AIDS narrative with a broad knowledge of literature, the arts and political and cultural debates. His critical perspective, as I will outline below, is that AIDS writing can be 'good literature' (although it often is not) and his own fiction and life writing aspire to this standard. Given that this is Dessaix's position, it is worth asking, with respect to AIDS narratives, what relationship there is between literary merit and therapeutic function.

I would argue that the literary quality of Dessaix's AIDS writing does perform a therapeutic function. The motif of AIDS, including personal affliction with HIV, can subserve literary and artistic purpose. For Dessaix, finding a voice, a confiding voice that can express vulnerability, becomes important not simply to tell and validate his own experience of illness, but to follow broader literary quests. HIV (as theme and as personal experience) is an impetus for artistic endeavour, for playfulness, for the creation of skilfully contrived, aesthetic works. He uses the AIDS motif to grapple with issues of ethics and meaning, what makes 'a good life'. The writing moves beyond a personal account of affliction and represents the therapeutic function of rescripting illness into a larger narrative. For Dessaix, the larger narrative is artistic tradition.

In the Introduction to Outrage Short Stories 1993 Dessaix applauds literary cleverness and mischief. He confesses to a certain elitism that finds delight in a shared cultural heritage, a 'wider conversation' and looks for writing to play tricks with literary tradition:

The more disobedient the story, the more, on the whole, I liked it.

I really preferred the stories which presumed some kind of culture, some understanding of genres and the games you can play with them, some shared reading . . . And then played tricks on me. That's the art of seduction. (iv-v)

The essay 'Death to Art' published in the collection (and so forth) encompasses many of Dessaix's critical perspectives on queer and AIDS writing. These notions provide a key to the ways in which he seeks in his own fiction to turn the illness motif to literary purpose, and how he thus effects a healing transformation. Dessaix applauds writing that is adventurous, playful and subversive. He suggests that AIDS writing is more powerful when it takes an oblique approach as opposed to direct 'representation', 'political statement' or exhortation:

artistic imaginations . . . bubbling over with new and illuminating representations of AIDS, new charades (in the creative, playful sense) for us to interpret, unthought-of narratives haring off in unexplored directions – sentimental, droll, unemotional, outlandish, spiritual, mocking, touching, abrasive, all full of exploding landmines of meanings about living and dying at the end of the twentieth century. (288-9)

He seeks intellectual challenge, aesthetic impact and emotional tension: 'art rewards . . . your intellectual questioning and the play of your aesthetic responses . . . it's demanding, contradictory, complex, anxious and unresolved' (284). Emotional ambivalence and multi-layered meaning can be conveyed through powerful metaphor: 'the explosion of meaning each image ignites' (285). Writing that deals with AIDS is inevitably concerned with sexuality and death and the connections between them: the 'death and sex nexus' (274). AIDS arouses issues of moral responsibility, blame and innocence, that Dessaix claims cannot be encompassed within the 'moral arithmetic . . . the old-style maths, based on Christianity'. Dessaix looks to the AIDS motif to provoke 'parody', 'blurring' of fixed categories, and questioning of established certainties. While self-confident biomedical and political voices might 'control the discourse', the writing that he values is characterised by 'polyphony, ambiguity, symbolic complexity and some knowledge of cultural traditions' (290).

Night Letters

Night Letters could well be described using Dessaix's own terms: 'playful', 'unthought-of narratives haring off in unexplored directions',

‘exploding landmines of meanings about living and dying at the end of the twentieth century’. The novel makes playful use of its erudite material. It is constructed from a diverse collection of narratives, linked by their common concern with death, eros and meaning. It draws upon literary and cultural traditions to explore ‘meanings about living and dying at the end of the twentieth century’. While Night Letters does not function as polemic it enters the public debate on AIDS as a work of literature, reaching towards the critical standards that Dessaix himself has proclaimed for AIDS writing. It functions as therapeutic narrative by rewriting illness into the wider narrative of literary heritage.

The narrator’s diagnosis as HIV positive is the starting point for the novel, but after the opening chapter his HIV status recedes to a silent presence in the background. Robert’s letters tell of a journey impelled by the fatal diagnosis, encompassing encounters and stories that deal in various ways with the theme of death and what it means to live. This tangential use of the AIDS trope, as a way of embarking on a search for understanding, performs a different type of therapeutic function than that shown in the other texts discussed. Dessaix avoids direct political statement and polemic such as that illustrated by Courtenay’s account. The gay community with its healing sense of belonging and support, central to the work of writers like Dunne, Maupin and Conigrave, is relegated to the background. The legitimacy of a gay lifestyle is assumed: Dessaix represents as commonplace the fact that the narrator is a gay man living in a stable ‘marriage’ with his partner. He takes for granted their place in the wider society and in this way poses a counter to normative assumptions about gender and sexuality.

Night Letters gives the impression of being confidingly, even intimately autobiographical. Dessaix presents the consultations at which his doctor gives Robert the HIV diagnosis, and subsequent conversations with his partner Peter (5-11, 103-111) as if transposing these scenes directly from his ‘real’ life. He gives an ironical commentary on the gym class for HIV positive men in which he takes part:

Everyone has such conflicting ideas about how to live when mortality's breathing on the back of your neck.

Take our gym group, for example. . . . I'd expected a more sensitive, feeling atmosphere, a kind of slightly mawkish bravery. No one here is being brave. They're just living and some of them with a certain panache. Half of us might be dead by Christmas, but there's Jamie on Knee Extension gabbling into his mobile phone, legs jerking stiffly up and down, there's Carl on Bench Press straining to lift and lower, lift and lower to the beat of the Village People (191-2)

These episodes carry a compelling sense of candour, suggesting that Robert and the writer are one, but the novel's concern with artifice and façade puts personal revelation in doubt.³⁰ The epigraph for A Mother's Disgrace, 'I'm telling you stories. Trust me', applies equally to Night Letters. There is tension between disclosure and façade, a deliberate blurring of the boundary between autobiographical candour and make-believe. The effect is a text that embodies notions of narrative identity and narrative meaning: we exist in and make sense of our experience through the stories we tell and the narrative identity we create. Thus 'narrative truth' is the basis for Dessaix's therapeutic endeavour – illness, AIDS, the threat of death and the search for meaning are confronted through narrative.

Alongside the intimate, confiding 'autobiographical' episodes and reflections in Night Letters are erudite, self-consciously 'literary' elements. The novel incorporates intertextual story-telling, anecdotes, legends, historical accounts both 'real' and fictitious, passages of literary commentary and critique and encounters with real authors including Patricia Highsmith and Salman Rushdie. Dessaix 'plays games' with genre and the cultural tradition. In many respects the story parallels Thomas Mann's Death in Venice, but whereas Mann is sombre, Dessaix is playful and inversive, in both the large scale and the small detail of Night Letters. Dessaix takes Mann's images and uses them ironically: Mann's 'tiger' becomes the leopard (or lion) that stalks Robert's dreams; von Aschenbach's 'angel' becomes a quiet, understated

³⁰ The pompous 'editor' of Night Letters places the reader at one remove from the narrator, the writer of the letters. Ironically the 'editor' is fictitious while the narrator of the letters seems to be identified with the actual Robert Dessaix. The effect is to problematise the whole question of authorship, and autobiography as distinct from fiction. That the 'editor' is Russian may be a play on Dessaix's academic background as teacher and critic of Russian literature - now his personal story is 'edited' by a Russian pedant.

Chinese doctor wearing 'a neatly pressed shirt' who gives Robert the news of his HIV diagnosis – 'Nor were his tidings a blessing' (5). While the homosexual pursuits of Mann's von Aschenbach are sinister and secretive, Dessaix's corresponding German professor, Eschenbaum, is the author of a controversial scholarly work on paedophilia. Such literary mischief occurs throughout Night Letters. Dessaix uses Eschenbaum as a device for satirising post modern notions of 'truth', 'self' and the body (150-1). The professor does not believe in 'truth' or the self, so on holidays he is 'wicked', indulging himself in erotic adventures in a space where 'truth exists', 'the body is not a book to be written in . . . but a self to be lived out' – 'it's balm to my soul, in which I also don't believe.' The 'wickedness' lies in the violation of his philosophical position that sexual adventuring implies rather than in the activity itself. Ironically as Robert listens to Eschenbaum's academic whimsy, the 'reality' of the body is underscored by his HIV status, the result of his own erotic 'adventures' (15).

Dessaix reworks Mann's central allegory linking Eros, artistic creativity and death. For Mann's hero, artistic endeavour becomes equated with Dionysian erotic abandonment and a courting of death. The letter writer of Dessaix's novel is impelled by his diagnosis with HIV to confront the probability of his own death and to explore what makes life meaningful. Both novels show a link between sex and death – Mann's writer remains, fatally, in the plague infested city due to his obsession with a beautiful youth; the writer of the 'night letters' has become (fatally) infected through sexual 'adventures' (15). The diverse episodes and narratives of the novel in turn confront, defer, flirt with or defy death, and point to connections between aesthetics, Eros and death.

Night Letters also carries allusions to Dante. Dessaix draws parallels between the narrator's plight, and Dante's journeys in Inferno and Purgatory. The allusions are a source of play on narratives from mediaeval Christian tradition, the possibility of an afterlife, notions of heaven and hell, questions of suffering and cruelty, guilt and punishment. These allusions, and others to the rich tradition of religious art in Italian cities, give ironic perspectives on the

‘master narrative’ of Christianity and the strong tradition that represents suffering and death through art. Dessaix draws on the cultural heritage for his literary play. His use is ironic and self-conscious, delighting in its own cleverness and artifice, as he plays multiple variations on the theme of illness and of mortality. The writer’s HIV diagnosis, the AIDS trope, is transformed and transcended into a work of exuberant ‘literariness’ and this transformation serves as answer to illness, as healing.

Night Letters ‘resonates’ with ambivalence and tension (to adopt another of Dessaix’s own critical benchmarks). There is a transgressive subtext of violence in the novel. Sadism and savagery are often present ironically, in darkly comic narratives. The pack rape of the courtesan Camilla is brutal and disgusting, yet is an ironic comment on her self-indulgence and ‘use’ of men for her own ends – and on her mother’s callous pandering. This intertextual tale also makes the recurring link between sex and danger, sex and cruelty. In another example, the multiple horrific deaths in ‘the story of the amulet’ become a parody, mocking the repetitive violence and sadism of oriental legends, but this tale too implies that savagery and death are an inescapable face of Eros and Aesthetics – sex and art. The exotic, the erotic and the cruel in this novel are set against the ordinary and mundane – toast and honey, bus timetables and broken suitcases, the small comforts of good wine and good plumbing. Dessaix suggests that there is a dark underside to everyday life: the letters are from the ‘night side’ of life, disease and death, (a reference to Susan Sontag’s Illness as Metaphor). Defiantly confronted, even courted, this element of darkness and danger can intensify experience and heighten the artist’s creative insight. Eros and Aesthetics, sex and art, are paths to living fully (as opposed to mere existing) but are necessarily associated with risk. Peter tells Robert, in respect of his diagnosis with HIV, ““You chose to have adventures. . . . You wouldn’t have wanted to live your life without those adventures”” (15).

