

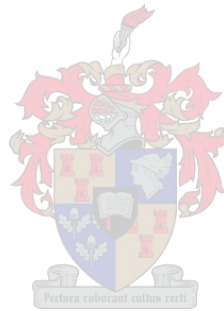
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Re-imagining the Body in Pain
Abjection and Spectacle
in the Representation of Pain

Maria Baumann

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Pain

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Abstract

This project examines the restrictive and onerous responsibilities Biomedical Language places on the subject in pain. Pain is subjective and immersive. Biomedicine insists that this subjectivity be categorised in terms of ill-fitting and ideologically constructed binaries such as 'healthy' and 'sick', 'normal' and 'abject'. Subjects in pain must make sense within these binaries, in order to justify their inability to perform as expected, or face scrutiny and isolation.

Relying heavily on Foucault's Birth of the Clinic, the Biomedical rhetoric of scientific impartiality is dismantled in order to examine the partisan concerns which it disguises. Communally and unconsciously, society weaves these assumptions, judgements and impositions through every layer of representation. Due to the inherently invisible nature of pain, subjects must perform their conditions in order to translate within this matrix. Voyeurism and performance of pain in Enlightenment society is compared to the work of contemporary body artists to examine how, if at all, this dynamic has shifted.

As a sufferer of Celiac Disease and Chronic Pain, I am interested in using a representational language that is founded on partiality and ambiguity rather than direct disclosure, or performance. With reference to avant garde 20th century artists who have championed this position, I examine potentials for operating within an ideologically laced representational framework with self-preservation.

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Introduction: Renegotiating the Visual Expression of Pain

How does one become part of the world? Relationships with others create meaning. Without them there is just the self, relating nothing to no one. Relationships rely on common language, not only linguistic but also pictorial and gestural. One submits to language to become part of the world. But what if the self is consumed by an experience that is untranslatable?

Physical pain is so entirely subjective that it cannot be forced into words which rely on the commonality of the experiences to which they refer. The world is uncomfortable with the inexpressible, that which is cast in darkness, the abject. It finds ways to translate the untranslatable. Ill-fitting concepts, words, images attempt to make sense of that which resists language.

This thesis explores the relationship between sickness and language, particularly visual language in terms of three filters: experience, theory and representation. Though remaining distinct, these categories will emerge as interdependent, intricately interwoven. My research has been guided and translated through my own personal experience. The representational work, which is the practical component of this written work, is a visual reflection of this interplay between theory and life.

I suffer from Celiac Disease and associated Chronic Pain Disorder. It took years of doctors' visits and painful invasive procedures before reaching these diagnoses. Medical practitioners tried unsuccessfully for years, to gain visual access to my conditions through various medical imaging techniques including X-rays, scopes and sonograms. Countless consultations failed to draw my ailments to the surface. My symptoms refused to conform to any tangible measurable form or traditional medical imagery. They are in most ways, 'invisible' diseases.

This is a problem in a system that champions the visual. As time passes, representations of the body continue to gain credence as more incredible inventions gain access to deeper recesses of the mysteries of the body. The scientific advances of the Enlightenment period, specifically the 19th century, meant that medical professionals could 'see' the body more entirely, close up, in greater detail than ever before. Since then, images have become exponentially foundational in medical diagnosis. The patient is expected to report to their own surface more than ever. Here they engage in an inherently unequal power dynamic with a doctor. This individual is allowed depth in the form

of extensive knowledge and interpretive capacities; in other words the ability to 'see' in a way the patient cannot.

Visual demarcation of the bodily abnormal is simultaneously a demarcation of the abject. Medical imagery attempts to pin down and contain the subject. It creates uniformity through proliferation. If translation into the visual is impossible, the subject is expected to construct a visual dimension to their experience through performance. One is expected to perform as being sick.

It is impossible to translate oneself as an active member of the world without these diagnoses and related visuals and performances. I have heard many people who suffer from bodily ailments say that they do not want to be labelled by their sickness. My experience was the opposite. Being sick, being unable to perform as expected without an explanatory label for one's condition, places one outside the conversable dynamic in which people relate. It places oneself outside language.

My artistic work explores the idea of the 'surface'; of the body, of subjectivity, of an artwork, on which language imprints itself. In the medical conception, the surface is an imagined plane where the body is presented, in its entirety, all ailments and abnormalities determinable, visually coinciding with a learnt inventory of maladies. Foucault refers to this as the 'flat surface of perpetual simultaneity'. 'Disease is perceived fundamentally in a space of projection without depth, of coincidence without development. There is only one plane and one moment. The form in which truth is originally shown is the surface in which relief is both manifested and abolished...' (1973:5).

For this reason the surface can also be an arena of psychological violence to the patient who is forced to inhabit this flat space, the medically knowable, see-able body, when within the doctor patient relationship. 'Depth' metaphorically, psychologically is denied the sick subject who quickly, arguably becomes the sick object.

My work explores the creative potential of inhabiting a space just below the 'surface'. I refer to this as the 'half-light'. In this space a visuality that does not offer direct explanation may materialise. It complicates the act of looking by alluding to, but never fully presenting the idea of the body in pain. Works from the half-light talk in voices that hope to be heard but not 'understood'.

My artworks draw on images created during art therapy. The bizarre, unsettling scenarios and characters that covered my pages, increasingly strange and remote, expressed something of my subjective experience of physical pain which has as yet found no combination of words to satisfactorily match them. Even if a doctor had presented me with a shiny black and white image

showing a bump, or a lesion, I am sure that this would not have satisfactorily reflected my experience of the 'way it is'.

The work attempts to re-visualise or perhaps even, de-visualise pain. The visuality referred to here is that which supports the fallacy that how something looks and how it is are one and the same thing. It conflates the idea of seeing with understanding. It seems to insist, 'look, you can see it, this is how it is'.

Through the following experiential account of my relationship with these diseases, the medical arena and public interactions, certain themes emerge that will be unpacked in chapter one. These are; the emphasis on visuality as a form of legitimacy in illness, the construction of 'normality' and how illness threatens this; the confused subject/object status of the 'patient', and the expectation that the patient 'perform' his or her condition.

My Story with Celiac Disease and Chronic Pelvic Pain

There is no science of the individual, and medicine suffers from a fundamental contradiction; its practice deals with the individual, while its theory grasps universals only.”(Boudreau, Cassell, 2010: 379)

Both Celiac Disease and Chronic Pelvic Pain include, but are not limited to constant fluctuations in pain. Pain poses a challenge to the tenets of biomedicine, particularly by eluding medical imaging. The various types of pain related to each condition are entirely distinct from each other. It was many years before I began to refer to the various sensations I had become used to, as ‘pain’. It is extraordinary to me that such a variety of feeling can be referred to by this word and yet, as I have alluded to before, I was grateful for the label, endorsed by a specialist, which translated my experience into something that others could make sense of.

Around the time I began to feel ill, I started attending art therapy sessions. I initially tended to draw myself looking unhappy, in bed, with a swollen stomach surrounded by the outlines of my bedroom. Eventually the images become expressions of an entirely personal lexicon of symbols. Without consciously deciding what I was going to draw, characters and scenarios from my psychological mythology would play out over the page. Not only this, but I began to draw in a bodily way. Scratchy pen marks were like itchy skin, hastily applied overly wet paint could reflect an uneasy digestive system.

In this process, my sickness was indecipherable from other elements of my life. Illness, elements directly affected by illness, elements more subtly affected and elements (arguably) entirely independent were all democratically negotiated within the same pictorial scenario.

This sense of integration conflicted completely with my interactions with doctors and hospitals. I always felt that part of the process seemed to be to separate out the ‘me’ from my body, as if the two operated independently. Medical investigations seemed to imply that my body was simply a faulty machine in which I was riding around. This comprehensive medical gaze paradoxically aligns with an increasingly fractured bodily identity. A sense of bodily unity is undermined by the medical

tendency to split off the offending limb or organ from the patient's subjectivity. There is a certain subtle violence that this approach does to the sick subject, to the person who is so particularly in their body, to be split into parts.

These tendencies interest me as a sufferer of a generally 'unseeable diseases'. Celiac Disease is an autoimmune disease that attacks the digestive system. It is characterised by an extreme sensitivity to gluten. It is also often accompanied by intolerances to dairy, sugar, carbohydrates, sulphur, spicy foods and citrus. The condition exists in degrees. Extreme cases may be picked up on blood tests and colonoscopies, though often only in the duodenum, which is not penetrated by routine colonoscopies. However, these tests are only effective if the patient is still eating gluten and even then are inconclusive, (Celiac Disease Foundation, 2015).

While mainly an affliction of the gut, the effects of Celiac Disease express themselves throughout the body and often more severely through attendant conditions. While the sufferer will generally experience painful digestive disturbances, extreme weight loss, hair loss, anxiety and depression, once gluten has been completely removed from the diet and the right medication and lifestyle are introduced, the condition is manageable. While the gut may work almost normally, the associative conditions, such as chronic fatigue, over sensitive allergies, ineffective immune resistance, anxiety disorders and pain conditions, including chronic pelvic pain, may continue in full force, (Celiac Disease Foundation, 2015). Neighbouring digestive organs, particularly the stomach, oesophagus and bladder, may continue to function abnormally. The process of balancing various medicines may be as onerous as controlling the primary bodily disturbances. So while Celiac is a disease of the gut, it is often 'seen' elsewhere.

Pelvic Pain Syndrome is often a spin off condition of gut disturbances. Pressure on the bladder can lead to the formation of ulcers on its interior walls. This is known as 'Interstitial Cystitis'. I suffered this condition for a few years but the ulcers have recovered significantly. However, like with many chronic pain conditions, my brain has continued to code for pain in the area. The muscles on the left side of my pelvic area have become unnaturally tightened in response to this coding. This is treated through physiotherapy and the practice of special stretches and exercises. The condition is aggravated by digestive disturbances caused by eating the wrong foods.

A celiac or chronic pain sufferer may look and act entirely normally. Many 'normal' activities, however, become complicated to manage. The slightest trace of gluten in food can lead to days of sickness. My mistrust of restaurants and other people's cooking, the awkwardness caused by my

dietary requirements, the sensation of being 'zoned out' due to various pain medications and volatile shifts in energy with friends and family has led to increasing isolation. The daily occurrence of this condition often means explaining unusual behaviours to others which can be irksome and repetitive. I so often felt like I needed to either 'act normal' or 'perform' my sickness to legitimise absences. If you are unwilling to perform, isolation is often the only alternative.

Both Celiac Disease and Pelvic Pain Syndrome are associated with anxiety disorders. There is a correlation in the experience of worsened symptoms and bad bouts of anxiety. It is often unclear what the instigator is, causes can run both ways and often interlace. Similarly, it is impossible to say whether a generally anxious personality is the cause of an underlying medical condition or the other way around. This alone is a serious challenge to the medically dualistic approach.

The possibility that my symptoms seem to intensify at periods of major change in my life has occurred to me. For instance, this year I started working after many years of studying. This frightens me for many reasons including the concern that my conditions may flare up unexpectedly and affect my performance or humiliate me. In my fantasies co-workers whisper that I am 'melodramatic', a prima donna', that I should not be 'indulged'.

This shift will also require driving, which I have managed to avoid up till now. If I accidentally eat food contaminated by traces of gluten, I become very disoriented, dizzy and sleepy. This can also happen in reaction to sulphur, inhaling strong chemicals and sometimes in reaction to my pain medication. I am terrified that I may become hazy and confused while driving and cause an accident.

Have my conditions made me fear fully engaging with a grown up life because I know, from childhood, my body's tendency to be unpredictable? Or, what if the conditions materialise as a way to avoid the responsibility of adulthood? These contrasting positions reflect the traditional western dualistic distinction between mind and body. The answer is probably a complex interrelation between the two. One position does not invalidate the other. While most chronic conditions have a psychological dimension, it is a mistake to dismiss them as purely psychological. The examples above show how entangled bodily symptoms and psychological states are. Bodily irregularities become a structural, integral part of the experience of life. Increasingly, progressive healthcare attempts to integrate the studies of psychology and medicine. This is referred to as the 'bio-psychological model' in opposition to the 'biomedical model'.

Through my self-imposed isolation and my struggle with doctors to uncover my diagnosis whilst attempting to maintain my subjectivity, I feel I have been rendered 'unseen'. Paradoxically, in a

literal sense, I have been more intimately and thoroughly seen as a result of my conditions, in terms of the powers of medical imaging.

Literature Review

The First chapter concerns itself with the visual nature of how sickness is demarcated from the 'normal', into the realm of the abject. Much of this relates to the semiotic structures which inform representation, including medical discourse itself. For this reason my interrogations rely heavily on Foucault's *Birth of the Clinic* particularly in the initial chapter, but also throughout my argument.

Foucault's work, characteristically, explores the hidden power dynamics, which exist within every discourse. His work characteristically explores how these narratives function and whom they serve. From discourses on particular subjects, to the very words we string together in order to inform discussion, the language we use is subtly encoded to support certain hierarchies.

Foucault outlines how medical discourses fundamentally changed during the 19th century. The developments in medical technology meant that doctors and physicians could 'see' more deeply into the body than ever before, through devices such as the X-ray and the microscope. Previously medicine had been considered an art, 19th century practitioners insisted that it was a science. A scientific discourse relies on empiricism, over and above the subjective account of the patient. The power dynamic in the doctor patient relationship was shifted in favour of the doctor who, as possessor of the supposedly objective 'medical gaze', could see and understand the patient's body in a way that they could not themselves.

Medical language denies that, like any discourse, it is laced with metaphor, myth, ideology and inherited power dynamics. Imagery relating to medicine often contains subtle illusions to ideologies that privilege certain peoples' rights to their own bodies over others, a distaste for 'otherness', notions of sickness as punishment and the idea that sickness is 'bad' because it undermines a stable work force.

Body Criticism: Imagining the Unseen in Enlightenment Art and Medicine, by Barbara Maria Stafford focuses on the Enlightenment era as the point in history when we moved from a text based to a visually dominant culture, (1993, xviii). The book is broken up into chapters reflecting various body/

medical metaphors, such as 'dissection', 'conception', 'wound' and so on, in relation to Enlightenment society, particularly within the realms of art and medicine.

This period is of particular interest to my first chapter as the age in which, both in art and in medicine, there was a marked emphasis on uncovering the unknown. In leaving behind religious explanations for being and meaning, scientists and artists sought empirical visual proofs to show how the world functions, (1993: xvi). The intellectuals of the Enlightenment yearned for uncontaminated direct evidence of the workings of man and the universe, (1993: 1). These desires, in terms of medical imaging, were to be realised in the advances of the 20th century, (1993: 26). This thinking is the historical predecessor for medical inventions such as the Computerized Tomography, (CT), Positron Emission Tomography (PET), and Magnetic Resonance Imaging, (MRI), scanners which 'see' the innermost secrets of the body and brain, (1993: xviii).