A key metaphor in Night Letters is the lion. The writer describes a dream that recurs after his HIV diagnosis, a dream in which he is ‘running through the jungle’ stalked by a ‘prowling cat’. He faces the terrible dilemma

of whether to turn and fight heroically, to certain death, or to run – and still be caught and torn apart. Night Letters records the journeying – geographical, psychological and metaphysical – that uncovers (and embodies) a third alternative:

the choice I thought I had between bravely facing the lion (and letting it tear me to pieces) and keeping on running. Fighting or fleeing . . . in this dream, I neither faced the lion nor kept on running - I leapt onto its back, stuck a hat on my head and rode off on it. Yes, it's true, with my heart in my mouth, but also with true exaltation. And I meant these letters to you to be part of that exaltation. (271-2)

Writing Night Letters ('these letters to you') is part of the 'exaltation'.

Narrative is one way of riding the lion, embracing danger to live defiantly in the moment.

Chapter 7 Strong Voices, Strong People³¹

Indigenous narratives of illness

'My Mum she's blind she's now asleep
she'll wake up soon
the fact of it
she won't go nowhere
but the bed
Commission said no house
Not fit
Or Black or something and...'
He said
'the dogs live better in this land
and we'd do better dead
my Mum she's blind'
he said. ('Mum' Kevin Gilbert Inside Black Australia 191-2)

Aboriginal poetry is at once 'poetry as therapy' and 'poetry as political weapon – as a hand-grenade' (McDermott 272). Kevin Gilbert's picture of the blind old woman living in a fringe shanty is a bleak image of hopelessness in a community where illness is inseparable from marginalisation – and healing often requires political expression of outrage. In Aboriginal narratives of illness, there is no clear boundary between private pain and public experience, and the healing thrust of these narratives is bound up with their political intent. Blindness and nowhere to go mark present and future as equally blank, but Gilbert uses the 'hand-grenade' of protest to resist entrapment.

The preceding chapters have shown an overall shift in emphasis from the personal to the public function of narrative. From Philip Hodgins, finding a voice to explore his experience of leukaemia and the prospect of death, through writing on ageing and dementia, to women's illness and HIV/AIDS, the perspective has widened from the personal experience of illness to encompass the patient's membership of a group that is stigmatised or subordinated. As cultural constructions and social marginalisation play a greater part in the meaning of illness for individuals, so resistance to stigma and disempowerment becomes more significant as a healing element in their

³¹ 'Strong' is a word used frequently in Aboriginal health promotion, as for example in 'Strong Women, Strong Babies.' In the health context it underlines the link between empowerment and well-being.

illness narratives. In this final chapter I discuss work by indigenous authors. While it is often difficult to separate illness from wider themes of loss and grief in these texts, I have chosen writing where physical and mental illness is a key concern. In these illness narratives subversive political engagement becomes a major element and therapeutic endeavour shades into polemic.

In the Introduction to Paperbark (Davis et al 1990) the editors characterise Aboriginal writing as having a dominant political and communal function.³² Aboriginal writers give voice to the oppression and suffering of Aboriginal people and seek to resist subordination through protest and affirmation of pride. Humour is used to subvert the dominant culture and build a sense of belonging. Aboriginal writers assert that their work is inseparable from political activism: ‘Aboriginal literature . . . has never been divorced from the Aboriginal struggle for economic freedom, legal recognition and reforms of basic living conditions’ (Davis and Hodge 2). Their writing often embodies communal rather than individualistic expression: ‘a *community gesture* towards freedom and survival, rather than the self-expression of an individual author’ (3). Oodgeroo Noonuccal (Kath Walker) considered her poetry to be the voice of the Aboriginal people, ‘a cry for help’ (Davidson 429). Many indigenous writers have been involved in political activism and Aboriginal controlled community projects, from the tent embassy and freedom rides of the 1970s, through ongoing campaigns for land rights and apology, to Aboriginal medical and legal services. Penny Van Toorn, in an overview of Aboriginal writing, comments that ‘the emergence of Aboriginal literature in the 1960s and 1970s was part of this entrance of the Aboriginal people onto the national political stage’ (Webby 2000 29). Teaching, public speaking, theatre and performance are part of the spectrum of communal assertion and solidarity in which Aboriginal writers participate.

Kevin Gilbert, in the Introduction to the anthology Inside Black Australia, emphasises that Aboriginal poetry reflects the history of wrongs

³² Authorship of the Introduction is not specified. I make the assumption that the views expressed represent those of the editors, Jack Davis, Mudrooroo Narogin, Stephen Muecke and Adam Shoemaker.

done to Aboriginal people by white settlers ('this poetry has been carved indelibly in blood over the past 200 years') as well as the 'continuing brutality, the national lies, the callous indifference to Black human life . . . today' (xix). Gilbert's refusal of the Human Rights Award because of the shocking state of Aboriginal health and living conditions (Narogin 208) aptly symbolises the crucial link between literature and politics in Aboriginal narratives of illness.

For indigenous people, poor health is just one thread in a narrative of fragmentation and loss. Health problems are inseparable from the historical and political context – the destruction of traditional societies, lifestyle and cultures. Aboriginal health is affected by material factors such as poverty and poor housing, but it is also undermined by cultural breakdown and social marginalisation. Life on the fringe, often impoverished and chaotic, puts health at risk, and a damaging lifestyle is compounded by discriminatory and punitive responses from the wider community. For Aboriginal people, positioning on the fringe of society is associated with loss of identity and pride. Therapeutic endeavour for indigenous people is inseparable from the quest for empowerment. Practical measures to deal with health problems are indispensable, but to be effective they must be accompanied by changes in the discourse: affirmation of identity and control. Greater Aboriginal agency in the political arena is demonstrated in recognition of traditional land rights and in Aboriginal ownership of community organisations such as legal offices, employment services and health centres. A discourse of pride and empowerment is also expressed through the cultural fabric – sport and community celebrations, festivals and ceremonies, oral histories and testimonies, popular music, dance and theatre, stories and poems.

There has been some debate, in the field of cultural studies, if not within health care and medicine, about who has the right to speak about or on behalf of indigenous people and the issues that affect them (Dalziell 114). In examining works by indigenous authors as part of an exploration of 'therapeutic narrative' I do not speak for the authors (any more than for other writers I discuss). However, publication of a text implies that it is accessible to a wider audience, and open to individual responses and readings (inflected as

these must be by the reader's cultural and personal history). Many texts by indigenous authors confront illness in interesting and provocative ways, and perform a healing function. My attempt to demonstrate therapeutic strategies in these texts is not an appropriation of the writing: my intention is to honour the authority as well as the achievement of the writers.

Overview of Indigenous Health – an Aboriginal Perspective

The survey of indigenous health documented in Aboriginal Primary Health Care: An Evidence-based Approach (Couzos and Murray) was a co-operative project between indigenous and non-indigenous workers, community groups, and professional bodies (iii-v). The text incorporates an Aboriginal perspective and provides an excellent overview of indigenous health with attention to the importance of the social context. The thrust of the survey is that 'Aboriginal people suffer the worst health of any identifiable group in Australia' (12) and the text provides detailed documentation for its conclusion. Average life expectancy is about twenty years less for indigenous men and women than for the Australian population overall. In a global perspective, statistics on life expectancy and other indicators of health status for indigenous Australians are comparable with those of the poorest countries in the world. Furthermore, health statistics 'obscure the true impact of excess mortality. What is remarkable is the excess contribution to mortality of young and middle-aged Aboriginal adults' (17).³³ High and premature mortality has a devastating effect on Aboriginal communities:

In effect, the last generation still familiar with traditional and transitional rural Aboriginal life prior to the ravages of urbanisation and alcohol has been devastated.

So common is the experience of premature death and its impact on community and family life that the funeral has become a central community activity and families have to be regularly reconfigured to absorb the losses. Where death is so common there is an expectation of mortality which strips the community of that essential ingredient for success – optimism. (17-18)

The funeral as a 'central community activity' echoes a motif found in AIDS writing, and is a telling image for a community under threat. The funeral

³³ For example, age-standardised death rates in W.A. in 1990-94 were about six times higher for Aboriginal adults aged 30-49 compared to the non-Aboriginal rate (Couzos and Murray 17).

motif occurs in many of the works of indigenous writers. Colin Tatz, whose study of Aboriginal suicide is discussed below, recognises the central place of the funeral in the life narratives of Aboriginal youth:

These youngsters do not read articles about their poor life expectation, but they do attend, from a very early age, an astonishing number of funerals of young relatives. In most towns in this study, one funeral a week would be the norm, the deceased often being a young victim of disease, accident or violence. (Tatz 104)

Aboriginal Primary Health Care documents in detail specific health problems that contribute to excess and premature mortality, and to the burden of chronic illness and disability. These conditions include diabetes, high blood pressure and heart disease, kidney disease and renal failure, chronic and recurrent ear infections and hearing impairment, eye disease and visual impairment, skin diseases and sexually transmitted diseases. There are high rates of trauma and of hazardous drug and alcohol use. Specific risk factors for disease and injury that are more prevalent amongst indigenous groups include alcohol, smoking, obesity, poor nutrition and inactivity. Throughout the text the authors demonstrate that high rates of illness and risk interlock with the cultural context. Poor health and lowered life expectancy are associated with poverty and unemployment, with fringe-dwelling and discrimination, with loss of cultural and community traditions, with despair and hopelessness.

Aboriginal community involvement and ownership is crucial in providing effective health care for indigenous people. Binanj Goonj: Bridging Cultures in Aboriginal Health (Eckermann et al) is an education manual written in collaboration by a team of Aboriginal and non-Aboriginal people that aims ‘to familiarise non-Aboriginal health workers . . . with the distinctive needs and aspirations of Aboriginal people living in rural Australia’ (1). It outlines the historical background of cultural destruction and demonstrates that Aboriginal health is inseparable from social inequities in employment, housing and education, and wider issues such as racism and land rights. Its central theme is the need, in this political context, for Aboriginal agency in addressing health problems. An Aboriginal person is often in a position of powerlessness and dependency, which compounds the entrenched relationship of power and authority between doctor (or other health service provider) and Aboriginal

patient (159). This has reduced the ability of Aborigines to access mainstream health services. A sense of self-worth on the part of Aboriginal clients and health workers (in conjunction with white respect for Aboriginal values) is fundamental to the success of health programs (117). The traditional Aboriginal view of health is holistic, and inseparable from belonging to a communal group, as opposed to the individualistic and biomedical focus of the Western medical tradition (125, 167, 174).

Historically, in the 1970s Aboriginal political will and community participation mobilised resources to develop health services based on principles of self-determination, accessibility and the needs of the community as a whole (Eckermann et al 173-211). The authors of Binanj Goonj argue that ‘Aboriginal/ Islander controlled medical services provide more effective primary and preventive health care to Aboriginal people’ than do mainstream health services (183). This view is supported by research evidence in government papers such as the Commonwealth Department of Health and Aged Care’s 2001 publication Better Health Care – Studies in the successful delivery of health care for Aboriginal and Torres Strait Islander Australians. The document enumerates examples of successful health care projects in which Aboriginal input and control have been key factors in identifying problems and providing solutions that are effective. In A Healing Place: Indigenous Visions for Personal Empowerment and Community Recovery Kayleen Hazlehurst gives an account of research and experience with Aboriginal community groups tackling problems of excessive use of alcohol, sexual assault, child abuse and domestic violence. Her report highlights the importance of breaking the silence and taking responsibility, and the effectiveness of community empowerment.

Community empowerment is essential in the political process of providing effective health services. The shift from a position of helplessness and dependency to one of agency and pride is equally crucial in the broader discourse of illness and healing for Aboriginal people. The power of narrative to bring about this shift through public testimony is demonstrated by the ‘stolen generations’ narratives. The data on Aboriginal health presented above

gives scientific and sociological perspectives on the links between illness and cultural discourse, healing and empowerment, for Aboriginal communities. The testimonies of the 'stolen generations' demonstrate the central role of narrative in healing a community ravaged by loss (Whitlock 2001). The 'Bringing Them Home' report, tabled in Australian Federal Parliament in May 1997, is the account of a national enquiry by the Australian Human Rights and Equal Opportunity Commission into the forcible removal of indigenous children from their families from 1910 to 1970. The public impact of the report and its power for bringing about reconciliation and healing can be attributed in part to its narrative basis. The Commission listened to over five hundred personal stories and had access to another thousand or so in written form, and the report combines analysis with first-person testimonies throughout. The Chair of the Commission, Ronald Wilson, attested that 'telling and listening to these stories was profoundly therapeutic, the beginning of a healing process for those who spoke' (Whitlock 1999). Whitlock identifies some of the key ways in which these narratives performed the function of healing. She points to the importance of the listener as witness to the trauma and shame of the teller, paralleled by recognition of the listener's implication and responsibility in the 'ruthlessness' of racism. Whitlock's analysis suggests that the narratives bring into question the unspoken assumptions (of racial inferiority) that marginalise and 'shame' the tellers. A central part of the healing power of these narratives lies in their subversion of 'dominant ways of thinking about history, identity, and race'. These elements – testimony and witness of trauma, subversion of the shaming narratives of inferiority, and empowerment through a new story – identified by Whitlock as significant for healing in stories of racial trauma, are central therapeutic elements in Aboriginal narratives of illness also. In the following section I discuss three texts that highlight the link between cultural breakdown and illness in Aboriginal communities and in which the narrative demonstrates healing possibilities: Colin Tatz's study of Aboriginal suicide, Kim Scott's novel True Country and Melissa Lucashenko's Steam Pigs.

Colin Tatz Aboriginal Suicide is Different

The Aboriginal health education officer in Narooma . . . describes . . . people living on the edge, who engage police in car chases, or who drink and then climb cliffs, the 'kids who have no care about tomorrow'. Many others have endorsed this perception of '*kids who don't necessarily want to be dead but don't want to be in life either*'. In both Kempsey and Taree, there is evidence of young people, especially girls, running in front of trucks at night. (103-4)

At Menindee in the far west, an 18-year-old hanged himself in the local park. He had mugged a kindly old lady and believed that she had died. She had not. Since his death, three Aboriginal men meet at the cemetery to visit the grave. One, aged 15, has attempted suicide; one, aged 25, is heavily sedated on Prozac and other anti-depressants (he persistently burns himself with cigarettes); and the other is a 28-year-old who has tried hanging himself six times. With a carton of beer, they commune with their dead friend: each drinks one beer, and they pour one onto the grave mound for the deceased, until a sense of communion is achieved. I talked individually and at length with each man, and believe, as do their parents, that they will probably suicide before long. (105)

Colin Tatz' report presents a grim picture of the social destruction and cultural vacuum that lie behind suicide and attempted suicide among Aboriginal youth. In his three-year field study Tatz used 'anthropological' methodology: in-depth interviewing rather than mere collection of statistical data. The narratives of individuals are central to understanding the self-destructive behaviour that he explores (50). Tatz interviewed over two hundred Aboriginal people: most were working in Aboriginal agencies, some had attempted suicide, some were family members and friends of attempted or successful suicides.³⁴ The report can be seen as a scientific document but also as a narrative. It rests upon the stories of individuals and communities, and it tells the larger narrative of a people who have lost tradition, social structure and sense of self-worth, and of a generation who feel their lives to be without meaning or value.

³⁴ Although Tatz is speaking 'on behalf of' Aboriginal people in telling the story of Aboriginal youth suicide, he does so with the endorsement of Aboriginal people and community organisations. His relationship with the Aboriginal people whom he interviewed is described as one of 'trusting rapport' (53) – he and his wife Sandra (co-interviewer) 'presented as middle-aged grandparents' and had earned credibility in 'some 38 years of working in Aboriginal societies' (51). Their efforts to maintain rapport rested on confidentiality and patience in listening. Individuals and community groups 'almost without exception', were 'eager' to respond to Tatz, and often requested further group meetings with him.

Australia has a high rate of youth suicide and the rate amongst indigenous youth is several times higher again: 'In 1990-91, Australia had the world's fourth highest rate of male and female youth suicide' with Aboriginal rates 'probably between two and five times the non-Aboriginal' (1). Tatz's research places the origins of the 'staggering' leap in self-destructive behaviour in a social and political context. He reviews a catalogue of historical (and continuing) injustices. The roots of cultural breakdown include historical genocide, dispossession, slavery, forced relocations and tribal breakdown; discrimination and lack of basic rights; the stolen generations; and short-sighted and 'lazy' approaches by governments and bureaucrats to 'decolonisation' with, for example, new Aboriginal 'communities' being created in the structural and cultural vacuum of former reserves.³⁵ The effects of these historical and cultural factors have been loss of meaning, self-esteem and identity.

Therapeutic strategies must take account of this political and cultural nexus. Tatz insists that 'the present medical and "mental health" approach, which so often seeks to "pathologise" Aboriginal youth suicide, will not succeed'. The 'social and political context of this violent behaviour' must be 'appreciated and . . . absorbed into intervention strategies' (55). The implications of Tatz's study, and his proposals for healing, aimed at rebuilding pride in identity and community, correspond to some of the therapeutic functions that I will demonstrate in Aboriginal writing: recognition and ownership of problems and empowerment through public statement.

³⁵ Narratives of denial perpetuate the injustice of the past and militate against healing narratives. Tatz presents other 'narratives' that have perpetuated the denials implicit in 'colonisation' – in particular, the efforts by the Howard government to minimise the 'Stolen Generations' report, and its refusal to make public apology. Tatz critiques Prime Minister John Howard's attempts to retell the narrative of white racism: Howard has made a 'systematic campaign against the "black armband" interpretation of Australian history . . . he requests that syllabuses be rewritten to accommodate his view.' While the Governor General, Sir William Deane, recognised (Australia Day 1997) that 'the past . . . is absorbed into the present and future', Howard showed a wish to deny the shaping narrative of the past: 'Australia should not be "perpetually apologising for sins of the past."' (19)

Kim Scott True Country³⁶

Kim Scott has both Aboriginal and white ancestry, and has worked as a teacher in remote Aboriginal communities. *Karnama* is a realistic depiction of an Aboriginal settlement in Western Australia, based on one where Scott taught. Billy Storey, the central character in the novel, comes to *Karnama* to teach, but also to hear its stories and to explore his own Aboriginal roots. The account bridges traditional culture and post-colonial reality. It records the multiple losses and destructions that have shaped the community as it is at the time of the story. The voices of Aboriginal elders, placed alongside Billy's perceptions, link the narrative to the old traditions, the spiritual life and the culture of their ancestors. Their tradition includes a magical or (to white understanding) supernatural component that defies western scientific explanation. In the novel magical events include the spirit possession of the black child Beatrice and her healing by traditional medicine after city doctors have failed to diagnose her illness.

Scott is direct in his depiction of social problems, speaking from within the community as one mourning its losses, not as a critical outsider. Aspects of the degradation that he portrays in *Karnama* are alcohol abuse and petrol sniffing, idleness, gambling, domestic violence and neglect of children. He shows the despair associated with lack of meaningful employment and depicts an ironic travesty of traditional occupations in activities such as hunting kangaroos by running them down with a four-wheel drive. Aboriginal guardianship and conservation of the land is undermined, and the land is degraded by the use of white man's machines and weapons: off-road vehicles, guns and uncontrolled fires are destroying plants and animals and eroding the landscape. Along with failure of care for the land is loss of respect for the secret knowledge and experience of the elders. This is reflected in a breakdown of the family: drunken men beat up their wives, children wander unsupervised late at night and arrive at school sleepy and unfed in the morning; young people form sexual liaisons across forbidden skin lines, adults

³⁶ The title comes from a song by rock group Midnight Oil. The significance of popular music and especially its element of protest for Aboriginal audiences is discussed below.

neglect the sick old people. Community breakdown is also evident in the corruption and nepotism that Billy sees pervading the town. Scott's bleak portrait of social disintegration forms the context for the illness in the community – from alcohol and drug abuse, depression and suicide, to the children's chronic ear infections and deafness. True Country is a fictionalised account of the same social breakdown, the same nexus of illness and despair, described by Tatz in his study of Aboriginal suicide.

Scott's writing, uncompromising and grim, has therapeutic functions. One is ownership: recognition of the problems that corrode indigenous communities, recognition that Aboriginal people themselves must resist and reverse their degradation. Scott goes beyond ownership of problems to suggest the possibility of new constructions of Aboriginal identity and community. Elements of traditional culture and wisdom can be combined with western knowledge and technology to rebuild a sense of meaning and of pride. The elders who retain traditional spiritual knowledge and power may use these within a western dominated society, as they do in healing Beatrice, whose illness mystifies Western doctors. Gabriella and Billy, younger city-educated Aboriginals, move between the cultures and incorporate aspects of both in their identity. They return to their community to teach and to demonstrate a new story – the possibility of resistance to stigma and degradation, the possibility of a wider future. True Country, combining traditional mythology and culture with present-day realism, bridges the gulf between Kim Scott's own diverse cultural heritages. His realistic account, bleak though it is, comes from within the Aboriginal community. It resists taking a victim position of helplessness and dependency and instead points to the need for Aboriginal people to confront the cultural breakdown that underlies illness. True Country points a way towards healing through ownership and empowerment.

Melissa Lucashenko Steam Pigs

Melissa Lucashenko is another Aboriginal writer who portrays the problems of social breakdown and attempts to show ways towards healing. She is one of many Aboriginal women who are speaking out about domestic violence and child abuse. Her fiction, aimed at young adult readers, expresses pride in Aboriginal identity together with a denouncement of domestic violence. Despite her indigenous focus, Lucashenko does not confine her critique to the Aboriginal community. In Steam Pigs she shows that domestic violence and child abuse are part of a larger pattern of cultural and family breakdown, inseparable from health problems that include drug and alcohol abuse, depression and suicide among indigenous people and in the wider community. She depicts in Aboriginal and non-Aboriginal men a pattern of frustration and loss of self-worth that often leads to heavy drinking, impulsive violence and abuse.