The book is helpful to my research particularly because of the presentation of this tension, the popular and medical avowal of the visual in spite of the critical acceptance of the tenuous relationship of what is knowable.

If Foucault's work is about the formation and maintenance of dominant or official narratives and ideologies then Lenore Manderson's *Surface Tensions, Surgery, Bodily Boundaries and the Social Self* is about the transformative power of the personal narrative. It includes various narratives of people with severe bodily limitations in order to study how people make sense of their bodies under these new conditions. People engage dominant and resistant narratives in coming to terms with their sick bodies. Narrative practices allow processes of selection, inclusion and exclusion of factors, and reconstructions which allow for a sense of intellectual or spiritual meaning. Narration imposes coherence and sense of trajectory on the formless confusion which is sickness, (2011: 38).

This emphasis on narrative healing is interesting to my study in terms of how it can be translated into visual practices. The first two chapters outline visual practices in the maintenance of dominant narratives of sickness/ otherness/ abjection. Chapter 3 explores the potential power of artistic creations as subversive storytelling which reintroduces a sense of meaning and subjectivity into the experience of pain.

The book also deals with how the notion of Dualism intersects in various ways with the experience of sickness. Though Cartesian dualism is now generally dismissed, people are still prone to see the mind and body as separate entities, particularly sick people. Otherwise, if one is to accept that the mind and body are intermeshed, how do severe negative bodily changes affect one's sense of self?

(2011: 24). Dualism allows the sensation of an un-eroded self to the sick subject, (2011:30). Conversely however, the body in this sense can present itself as a 'thematic object' or 'alien presence', a problem needing solving, (2011: 30).

The question of dualism emerges constantly throughout my argument, in relation to how the body relates to identity during periods of illness.

Pulse, Healing and Transformation discusses the works of various artists who are concerned with ideas around the body, particularly the sick body. The book explores the roles of ritual, narrative and metaphor in the advance of healing.

Lygia Clark and Joseph Beuys are used as points of inspiration in terms of how they destabilised the position of the visible in favour of the creation of experimental spaces, '...ephemeral in substance, radically infinite in proposition' (Bender, Bruguera, Clark, Hohenbüchler, 2003).

Lygia Clark's work features prominently in my third chapter in relation to her alternative model of dealing with the body in art, which does not respond to dominant narratives about the body, illness and healing encoded through imagery. In her manifesto of 1983, Clark declares, 'We reject the representative space and the work of passive contemplation...' (Bender, Bruguera, Clark, Hohenbüchler, 2003:17). The purely visual in art is perceived as 'cold' and 'overly analytical' whereas the more intuitive responses to the other senses engage the subconscious more directly and may even awaken a preverbal form of experience, (Bender, Bruguera, Clark, Hohenbüchler, 2003:16).

This work has been significant to me both in the destabilisation of the traditional role of the visual and the way in which it expresses 'healing' as a process of integration between self, image and narrative.

Beuys and Clark address notions of 'health' in both its specific and broader metaphorical senses as the ideological foundation of the exhibition. They shared the belief in the 'transformative effects of art', particularly in using the body as a medium of expression, (Bender, Bruguera, Clark, Hohenbüchler, 2003:12, 13). Their unique bodily experiments have been described as 'ritual without myth', (Bender, Bruguera, Clark, Hohenbüchler, 2003:12). 'Myth' here corresponds to dominant narratives. The limits of what the body can mean, outside of the restrictions of the official, accepted, historical account of itself, are limitless.

The artist functions as a 'mediator' rather than creator of the artistic experience, (Bender, Bruguera, Clark, Hohenbüchler, 2003:12). Their art was not articulated as an end product, the accumulative

final stage of an artist's vision, but rather a spring board for the viewer's personal psychological response to the work. For this reason both oeuvres seem to place emphasis on incompleteness in their works. It is up to the viewer to 'complete' or activate the work through engagement, (Bender, Bruguera, Clark, Hohenbüchler, 2003:17, 18). It is in this gap, left open by the artist, that healing interactions occur, unique to the experience of each participant.

The thirteen artists referenced in this book are selected in response to these ideas. They hail from different times and environments, and yet their concerns are fundamentally the same. Emphasising the participatory and psychological and moving away from an emphasis on the visual, these art works offer up opportunities for 'healing' by setting up spaces that encourage conversation with the body, (Bender, Bruguera, Clark, Hohenbüchler, 2003: 19).

While both my medium and approach is fundamentally distinct from every artist discussed in this book, the emphasis on the healing aspect of art, as an accumulation of ritual rather than representational object, has been foundationally influential to my work.

I have also looked at the work of William Burroughs as an example of creating outside traditional meaning-making. While Clark used performative interactions, Burroughs used language to destabilise dominant discourses around the body.

In the chapter, 'Two Sounds of the Virus: William Burroughs's Pure Meat Method', in *Noise, Water, Meat: A History of Sound in the Arts*, Douglas Kahn discusses William Burroughs' conceptions of his own particular notion of 'the virus' in reference to language. In this theory the body is an undifferentiated gelatinous protoplasm informed by Burroughs' own experience as a heroin junkie, (2011: 294). This body is driven by pure need, hunger for bodily pleasures. In *Naked Lunch* 1959, the experience of drugs and that of reality are totally undistinguishable. In a moment of pure need, the main character absorbs another completely. The irreverent use of traditional meaning making, in defiance of complete communication in favour of partiality and ambiguity, is what interested me in Burrough's work.

Alain de Botton and John Armstrong's *Art as Therapy* served as one of the significant departure points in my initial thoughts around my topic for this thesis. This is particularly due to the emphasis on art's potential to heal. It insists that art can function as a therapeutic medium that can help guide, exhort and console its viewers, enabling them to become better versions of themselves, (de Botton, Armstrong, 2013: 5). 'Art invites us to a culture that anticipates suffering and decay, which our own culture denies. The galleries of the future will take it seriously, and make an adequate, public and

consoling home for our fleeting, middle-of-the-night apprehensions’, (de Botton, Armstrong, 2013: 149). In short, art can teach us how to feel.

A tool is an extension of the body that allows a wish to be carried out, and that is required because of a drawback in our physical make up. A knife is a response to our need, yet inability to cut. A bottle is a response to our need, yet inability to carry water. To discover the purpose of art, we must ask what kind of things we need to do with our minds and emotions, but have trouble with. What psychological frailties might art help with? (2013: 5)

To define a mission for art, then, one of its tasks is to teach us to be good lovers: lovers of rivers and lovers of skies, lovers of motor ways and lovers of stones. And –very importantly- somewhere along the way, lovers of people, (2013: 103)

This has been a guiding concept in my approach to my practical component. Gestural marks do not need to outline the thing that is being represented, shade and model it into place. They can also release that thing into non-representation, leaving only traces and, most importantly, feeling behind. This is not only expressive but also acts as a structural device in the formation of personalised healing narratives as discussed in the final chapter.

In *Art as Therapy*, Alain de Botton and John Armstrong reimagine the traditional art museum as divided up depending on the emotive properties of work rather than their historic or topical classification. There may be a ‘gallery of suffering’, a ‘gallery of compassion, ‘gallery of self-knowledge’ and so on, each on a different floor. Art itself would not need to change but rather how its presentation sets up relationships between work and viewer. (de Botton, Armstrong, 2013 90)

For instance, the ‘gallery of sorrow’ would contain works that encourage a quiet dignified contemplation on what it means to be sad. Richard Serra *Fernando Pessoa*, 2007-8 is a vast undifferentiated steel rectangle, somewhat taller than a human, which stands alone in a gallery setting. According to de Botton, this work is a ‘profound engagement with sorrow’, presenting sadness with dignity as a ‘grand and ubiquitous emotion’, (de Botton, Armstrong, 2013 26). In this conception of the gallery space, this work could be exhibited alongside Caspar David’s *Rocky Reef on the Sea Shore*, c. 1825. This moody romantic image ‘makes us aware of our insignificance, exciting a pleasing terror and a sense of how petty man’s disasters are in comparison with eternity, leaving us a little readier to bow to the incomprehensible tragedies that every life entails, (de Botton, Armstrong, 2013 30).

This idea not only reorganises the gallery space but also how art should be qualified in terms of value. This model implies that art is 'good' if it can teach and aid feeling, (de Botton, Armstrong, 2013:)

While I have not made use of the idea of the 'galleries of the future', the emotional premise of the idea has been very influential in my writing. *Art as Therapy* inverts the shift in medicine, from an art to a science which occurred during the 19th century, outlined in the first chapter. 'Healing' is re-understood in terms of potentials of a subject's relationship with artworks. The language of objective diagnosis is emphatically absent here. Healing is personally specific and mediated. It is also a process which can be as romantically beautiful and mysterious as the artworks that guide it.

Theoretical Approach

A Post Structural approach has guided the gathering of sources and the construction of my argument. Post structuralism acknowledges the mechanisms of systems we take for granted, regarded as natural or beyond dispute. It rejects the idea of objective truth, unhinging the notion of what is known in exchange for the promise that nothing can be thoroughly known. Not only this, but also that what we think we know belongs to a complicated set of systems which operate to keep us in our place.

In terms of medicine, what is 'given' is the idea that medicine is an objective science. Medicine operates largely on a system of observing and naming which precedes 'fixing'. Fluency in any of these processes is necessarily the result of a long period of study, through which a standardised body of knowledge is imparted supposedly reflecting an objective truth. Post structuralism reorganises this assumption in terms of a hierarchical framework that supports the smooth functioning of a Capitalist Society.

My approach is also largely informed by Art Therapy, which sets itself apart from traditional therapy's inherently unequal power dynamic between therapist and patient, emphasizing the belief in the healing powers of art making, beyond its traditional function as a diagnostic tool.

It will become increasingly evident, that I have steered clear of a feminist reading of the medical encounter and the role of the visual. As an upper middle class white woman, I neatly fitted the stereotype for anorexia that stood in the way of a true diagnosis for many years. My female body added another layer of bias to the power dynamic implicit between doctor and patient. Through the medical gaze, I am doubly encoded as inert and submissive. It may seem strange to discuss performativity without reference to Butler and the construction of femininity or to steer away from a discussion of the medical practice as yet another manifestation of oppressive patriarchy. I certainly appreciate the gravity of these considerations but have specifically avoided a feminist approach because this so often swallows up an argument. I don't want feminist theory to overwhelm the emphasis on how the visual functions in relation to the sick body in terms of a collective containment in classification, stereotype and abjection. I simply wish to write about the sick body

rather than specifically the female sick body, for this reason I have strategically arranged my argument so as not to intersect with feminist theory, despite its relevance in this subject.

Chapter Breakdown

Chapter 1

The first two chapters outline the relationship between sickness and representation which my practical works seeks to renegotiate, as discussed in chapter 3.

This chapter examines the emphasis of the visual in medical notions of healing, from the Enlightenment era till today. Particularly, it explores the legacy of the historical conflation between seeing and knowing.

Part of the purpose of representation is to demarcate sickness as something outside 'normality', to mark it out as abject. Either the abnormality may be corrected, in which the patient is restored to 'normality' or it may not, and the patient will be re-categorised as 'abject'. Either way, the binary and its boundaries are maintained.

The notion of 'normality' is unpacked, examined as a discursive construct rather than a simple description of what is most common. This construction functions through written and visual language that shame bodily otherness and affirm functionalism.

Abjection is the dark space beyond society, language and safety. A sense of abjection emerges during the mirror phase when the child simultaneously recognises itself as a thing with a boundary while seeing how it will be seen by others. It continues to haunt the edges of consciousness, keeping one on the right side of the dividing line.

This 'line' is maintained by the idea that abnormality is 'seeable'. If you keep your abnormalities hidden to the outside world, you may pass as 'normal'. This idea developed during the enlightenment when medical imaging overtook conversational doctor patient consultations as the leading form of diagnostics. Despite the incredible success of such imaging, the pretence of science objectivity disguises its position as a discourse, specifically a discourse that maintains the idea of the distinctly 'abject'.

Pain is entirely subjective and can therefore not be visually represented. Sufferers of pain impose various visual devices into their unseeable experiences, simply to be part of the conversation, to make sense within the binary. In this way, they are doubly encoded as abject, firstly for existing outside the confines of language and secondly by their own self-imposed inscription of otherness.

The sufferer of pain is in constant negotiation and renegotiation in how to meaningfully represent him or herself to the world.

Chapter 2

This chapter focuses on the idea of 'performance' introduced in the previous chapter as a means to impose visibility on pain. Pain legitimises itself through performance while simultaneously marking the sufferer out as object.

I have examined this dynamic by borrowing Butler's notion of 'performativity', repurposing it from the female body to the body in pain. In the same way, the reiterative daily performances, which seek affirmation from the world outside, structure our ideas of ourselves.

Foucault's conception of the 'Panopticon' reflects this position. The famous prison, designed by Jeremy Bentham, was a circular structure lit on the outskirts but cast in darkness at the centre. The prisoners were to be placed around the edge. The idea that the warden may or may not be watching them from the darkened centre was intended to encourage the prisoners to 'self-regulate' their behaviour. This self-regulation is, however, maintained through the threat of punishment.

Similarly the sick body is 'illuminated' by real and imagined public scrutiny. Punishment in this sense means being judged as lazy or duplicitous, being abandoned by loved ones, being unable to support oneself financially. The performance is necessary to keep the rest of the world engaged, to keep oneself relevant. The reiterative nature of performance makes the subjective bodily sensation of pain indistinguishable from its public enactment.

The sick body is socially inscribed with the responsibility to perform itself. This claim is explored through examples from the Enlightenment period until the present, seen within popular culture and high art.

Chapter 3

This chapter introduces alternative models for the expression of pain which are defiantly non-performative.

Art Therapy encourages the process of symbolic story telling. This can redirect the person in pain to his or her subjective experience, acknowledging but not indulging the sense of a social audience. Personally generated symbols step in where traditional language fails. However, unlike language, visual and written, their meanings are not fixed but change according to the needs of the patient. Language can therefore become an imaginatively generative play thing rather than an instrument of social control. Two artists who display an affinity with this approach are discussed in terms of their ability to sidestep the restrictions of traditional representational language.

This provides the theoretical framework for a discussion of my practical work. I have described this work as issuing from a place of 'half-light'. This responds to a metaphorical quandary of wishing to be seen, to have light cast upon one, without being 'illuminated', forced to perform in fear of punishment. It refers to a communication which is partial, playful and visceral rather than fixed or literal. These images tell experiential stories without strict reference to narration. They express a desire to re-enchant my relationship to the unpredictability of my body, demonised by biomedicine. Vague symbolic scenarios, neurotically scratchy pen lines, a sense of gurgling bodily play, are pooled together in an attempt to share my experience, without being willing to step out entirely into the 'light'.