Set mainly in Brisbane, the novel has a contemporary urban background that is familiar and relevant for many young readers. The story is fast-moving and the language colloquial and streetwise. Lucashenko portrays the rough streets and bars, casual sex and recreational use of ganja (marijuana) as commonplace background to the daily lives of her characters. She uses this setting for a sharp indictment of child neglect and male violence and a strong message to women to assert themselves. The novel's humour, its frankness about tough issues and its depiction of contemporary lifestyles make it relevant and empowering for young readers.

The story line is straightforward and has a clear polemic intent. Sue, a seventeen year old Murri girl, becomes involved in an affair in which her boyfriend repeatedly bashes her. Roger, like Sue, has both Murri and 'white' ancestry – in his case Islander and Irish. He is clever and good-looking but drinks heavily and becomes violent when drunk. With the help of young lesbians from a women's support group, Sue finds the self-confidence to leave Roger and later to brave the intimidating world of university. In Sue, Lucashenko creates a strong Murri girl. She is attractive and athletic, and

works at gruelling karate classes to keep fit and self-disciplined. She is resilient despite all the difficulties that drag her down: as a child she suffered her father's beltings and her mother's alcoholism; now her brother makes constant demands on her. He is often unemployed, he drinks too much, and his children are neglected and abused by his new partner. An episode where Sue plays with these little nephews at the beach captures her youthful vigour and optimism, as well as her caring nature. Sue represents the possibility of a new 'hybrid' identity: she is proud of her Murri ancestry and she values attributes and cultural traditions from both Murri and white forebears. She sees her good looks, golden skin and athletic body as Murri, she feels ties to traditional land and loyalty to her family, but she also sees as important the responsibility of a regular job and the intellectual heritage represented by university education.

The therapeutic achievements of this novel for young readers lie in its frankness about emotive issues, its affirmation of pride in Aboriginal identity and the model of self-reliance it provides for indigenous women. The sense of Aboriginal identity and strength carried by the text is enhanced rather than undermined by its directness about difficult issues. The novel depicts drunkenness, violence and abuse towards women and children with a clear message. The perpetrator may be white or black, the causes of violence against children and women often lie with cultural breakdown and disempowerment, but the abuse must never be excused or hidden. Women must assert themselves. Indigenous women in particular, with the double oppression of being woman and being black, must have pride in their identity and stand up against abuse.

The Oral Tradition: Aboriginal popular music and therapy

Aboriginal narratives of illness and healing exist in a diverse range of genres. Writing, performance, song, rock music, stage drama, film, public speech and the street theatre of political protest overlap and sometimes merge into one another. In the rest of this chapter I will present some of the diverse narratives that deal in some way with themes of illness, and explore their healing function. The field of popular music, song and poetry is a good place

to start this examination, since it combines traditional with new elements, Aboriginal with non-Aboriginal, and resides in the public domain, drawing together entertainment and political protest.

Story telling, dance and song are a significant part of Aboriginal life. Ancient story song cycles combined mythical knowledge with information about landscape, food and water, kinship and social mores. The power of singing in traditional societies is outlined by Penny Van Toorn (19), and the editors of Paperbark claim that contemporary Aboriginal stories and poems have ‘roots in the oral traditions which for centuries have been the lifeblood of the Aboriginal and Islander cultures’ (1). Peter Dunbar-Hall, in an article on rock music and health messages in Aboriginal communities (discussed in detail below) suggests that ‘comparison of the roles of music in traditional Aboriginal cultures with those of these rock songs reveals a continuing Aboriginal understanding of the power of music’ (45).

Clinton Walker has examined the popularity of country and western music, blues, reggae and rock amongst Aboriginal audiences. Such music is represented by Aboriginal artists like Archie and Ruby Roach, and bands like Coloured Stone, Warrumpi Band and Yothu Yindi. Yothu Yindi is internationally known, but many Aboriginal bands and artists are ‘settlement bands’, playing mainly within their local communities (Buried Country 236). Walker attributes the popularity of country music not only to its continuity with the Aboriginal oral tradition, and its ‘narrative drive’ linking to the old song cycles (237), but also to its ready accessibility, its basis in local rural communities, and its themes of lament and loss. Contemporary Aboriginal music is part of a folk tradition associated with oppressed peoples, such as the reggae music of the Caribbean and the blues of Afro-American slaves, and carries protest as well as testimony. It gives voice to the multiple losses and oppression suffered by Aboriginal communities. For example, many singers, including Archie Roach, have mourned the separations and family dislocation

revealed by the ‘Stolen Generations’ report.³⁷ Popular music, like Aboriginal poetry, often functions as ‘grass roots’ protest. Country music gave Aboriginal people a voice for contesting their position as outcasts, and a way towards empowerment. Interviewing Aboriginal musicians Walker felt:

humbled and often moved by the way these people could sit there and, with humour, dignity and courage over and above bitterness or anger, talk of being stolen as a child,
. . . of being beaten down by bigotry every day. Or talk about . . . being prone to alcoholism . . . doing hard time in jail; about pervasive ill-health and death itself, which still seems to descend more frequently among Aboriginal people, stealing the youngest and the best. (Buried Country16)

Walker’s comment reiterates an understanding that the burden of illness in Aboriginal communities is inseparable from the oppression that their music protests.

Popular Aboriginal music has the broad therapeutic function of celebrating survival and expressing pride in traditional and contemporary images of Aboriginal identity. It counters negative images of cultural destruction and loss of self-worth. Coloured Stone’s ‘Black is beautiful’ and Wirrinyga Band’s ‘Great turtle hunter’ affirm pride in black identity. Many popular songs celebrate the land, its animals and plants, and affirm ‘belonging’ to country. Others such as Coloured Stone’s ‘Whale dance song’ depict traditional occupations and ancient song lines and stories. Yothu Yindi’s album Birrkuta – Wild Honey combines rock and protest songs, satire on the materialistic values of modern society, social comment on unemployment, and celebration of the traditional search for wild honey – a joyful time of legends and stories as well as communal co-operation in gathering food. The compilation album Our Home, Our Land was released in 1995 as a celebration of Eddie Mabo’s challenge to the legal doctrine of *Terra Nullius*. Many of its songs relate to the right of indigenous people to claim ownership of ancestral lands, and connection of Aboriginal people to the land is a recurring theme.

³⁷ These tragic experiences can sometimes be linked directly to ongoing patterns of illness such as depression, as illustrated by Wayne King’s autobiography Black Hours and Doris Kartinyeri’s story in Kick the Tin.

Empowerment is a common thread in much of this music. Coloured Stone's 'Imagination' carries this challenge:

You think your life is helpless
Use your mind
There's help for those who help themselves . . .

Don't let your world become so pale
Just change the colours . . .

Imagination – the power of song and story – is a path to finding agency and meaning, a path to healing, in lives that are often fragmented and oppressed.

In communities where health and illness are inseparable from the heritage of cultural breakdown, all narratives of empowerment and pride are part of the healing process. However there are Aboriginal songs that deal with specific social problems and with illness and health in particular. 'Jessie Smith's park' by Wirrinyga Band is a tribute to a nurse who worked with Yolŋu people and trained them in health care. The song is a light-hearted demonstration of the close link between empowerment and health. Songs may carry didactic messages or direct exhortation of the need to seize ownership in confronting social problems. Popular music by Aboriginal artists often deals with issues such as alcohol misuse, tobacco, drug addiction, petrol sniffing, neglect of children, violence and trauma. The songs can be therapeutic through barbed humour and satire, through messages of protest and resistance or through facing up to tough issues such as domestic violence and drunkenness (while resisting 'shame') and taking responsibility for countering them. Wirrinyga Band's song 'Balanda's totemic waterhole' depicts the pub as the balanda's (white man's) dangerous 'totemic waterhole'. It combines lament for lost traditions with protest and satire, warning of the damage that white man's poison, alcohol, has brought to black communities:

We living so simply in the mysteries of the Dreamtime
Yolŋu people taking good care of the land
Now here we are living in this modern world today
Many things are changing and our people are dying.
Chorus:
City lights are shining and the totem of the pubs are calling . . .
Yolŋu women and Yolŋu men
Don't you get fooled by the Balanda ways
(Dreamtime Wisdom Modern Time Vision)

Peter Dunbar-Hall has investigated the function of popular music in carrying specific health messages to Aboriginal communities. He notes that song in traditional central Australian societies was important as a repository of cultural knowledge – about the law and right behaviour, terrain and place, food sources and healing – and a way of passing on this knowledge. Music and song were believed to have a practical influence on factors such as weather, food and water supplies, fertility, health and the cure of illness (‘Rock songs as messages’ 61). In present day central Australian communities:

Rock songs, heard on cassette players and over the radio and television, not only bypass cultural, gender, and literacy barriers, but as a form of oral communication conform with accepted Aboriginal ways of “passing on” knowledge (60).

The media network Central Australian Aboriginal Media Association (CAAMA) is owned and operated by Aboriginal communities. Its stated aims are not just to entertain, but to inform, educate and “help alleviate problems of social disintegration and other special problems in the areas of health, law, social services and literacy” (Dunbar-Hall 43). One way in which CAAMA has tackled issues such as “the ravages of grog in Aboriginal communities” is by promoting rock music that carries messages about health and lifestyle and particularly about the problems of alcohol, petrol sniffing and AIDS (44).

Dunbar-Hall provides and discusses many examples of such music. One is the Uwankara Palyanyku Kanyintjaku (UPK) cassette released by CAAMA in 1989, following a government report on Aboriginal health in central Australia. The ten songs on the cassette promote healthy lifestyle practices targeted by the report, including looking after children, use of septic tanks, regular showering, and avoiding alcohol, and include other topics such as traditional values, life in the past and land ownership. As Dunbar-Hall notes, it is ‘significant that mixed in with songs about physical health are ones about emotional and spiritual issues, such as the ownership of traditional lands. These recognize the importance of the non-physical in the attainment and maintaining of good health’ (47). Health as part of well-being, physical, spiritual and communal, is a recurring theme of Aboriginal healing narratives.

Petrol sniffing amongst Aboriginal youth has become a serious problem in some communities of Arnhem Land, central Australia, and the eastern goldfields region of Western Australia. It can lead to severe neurological damage or death, and is associated with marked social breakdown and crime (47-8). The songs reflect community ownership and response to this problem. The bands that have put out songs deploring the practice of petrol sniffing are from affected local communities; one uses the local language for its lyrics (49). Wedgetail Eagle Band, from Fregon in the Pitjantjatjara lands, laments and warns:

Out in the cold night
Our children wanders around . . .
You're throwing your lives away
With a petrol can today
Please listen to what I say.
(Dunbar-Hall 48).

Alcohol misuse is a much more widespread problem in Aboriginal communities than petrol sniffing, and is the major health concern for many communities. Its impact includes not only multi-organ damage to physical health, but associated domestic violence, child maltreatment and neglect, family breakdown, unemployment and crime (50). There are many songs dealing with this issue, including a compilation album Wama Wanti (Drink Little Bit) put out by CAAMA in 1988 as part of its campaign against the destructive effects of alcohol (51). As with the petrol sniffing songs, songs about alcohol give vivid and emotive pictures of the devastation it causes, referring to the effects on wife, children, family and local community as well as on the individual, as in this example quoted from Danny Plain's song, 'Who's Goin' Wipe Their Tears?'

Our children sit and watch their elders dying
Sitting drinking poisons all day it makes them cry
And who's gonna wipe the children's tears from their eyes?
Who's gonna lead them through with their young lives?
Will the poisons kill our race?
(Dunbar-Hall 54)

Lyrics like this appeal to traditional and community values. Use of local languages in some songs, and of reggae style that 'has become identifiable with a musical statement of Aboriginality' are both ways of 'intensifying a song's significance for Aboriginal listeners' (55).

AIDS, along with other sexually transmitted diseases, is an issue of concern to Aboriginal communities. Dunbar-Hall points out that the risk of AIDS is higher for some Aboriginal groups than for the general population, as a result of the higher prevalence of sexually transmitted diseases, the disproportionate number of Aboriginal people in prison (where intravenous drug use and needle sharing increase the risk of AIDS transmission) and gender based restrictions on discussion of sexual matters that may hinder educational and preventive campaigns in some communities (59-60). Popular music, with its accessibility, its appeal to young people and its ability to overcome barriers of gender and literacy, is a useful medium for carrying messages about safe sex. CAAMA put out a compilation album of ten Aboriginal rock songs about AIDS in 1989. The songs warn about the epidemic and carry messages about casual sex, condoms and the role of alcohol in causing carelessness and exposure to infection. One example quoted is 'Ini Panya AIDS Ngku' ('The disease's name is AIDS') recorded in local language by Kunmanara Yamma and the Pitjantjatnara Country Band:

here they get the grog
Drink and sleep around
And everyone gets diseased
The name is AIDS
The disease's name is AIDS
(Dunbar-Hall 58).

As with other songs discussed by Dunbar-Hall, these songs may appeal to family, community and traditional values, and use local language and music style such as reggae to increase identification with Aboriginal audiences.

The preceding examples illustrate some of the healing functions of Aboriginal music. The therapeutic role of music ranges from affirmation of pride and identity to specific and didactic health messages. Even the songs that seem merely to provide education about health are healing in a broader sense because they embody a sense of Aboriginality and assert agency.

Contemporary music conveys protest, defiance and lament. It looks back to traditional values and links them to new identities. Aboriginal music itself represents a hybrid of old and new cultures: the combination of traditional instruments, such as didgeridoo and clap sticks with modern electronic

keyboard and guitar; the melding of styles such as reggae, blues and country with traditional song and chanting; thematic and stylistic links with traditional song lines; the use of local languages as well as English, often combined in the same song; and themes that show the inseparable connection between physical and spiritual well-being. Music addresses specific problems of health and lifestyle, and broad cultural factors that are inseparable from health – narratives of cultural loss and cultural renewal.

Healing elements in Aboriginal poetry

In Aboriginal art there is a blurring of the boundary between music, song and poetry, and between writing and performance. Like the musicians and song-writers discussed above, Aboriginal poets often perform in the popular arena, giving public expression to private pain, voicing the sadness and the anger of their communities. Motifs of illness and death recur in Aboriginal poetry, and public testimony and protest are an important part of its healing function.

The anthology Rimfire: poetry from Aboriginal Australia features three poets whose writing exemplifies the public and polemic function of indigenous poetry. Alf Taylor is a singer songwriter who confronts the degrading realities of life on the fringe, Michael Smith is a health worker as well as writer and Romaine Moreton is a performance poet and political activist. These writers deal with issues that directly affect Aboriginal health. Rimfire includes poems on grog, jail and deaths in custody, suicide, glue sniffing, rape and domestic violence. For these writers oral tradition and performance overlap with written poetry, and healing intersects with polemic.

Romaine Moreton has been giving public performances of her poems since 1995. She has written for film and her work has appeared at indigenous and international festivals. Her poems are written ‘with the intention of poetry becoming a site of resistance’ and her poetry was initially rejected by publishers as ‘more polemic than poetic’ (Rimfire vii-viii). Themes in her

work include child sexual abuse, the imprisonment of Aboriginal men, and the denigration of Aboriginal women as sex objects. 'Rushin' rule-ette' (Rimfire 48-9) uses black humour to protest at the degradation of Aboriginal men in white society ('When my brother was twelve years old,/ the local police played Russian roulette/with him. . . . Now/ the pistol is an almost empty bottle of port . . . Now/ the pistol is an inviting noose made of shoelace'). 'China Dolls' (17) and 'Raggedy Anne' (61-4) speak out about hidden child sexual abuse, and especially the corroding effect of silence and secrecy: 'my throat is frozen . . . I am sentenced to a lifetime of never being able to forget' ('Raggedy Anne'). Images of dolls in these and other poems such as 'Ode to Barbie' (21-5) parody the positioning of women – especially young, black women – as sex objects, and the pressure to comply with subordination. Moreton's writing makes a defiant, public statement. Its therapeutic functions lie in giving voice to what is hidden, resisting shame and asserting pride in identity.

Alf Taylor exposes the realities of existence for many Aboriginal people – the hardships and degradation of daily life. His poems, like those of Romaine Moreton, contest stigma and oppression through public statement, by ownership of problems such as alcohol and drug use, glue sniffing and suicide. Many poems, such as 'The trip', 'Pension day' and 'Fight' deplore the destructive effects of alcohol. Taylor's depiction of the lot of ordinary Aboriginal people is bleak:

Why
do you sniff glue . . . ?

In our household
there is
a lot of sorrow,

Nan is sick
Mum cannot cope
and Dad
he is drunk again
('Sniffin' 106)

He laments the loss of dignity and meaning reflected in unemployment, drinking away the 'dole cheque' (109), thrill-seeking in stolen cars ('Last ride' 126) and imprisonment for trivial offences ('The fine' 123). The tragedy of jail

suicides and deaths in custody ('Alone in a cell' 99, 'No names' 110) are part of the pattern of cultural destruction, placed against the old values and ties to the land ('Elders' 135; 'Kimberley' 101). In poems such as 'Gerbah' (128) and 'Leave us alone' (134) he suggests there is hope for the future through education and Aboriginal agency.

Michael J. Smith dedicates his poetry 'to the healing of the stolen generations' (Rimfire 143) His story is a common one amongst Aboriginal people. He lived with a foster mother from the age of three and was educated in the 'white' community of Perth. He met his tribal family when he was twenty-two, the start of 'my journey of healing' (139). His work reflects an impetus to heal through both practical work and narrative. He is a health worker and counsellor with the Aboriginal Medical Service and has worked in the Kimberley, Broome and Darwin. He has acted for videos and plays about health issues, promoting health messages for Aboriginal people, as well as writing poetry. His poetry carries clear didactic messages about issues such as pride in Aboriginal heritage, outrage at the injustices suffered by his people, the damage caused by alcohol, and the power of modern education. 'Heducation' (157) is a humorous picture of older blacks grappling with the notion of (western) education as the path to a 'better future' ('We got good job on this farm/but what's this word heducation . . .!') but the poet's message is direct: 'education will lead our people into the future.' 'Wine along' carries a similarly direct message about the harm caused by alcohol: 'wine along no good in our life/ . . . Gotta get the drink away from me' (160). Michael Smith stands as a strong model for young Aboriginal people. Like Aboriginal sports heroes, musicians and entertainers he represents the possibility of forging new cultural traditions while maintaining pride in Aboriginal ancestry: 'we don't have spears/ kangaroo fur across our bodies,/ no more stone axes,/ even the mia mia has gone . . . / the old ways have turned to the new ways' ('Identity' 163).

These three poets are not widely known, but they represent the voices of Aboriginal people speaking on behalf of their communities. For them as for most indigenous writers, writing is one facet of political engagement. The therapeutic function of their work lies in its public voice and polemic intent.

The messages are direct and clear. The writers grapple with difficult issues such as alcohol and violence, and they emphasise that health is inseparable from holistic well-being and from the social context. They speak with pride and hope as well as lament.

Two themes that recur in the poems from Rimfire are ‘grog’ and burial. Alcohol, with its destructive effects on health, family and community, and the funeral as a central feature of Aboriginal community life, are significant tropes in Aboriginal writing. In the examples that follow, these motifs are used in ways that move beyond simply restating problems and re-entrenching despair. As key images of degradation and loss, grog and burial are given subversive and ironic meanings that serve a transformative healing function.

Bobbi Sykes poem ‘Rachel’ is an elegy for a black child aged eight months who ‘died on Palm Island Reserve after a doctor refused to treat her in the middle of the night’:

Named from the Bible/
That good and holy book/
Which came into this country
Along with Cpt. Cook
And metal axes
And beads and mirrors
And money and guns.

. . . suffer the little children
(Gilbert Inside Black Australia 36)

The poem subverts the discourse of the white invaders in order to expose and condemn their hypocrisy: betrayal of their Christian principles (‘suffer the little children’); a civilisation epitomised by ‘money and guns’; the doctor’s ‘benign neglect’ and his callous betrayal of ‘Hippocrates’ oath’. The burden of Aboriginal illness and suffering is tied to the injustices of white invasion. The child’s death becomes an ironic indictment of white civilisation so that the funeral motif functions as counter discourse to the dominant culture.

Kevin Gilbert’s ‘Same Old Problem’ links illness and the tragic deaths of children with disgraceful living conditions on the fringe of white society:

Remember the hate

the mortality rate
the tumbledown shacks and the rain
the children you bury
the pain that you hide
the despair and denial out-back. . . .

you're *their* problem again
by your stubborn refusal to die
(Gilbert Inside Black Australia 195)

The 'invisibility' of the black people is reversed: the fringe dwellers are foregrounded and dominant society is only implied ('the hate', '*their* problem'). Here the funeral – burial of children – is countered by the subversive irony of the last two lines: the Aborigine's *refusal* to die places responsibility and shame firmly with the invisible oppressor.

Frank Doolan's poem 'The Last Fullblood' is a satirical lament for the loss of culture and human dignity. The white invaders have brought grog that destroys men and diseases like trachoma. They have brought about dispossession that has left little meaning in life ('Our stories are passed on/ By word of mouth or paintings/ But vandals wrecked our caves') so that numbing with alcohol seems the only escape from despair:

He ain't in the best of health...
You broke his spirit long ago
Now he just lives for grog. . . .

I might hit the wine myself
Pretend it doesn't hurt
Cause the only land he'll ever own
Is six cold feet of dirt.
(Gilbert 92)

Here again the therapeutic function lies in the counter discourse of dark satire – the 'superior' white civilisation has brought only damage and destruction of Aboriginal culture ('vandals wrecked our caves') and loss of the 'stories' that gave meaning to life. Illness and drunkenness are inseparable from cultural dispossession. 'Grog' substitutes for the loss of spiritual meaning and the grave becomes an inversive image for the loss of land and sacred places.