Chapter 1: Discourse disguised as science: The creation and maintenance of the normality/ abjection binary

Now out of the ground the Lord God had formed every beast of the field and every bird of the heavens and brought them to the man to see what he would call them. And whatever the man called every living creature, that was its name, (Genesis 2:19).

The word 'image' is linked by its very etymology to the body and its mortality: the Latin *imago* referred to the wax mask the Romans made to preserve the likeness of the recently deceased. Pliny the Elder warned about trafficking in these images, which he called *luxuria* - a negative term which can be translated as 'lust' and referred to a taste for all things foreign, indulgent and opulent. The world is more saturated with images now than ever before: we live in a society that revels, lustfully, in a lavish surfeit of images, (Gioni, 2013: 25).

...If you are not like everybody else, then you are abnormal, if you are abnormal, then you are sick. These three categories, not being like everybody else, not being normal and being sick are in fact very different but have been reduced to the same thing, Foucault in (Droit, 2004: 95).

Foucault argues that abnormality is not simply a deviation from normality; rather it is a structural element in knowing what the normal is. While the particulars of abnormality may change depending on time and place, its function stays constant. This function is to define and mark out the abject for the sake of the maintenance of the non-abject, (MacLachlan, 2004: 7).

To name something is to assert power over it. Adam was given power over beasts through the practice of naming them. There is a visual dimension to naming, and there is a linguistic implication in every recognisable visual. The label and the responding labelled spring into significance at the same time. They are inseparable. Is the power of the label all the more powerful when instantly accompanied in the mind by an image rather than a hazy abstract concept? Is the 'lust' Pliny describes in relation to images, the lust for the sense of explanation or lucidity that the visual

provides? Do we not sometimes assign visuals to ideas even when the two are not necessarily compatible? Is the failure to name experience seen as an insult to human prowess and language? Is the abject, as an uncomfortable, even terrifying idea, all the more requiring of visuals to pin it to the relatable, the knowable, specifically because it is not these things? I am interested in the visual side of language which simultaneously creates and then attempts to contain the abject within image.

This chapter examines the idea of the sick body through various 'lenses', each forming a subsection. Each lens deals with a separate aspect of representing the sick body. Other themes run parallel along these subsections. Such themes are; the tenants of the Biomedical model; the legacy of enlightenment thinking and the effect of the medical system on a patient's subjectivity.

The Biomedical model of medicine is the most commonly practised system in the West. It is defined by a tendency towards 'biological reductionism', (Kleinman, 1962: 6). Medical attention often focuses solely on the science of suffering, arguably only addressing a fraction of the problem, (Kleinman, 1962: 4-6).

The influence of Enlightenment scientific enquiry, specifically that of the 19th century, on modern day medical thinking is relevant to several key concepts that shape the representation of sickness, especially in terms of the relationship between the sick subject and its body.

What happens to the patient's subjectivity during the process of medical labelling? The medical gaze denies its own subjectivity by drawing on the apparent objectivity of scientific language and in so doing, the subjectivity of the patient is also denied. Medical labels jostle against other labels relating to the self until they occupy prime position. What is relevant is what can be sliced, X-rayed, regulated, reconstructed, in other words, in some sense, 'seen'. 'To know nature is to see it: in the body, in the test tube, under the microscope', (Good, Good, Brodwin, Kleinman, 1994: 9).

What is not seen, character, belief, dreams, is unimportant in the process of diagnosis and 'cure'. To be 'cured', according to this model, means that one's bodily organs and systems are made to resemble the general mean of what most people display. To be cured is to look and function 'normally'.

The socio-cultural Construction of 'normality'.

'... the magic of the word 'normal' is that it can be used at one and the same time to say how things are, but also how they ought to be. The seemingly innocent and objective notion of the norm 'lays claim to power', providing a foundation and legitimation for diverse techniques of institutional intervention and correction (Tyler, 2008: 114).

Notions of normality and health are not natural standards from which sickness is a deviation. They are ideological linguistic inventions. 'Normality', as a discursive construction, is moulded by every particular society and culture, as a means to maintain social order. 'The body is a social construction, vulnerable to ideological shifts, discursive processes and power struggles', (Lupton, 1994: 20). This does not mean that bodies hold no physical reality but rather that they are a 'mixture of discourse and matter, one whose inseparability is a critical, though complex attribute', (Lupton, 1994: 22).

If it is not an objective standard, then what is 'normality'? Common sense would insist that it means the state of being that is most common. However, while most people suffer bouts of depression, stomach upsets, unsightly skin and so on, none of these conditions are considered 'normal'. 'Normality' is a quest which cannot be completed. The very abundance of products promising to return us to normality begs the question, what is the punishment if we fail to do so?

One answer seems to be that we will become abhorrent or distasteful to other people, will be cast out, socially unacceptable.

This is subtly alluded to through the cult of 'health'. The idea and image of wellness is all pervasive, it is so familiar yet none can claim to embody it entirely. Our ever more powerful and expansive commodity culture emphasises youth and vitality while banishing age and illness from commercial spaces, (Morgan, 2003:19). It exerts itself on the body through the invasive emphasis on 'health' which permeates every avenue of visual culture, very often with airbrushed and half-starved models as its brand ambassadors. 'Ugliness' is punished by being made into a spectacle or simply rendered invisible.

The fixation with the publically immaculate body was well established by the 19th century. The emphasis on makeup exemplifies this. It was not only an expression of vanity but a 'social duty', a

gesture of politeness, (Stafford, 1993: 288). Stafford describes it as a ‘... foreign remedy pasted over material poverty, whitewashing disfigurement and miraculously restoring a ravaged corporeality, (Stafford, 1993: 289).

In Enlightenment imagery, pain is often represented as synonymous with ugliness. Pain was seen as a symptom of being too much in one’s body, not engaged with higher ideals of thought and reason. Gotthold Ephraim Lessing was a prominent eighteenth century Enlightenment thinker, expounder and advocate for Neo-Classical thinking. For Lessing, overt expressions of pain or illness in art were tantamount to both physical and moral ugliness. ‘Ugliness offends our eyes, contradicts the taste we have for order and harmony and awakens aversion irrespective of the actual existence of the object in which we perceive it’, (Stafford, 1993: 180). In this way, ugliness in the form of pain, has lasting detrimental effects on the viewer long after the moment of contemplation has passed. The *Laocoon* is used as a paragon of this position. Though facing attack and impending death from a sea monster, the figures remain heroically athletic, their faces, though somewhat contorted, do not cross over into the realm of the ugly. Decorum is maintained, (Stafford, 1993: 179).

In Christian Ludwig von Hagedorn's work pain, physical or emotional, was expressed by an ugliness close to monstrosity. He describes Hesiod's goddess of Sorrow as 'awash in tears, grinding her teeth, pale, dishevelled, desiccated, knobbly kneed, with bloody cheeks, talon nails, dusty shoulders, and nostrils filled with phlegm, (Stafford, 2003: 183). The human in overt pain is then degraded to the space between humanity and animalism.



Figure 1, Hagedorn, *Grotesque Head*, (18th century)

The ban on the hideous effectively filtered artistic representations of the ill into the domain of caricature. This medium inevitably highlighted the ridiculous, embarrassing elements of illness, tending to hyperbolise any visual markings, (Stafford, 2003: 179).

In George Cruikshank's *Indigestion*, 1825, the characters are beset on by small devilish characters. These demons enact and employ the effects of the affliction, winding rope tightly around a waist and shoving sausages into an unwilling mouth, while the central subject sits powerless and unengaged by anything other than his pain. He is both pitiable and laughable.

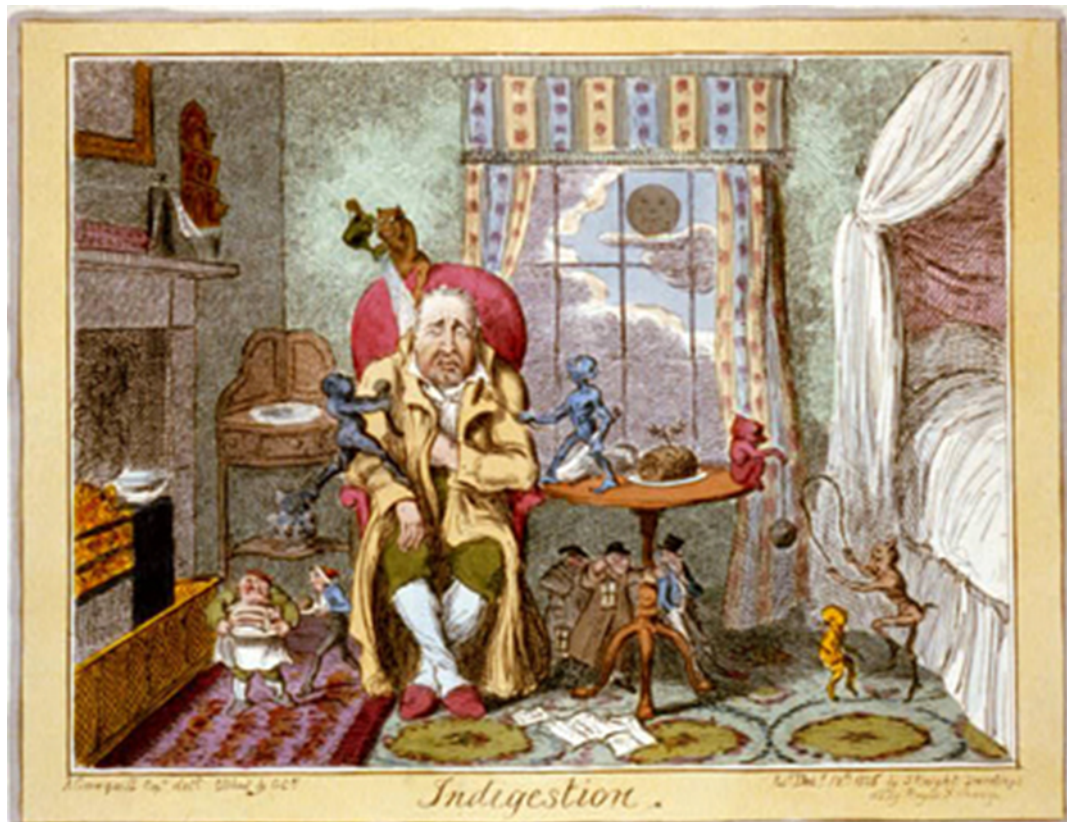


Figure 2, Cruikshank, G. *Indigestion*, (1825)

The contemporary continuation of the Enlightenment's anathema for the 'ugly' in relation to the constructed notion of the 'normative body', in many ways reflects Plato's idea of the perfect original to which all nature is at best an imperfect copy. This idea gets revitalised throughout history in the form of 'Neoplatonism', (Stafford, 1993: 252). A permanent essence was thought to exist in all things in the universe, the alterations and deformations of which only existed in the empirical world. This idea is remarkably similar to the unattainable notion of 'normality'.

We simultaneously realise this ideal is impossible while maintaining a culture of self and mutual chastisement in being unable to fulfil it. The idea of 'fault' is absolutely essential to the maintenance

of this bizarre, contradictory reality. You would have a more pleasing physique, better skin, more energy, digest your food more efficiently, feel generally happier, if you did not smoke, if you exercised more, if you ate less unhealthy foods, if you used/ applied/ ingested a particular product and so on. Your inability to achieve the ideal is your own fault.

Similarly, contemporary culture places pressure on individuals to maintain 'healthy bodies' by associating so-called 'lifestyle diseases' with deviant personal behaviour, (Lupton, 1994: 31). These illnesses exist further down the same continuum line of 'fault' as that of being incapable of attaining bodily perfection. Platonism insists that the external physical body emanates, in some way, from a person's character. Deviations from the perfect original were caused by sparks of human passion, giving rise to distortions, ugliness and disease, (Stafford, 1993: 251). Historically, illness has been narrated alongside ideas of guilt and punishment. From ancient beliefs in holy vengeance through pestilence and plagues, to pre-Enlightenment ideas of sickness as inseparable from dirt and dirtiness to more contemporary notions of illness as a direct result of unhealthy lifestyles, such as consuming 'bad' foods and the various conditions that it may cause, the idea of punitive sickness is constant.

The need for punishment arises from the civic need for a stable work force. If sickness prevents one from working, one's body ceases to perform a civic duty. This is yet another threat to the maintenance of 'normality'. You will cease to make sense within society, will have no function, become a floating signifier.

'Functionalism' is a dominant theoretical perspective on the role of medicine in society. Functionalism views the medical realm as an essential cog in a consensual society in which sickness is constructed as a social digressive. Sickness prevents the subject from engaging meaningfully with the expectations of society and must therefore be alleviated as soon as possible. Examples such as Stephen Hawking and Helen Keller are arguably the 'exceptions that prove the rule'.

A simple Google Image search of 'indigestion' is a testament to this. The images below represent an overview of the most frequent types of images.

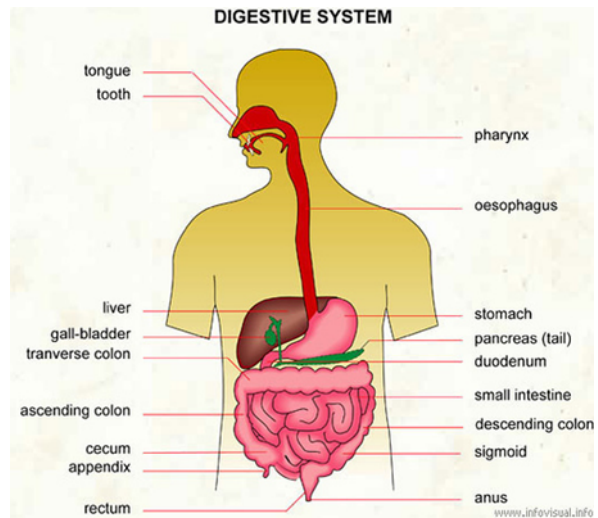


Figure 3 Indigestion Diagram 1, (n.d.)



Figure 4 Indigestion Diagram 2, (n.d.)

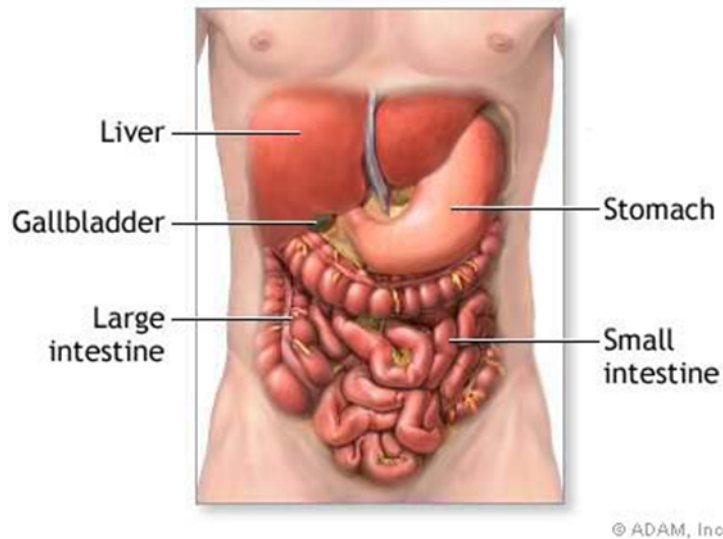


Figure 5, Indigestion Diagram 3, (n.d.)