In Lionel Fogarty's provocative poetry alcohol and drug use are recurring themes. In poems such as 'Blackfella Drunk, Blackfella Fights'

(Fogarty 131) and 'At Home: To: Musgrave Park People' alcohol is a self-destructive escape from grief and loss:

Our sorrows drown in waters of grog . . .
Our dole money told me we'll thrash port wine
today black child breed, yesterday a bottle of beer
(Fogarty 113)

'The Buzz' uses coarse Koori and English expletives to make fierce comment on the ravages of drug abuse amongst young Aboriginal people, and ironic reference to the cultural losses that underlie such self destruction ('help you to know we is sacred/ people takin'' 69). Loss is explicit in 'Ngunda Man Koori':

Drunken blackfella
crying of a day gone by
and then, buy buy more nyarndi³⁸
(Fogarty 73)

The therapeutic function of these bleak images lies in the context of Fogarty's poetry as a whole. It is poetry of protest and defiance, not merely an expression of injustice and loss, but a call to take pride and to build new identity. Fogarty uses the motifs of alcohol, drugs and death to recreate the despair that underlies chaotic lives. His poetry gives voice to anger and lament, but above all it contests powerlessness.

In these poems, the invading 'civilisation' has brought illness and death, represented in the motifs of grog and of burial. These symbols of degradation and loss are used ironically to subvert and defy the dominant culture and to contest Aboriginal subordination. Poems that attribute black suffering to injustice or indifference on the part of the larger society are placed against poems that celebrate traditional culture, the land and new identity. The voice of protest becomes a voice of resistance, an assertion of survival and strength, a 'stubborn refusal to die.'

Strong Women: illness and defiance in Aboriginal women's narratives

³⁸ Nyarndi=marihuana

Personal ill health and the illnesses and deaths of children form a significant thread in the life writing of many Aboriginal women. Ruby Langford Ginibi describes serious injuries and illnesses that she and her sisters suffered as children. As a young woman she had multiple unplanned (not unwanted) pregnancies and little medical care during pregnancy and childbirth. Her children suffered from life-threatening infections including meningitis, chest infections and severe gastroenteritis; her son Bill had epilepsy and drowned after falling into a bathtub when having a fit. ‘Mum Shirl’ suffered from epilepsy from early childhood: there was no effective treatment at the time, and she was at constant risk of uncontrolled fitting. She had recurrent miscarriages; in middle age she developed diabetes and arthritis. Doris Kartinyeri suffered from bipolar mood disorder, and used alcohol to help deal with depression and isolation. Roberta Sykes³⁹ was a ‘sickly’ child, suffering asthma, severe chest infections and an episode of meningitis that was almost fatal and left her debilitated and bedridden for months. In adult life she was subject to recurrent depression.

Despite the severity of their illnesses and the constraining effects on these women’s lives, illnesses are not foregrounded in their life writing. Aboriginal women writers tend to downplay their personal suffering. They are far more concerned with the humiliation and oppression of racism, for themselves and for their people. The burden of illness in Aboriginal people is inseparable from racism, and these life stories demonstrate the connection. Poverty and hardship, increased exposure to risk, unequal access to medical care and the dismissive and discriminatory attitudes of nurses and doctors add greatly to the severity of illness, poor outcomes and the suffering and humiliation experienced by the writers. They are strong women whose impulse to heal is reflected as much in practical action, community work and political activism as in the subject matter of their writing. In the accounts that I will

³⁹ Penny Van Toorn has discussed the controversy over Roberta Sykes’ identity and the arguments for her right to be recognised as Aboriginal on the grounds of having suffered as an Aboriginal and allied herself with the cause of Aboriginal rights (Van Toorn 2000 42). Sonja Kurtzer in her essay ‘Is She or Isn’t She?’ examines the ambivalence surrounding Sykes’ identity in the perspective of the wider debate over what it means to identify as Aboriginal.

examine, it is difficult to separate personal illness from communal injustice, the private voice from the public, narrative from political engagement.

Ellie Gaffney Somebody Now

Ellie Gaffney is a Torres Strait Island woman. Her father was an Indonesian, shanghaied as a young boy into work on a pearling vessel, who married an Islander. Gaffney was the first Torres Strait Islander to train as a nurse. At the time, nurses in Islander communities were white, and Island women worked as Nurse Aids, a lower status position that required no formal training. It was commonly assumed that Indigenous women were incapable of learning the skills required for nursing – Gaffney herself encountered such prejudice many times when seeking training, and during her professional life.

Throughout the account Gaffney combines the personal story of her nursing career with anecdotes and analysis revealing the breakdown of Islander communities caused by European settlement. She depicts the happiness of the Islander lifestyle that she knew as a child and the changes brought by European contact. World War II in particular marked a significant disruption. A large number of Islanders were evacuated and many of the local men enlisted. Gaffney's brother Ted Loban lost an arm; other Islander men were wounded, disabled or killed fighting for a country in which they were not accorded citizenship. Ted Loban's injury is an ironic symbol of what white 'civilisation' meant for Islanders.

From the perspective of her career in nursing, Gaffney depicts the health problems and needs of her people. She decries the damage caused by white colonisation but is also frank about the problems within Islander communities: issues such as excessive use of alcohol, neglect of children and the traditional low status of women. She is sharp about the arrogance and irresponsibility of many Islander men – women do the hard work for political and social justice, the men take the credit and rewards (91). Gaffney argues that in order to improve health Islander people must take responsibility for

addressing wider issues of inequity and social breakdown in their own communities.

The impulse to heal runs through Ellie Gaffney's narrative. Her desire to nurse arose from her early experience as a Nurse Aid: she loved caring for patients. However she confronted racism once she tried to go beyond the menial role of Aid and gain professional status. When she was working for the high school qualifications required for entry to Nursing she was told abruptly by an Anglican priest (who demanded a substantial fee for coaching her) that someone like her (a 'native') would never be able to achieve the required educational level. Despite discouragement and belittlement, and other barriers such as having to live far from home and adapt to unfamiliar cultural settings, Gaffney succeeded in becoming a double certificate nurse (she later obtained further qualifications). She worked as a trained nurse for twenty-six years including many years as a matron. Much of her work was in Aboriginal and Islander communities.

Gaffney encountered stigmatisation of indigenous people in her personal dealings with health staff as well as in her professional experiences. Indigenous people were stereotyped as lazy, careless and neglectful of their children. When Gaffney's six-month-old baby was severely ill with meningitis, a hospital sister scolded her for waiting until late at night to seek attention. In fact she had consulted a doctor the previous day and followed his advice (he had not recognised that the child was dangerously ill), coming to the hospital when the child did not improve with the recommended treatment. Once the baby was admitted, Gaffney had to go back to the Aboriginal community where she was working as matron of the local small hospital, to fulfil her responsibility there. On returning that night to her child she overheard the nurses talking: 'they all agreed that it was typical of the Aborigines' to abandon their children at the hospital and not come in to care for them (68). Gaffney points out that (setting aside her own particular commitments) the Aboriginal mothers from her area had other children to care for, and were many miles from the hospital in a remote community served by only one boat a day. Prejudices like these were commonly used as justification

for discriminatory and dismissive treatment of indigenous people when they presented for medical attention.

As she recounts her nursing experiences, Gaffney argues for the advantages of having indigenous people in positions of professional authority in their own communities' health centres. Local people are able to understand and work with patients and other indigenous carers (such as Nurse Aids), giving and commanding a respect that is often absent with white professionals. Gaffney describes how as matron she was able to tackle problems of unreliability and stealing among Nurse Aids. The Aids were poorly and inequitably paid: she negotiated better conditions and pay for them. She improved staff relations and morale by contesting discrimination such as the exclusion of indigenous staff from the 'white' staff dining room.

Gaffney's autobiography demonstrates the healing impulse that threads the lives and the writing of many indigenous women. She attests to the importance of belonging to community. She demonstrates the value of her cultural traditions and exposes the breakdown of community that colonisation has entailed. She argues the need for indigenous people to take responsibility and control in confronting the problems that beset their communities. Somebody Now is the story of a strong woman. It affirms Ellie Gaffney's achievement against the odds of racism and denigration. It is narrative of empowerment – the writer was empowered by her education and professional role. It is also an empowering narrative: it serves as a model of personal determination and strength; it affirms pride in identity.

Roberta Sykes Snake Dreaming

Snake Dreaming⁴⁰ is an autobiographical account of hurt and healing by a black woman. Rape is a key theme of the first volume, Snake Cradle. As a sexually naive girl of seventeen Roberta Sykes was the victim of a brutal

⁴⁰ There has been controversy over Sykes' right to appropriate the snake totem as well as over her Aboriginal identity (Kurtzer). However this controversy does not invalidate the themes of illness and healing in her autobiography.

pack rape. She was abducted, bashed and left unconscious by a gang of white men. Sykes understood her assault and humiliation as inseparable from the men's placing of her as Aboriginal. After his conviction one of her assailants shouted in Court: "What the hell! She's an Abo! She's just a fucking boong!" (Snake Cradle 320).

The attack left Sykes physically injured, infected with pubic lice and pregnant. Her autobiography gives evidence of a severe stress reaction in the months after the attack, characterised by withdrawal and apathy, sleep disruption, nightmares and anorexia. She recovered from her injuries, and took up the challenge of remaking her life and being a good mother to her baby son. Once the trial of her attackers was over she felt impelled to guard her privacy – to protect her son from knowing the circumstances of his conception, and perhaps also as a way of protecting herself from the memory of the terrifying and degrading assault. She made up her mind to silence:

My silence became an imperative . . . My mental rehabilitation might have depended on being able to talk about the emotions which were caused by my trauma, but this might have had a very negative effect on my child. . . . Would I be able to carry the additional burden of silence – without losing my mind completely? . . . I was to assume the silence of the serpent as a cover for myself and my child, . . . for the next thirty years. (Snake Cradle 326-328)

The cost of her silence was a sense of worthlessness and recurrent episodes of depression over many years.

Sykes' public retelling of her rape in the autobiography has a therapeutic function. Healing comes from open expression of the long hidden shame and from regaining self-esteem. She comes to understand that the rape represented a racist attack – she was targeted because she was a black girl – and to realise that she has internalised the demeaning attitude that her attackers held towards her. Recognising this is a step towards rebuilding her self-esteem. The autobiography draws into a narrative whole the healing experiences of her lifetime – political activism, community work and caring for others, empowerment through education and academic success, achieving recognition and respect.

Rape epitomised the racism that impelled Sykes towards political and social activism. She worked in Aboriginal health and with the interlocked problems of poverty, poor living conditions and unemployment, she confronted the hardship faced by Aboriginal (and white) women and girls in positions of subordination and vulnerability. She counselled and helped white as well as black victims of sexual assault and domestic violence. Her commitment went beyond the cause of Aboriginal people and she allied herself with marginalised people in many circumstances – including prostitutes, gay men and indigenous and black Americans.

Sykes' accounts of her interactions with the health care system form a critique of the medical world. As a 'sickly' child she suffered from recurrent chest infections, and an episode of life-threatening meningitis. She was often in hospital for prolonged periods. Her childhood experience of sickness promoted an interest in the healing profession. She formed the ambition of becoming a surgeon, and as a very bright and high-achieving girl would probably have succeeded. However her hopes were thwarted by the racial discrimination that saw her excluded from school when she reached leaving age, despite her outstanding academic ability. Later she undertook training as a nurse. She did well and was liked by patients and other staff but her training was terminated, partly for racist reasons. Sykes' impetus towards healing, frustrated by the racist assumptions of the health profession, found expression in her work for Aboriginal health and in her writing.

When she worked with Aboriginal rights and welfare groups, including the Redfern Aboriginal Medical Service, Sykes confronted discriminatory racist attitudes and practices within the Medical world, affecting to a marked degree the health care available to Aboriginal people in Australia. Her journalism, reports and speeches at the time as well as her autobiography expose hypocrisy, injustice and sometimes gross violations of medical ethics. She was a strong advocate for Aboriginal controlled health care services, which provided an early model of empowerment that has now become widely implemented. Placed against her respect for the healing profession, Sykes'

critique of the Medical world forms a counter discourse to its authoritarian assumptions. Sykes, like other Aboriginal writers, seeks healing by contesting the basis of her oppression and denigration. Writing and political engagement, narrative and polemic, are inseparable aspects of that resistance.

Doris Kartinyeri Kick the Tin

Doris Kartinyeri's story is an account of mental illness (bipolar mood disorder) embedded within a 'stolen child' narrative. She was taken from her family as a one-month-old baby after her mother died, and grew up in Colebrook Home, a United Aboriginal Mission home in Eden Hills, South Australia. Sexual assault is a motif throughout Kartinyeri's account. She and other girls and boys were prey to sexual harassment both within the Home and when they were sent out as domestic servants (54). She emphasises the hypocrisy of the perpetrators. The assaults she describes were by pious and moralistic church people; one especially vicious offender was a lay preacher (62). The racial basis of the sexual attacks that Kartinyeri describes is plain. Like Roberta Sykes' attackers, the people who preyed on these children saw Aboriginal people as fair targets, as less than human.

Doris Kartinyeri associates her mental illness with separation from family and community, and the further isolation entailed by shame and secrecy over sexual assault. Her mood disorder was compounded by use of alcohol to numb pain and loneliness (81). Whether or not these factors were responsible for the illness, it is clear that her disorder and her suffering were aggravated by denigration – as a servant, as an object of sexual assault – and by uncertainty about her identity, by lack of belonging. As she grew up and was able to make contact with her family, she found she was not readily accepted as part of the Aboriginal community at Murray Bridge (78). She had great difficulty getting to know and feel part of her own extended family, since she had been completely cut off from them throughout childhood and youth. The violence against family represented by 'stolen children' stories such as Kartinyeri's parallels rape as a dehumanising assault.

In her autobiography, Doris Kartinyeri enacts healing by breaking the silence and contesting subordination. Her exposure of the dominant whites is subversive: their exploitation and sexual assault of Aboriginal children is revealed as deeply hypocritical, counter to their loudly professed Christian and humane principles. Her account affirms the humanity and the resilience of her Aboriginal community, despite the disruption it has faced. Part of the healing process lies in regaining a sense of belonging as an Aboriginal woman. She demonstrates her personal sense of identity and worth by overcoming the obstacles of limited education and mental disorder to write her story.

The representation of the Medical world in Kick the Tin is nuanced. Kartinyeri accepts her need for its special knowledge represented by the medication that controls her chaotic mood swings and behaviour. She pays grateful tribute to the understanding and support of her general practitioner who ‘always had time to listen’ (99). At the same time she is scathing about the limitations of medical authority, exposing the arrogance of many doctors and the shortfall in their ability to treat her condition. Medications given were ineffective and often had troublesome side-effects (92). One psychiatrist she saw is depicted as aloof and pompous. His questioning is intrusive, leaving her feeling ‘helpless’, ‘isolated’ and ‘more confused than ever’ (96). As she has done with the Home, so she exposes the dehumanising face of Medicine. The subordination imposed by white authority stands in contrast to the warmth and support of her daughter and other Aboriginal people. Healing for Kartinyeri ultimately rests not on medical treatment but on telling her story. Her narrative affirms survival, self-worth and belonging. It tells of a life that has meaning. Despite every assault on her personhood – separation from family and people, racial humiliation and sexual abuse, and a debilitating mental illness – Doris Kartinyeri asserts her resilience and pride in Aboriginal identity.

Ruby Langford Ginibi

Illness is a recurring theme in Ruby Langford Ginibi's accounts of her life and in the stories she tells of her family and community. In 'The Trials of Nobby' she relates her attendance at her son Nobby's trial in 1987, the deaths of three of her nine children, and her own illness at the time, linking them thematically. She has a remarkable ability to capture a sense of sadness and struggle without wallowing in self-pity:

I had major surgery on my stomach . . . it left me with a lot of stress and depression. . . . I was doing rewrites of my book . . . writing up the deaths of my children. And also the death of my son David, through a drug overdose . . . I started to feel real crumbly . . . I'd start crying at the drop of a hat. [returning to the surgeon for a check up] I burst out crying in front of everyone and couldn't stop. "Now, now Ruby it's not that bad, your wound has healed splendidly, I'm real pleased with it," he said. I thought to myself, what about all my other scars, the battle for life and the struggles I've had to contend with, I knew he couldn't heal that, no-one could, only me. ('The Trials of Nobby' 144-5)

Here the writer ironically contests dominant positionings – white, male, medical. There is humour in her report of the surgeon's kindly meant but inadequate response: he does not see beyond the immediately obvious, the surgical scar, to the grief that springs from a lifetime of battle and loss. Ginibi takes ownership of her struggle, proudly asserting her self-reliance. Despite the skill of medical men, in the end she is the only one who can heal herself.

Ginibi's autobiography Don't Take Your Love to Town tells many stories of illness in herself and her family. Injury or illness in Aboriginal people was often neglected or inadequately treated, due to discrimination or limited access to medical care. At Box Ridge mission when Ruby was about seven and her sister Rita about three, 'Rita fell on a squaring axe and needed about ten stitches, but they didn't take her to a doctor' (8) and when Ruby burned her face badly 'all my face was blistered. They didn't take me to the doctor' (9). Dalziell, in her review of the autobiography, identifies as a cause of such neglect the myth 'that Aborigines have fewer health needs' (Dalziell 136). Ginibi's son Bill suffered from meningitis as a young child. When she took him to the hospital he was fitting repeatedly, but the doctor, called by the nurse, 'said he'd see him in the morning' (Don't Take Your Love to Town 66). Bill survived but remained an epileptic, subject to frequent fits. On another occasion when baby Pearl suffered from severe bronchitis, Ginibi

had to carry her four miles through the bush at night to the hospital in town. Local hospitals such as the one at Coracki in Northern NSW were segregated in the 1930s and 1940s, and the ‘special wards for Kooris, down the back’ marked the Aboriginal people as outcasts (9). These episodes reflect the injustices that compounded Aboriginal illness: poverty, and discrimination by white people and the ‘white’ health care system.

As a young woman Ginibi had many unplanned pregnancies, the first at the age of sixteen – by the age of twenty three she had six children under the age of six. She is frank about her ignorance of sexual matters: ‘this was quite common, young women, girls, not knowing what would happen. And being given one sentence, that’s it’ (57). She received little medical care during most of her pregnancies, and her chief support came from older women in her community. In later life Ginibi developed chronic medical problems including diabetes, obesity and abdominal hernia. While it is clear from her autobiography that she received appropriate medical care, her cynicism towards doctors may be partly explained by the early experiences of humiliation and alienation from mainstream health care.

Ginibi’s story recalls the central place of the funeral in Aboriginal communities. Her father died of a heart attack aged only forty four, and her comment reflects a bitter sense of injustice: ‘He was a man who worked too hard, had a lot of stress, and who lifted the anvil for white men to win bets.’ (46). Her oldest child, Bill, died when he had an epileptic fit while washing his trousers in the bath: he fell into the tub and drowned. Pearl was hit by a van while walking on the footpath and died in hospital shortly afterwards, aged sixteen. Another son, David, suffered from severe depression and eventually died of a drug overdose. The funeral motif highlights the sense of an embattled community. Premature deaths, unjust and meaningless, undermine the resilience of the survivors.

In Don’t Take Your Love to Town Ginibi depicts illness in the context of her life as a battler. As well as depicting the discrimination and injustices she and her family faced, she is frank about the problems of alcohol and drug

misuse, violence and self-harm. Her narrative shows plainly the difficult lives and the despair that lie behind harmful practices such as binge drinking. Her own bouts of heavy drinking were associated with times of great sorrow: one episode followed Pearl's tragic death (148-9). Her son Nobby's drinking was also related to grief, to the deaths of his sister and brothers, as well as to hardship and the struggle to survive. Nobby's story of entrapment in a cycle of depression, heavy drinking, crime and imprisonment is told in Haunted by the Past. Nobby's story is an important part of his mother's story. It is a narrative that illustrates the power of Aboriginal women to speak out about the problems that destroy their men, and by speaking out to find ways towards empowerment and healing within their communities.

Haunted by the Past tells how Nobby's experiences of overwhelming loss and sadness were followed by years of 'trouble', in and out of Boys' Homes and prisons, often bashed and brutalised by police. Nobby was devastated by the deaths of his sister Pearl at seventeen and his idolised older brother Bill. He was with his mother when she found Bill drowned in a bathtub after an epileptic fit. Fourteen years later (1984) his brother David died of a drug overdose. Ginibi attributes much of Nobby's impulsive and reckless behaviour and his episodes of heavy drinking to unresolved grief. After David's funeral he went on drinking binges and once his wife found him after a night out drinking 'sleeping on David's and Bill's grave out at Botany cemetery' (44-5). Nobby himself attempted suicide on more than one occasion.

Ginibi writes Nobby's story, but allows her son to speak by including passages from conversations she had with him. Together they give voice to the long unspoken sorrows that have corroded Nobby's life. The narrative resists shame by placing the cause of Nobby's problems with the hardships and discrimination he faced as an Aboriginal. It reveals how Nobby and his mother take ownership in 'rehabilitating' Nobby's life. Nobby becomes a successful artist, and mentor for other young Aboriginal men and Aboriginal artists. His mother takes him to rediscover their traditional country and extended family. Nobby's story illustrates one aspect of the therapeutic power of Ginibi's

writing. She shows the damaging legacy of white oppression but is able to move on, taking agency and remaking the story of hardship and injustice into one of achievement. The problem-drenched narrative – of illness, depression, alcohol abuse and tragic deaths – is ‘retold’ and the new story opens up possibilities for the future.