Figure 3 represents the popular sanitised bodily diagram which so eloquently expresses distaste for the abject it is forced to represent. These post-bodily images are perhaps the most bizarre representations here. There is nothing human, let alone painful left in these images.

Figure 4 presents the standardised visualising cliché for indigestion, the metaphor of having a fire in one's stomach. More interestingly, figures 4 and 5 both portray remarkably young, evidently well maintained bodies, hardly prime candidates for frequent indigestion. Even within the sphere for representing bodily disturbances, ableism dominates.

In Figures 6, 7 and 8, a business man, indicated by the 'work shirt' and tie, is represented in gastronomic distress. The subtext in these images is that the greater evil is that indigestion keeps one from work, not that it causes bodily, psychological pain. Medicine steps in to curb social deviant position of being able to function.



Figure 6, *Business Man 1*, (n.d.)

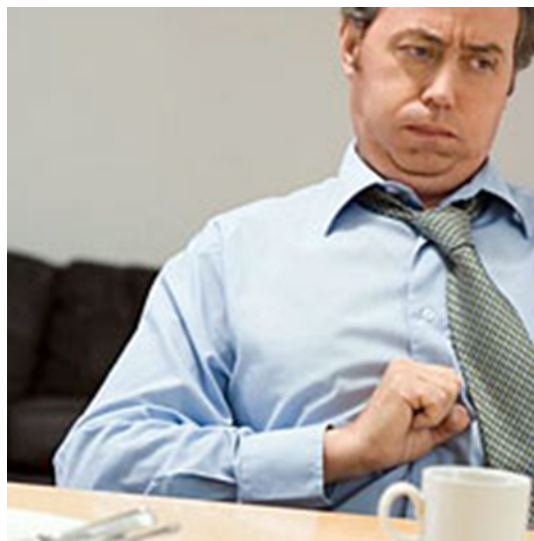


Figure 7, *Business Man 2*, (n.d.)



Figure 8, *Business Man 3*, (n.d.)

No one person or groups sustains these ideas. They are subconscious, learned and communally maintained. The body acts as an ultimate medium for civic control. This filters through into popular culture in all forms of representations. The hyper visibility of aggressive ableism effectively denies the voices of the ugly, fat, old, disabled and the ill, with few exceptions.

Finally 'normality', paradoxically seems to align itself with an invisibility of bodily functions, (Manderson, 2011: 27). Often the lack of particular internal corporeal perception is a sign of healthiness, (Manderson, 2011: 26). The body is 'taken for granted' in the healthy. The healthy are not aware of their eye balls seeing, they simply see. They do not feel their internal organs. They are not generally aware of the intricacies of their digestive system, (Manderson: 2011: 24, 25, 26). Awareness of the body is heightened when it is dysfunctional, when it is not behaving normally. Then the surface, organ or system jumps into sharp relief and the rest of the body 'slips into disregard', (Manderson, 2011: 26).

Perhaps this is the greatest threat posed by the 'abnormal body'; its ability to subsume the self. When one is overwhelmed by internal processes that should be taken for granted, it is easy to start thinking of one's body/self as simply defective organic matter without any purpose outside itself.

The Sick Body as the Abject body

During a period of intense physical illness, Francis Goya produced a private, un-commissioned series known as the 'black paintings'. These dark shadowy scenes are inhabited by hollow eyed, pale women and men, desperate, menacing or entirely wild. Goya's terrifying monstrous post humans represent the shadow side in the construction of normality. In order to define something, borders need to be drawn between what it is and what it is not. Abjection occupies the space which the 'normal' and the 'healthy' have vacated.



Figure 9, Goya, *F. Yard with Lunatics*, (1794)

The concept of abjection in any given subject may arise during the 'mirror phase'. This is a Lacanian concept which accounts for the formation of a 'body image'. When a child is very young, they have no sense of a distinction between themselves, their mother and the world around them. At some point, around the age of two, the child sees themselves in the mirror, realises that he or she has a bodily outline that divides them from everything else. 'That which is lost or resists incorporation is also precisely what makes the coherent body image possible because it marks the boundary between the body image and what it is not', (Benthall, Polhemus, 1975). From then on, a subconscious fear exists that the boundary will dissolve, and the self will be submerged, lost. The

'abject' is this threatening outside that both outlines the limit of the self while threatening to destroy it.

Elizabeth Grosz describes the abject as an abyss that is always beckoning and enticing the subject closer to the edge, (Benthall, Polhemus, 1975). This idea has held particular symbolic traction for me since the first time I came across it and has played a decisive role in helping me understand my own practice. The 'abyss' is the dark space that exists in every subjectivity that language and representation have been unable to make sense of. It is the indigestible stuff left over on the margins of our socially acceptable selves.

For Julia Kristeva, the abject is...

An extremely strong feeling which is at once somatic and symbolic, and which is above all a revolt of the person against an external menace from which one wants to keep oneself at a distance, but of which one has the impression that it is not only an external menace but that it may menace us from the inside, (Benthall, Polhemus, 1975).

The abject haunts the ego in a continual disruption of the body's boundaries in the form of blood, spit, mucus, faeces, urine, pus and vomit, (Benthall, Polhemus, 1975). Illness is a literal example of a threat to psychological order that threatens us from the inside. For the sick subject, the disruptions of bodily boundaries are generally more frequent, the threat on their boundaries more pervasive.

Certain tropes exist within the tradition of representing illness and the ill that mark them out as abject. These are recyclable rather than tailor made for particular disorders.

Icons of disease appear to have an existence independent of the reality of any given disease. This "free-floating" iconography of disease attaches itself to various illnesses (real or imagined) in different societies and at different moments in history. Disease is thus restricted to a specific set of images, thereby forming a visual boundary, a limit to the idea (or fear) of disease... For instance, by the sixteenth century, leprosy was no longer endemic in Western Europe, its iconography remained as part of the popular storehouse of images of disease and pollution and was immediately attached to the new disease of syphilis', (Gillman, 1987:88, 95)

Stereotypes assist in fleshing out an illness' 'look'; an AIDS patient is black and or homosexual, an anorexic is white, female and upper class. There seems to be a certain communal comfort in being able to neatly designate the behaviour and image of illness. The abject must be carefully defined,

delineated, to ensure that non-normativity is not allowed to seep into the realms of the healthy. This systematic response and social psychological containment of illness is disturbed when the subject does not act or appear sick. This is evident in the collective panic about STDS, anyone could have them and spread them, and there is often no way of knowing/ seeing who.

Similarly, if one does appear ill, but does not offer up a neatly contained explanation of their appearance, society, and often medicine, is quick to offer up one. Before being diagnosed as a Celiac, I was repeatedly told by people I knew, people I did not, and various doctors, that I was starving myself. I come from a wealthy family, am young and obviously concerned with my appearance. I fit the stereotype. My overly skinny, abject body became public property, repurposed to the socially imperative task of explaining itself away. Labels such as 'anorexic' attached themselves, ill fittingly, to me, up to the point when I almost convinced myself that I was somehow not allowing myself to absorb the food I knew I ate.

Labels respond to the same 'seeing is believing/ understanding/ knowing' impulse that is a structural element of how both modern medicine and popular culture perceive the sick subject. The notion of abjection is maintained communally. Stepping too close to the boundary line may mean social ridicule or exclusion. In order for society to govern these boundaries abjection must be identifiable, (Gillman, 1987: 103). Representation serves this purpose.

Sickness as 'See-able'

The idea that sickness is 'seeable' is a pervasive one. The stereotype of the mottled bed bound skeleton has survived for centuries with little deviation. The image is clearer and more ubiquitous from the proliferation of bodily representations from the enlightenment period on.

In 2015, the Oscars for best male and female lead went to depictions of incurable diseases. Eddie Redmayne portrayed Stephan Hawking's struggle with Motor Neuron Disease in *The Theory of Everything* and Julianne Moore played an early-onset Alzheimer's patient in *Still Alice*. In 2014 Matthew McConaughey and Jared Leto were celebrated as Best Actor and Best Supporting Actor respectively, for their roles as AIDS sufferers in *Dallas Buyers' Club*. Both actors lost significant percentages of their total body weights for the parts.



Figure 10, *The Theory of Everything*, behind the scenes, (2014)



Figure 11, *Still Alice*, (2014.)



Figure 12, Matthew McConaughey weight loss, (2013)



Figure 13, Jared Leto weight loss, (2013)

Behind the pretence of celebration of these characters' heroism given their conditions, it is perhaps voyeurism that accounts for much of the appeal of these stories. The morally beautiful premises make space and excuse the desire to see what these diseases 'look like'. There is something guiltily thrilling in seeing Matthew McConaughey's usually muscular bronzed body reduced to skin and bones.

These examples reflect Pliny's concerns over desire for image. They also represent the popular notion that illness can be directly translated into the visual. With make-up, props, weight gain or loss, the illness can be visually assimilated. In other cases it can be drawn, photographed or modelled. The voyeuristic pleasure in watching McConaughey's body may not just be derived from the thrill of recognising the abject as something completely and fascinatingly distinct from oneself. It may also derive from the simple fictitious reassurance that the sick look sick and the healthy do not.

This is not to imply that a strong causal link does not exist between an illness and appearance. Illness may express itself on the bodily surfaces, easily detectable by doctors, and to a lesser extent the public, depending on the severity and placement of the irregularity. Medical advances have meant that modern doctors may see deeper and more profoundly into the interior of the body, even to a microscopic level. 'Seeing' may mean the visual evidence of a non-uniformity in an X-ray, a fissure or bump detected by a scope, positive results from a blood test. If the affected area can be fully visualised, the problem will be detectable.

A reliance on imagery gained momentum in the medical understanding of illness since the scientific advancements of enlightenment inquiry. In the eighteenth century a visit to a doctor commonly opened with the phrase, 'what is the matter with you?' Now the clichéd line is 'Where does it hurt?' Foucault argues that this marks the shift in how medical discourse operated before and after the advent of the clinic in the nineteenth century. It entirely re-engages the idea of signifier and signified in terms of bodily symptom. The visible signifier is now thought to correlate directly to a specific condition, signified, (Foucault, 1973: xxii). The former question also notably places more importance on the voice and interpretive abilities of the patient. One acknowledges subjectivity, the other imposes an objectivity.

Pre-Enlightenment medicine generally relied on the belief of bodily 'humours'. These were blood, black bile, yellow bile and phlegm. An excess or deficiency of a humour was thought to be at the root of all diseases, (Barnett, 2014:21). The study and treatment of these irregularities was considered an art, as much intuition as anything else. During the Enlightenment the notion of the body as a medium of semi-mysterious, half known humours was replaced by the idea of the body as a machine. Disease was now simply a matter of wear and tear, (Barnett, 2014: 24,25). The access to various manifestations of visual material in relation to the body, especially during the 19th century, allowed for a sense of objective empiricism. Medicine was reconceptualised as a science, (Barnett, 2014: 22).

This shift is accompanied by an inversion in the power dynamic between doctor and patient. Traditionally, more emphasis was placed on the patient's account of his or her illness. Medical students in 19th century urban hospitals could 'diagnose and dissect on a near industrial level', (Barnett, 2014:26). Catalogues created through observations of dead bodies provided visual correlations to living bodies. New devices such as the stethoscope, meant that diseases could be identified within the patient's body without any recourse to the patient's voice, (Barnett, 2014:26).

The doctor acquires a thorough and complete knowledge of the body, gained through a long period of study. Doctors possess the 'medical gaze', he or she can 'see' the body in a way that the patient simply cannot. Where the patient sees a strange lump, the doctor understands its cause, its nature and how it should be treated. In this dynamic, the patient is only the *ignotus* in possession of the raw material of the defective body, which will make sense only when exposed to the illuminating clinical gaze of the doctor, who alone can 'unlock the secrets of the disordered body', Susan Bordo, 1993 in (Benthall, Polhemus, 1975) .

This conception of the medical gaze is perhaps more pervasive today than ever, inspired by the miracles of modern medical technology. Doctors still ask patients how they are 'feeling', however their answers are more thoroughly gleaned through inert replicas of the patient's insides, with the help of the CT scan, the biopsy and the X-rayed image. The supposed objectivity of these resources together with the doctor's capacity for translation, has led to medicine being described as an 'aristocratic discourse', the resulting authority becoming 'monologic, monoglossic, univocal, and sacred', (Naryvey, 2002: 133).

The emphasis and access to sophisticated imagery in medicine have been accompanied by unprecedented success. Cancerous lumps can be detected and removed. Diseases can be identified through the testing of bodily fluids and accordingly treated. Access to the historically sacrosanct realms of the brain and the womb can mean the early detection of potential problems.

However, through these triumphs, by annexing itself to notions of complete scientific objectivity, medicine denies its status as a discourse. In so doing it disguises the attendant myths, presumptions and most importantly, agendas that accompany every discourse. In terms of medicine, this hidden agenda can be described as regulating and maintaining a workforce by encouraging a mentality of productivity, self-reliance and self-care, (Lupton, 1994: 31). The body is the 'ultimate site of political and ideological control, surveillance and regulation', (Lupton, 1994: 23). Through medicine, psychiatry, the educational system, the media and the state, bodies are subtly punished for deviating into the realms of sickness, (Lupton, 1994: 23).

In *The Birth of the Clinic*, Foucault argues against the popular idea that nineteenth century Enlightenment marked the point in history when medicine moved away from vague superstitious hypotheses to a basis in empirically provable fact. Instead, he argues that this notion was absorbed into a new discourse of benevolent medical objectivity, which justified increased intrusion into the privacy of its subjects.

Modern medicine has fixed its own date of birth as being in the last years of the eighteenth century. Reflecting on its situation, it identifies the origin of its positivity with a return—over and above all theory—to the modest but effecting level of the perceived. In fact, this supposed empiricism is not based on a rediscovery of the absolute values of the visible, nor on the pre-determined rejection of systems and all their chimeras, but on a reorganization of that manifest and secret space that opened up when a millennial gaze paused over men's sufferings, (Foucault, 1973: xiii, xiv)

‘At the beginning of the nineteenth century, doctors described what for centuries had remained below the threshold of the visible and the expressible, but this did not mean that, after over-indulging in speculation, they had begun to perceive once again, or that they listened to reason rather than to imagination; it meant that the relation between the visible and invisible—which is necessary to all concrete knowledge— changed its structure, revealing through gaze and language what had previously been below and beyond their domain’, (Foucault, 1973: xiv).