Ginibi’s stories of hardship give a view of Aboriginal illness in the context of life on the fringe. Her narratives have a healing effect, not only for herself and her people, but for other ‘battlers’ who are marginalised by the dominant culture. Key therapeutic functions of her writing are testimony, counter discourse and assertion of pride in Aboriginal identity. In testimony to suffering she shows the odds she and her children faced, poor and black on the fringes of a racist society, in the gut-breaking struggle for survival. Illness is part of the wider pattern of hardship and disadvantage. However her narratives avoid self-pity. Her writing performs a counter discourse by unsettling the white/ black hierarchy. Humour and irony show up the hypocrisy and arrogance of white racists, who betray their own principles of Christian compassion and democratic equality. Aboriginal battlers demonstrate superiority to whites by surviving against the odds. Aboriginal people in her story show up those who denigrate them: Ruby and her father are exemplars of hard work and frugality; other Aboriginal characters are pious and generous Christians. The ‘transvaluing’ of Aboriginal identity in terms of other (dominant) narratives also unsettles the hierarchy of subordination: Ginibi shows Aboriginal people succeeding in new areas such as sport, art and writing. She also emphasises the importance of traditional culture including language, myths and stories, family ties and community solidarity, as part of her own Aboriginal identity. Ginibi in her own person stands as a successful writer and a strong woman who continues to protest at injustice. She demonstrates the ability to forge a new identity that can bridge two cultures. Ginibi’s narratives embody empowerment and pride among indigenous Australians.

Ruby Langford Ginibi’s autobiographical writing displays many of the key therapeutic elements that transform Aboriginal accounts of illness and loss

into healing narratives. The songs, poems, drama and stories that I have examined in this chapter give a public voice to private pain. They move from personal experience of illness and suffering to give public testimony and to implicate the listener as witness. They empower the teller, enabling a shift from the position of helpless victim to one of agency and strength, from shame to prideful identity. Public narratives resist the stigma and marginalisation that cause or compound illness. They assert the strength of community, reflected both in the traditions and culture of the past and in possibilities for new identity. The healing thrust of these narratives lies in their power to transform degradation, loss and illness and create a new story.

Conclusion

Someone from the family

Gary
is our family's
skeleton:
out of the closet.

But it's not funny, really, I remember
he used to play the organ for church,
Sunday services, weddings, funerals,
everyone said he was so good at it,
so generous, always willing to please.
Then he decided he was
one of them and it all stopped.

It hit my mother worst, it broke her heart,
my brother was her favourite, we all knew that,
his music gave her a great deal of comfort, she'd had it hard,
she didn't deserve this as well. The family thought it best
not to tell him she was dead. At the time
he was in the city, no doubt sinning, sliding
with one of his men. He would not have come.
And mother, at the last, didn't ask for him.

Of course, he caught the dread disease,
and now, of course, someone from the family has got
to do the cleaning up, the flat, the funeral arrangements,
the will, if there is one. I don't believe it's possible still
to save his soul. The friend this time is Thai, a pagan and useless.
I threw his Buddha out the door and he'll be next.
I've got a lawyer looking into it. I tell you,
he had the cheek to call a Buddhist monk, the monk even asked
to speak with me. 'I don't need to speak to you,' I said,
'I'm a Christian.' As soon as Gary dies, I'll be on the phone
to Immigration. If I have anything to do with it,
he'll be lucky to even see the funeral.

I'd better get back, though there's not much point,
the hospital staff are marvellous and doing all they can,
but, would you believe, the silly Thai
wanted to take him home to die,
as if anyone could call what they had home.

Gary's in a coma now,
and sometimes his hands, they're little more than bones,
move across the counterpane as if to play a song.
It's sad really, but I suppose
someone from the family should be there
when he goes to his
reward.

(Noel Rowe Next to Nothing 38)

I discovered this poem when I was more than a year into research on medicine and literature, so I cannot claim that it was the inspiration for the thesis. Nevertheless it brought into focus the argument that narratives of illness can become healing narratives. The poem encapsulates many of the elements that transform accounts of illness and give them therapeutic power. It tells a story of illness and death, and its therapeutic function is unrelated to cure. Despite its sombre subject the poem is witty and has a mischievous edge. It sets up and ironically subverts dominant discourses that marginalise the patient, and creates a sense of community and belonging for the outcast. Its metaphor provides a language for the silence of liminal illness: the poem is grounded in imagery of the body, and provides a transforming vision.

The following discussion of ‘Someone from the family’ exemplifies the mode of research that I have followed in this thesis: the poem rather than the illness is the focus of interest. I have taken a text based approach throughout, examining works of literature that deal with illness to discover what healing elements they might contain. Medical information about particular conditions such as dementia, and an overview of the wider community impact of illness in areas such as HIV/AIDS and indigenous health, provide a factual grounding for the illness narratives explored and set up a cross-disciplinary approach to literature and medicine. Theoretical perspectives in areas such as ageing, feminism and gender debate give a cultural and historical framework, but the literary texts themselves are central.

The disease in ‘Someone from the family’ is AIDS, referred to only obliquely by the speaker, who is the patient’s sister. Through her voice the poem exposes the judgemental stereotypes that may surround this illness. Gary is ‘one of them’, outside the acceptance of family and Church. ‘Of course’ he catches ‘the dread disease’ which becomes both brand and punishment for difference. The sister’s self-righteous commentary is a parody of the dominant assumptions that she represents. She is revealed as spiteful and vicious: in her jealousy of Gary (he was the mother’s favourite), her high-handed refusal to allow reconciliation between Gary and his dying mother, her dismissal of ‘the

Thai' as 'pagan and useless' and her smug certainty that Gary's soul is beyond saving, that his 'reward' will be damnation. Her outrageous arrogance is captured in her response to the Buddhist monk: 'I don't need to speak to you . . . I'm a Christian'. Her platitudes are stale and cliché ridden, her garrulous words reveal small-mindedness and hypocrisy – ironically her speech in its failure of compassion is emptier than Gary's silence.

The poem has a narrative basis. It tells the story of Gary's illness and foreshadows his death, but it also tells of his larger life: rejection by family and church on the assertion of his homosexual identity, and movement into another 'family' and spiritual life in the gay community and Buddhist tradition. His sister tells the story in order to condemn and dismiss Gary and demonstrate the moral superiority of her own position, but the poem's mischievous irony overturns her normative assumptions. It uses her own words to condemn the speaker and return Gary to the centre of his life story and of a loving community. This inversive wit is central to the poem's healing power. Gary cannot be cured of AIDS but his identity is restored and his life given witness and meaning.

Gary is a central but 'absent' figure. Unconscious and near death, he is disempowered by illness and coma, as well as marginalised by homosexuality. The friends who surround and support him – the Thai companion, the Buddhist monk, the implied wider circle of the gay community – are disparaged by the speaker yet represent the therapeutic force in the poem. They have become Gary's true 'family'. At the same time as the poem subverts dominant discourses of gender, family and Church it creates a healing sense of belonging and community for the marginalised.

The poem employs the powerful imagery of the body: Gary is a 'skeleton', his hands are 'little more than bones'. The imagery of bones is used in the poem's satire of marginalising discourses with the opening pun on skeleton but it is also used as a transforming metaphor. The ravages of AIDS with its wasting of body and brain are evoked in the final stanza. Gary is in a coma but his bony fingers seem to 'move across the counterpane as if to play a

song'. Returning to the image of the skeleton, the closing lines give it a transformative meaning. This image restores the music, the organ playing that Gary lost when he asserted his homosexual identity and so gives him a form of language. His organ playing ('Sunday services, weddings, funerals') was part of a larger spiritual narrative that gave meaning to life and death. Song represents a creative and healing force countering the silence that surrounds Gary now, both the silence of denial and the silence of final illness and death.

My argument that 'Someone from the family' carries these therapeutic elements raises the question: therapeutic for whom? The writer is effaced – the poem gives no evidence that it is enacting (or not) a therapeutic function for the poet. Clearly it is not therapeutic for the narrating sister who displays self-justifying exasperation. There is a hint of genuine grief in the final stanza, but it is swamped by her sterile respectability. Gary is beyond any conscious benefit from the poem. Perhaps the poem could be seen as therapeutic for readers who can identify with Gary or with his friends – in a narrow sense, those who have HIV/AIDS or who are carers for someone with the condition, and those who are gay or 'queer-friendly', but in a wider sense, any readers who have felt scorned or outcast, whether by illness or 'difference'. In speaking for Gary, who has no voice, ironically authenticating his identity and his life narrative, the poem becomes a therapeutic narrative for all who are marginalised. In a sense it does not finally matter who might find the poem therapeutic. The approach I have used in exploring this poem, as in the thesis as a whole looks for transformative elements within the narrative rather than trying to prove transformative effects upon readers.

Thomas Couser suggests that narratives of illness may serve different readers in different ways. He pictures 'concentric circles of readers' with the ill person and those immediately concerned such as the caregivers and the bereaved, at the centre. Beyond these are friends and family who are less directly involved and finally the broader public (*Recovering Bodies* 292). Illness narratives can serve quite pragmatic purposes for those at the centre – providing information about the illness and treatments – as well as giving witness and testimony to suffering and perhaps assigning illness with

‘redemptive meaning’. For acquaintances and families illness writing may provide a better understanding of what the person is going through, and ‘teach those who are well how to respond to those who are ill’ (293). Couser suggests that the functions of illness narratives are less clearly defined for the broader public, and for these readers the aesthetics of illness writing may be of more concern than practical knowledge or validation of suffering. However these different levels of response cannot be sharply separated. Decline and death are so much a part of the universal human experience that all readers may feel a sense of personal involvement in illness stories, while the ‘aesthetic qualities’ of the writing may have as much therapeutic significance as its pragmatic messages for the ill person at the centre.

My study has not sought to prove a therapeutic effect for either writers or readers of illness narratives. It is not a survey aiming to elucidate how writing or reading affects a person’s medical condition. Some of the writers discussed in the foregoing chapters have declared a therapeutic intention or claimed benefit from writing. Les Murray asserts that he wrote certain poems, including the epic Fredy Neptune, (at least partly) in order to combat depression, and that they achieved this purpose for him. Amy Witting’s biographer quotes evidence that the author faced near mental breakdown and found healing in transforming her experience into poetry as well as confronting it in the Isobel novels. Kate Jennings and Jonathon Franzen claim that they were impelled to write about dementia following intimate experience of the condition (in husband and father respectively). Diagnosis with HIV was one impetus for Robert Dessaix to explore the theme of death in Night Letters. Many Aboriginal writers declare a polemical aim of seeking communal healing through public testimony to illness and degradation. However the auto/biographical evidence of therapeutic intention is peripheral rather than central to my thesis – it is a signal that a text may incorporate therapeutic elements. I have examined the texts themselves for ways in which they challenge disempowering assumptions embedded in dominant discourses, provide innovative language for liminal experience and give a transforming perspective on illness.

If this study does not try to prove actual healing of illness or improvement in well-being for patients who read or write narratives of illness, if it does not have direct bearing on improving measurable 'outcomes' in health or medical education, what is its relevance for doctors, medical students and patients? In a practical sense, the material presented in this study could be readily adapted for work with patient groups and for teaching courses in medical humanities. For patients, the narrative perspective that the study provides may help to challenge disempowering constructions of disease. It may point towards new ways of understanding their own stories of illness, giving validation and meaning to their experience. For medical students and health professionals, study of illness writing can do more than have a 'humanising' effect on their attitude to patients. It can demonstrate that healing for the patient does not necessarily coincide with cure. Innovative illness writing can provoke a shift in perspective that places the patient's story of illness in the foreground of the clinician's concern.

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