In these quotations, Foucault emphasises how visibility became interchangeable with understanding through a scientific language that emphasised the observable. From the nineteenth century onwards, the idea of ‘truth’, in medical terms, seems to align itself with how closely a case is observed, or the extent to which it can be observable, (Foucault, 1973: xv). Foucault argues that rather than removing the bias and superstition of previous discourses, these elements are simply differently materialised. ‘Far from being broken, the fantasy link between knowledge and pain is reinforced by a more complex means than the mere permeability of the imagination’, (Foucault, 1973: xii). So while the modern medical language may masquerade as a transparent means through which objective truth is relayed, it is still a language. The character and manifestations of the prejudices it contains are simply better camouflaged to those who engage with it. A principle player in the efficacy of this camouflage is the idea of the infallible medical gaze. ‘The figures of pain are not conjured away by means of a body of neutralized know-ledge; they have been redistributed in the space in which bodies and eyes meet’, (Foucault, 1973: xii).

Foucault’s argument is not to discredit modern medicine or suggest the superiority of previous systems, but simply to draw attention towards the fact that, the successes or failures of pre-clinic and post clinic medical language notwithstanding, both are discourses, (Foucault, 1973: xxiii).

The idea of seeing and recognising a discordant element also implies that discordant elements of a particular type, will always resemble each other. Medical classification depends on this. It is a semiotic principle that sufficient similitude be evident in bestowing a single name on a multitude of objects or occurrences. In *Birth of the Clinic*, Foucault states, ‘the first structure provided by classificatory medicine is the flat surface of perpetual simultaneity, (1973: 5). And later, ‘in a flat, homogeneous, non-measurable world, there is essential disease where there is a plethora of similarities’, (1973:6).

The premise of similitude allows for the potential of verisimilitude, as in the examples of the actors taking on the appearance of sickness. What is fascinating is that these actors' bodies satisfy a voyeurism to see what these conditions look like, despite the audience being perfectly aware that each actor is depicting a condition which he or she does not suffer from. Is it possible that the biomedical model has set up a dynamic in which the representation of the sick body is more significant than the sick body itself?

Pain: a semiotic impossibility?

English, which can express the thought of Hamlet and the tragedy of Lear, has no words for the shiver and the headache. The merest schoolgirl, when she falls in love, has Shakespeare and Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry. There is nothing made ready for him. He is forced to coin words himself, and, taking his pain in one hand, and a lump of pure sound in the other (as perhaps the people of Babel did in the beginning), so as to crush them together that a brand new word in the end drops out. Virginia Woolf, 1930 in (Lupton, 1994:55).

Perhaps Woolf is hasty in declaring there is little creative literature on the theme of illness. Canonical giants such as Camus, Ibsen, Dumas and Joyce have all tackled the subject, (Lupton, 1994:51). Perhaps illness does not maintain the same social taboo that it did in the 1930s. However there is something in Woolf's description that rings undeniably true. Pain resists language, (Good, 1994: 30). When faced with explaining pain to a doctor one is restricted to reductive phrases like 'it hurts', 'it's sore', its 'painful', perhaps with unsatisfactory modifiers such as 'very' or 'really'. Otherwise one resorts to time worn metaphors such as 'splitting', 'pounding' or 'throbbing'. These terms have been so continuously overused that the visceral quality of what it would really be like for a head to be 'splitting' is long lost.

Elaine Scarry proclaimed that pain, '...is expressed in cries and shrieks, in a pre-symbolic language, resisting entry into the world of meaning. It 'shatters' language ', (Good, Good, Brodwin, Kleinman, 1994:29). 'The objectlessness, the complete absence of referential content, almost prevents it from being rendered in language; objectless, it cannot easily be objectified in any form, material or verbal, (Scarry, 1987:162). If pain defies language, how is the subject in pain supposed to communicate their experience to those around them? A sharing of subjectivity is near impossible.

Pain holds a tenuous position in both the popular imagination and in medical science because it cannot be measured, monitored or conceptualised. Pain cannot be seen. The notion is accompanied with a strong sense of lack. It is uncontainable by language because it upsets the semiotic structure on which language relies. A semiotic system, be it expressed through the written word or through visual culture, ensures that meaning can be shared. Pain, so inherently subjective, untranslatable,

challenges this coherence, (Good, Good, Brodwin, Kleinman, 1994: 5). The signifier 'pain' whether it be written or spoken does not lead directly to a signified conception of what pain is.

Classification, an essential element of language, depends on similitude. Two objects or ideas must be significantly similar when they share a word that references them. The differences between the two objects/ideas fall away while their similarities are contained by language in the form of the particular word. The idea of a 'disease' implies a definable set of symptoms and conditions, a knowable enemy. In fact, many diseases are really a series of relatively unpredictable biological processes (Sontag 1978: 67). HIV/AIDS, particularly, is better described as a condition rather than a disease. By its nature, it is comprised of a spectrum of various illnesses. Despite this, it is common to talk of HIV/AIDS or Cancer or Diabetes as a single finite ailment regardless of the variety of their permutations.

How then can pain be classified, given a containing word, if it cannot be seen, if two subjects may use contradicting descriptions in reference to the same sensation, resulting from different cultural or psychological backgrounds? Conversely, patients may use the same language, for example, 'my head is splitting', to describe two entirely different experiences, both in terms of sensation and extremity, given the limited expressions available to them. In this way pain challenges the tenants of the biomedical system, the limits of visibility and classification, (Good, Good, Brodwin, Kleinman, 1994: 7).

The focus here is not 'acute pain' which relates to a specific bodily trauma and fits neatly into a narrative of a period of illness followed by a return to health, incapacitation or death. This pain is somehow made visual through attendant rituals, such as the appropriate dress and behaviour of the patient, confinement to bed for example. The finite time frame of acute pain also provides a sense of containment in terms of the notion of pain to patient, family, friends and doctors. 'Chronic pain' defies visualisation. The patient most often does not wear the associated garb of illness, is not confined to bed, moves around and interacts as 'normal'. The pain is not contained by the space of the hospital or bedroom or by a neat time frame of illness. Instead it seeps through every part of the patient's life, becoming an active element of their personality and the lives of those around them, (Good, Good, Brodwin, Kleinman, 1994: 13).

The lack of meaningful language for pain, and the uneasiness this causes, often results in the patient attempting to make his or her condition relatable by other means. This may be achieved in various ways. One way is for the patient to 'perform' their illness in order to draw it into the realm of the

visual. Performance allows pain to be communicated, for needs to be expressed. This will be discussed in more depth in the beginning of chapter 2.

The simple naming of the set of symptoms in medical terms allows a sense of legitimacy and containment. For this reason, it is common for sufferers of chronic illnesses to regularly refer to the medical label of their condition, almost ritualistically, soothingly.

Otherwise, sufferers attempt to share their experiences through the visual language of metaphors, (Good, Good, Brodwin, Kleinman, 1994:77). References to sensory adjectives such as, 'splitting, pounding, and throbbing' provides a visual dimension to a condition that, by its nature, denies it. In medicine, sickness is usually described in terms of various acts of warfare, the body is 'under attack' and it's 'besieged'. There is no literal connection between warfare and a sick body but when a patient uses this imagery, he or she is engaged in the act of communal meaning-making, (Brodwin, 1994: 78).

'Biomilitarism' refers to the medical language of disease that makes use of military imagery. It is common to describe war as a 'sickness' of society and illness as a 'war' on the body. War and illness have been interchangeable concepts since classical thought, the god Apollo presiding over both threats in the maintenance of order in civilisation. Biblically, war and pestilence are holy allies in punishing the wicked. Half way through the 19th century, the medical scientist Pasteur was studying the nature of germs. Due to advances in medical technology, particularly in the microscopic, for the first time scientists could observe germs entering the body. Illness became understood as an 'invasion' of innumerable 'hostile' microscopic agents that could, at last, be observed and classified, (Sontag, 1978: 95).

Pain metaphors are time and culture specific. They reflect the particular ideological concerns of their subject's context. For instance, in the middle ages, sickness metaphors described illness as nature entering the body. Bodies were often described as houses or fortresses, bastions of civilisation. In the 17th century, biblical imagery dominated. The sinner was said to be ill, or made well by repentance, (Lupton, 1994: 56). The industrial revolution ushered in a tide of body-as-machine metaphors. We still commonly refer to being 'wound up', 'blowing a fuse', needing to 'recharge our batteries', (Lupton, 1994: 59). In the late twentieth and early twenty first centuries, this has translated into computer imagery. We refer to the brain as 'storing information', computers as having 'memory', (Lupton, 1994:60).

These examples show how culture and ideology are inscribed onto the personal experience of the body in pain. The metaphor actively creates and reconfigures reality rather than reflecting it. Metaphor creates similarities, drawing together two unrelated ideas and forcing them into a shared significance, (Cresswell, 1997: 332, 333). These metaphors are drawn into our experiences of our bodies, (Brodwin, 1994:93). Absorbing the medical terminology of warfare can lead to the patient feeling 'at war' with their own body. The subject is violently split in two and set at odds with his or herself. Chapter 3 deals with the process of creating a set of personal metaphors that are uniquely applicable to my experience. This has served to actively re-engage and reintegrate my sense of self with that of my body, to end the war.

Scientific Language as Discourse

Despite the semiotic conundrum discussed above, medicine determinably draws the vagaries of pain conditions into the realm of language through medical labels. The authoritative sounding terms, 'Celiac Disease' and 'Chronic Pelvic Pain', seem to imply a full understanding of the mechanisms, causes and treatments. This is not true in either case. They do however translate the mysterious and subjective into something which can make sense within a grander narrative.

Biomedicine, for Kleinman, corresponds no more to an essentialist definition than any other medicine, be it shamanism, traditional medicine, or Chinese medicine. However, all medicines share these features: "categories by which health is normalized and illness diagnosed, narrative structures that synthesize complaints into culturally meaningful syndromes, master metaphors, idioms and other core rhetorical devices that authorize practical therapeutic actions and the means by which their 'efficacy' is evaluated, healing roles and careers, interpersonal engagements that constitute a vast variety of therapeutic relationships and modes of clinical interaction, an immense panoply of therapies, seamlessly combining symbolic and practical operations... whose intention is to control symptoms or their putative sources", (Janzen, 2010: 352).

Biomedical discourse is unique in that it maintains its authority by denying and disguising its status as a discourse. Through the assertion of medical objectivity and scientific reasoning, it implies a direct access to the truth. Such an access has been disputed by post-structural theory because of the layered connotative quality any language invariably takes on. A post-structural approach interests itself in uncovering the role of language in maintaining social order and constructing notions of reality, (Lupton, 1994: 17). No matter how far medicine advances in terms of its abilities to eradicate sickness through a thorough understanding of the functions of the body, it will always remain a discourse.

Foucault makes this point in the very opening passages of *The Birth of the Clinic*. He describes two medical cases, separated by roughly a century. In an eighteenth century account of the treatment of an hysteric who was advised to take ten to twelve baths every day, it is recorded that thin sheets of tissue detached themselves from the surface of the patients skin and also various organs, and then

passed through the digestive system. The latter account of Chronic Meningitis similarly describes thin veneers of tissue on the folds of the brain referred to as 'false membranes' (Foucault, 1973: x, xi). The imagery is the similar but the language is different. The emphatic scientific descriptions used in the latter display a 'qualitative precision', which 'directs our gaze into a world of constant visibility', (Foucault, 1973: xi). The only reason why the modern subject reads one as obvious fantasy and the other as a description of truth, is because the reader is embedded in a system in which that particular type of language denotes truth.

The previous section discussed the embodied experience of metaphor, particularly war imagery. Beneath the pretence of scientific objectivity, medical language is deeply influenced by this metaphor. This is evident in various elements of hospital and patient culture. Disease is treated as an invading enemy, as Barbara Kruger put it, 'the body is a battleground', 1989. The aptitude of the enemy, or invading disease, is posited against that of the defenders of the threatened territory. There is emphasis on state of the art 'techno weaponry' medical machinery. This attitude is reflected in the frequent referral to 'mobilization' of public resources to 'fight' a disease, (Sontag, 1978: 95).

Biomedical Language illuminates bodily maladies for the purpose of potential correction. However, while doing so, it simultaneously colours the body with hidden culturally specific judgements.

Scientific versus Lived Experience of Sickness and the Legacy of Cartesian

Dualism

Chronic pain challenges biomedicine's underlying reliance idea of dualism, existing in a liminal space between emotions and bodily sensations, (Kleinman, 1994: 169).

There is a fundamental fissure between the medical and lived experience of sickness. For the subject, it may mean an inability to work and the related pressure of medical expenses. It may mean being too tired to engage socially. It is often accompanied by a sense of hopelessness, alienation and anger. However, from the medical perspective, the same body represents, perhaps, a certain malfunctioning organism and the need for certain interventions and treatments. There is limited possibility for intersection in such divergent narratives. This incompatibility can be simplified as: medicine 'sees', the patient/ subject 'feels'. The impracticality of the relationship is evident; feelings are invisible.

The underlying assumption in this approach is that the body can be treated as something separate from the mind. The subject hands over his or her body for medical inspection and intervention in order to 'fix' it. The subjectivity of the patient, theoretically, does not affect this process. This way of thinking is referred to as 'dualism'.

Rene Descartes proclaimed '*cognito ergo sum*', 'I think therefore I am' in the seventeenth century in response to the question 'what can we know?' This responds to a line of thinking that purports that 'pure knowledge' can only be achieved through the mechanisms of reason, disregarding the mendacious data garnered by the senses. This drew on a tenant of Platonic thought that insisted that 'pure form' or 'truth' existed in a 'higher reality' than that accessible to the senses. What these theories do, in effect, is create a hierarchy between the empirical world and the idea of a higher truth sought through reason. The body was thought to respond to the former, the mind to the latter. This split the self into two components, with the body as the mind's earthly restraint, (MacLachlan, 2004:3).

The philosophies of Merleau-Ponty renegotiate the idea of reality in terms of what can be accessed through the sensory mechanisms of the body. Rather than consciousness existing somehow outside

the body, it emanates from bodily processes. In this way the mind and the body are reconciled into the body-subject. Our subjectivity is not a hindrance to comprehending reality but an active component in constituting reality. Reality in this sense is relative, personal, mediated. This is referred to 'being in the world', (MacLachlan, 2004:4).

While the 'embodied' philosophies of Merleau-Ponty have been undeniably influential, Dualism continues to define the relationship between mind and body both in the realms of language and in the health care system. Language is simply organised around dualistic ideas. We speak about our bodies as something we own rather than something we are; 'My body is broken', not 'I am broken'. Whilst many of us acknowledge the mind as simply another bodily process, we defer to dualistic thinking as a convenience.

One often slips into dualistic ways of thinking because much of our experience of our body does seem to be as something separate from us. We would not know that we had kidneys, pancreases, a gall bladder, unless someone told us. We can never see our own back without visual mechanisms such as cameras or mirrors. How can I think of my body and mind as being one collaborative whole when a deadly tumour could grow inside me without my mind being consciously aware of it?

Almost anyone who has had any medical intervention has experienced a sense of alienation when reviewing their 'case' with their doctor or nurse. They stare at an x-ray, which they understand as representing their insides, but they do not recognise it as themselves.

Paradoxically, it is those most immersed in the experience of their bodies, particularly those in pain, who most benefit from a dualistic ways of thinking. Dualism offers patients with debilitating conditions an avenue to exert a sense of self independent of their bodies which may be a source of constant pain and humiliation for them. If the sick subject is to accept that the mind and body are intermeshed, how do severe negative bodily changes affect the sense of self? (Manderson, 2011: 24). Dualism allows the sensation of an un-eroded self to the sick subject, (Manderson, 2011: 30). Conversely, the body in this sense can present itself as a 'thematic object' or 'alien presence', a problem needing solving, (Manderson, 2011: 30).

What this unspoken reliance on dualistic thinking in modern medicine means is that one's own body can become increasingly unfamiliar territory. Within this context, a stranger can be the expert on a body, not its owner. It is this layer of scientific mystification behind which partisan ideologies can so effectively hide.

Chapter 2: Pain Performers, The Spectacle of Sickness

It is in the world of representations that we manage our fear of disease, isolating it as surely as if we had placed it in quarantine. But within such isolation, these icons remain visible to all of us, proof that we are still whole, healthy, and sane; that we are not different, diseased, or mad' (Gillman, 1987: 107).

This chapter investigates how the abject is played out through performance. Performance can refer to acts design to be watched but also the everyday way in which we present ourselves to the world. The term is used here in a very similar sense to Judith Butler's writing on performance and performativity in relation to gender. I have replaced the female body with the sick body.

Performance forces the unseen into the realm of representation. Physical and emotional pain need to be acted out, theatrically and intimately, publically and privately, to draw others into its unique subjectivity. However, while making bodily pain visible, it also demarcates it as abject.

Foucault's theory of the Panopticon, a prison designed by Jeremy Bentham, is a useful theory for examining the role of performance within the medical sphere. When one enters into the power dynamic implicit in the doctor patient relationship, the persona of the patient becomes self-regulated, constantly reasserted, whether the authority figure is there or not. This idea will be explored in relation to various 'performances' of illness, from the 19th century till today.

Foucault uses the idea of the 'Panopticon' to illustrate his theory on the gaze. The Panopticon is a circular prison in which the inmates inhabit the outer edge and the warden sits in the middle. The edges are illuminated while the centre is cast in darkness. For this reason, the prisoners never know when they are being watched and start watching themselves, self-regulating.

This idea is equally applicable to the relationship between doctors and patients. Indeed Bentham acknowledges how the design could be just as applicable in hospitals, and even schools. Subjects of the health care system imagine the constant authoritarian medical gaze bearing down on them, forcing them to constantly conform to the 'patient' persona. The patient is always on the lower end

of a power dynamic, even when the other side is not present to assert its dominance, (MacLachlan, 2004:7).

The sense of punishment plays a prominent role in this allegory. The sick body is, or experiences itself, as 'illuminated'. Performing illness responds to the imaginary stage light cast on this body. By doing so, it seeks to legitimise itself. It attempts to visualise its conditions in explanation of why it cannot function as it is expected to. Performance, in this sense, is a reaction to a fear of punishment.

Punishment, for a sick subject, could mean alienation, emotional and financial abandonment, being fired from a job or being treated as a social abnormality.

The patient needs to 'perform' their condition to their various peers in order to force their experiences into the realm of the relatable. The audience are their friends, family, co-workers and the Panopticon of imagined watchers, (Brodwin, 1994: 80). They do this to garner sympathy or provide explanation for their limited ability to fulfil expectations, (Good, Good, Brodwin, Kleinman, 1994: 17). Because visual markers of suffering are so significantly lacking in the sufferer of chronic pain, he or she is all the more reliant on continual performance and the limited expression of language to draw attention towards their condition, (Good, Good, Brodwin, Kleinman, 1994: 91).

I have often felt that people expect me to 'act' sick, especially when explaining my absence or a particular behaviour in terms of my condition. In these situations, I feel like I am expected to pull the 'pain face', groan, sigh and complain about my ailments. If I am able to walk around and I sound and look normal, how can I be sick? Society seems to like to have a visual mental appendix of what certain illnesses 'look' like, for instance the iconic baldness of the cancer patient. If such icons are not part of your condition, you are expected to offer up alternative visual cues.

Conforming to certain 'sick roles' legitimises the exemption from social expectations, both of productivity and engagement, (Lupton, 1994: 7). There are various categories of 'sick roles'. The question, 'Is he or she the heroic sufferer, the hopeless hypochondriac, or the malingerer?' will be answered in accordance with the quality of the subject's performance. It is up to them to prove their status. Similarly to Butlerian gender performativity, this performance is reiterative, needing to be continually repeated to assert its legitimacy.

The socially accepted 'sick role' comes with various prerequisites. Other natural human qualities are denied. The acceptable sick person is not angry about his or her allotment, but stoically accepting. He or she is not sexual. That time has passed or is on hold until health returns. Similarly they do not

flaunt their bodies, they are always respectably covered. Above all, the sick person does not draw attention to him or herself. They exist quietly and contentedly on the fringes of society, suitably grateful when focus is drawn in their direction.

Pain never relates only to the sufferer. Performance of pain becomes a structural element in their relationships with all of those around them, driven by both fear and desire to remain integrated in the world around them.

By instantly articulating its difference from the normative, it provides the very boundary line behind which it will be denigrated. This paradoxical position is examined below in relation to public performances of pain from the Enlightenment period until the present, within popular culture and high art.

Sickness and Performance: Enlightenment Inclinations

In *Fasting Women, Living Skeletons and Hunger Artists: Spectacles of Body and Miracles at the Turn of a Century*, Sociologist Sigal Gooldin discusses the 'socio-symbolic' significance of the public displays of the hunger artist in the 19th century, (2003: 28). Most significantly, she emphasises the element of spectacle as the driving force behind these practices, (2003: 31). The performances sought to make the act of hunger seen. Gooldin refers to the 'appeared, performed, visible, gazed-at phenomenon of fasting', (2003: 32). These semi-commercialised performances evolved around the spectacular representation of the body; the 'self-starving', the 'emaciated' and 'the hungry' body at a time both driven by the allure of scientific enquiry and nostalgic for the belief in miracles, (Gooldin, 2003: 48).

In the middle ages, prolonged loss of appetite was expressed in spiritual terms. 'Anorexia mirabilis', is the term for the medieval notion of a miraculously inspired loss of appetite, (Gooldin, 2003: 28).

Famous fasting women gained particular prominence during the Victorian era. Their public renown was replaced by figures such as 'living skeletons' and 'hunger artists' towards the end of the nineteenth century.

Ann Moore was a famous fasting woman who was known to have avoided food and drink for several years. Her story appeared in various publications and her likeness was even cast in wax in the Columbian museum in Boston, (Gooldin, 2003: 31). In the case of Sarah Jacob, a girl of 12 living in Wales, a sign had to be posted at the train station to direct her many visitors to her house, (Gooldin, 2003: 34).

At this time, two explanations competed with each other in terms of these phenomena. The first was that it was a miracle, or spiritual intervention. This explanation harkens back to a medieval preoccupation with mysticism. The second, espoused by the archetypal Enlightenment man of science, insisted that these women were frauds (Gooldin, 2003: 33). These women, at this very particular time, marked an uneasy in-between point between sainthood and patient hood, (Gooldin, 2003: 36).

'Watchers' were often employed so that the woman was not left alone for any amount of time when she may possibly eat or drink. Specimens of urine were routinely tested, (Gooldin, 2003: 34). Far from imagined, or implied, these wardens closely monitored their charges. Journal articles, widely circulated in medical journals, labelled these women as 'imposters', showing the intensity with which medical professionals attempted to refute them, (Gooldin, 2003: 34).

The practice of 'watching' seemed to respond to the two conflicting explanations mentioned above. The watchers both scrutinised the woman's movements but also marvelled at her abstinence. The appeal of both of these types of 'watching' is evidenced by the sheer numbers these performances drew, sometimes hundreds of onlookers a day. Posters would tempt viewers to 'disprove the fact' and 'watch for themselves', (Gooldin, 2003: 35). The interplay between doubt and belief seem to have been what made 'watching' so appealing.

The following is an extract taken out of a Welsh News Paper in 1870, on the advent of Sarah Jacob's death. Her death occurred after medical professionals were called in to 'watch' her, ensuring that she was not secretly taking in nourishment. Her parents were eventually found guilty of manslaughter.

So these four skilled nurses watched the girl closely. Night and day did they keep up their fatal vigil. The watching commenced at four o'clock in the afternoon of the 9th of December last. Day by day, and hour by hour, the child grew weaker and weaker, and yet not a morsel of food, nor a drop of stimulant! The watchers remained remorselessly at their post; and medical men came in and out of the dying girl's chamber, and spoke calmly and analytically of her "altered appearance," and of the "heightened pulse," and of the "flushed face," and of the "peculiar appearance" of the little creature's eyes. She was spoken to on the 14th by one of the medical men, but "she did not complain." Not likely, with life ebbing away, as the natural result of a five-days' fast. Not likely, with the physical powers prostrate from starvation, and the dreaminess of delirium rapidly setting in. She "did not complain," and they forgot she was starving. She "did not complain," and they knew not that she was dying. Well, on Thursday, the 16th of December, the parents were spoken to. "Your daughter will die if she takes no food, say the medical advisers; and still no food was forthcoming. Parents, nurses, medical men, relatives - all seemed influenced by the fatal fascination of superstition, or of sordid cupidity, or of clumsy scientific research; and the little creature's vitality ebbed away, slowly, but surely, with life and plenty within easy reach, and no one with heart enough to give to the prostrate victim that nourishment which would have saved

her from death. But it was too late now. They spoke to the little sufferer at ten o'clock on Friday morning, and "received no answer." The parents came in, and friends of the family gathered around, and the nurses hovered about the little low bed, and all of them watched the convulsive throes and the delirious moaning's of the child they had killed between them. Yes, she died at 3 o'clock in the afternoon of Friday, the 17th of December - just seven days within one hour of the time when the fatal watch commenced, (Assizes ,1870).

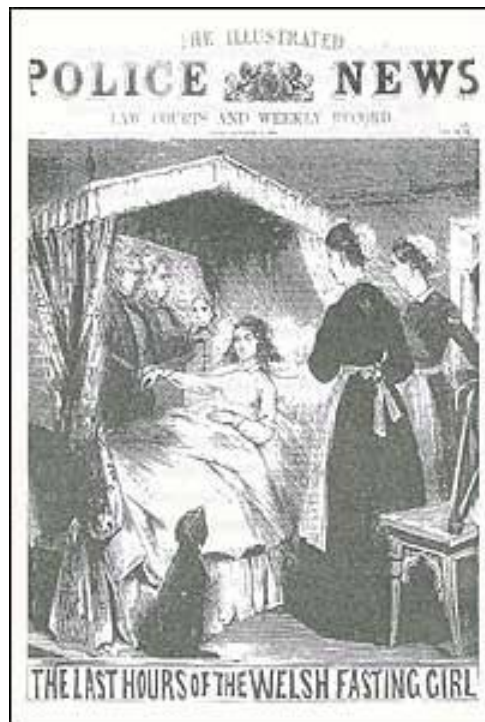


Figure 1, *Sarah Jacob*, (1870)

This piece portrays a hyperbolic example of the implicit, dangerously lopsided power dynamic, in the traditional relationship between 'performing' and 'watching' within a medial scenario. Superstitious fascination and scientific observation are compatible here, both with each other and with a violently oppressive gaze, in spite of seemingly diametrically opposed positions. The same dynamic is at play, simply under different guises. This story is an allegory of the dangers of the biomedical approach, particularly in its tendency to silence the patient by disregarding the subjectivity attached to the discordant body.

The aspect of spectacle was clearer still in the 19th century tradition of 'Living Skeletons'. These were unusually lean men who displayed their bodies in travelling freak shows, (Gooldin, 2003: 39).

These shows, 'formally organized exhibitions of people with alleged and real physical, mental, or behavioural anomalies for amusement and profit,' Bogdan in (Gooldin, 2003:29).

The Living Skeletons presented a far more explicit example of the spectacle of the body than that of the fasting women. All the spiritual language around the fasting women disappeared in this context. The emphasis on secularism and the body as no more than a body seems evident both in the fact that these were openly commercial ventures and that the usually male performers were often either semi-nude or dressed in body stockings, (Gooldin, 2003: 40).

Claude Seurat is perhaps one of the most famous living skeletons. He travelled Europe in the 1820's and 30's, even being presented to the British Royal family, (Gooldin, 2003: 40). Once, in Rouen, 1500 people flocked to see him in one day. When he arrived in London in 1825, he was exhibited in the Pall Mall Gallery. Despite the half a crown entrance fee, which was exorbitant at the time, people arrived in droves and he was soon a household name. His skeleton was finally placed at the museum at the Royal College of Surgeons in London, (Park, Park, 1991: 1595).

He attracted the attention of two famous artists of his age, George Cruikshank and Francisco Goya, who both reproduced his likeness. Both studies portray Seurat semi naked save his famous negligible petticoat. While Cruikshank takes the semi scientific approach of portraying Seurat's figure from different vantage points, in order to fully appreciate the figure's deformity, Goya focuses on the sadness of the character, (Park, Park, 1991: 1595, 1596).

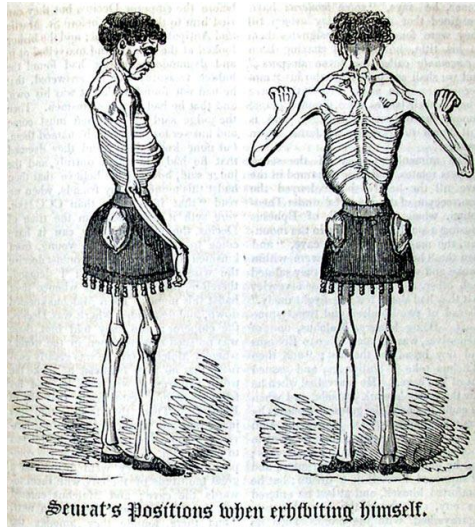


Figure 2, Cruikshank. *The Living Skeleton* (1826)

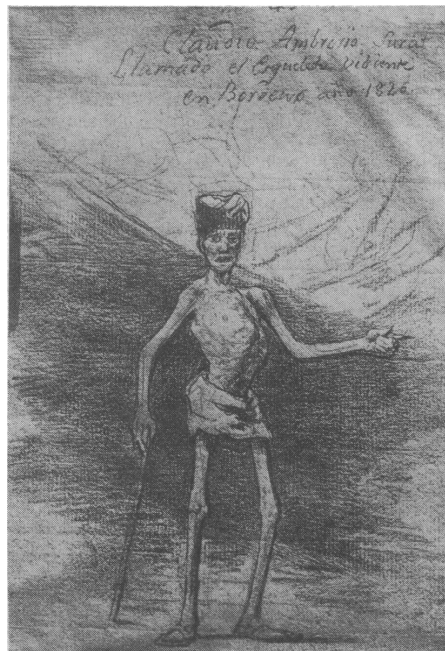


Figure3, Goya,F. Claudio Ambrosio Seurat, (c.1826)



Figure 4, *Claude Seurat*, (c.1826)

The image above shows Seurat proudly showing off his shocking visage for a photographer. This is a man who has clearly absorbed the curious gaze, allowed it to become part of himself. Every bit of his body is twisted to best show off his famous skeleton. The coy half smile seems to denote pleasure. He seems to be basking in the voyeuristic gaze cast upon him.

While the discourse of the divine had notably receded in this arena, there is still the sense that Seurat excited a sense of mystery and wonder, perhaps particularly because he could not be explained away by scientific language. He represented an example of what is external to the 'natural', 'orderly' experience of the human body, an exhibition of the impossible, the bizarre and miraculous, (Gooldin, 2003: 40).

While no particular disease has ever been identified, it is clear that Seurat suffered from severe skeletal and bodily abnormalities. His skeleton was compressed in places meaning that his heart was significantly lower in the chest cavity than is 'normal'. However there is no evidence on record of problems with malabsorption. His emaciated form was more than likely due to very limited intake of food, (Park, Park, 1991: 1594). It seems possible that he starved himself to better show off his fascinatingly irregular skeleton.

Similarly 'Hunger Artists' performed acts of prolonged starvation in cages. An unbreakable record was set by an American physician by the name of Henry S. Tanner, who fasted for 40 days in the city

of New York in 1880, (Gooldin, 2003: 46). Like Fasting Women and Living Skeletons, Hunger Artists represented a fascination with a body poised between life and death, (Gooldin, 2003: 46). However unlike these predecessors, the Hunger Artist engages more blatantly with the notion of suffering. 'He had to overcome his desires and mortal being. It was this very struggle that was put on the stage, just as much as the material body that was the product of it'. This aspect of the tradition is beautifully examined in Franz Kafka's short story *The Hunger Artist*, published in 1924.

The story is about the fate of an unnamed Hunger Artist once the public passion for his craft has passed. It looks retrospectively over his glory days when thousands of people used to travel to see him. Fans would keep a constant vigil outside his cage to ensure he was not eating. He pushed his limbs through the bars to be inspected. His only sadness was that people doubted his authenticity and also that he was not allowed to starve himself beyond the standard forty day period. At this point, in front of huge crowds, he would be led out of his specially decorated cage, to a specially prepared hospital meal. He would routinely collapse on one of the girls, always selected to hold him up to the public, and note her revulsion with him. The spectacle would end with the first bite of food and a message from the event co-ordinator, which was supposedly whispered in his ear by the Hunger Artist, (Kafka, 1924).

When the public interest in him wanes, he sells his act to a large circus where he is displayed outside the main attraction tent, next to the animals. He is finally allowed to fulfil his ambition of starving himself beyond the forty day period but now no one is interested enough to count the days. Anyone intrigued enough to hover outside his cage is quickly shoved along by the crowd more interested in seeing the animals. He is discovered at the point of death just because someone complained of the 'empty' cage. After he is gone, a young panther replaces him, (Kafka, 1924).

His life is over when he can no longer starve for an audience.

These figures may represent an embodied response to a moment of 'cultural trauma', the Enlightenment era's shift 'from collective order to individualism, from Gemeinschaft to Gesellschaft, (Gooldin, 2003:43). These acts mark a 'cross roads in history between belief in the miraculous and inexplicable and the celebration of reason above all else', (Gooldin, 2003: 38). They represent a symbolic collapse of the miraculous and the mundane into one another, (Gooldin, 2003: 44).

More importantly, for the purposes of this argument, they represent a historically embedded dynamic in illness between performing and watching. This time represents the beginning of our contemporary approach to medicine. Popular responses to the notion of illness show how the

relationships the medical model set up permeated into culture. In the examples discussed above, the act of watching the ill, the insistence that they perform diligently, is demonstrated in all its ghoulish possibilities. In the following section, the legacy is examined in the sphere of contemporary high art.

Tehching Hsieh, a Contemporary Hunger Artist

Kafka's story about the hunger artist reminds me of the work of performance artist Tehching Hsieh. His 'endurance performances' allude to the acknowledgement of and relationship to the 'watchers', the Hunger Artist displayed. In short, both men severely limited their most basic human comforts for the appreciation of an audience. Both men self-impose the conditions of a prisoner.

Hsieh confined himself to a cage within his apartment from 1978 to 1979. A friend disposed waste and brought food and water. He did so without ever conversing with the artist. Hsieh was completely cut off from the outside world, with no access to a telephone, radio or television. The following year, he punched a time clock once per hour on the minute. He took a photograph of himself every day. He spent the year between 1981 and 1982 outdoors in New York, never allowing himself any shelter, equipped only with his clothes and a sleeping bag. From 1983 to 1984, he was tied to artist, Linda Montano, by an eight-foot rope. They neither ever touched each other nor occupied a different room. From 1985 to 1986 he neither made nor talked about art. He kept his final work secret from 1987 to 2000. Finally, he revealed a simple placard placed on an easel, reading 'I kept myself alive'. Each work is characterised by endurance, deprivation of stimulation, rest, comfort and privacy. Each is carefully documented, (Shapiro, 2013: 195- 196).

His works are described as maintaining a 'psychological opacity', (Shapiro, 2013: 196). The photographs that survive these performances show an expressionless, emotionless Hsieh in contrast to the extremity of the situations in which he places himself. One may assume that such scenarios may draw one's subjectivity to the surface but Hsieh denies his audience any access to the emotional trauma he may or may not be experiencing.

Hsieh work has been described as a collection of allegories on the universal conditions of alienation, meaningless labour, and notions of 'home'. The performances have been drawn into both post structural and Marxist discourses. They are said to take on subjects as divergent as race, gender, immigration, the labour force, homelessness and incarceration. Hsieh himself is consistently vague when asked to account for his work's meaning, (Shapiro, 2013:197-198). This multitude of projected meanings is possible because of the impenetrability of the surface which he so stoically and unfathomably maintains.

Hsieh's famous vacancy exposes the shortcomings of the 'surface'. It shows how an image, or images, cannot satisfactorily express the entirety of its subject. The extraordinary emotional depth to these scenarios is hinted at but never presented for inspection. In this way, they are beautifully frustrating. We desperately want to know how he is feeling, what effect his imposed alienation is having on him.

Like the hunger artist, Hsieh is performing for an audience, in this case, it is the art world. He exploits the paradox of the visually dependent acts of watching and performing with the unseen nature of pain. Both figures seem to have something to prove, with both it is unclear what this is. In Hsieh's case, it seems intentionally ambivalent. Both cases leave the watcher fascinated by the question of why anyone would do this to themselves.

Stepping back from the particulars of Hsieh's project, these performances may seem like a contemporary manifestation of Enlightenment acts of public suffering, discussed above. While the dynamic may be consciously engaged, even questioned, it is still maintained.

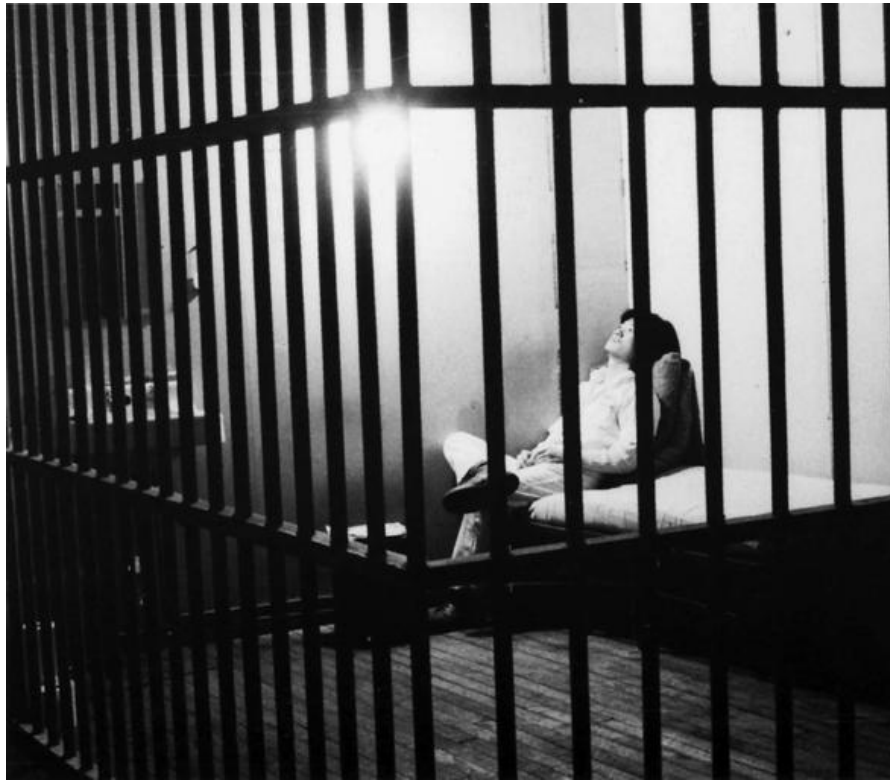


Figure 5, Hsieh, T, *Cage Piece*, (1978-9)

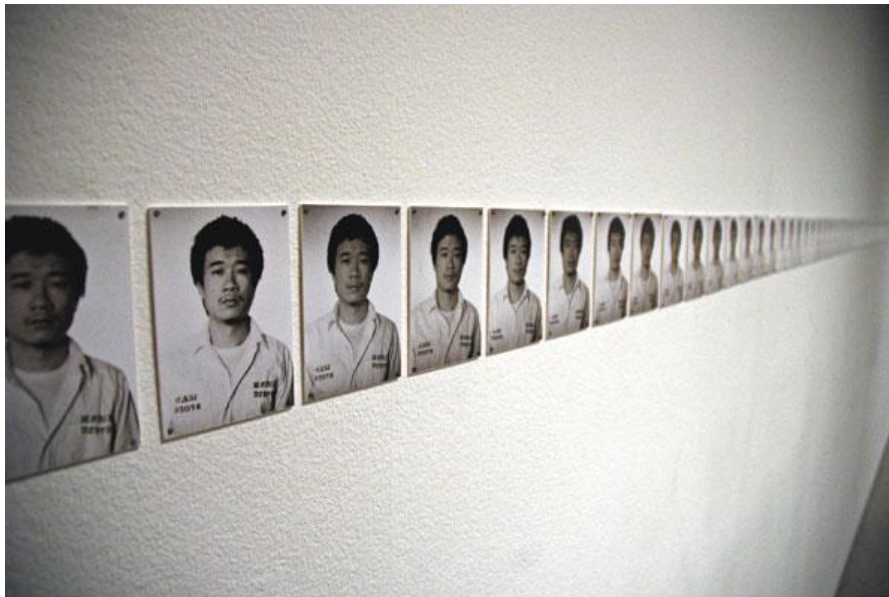


Figure 6, Hsieh, T, *Time Clock Piece*, (1980-1981)

Hannah Wilke, Performing or conforming?

The previous section established the tradition of a close relationship between sickness and watching in the public arena. Contemporary body artists who deal with illness can, arguably, be seen as part of this legacy. The purpose of the following discussions is to examine the continuation of this tradition; the displaying of bodies for the purpose of spectacle. This is not to undermine, or even really critique the body artists of the 20th and 21st century, but rather simply to consider their legacy through this lens. It looks at the visual politics within an art historical context of being 'seen' as possessing a sick body.

Hannah Wilke proudly asserts her position as being on the edge of 'normality'. This is a strategy of resistance against a system of representation that would rather ignore her. Her work insistently, irreverently rejects the 'sick roles' that would have legitimised her within society.

Hannah Wilke's work has been described as a 'feminist organic abstraction'. In the 1970s she began to incorporate the vagina-reminiscent sculptural forms she had been exploring in the 1960s with her own body. In a feminist reinvigoration of the traditionally male-dominated, female-objectifying realm of sculpture, she made irreverent use of sexually evocative materials such as latex and chewing gum in works that were as playful as they were provocative, (Pollock, 2010: 34). She makes a spirited mess of patriarchal delineations between both various mediums, incorporating many at once, and distinctions between high and low art, shamelessly re-enacting popular fantasies about the female body in the hallowed gallery space.

Wilke addresses the role of woman in art as 'prisoners of an idealisation' (Fascina, 2014). Insisting that female bodies need not be reduced to sites of exploitation, but could rather act as sites of subversion, she wished to 'revalue the denigrated cunt', (Naryvey, 2002:133) (Fascina, 2014). In *I object*, Wilke poses naked against a boulder in two separate adjoining images, as if for the cover of a book. The title itself shows the 'creative ambivalence' of the piece. While the 'I' stands for the subjective, 'object' necessarily implies the opposite. Together the words 'I object' mean a protest, contradicted by the seeming complicity of her body in the photograph. In this way, Wilke acknowledges the precarious position she chooses to inhabit, stepping into the realm of patriarchal desire in order to destabilise it. The angle of Wilkes body, the prominence of her genitals clearly

references Courbet's 1866 *Origin of the World*. The painting was destined to belong first to a collector of erotic imagery and later to the famous psychoanalyst and theorist, Jacques Lacan, (Fracina, 2014). Her pose is most reminiscent of Duchamp's reimagining of the Courbet's work *Etant Donnes*, 1946–1966. Importantly, in Wilke's image, there is a human being attached to the vagina. Making visual references to a works rendered by and owned by famously patriarchal figures, this series challenges traditions of male objectifications of sexual parts of women's bodies rendered as anonymous commodities', (Fracina, 2014).



Figure 7, Wilke, H. *I Object*, (1977- 1978)

Her final series, 'Intra-Venus', 1992 chronicles the demise of her famously beautiful body, through the ravages of cancer and chemotherapy.



Figure 8, Wilke, H. Intra-Venus, Installation Shot (1995)



Figure 9, Wilke, H. *Intra-Venus*, (1992)

In the image above, Wilke revisits her contemplations of the glamorous female body in art. This time around though, while the posture is reminiscent of glamour models and classical Venus figures in contrapposto, her body is no longer the idealised, canonised female form. Her mottled skin, hairless body and swollen limbs and stomach are shocking in comparison with the radiantly healthy body in her earlier works. In this work Wilke refuses the classical cancer patient's role; silent, meek and post-sexual. Simultaneously, she addresses the instability of her body as a site for the projection of desire. Looked at in its entirety, in some ways as a chronicle of a beautiful body, her work seems to say, 'this beauty is exquisitely fragile, death is an unavoidable reality and it may be just around the corner'.

However, I cannot help, when looking at this image, of being irresistibly reminded of the early photograph of Claude Seurat, languishing on his chaise longue, displaying his gorgeously abnormal body for the pleasure of onlookers, beautifully dying for his spectators' pleasure. There is the very real danger that these images will appeal to a ghoulish fascination with otherness. A fascination attested to by Hollywood's continuous production of visually consumable physical strangeness. To

dismiss this work as simply indulgently voyeuristic is far too simple. Certainly there is something of the abject at play here, which allows itself to be seen and cornered off.

Wilke, as a site of the grotesque, is now structured through the constructed corporeality in the viewer's imagination. This imagined grotesqueness instils a fear of life rather than a fear of death. It threatens the body with a loss of identity, it distorts size and shape, and above all, it sets in motion a fragmentation of order, (Naryvey, 2002:19).

In her famous essay 'Art in America', on female body art, Lucy Lippard acknowledges Wilke's aims to subvert the subject/object relationship of the female form in representation. However she warned that, like many female artists in this arena, Wilke had, instead of avoiding self-exploitation, rather confused her 'roles as beautiful woman and artist, as flirt and feminist', resulting, at times in 'politically ambiguous manifestations', (Frascina, 2014). I would argue that this does not only apply to her self-representation as a woman, but also, later in life, as a sick subject. It is difficult to ascertain whether stepping into traditionally repressive forms of representation unsettles and subverts or simply reinforces its power.

I return here, to the scheme of the Panopticon. Perhaps Tehching Hsieh and Hannah Wilke attempted to illuminate the darkened space of the wardens through their work. By drawing the 'watchers' into their space on their terms, they complicate the power dynamic implicit in the concept. However whether the centre of the Panopticon is peopled, illuminated or left in darkness, the ideological structure that the metaphor outlines, is unaffected. The sick bodies remain brightly lit, on the outskirts of the circle, in the space demarcated for them to perform their own abjection.

Chapter 3: Work from the ‘Half Light’

This chapter introduces my own art making process, which is the practical component to this written work. My artistic production is a reaction against the legacy of imagery surrounding the sick subject. It attempts to inhabit and stretch out the historically tight gap between seeing and knowing within this context. Communication between image and onlooker is not abandoned but rather the meaning which is communicated is multifarious, contradictory and visceral.

Chapter 1 established a link between language, visual and written, and the containment of illness within the notion of the abject. It destabilised the historical relationship between what is seen on and in the body and what can be known about it. Chapter 2 established a legacy of how abjection is ‘written’ into society through the reiterative process of performing itself. It also explores an ingrained tendency in sick subjects to feel the responsibility to perform their own abjection. This chapter outlines an alternative symbolic space from which abjection can be expressed artistically. The works of William Burroughs and Lygia Clark offer unconventional approaches to the use of language which meaningfully renegotiates how the communication of pain can function.

I will relate these practices to the philosophies of art therapy, as part of the bio-psychological model which specifically defines itself against the biomedical model. These discussions will provide the psychological and theoretical framework through which my own practice can be understood.

Alternative Discourses to the 'Biomedical Model'

'Imagination is the natural correlate for pain', (Scarry, 1987:161, 162).

The Biomedical approach is antithetical to the imagination. One insists on clarity and certainty, the other on infinite possibility. How then, can pain, as a medical irregularity, be treated within the playgrounds of the imagination?

Pain is unique amongst bodily sensations because it has no object in the world external to the body, (Scarry, 1987:161, 162). '... Desire is desire of x, fear is fear of y, hunger is hunger for z; but pain is not 'of' or 'for' anything- it is itself alone', (Scarry, 1987:161, 162). Similarly and inversely, imagination is definable as all object without specific sensation. (Scarry, 1987: 162). There is no particular bodily feeling that accompanies imagination; rather the objects that the imagination conjures up may induce certain feelings. Imagination can provide 'objects' onto which pain can hook itself. For this reason, they can be viewed as 'natural correlates'.

The late twentieth, and early twenty first century, have been marked by emerging discourses which recognise the potential for models of healing which are imaginative rather than simply mechanical, (Lupton, 1994: 56). Biomedical claims of scientific objectivity and political neutrality are increasingly challenged. Foucault's argument, outlined in chapter 1, highlights the bio-medical model's denial of its position as a discourse, the conflation between seeing and understanding and the inherently lopsided power dynamic between doctor and patient. The 'bio-psychological' model has been designed around addressing these concerns.

Arthur Kleinman, Harvard psychiatrist and anthropologist, is a particularly prolific champion of the 'biopsychological model'. Kleinman insists that 'bio-medical model' is inherently inefficient because of what he refers to as 'biological reductionism' (1962: 6). He insists that, with the symptoms-based modern western approach, the patient is significant only in terms of science (Kleinman, 1962: 52).

Biomedicine, which only considers the biological dimension of suffering, arguably only addresses a fraction of the problem. He demonstrates how a disturbance in the body is experienced far beyond itself by distinguishing the meaning making processes on various strata's of experience, (Kleinman,

1962: 4-6). These spaces are shown to be vastly divergent, almost unrelated, by being assigned different titles.

'Illness' is the patient's lived experience of his or her symptoms. It is both personal and cultural. Only the patient really appreciates the daily complications and indignities that accompany their symptoms. However, the patient also learns how to experience and communicate his or her suffering according to cultural norms. This is evidenced by the cultural specificity of certain gestures and expressions that regularly accompany bodily complaints, (Kleinman, 1962: 10-11). In Nigeria, a headache is described as ants crawling through one's skull, while in the West the head is described as 'splitting' or 'throbbing', (Kleinman, 1962:15, 16).

'Disease' is how 'illness' is recreated by Western medical practices. The layering implicit in the idea of 'illness', is replaced by the sole concern with the functioning of the body. 'Disease' is what medical practitioners are trained to isolate from the mess of information each client presents, within the parameters of their particular specialisation (Kleinman, 1962: 6). Under this model, body and disease become 'its', separate from the subject.

'Sickness' refers to the political, social and economical way disorders are understood (Kleinman, 1962: 6). An epidemic may be constructed as the evidence of some failing in society. Terms like 'a plague' infer ideas of punishment for social evils.

Within the sphere of 'disease', the psychological effects of illness are also often overlooked. The bio-medical model does not consider behavioural and social disorders that can result from long periods of pain, (Kleinman, 1962: 7,57). Many illnesses lead to demoralising and humiliating bodily disorders. One may lose control over one's digestive processes; one may be visually disfigured or perhaps be too exhausted to perform the everyday expectations they used to fulfil. A mourning period for the body as it used to be, may be necessary, (Kleinman, 1962: 46-8). Certain conditions lead inevitably to social exclusion, either because of physical restrictions or stigma. An integrated appreciation of the patient's personal life, culture and symptoms is necessary to break the cycle of helplessness that the bio-medical model promotes.

Kleinman promotes the 'biopsychological' model which reconstructs disease as the 'embodiment of the symbolic network linking body, self and society (Kleinman, 1962: 6). He emphasises the role of storytelling as a form of treatment, (Kleinman, 1962: 26). Storytelling presupposes a more mediated interaction between doctor and patient, undermining the potential for 'aloof scientific hubris', (Kleinman, 1962: 228). Storytelling bridges the gulf that dualism sets up between self and body. It

can allow for a degree of creative distance from the painful experience that promotes the sensation of containment, (Kleinman, 1962: 49). It gives shape to pain, constructs it in terms of a biography that is meaningful to the patient in terms of their personal, cultural and social ideologies, (Kleinman, 1962: 49) (Good, Good, Brodwin, Kleinman, 1994: 31).

Art Therapy is an excellent example of how the bio-psychological model can be translated into practice. Art Therapy rejects grand narratives and the idea of 'objective truth' in favour of multiple, layered, fractured, contingent stories. Fact is no more meaningful than fictions, disciplines and cultures are treated without hierarchy and history is variable and re-creatable, (Alter-Muri, Klein, 2011: 82). It privileges dialogue and engagement over final product, (Alter-Muri, Klein, 2011: 82).

In the biomedical model, the body of the subject is the 'passive tablet on which the disorder is inscribed', Susan Bordo, 1993 in (Lane, 1975). In art therapy, both subject and body are imbued with agency in the act of creating. The therapist's main role is to aid and encourage their clients to tell their stories, (Alter-Muri, Klein, 2011: 85). In this way patient and therapist do not conform to the traditional doctor patient dynamic in which one interprets the other from a position of superior knowledge and power. The artistic outcomes of an art therapy session are better understood as imaginative play rather than manifestations of pathology, (Alter-Muri, Klein, 2011: 84).

The artists discussed in the following sections are British beat generation writer William Burroughs and Latin American, body and performance artist, Lygia Clark. These artists were not art therapists or art therapy patients. Rather they display a philosophical affinity with the tenants of art therapy. Both artists reject the cerebral formalised use of language in favour of an emotive bodily one. Both present an artistic 'surface' which acts as a meeting place where multiple subjectivities are free to express their internal experiences. Both use metaphorical language. This language is particularly powerful because it cannot be entirely interpreted. The metaphors are personal and specific in contrast to the totalising examples discussed in relation to the work of Susan Sontag.

William Burroughs, Word as Virus

The impulse to contextualise my water colour and pen drawings in terms of the famous murder, heroin junkie and literary genius, William Burroughs may seem strange. However his irreverent absurdist use of language emotionally correlates to what I am trying to achieve through drawing. A sense of a story manages to emerge despite only the loosest reference to the laws of syntax. These 'stories' are never linear. It is impossible to retell them in your own words. The subject of the story is the particular emotive, bodily use of language, over and above the characters and occurrences to which his words so precariously relate.

For Burroughs, language is not only a bridge over the impossible gulf between self and other, but an addictive, degenerating and restrictive necessity which inscribes us with the agendas of others. In his writing, language is more significant for what it obscures and hides as for what it communicates, (Breu, 2011: 203).

In *Nova Express*, Burroughs wrote 'Word begets image and image is virus' (Breu, 2011: 48). Like a virus, language reorganises who we are from the inside. While promising to provide access to 'reality', what it offers instead is a manipulated lens that controls how and what we 'see'. 'Reality is apparent because you live and believe in it. What you call 'reality' is a complex network of necessary formulae... association lines of word and image presenting a pre-recorded word and image track', Burroughs in (Breu, 2011: 204).

Similarly he compares language with 'junk'. Language/ Junk is the 'ultimate commodity, a super addictive drug that interacts directly with the substance of the body, reshaping and reorganising it on a microcellular level', (Breu, 2011: 210).

Providing a contemporary voice to the writings of Foucault, he described it as, 'a viral yet necessary imposition on material life, a system of social control structuring our very conception of reality', (Breu, 2011: 204). Foucault believed that language creates rather than reflects the way we think and live. Burroughs pushes this idea to a hyperbolic and absurd place, with descriptions of bodies which absorb other bodies in moments of pure need for Language/Junk, (Kahn, 2001:295).

Burroughs novels are written 'as much against language as inevitably within or through it', (Breu, 2011: 48). In this way he 'fights back' against language and thereby constitutes a new reality. The traditional dynamic between signifier and signified is destabilised, very often there is a proliferation of the former with only the vaguest sense of the latter. There is an impression both of excess and terrible lack. The rush and tumble of words are dissonantly lonely in their defiant opacity.

Burroughs demonstrated his irreverence to language through the 'cut up technique', which he developed along with painter Brian Gysin. They cut up newspapers, Homer and the Bible, creating poems out of the rearranged pieces. This process allowed for a new outlet for the 'rapid-fire, free associating' use of language that Burroughs strived for, (Grauerholz, 1998: 120). Importantly, none of the words or phrasing were his own. Through these practices, new words emerged and meanings changed and mingled with each other in unexpected ways. Language is turned against itself through this process of simultaneous destruction and creation.

This technique was to inform most of his later work, namely the 'Cut-up trilogy' comprising of *The Soft Machine*, *The Ticket That Exploded* and *Nova Express*, 1961- 1968. In these works he revisited, destroyed and reconfigured everything he had written before.

This process meant 'turning in' on himself and his practice, already so inherently and structurally self-reflexive, (Grauerholz, 1998: 179). Emphatically, it reflected his experience of a long addiction to heroin. Drugs can both devastate one's body and create altered states in which the body appears to morph into extraordinary new configurations. Language and body become unstable amorphous entities. The writing reflects not only the disjointed reality of a drug trip but also the experience of a body that is 'fragmented, perforated and reformed' (Breu, 2011: 206).

The following extract from *The Soft Machine*, 1961 is an example of the slippery linguistic mess of banality and terror, perversion and poetry that this technique generated.

'What do you get out of all of this?' I ask bluntly.

' A smell I always get when their eyes pop out'- The boy looked at me his mouth a little open showing the whitest teeth this Private Eye ever saw- naval uniform buttoned in the wrong holes quilted with sea mist and powder smoke, smell of chlorine, rum and mouldy jockstraps- and probably a narcotics agent is hiding in the spare stateroom that is always locked- There are stairs to the attic room he looked out of and his mother moving around- dead she was they say- dead- with such hair too- red.

‘Where do you feel it?’ I prodded.

‘All over,’ he said, eyes empty and banal as sunlight- ‘like hair sprouting all over me’ – He squirmed and giggled and creamed his dry goods’, Burroughs in (Grauerholz, 1998:191).

One’s imagination fills in meaning where the writer has refused to provide it. This is not a conscious decision, it is a reflex of the imagination. The dream-like engagement and disengagement with images and ideas invite projection. In this way, the writing is incredibly invasive. Personal associations, preoccupations, memories flow into the spaces left open by the unstable narrative sped on by the hypnotic often musical rhythm.

The writing is sometimes gentle and beautiful, sometime prosaic and crude; a torrent of words, only some of which can be read in relation to each other. In this ‘symbolic breakdown, the familiar becomes strange, and the un-coded stuff we consume becomes visible at the end of our forks’, Burroughs in (Breu, 2011: 204). This ‘un-coded stuff’ is language itself. In the rip tide of Burroughs’ writing, language fails in its operations and becomes a strange thing to be looked at.

The following extract from *Naked Lunch* represents the reconfigured strangeness of Burroughs use of language. It entirely denies the possibility of cerebral interpretation. Rather brain and body become indistinguishable in the process of ingesting his writing.

The word is divided into units which be all in one piece and should be so taken, but the pieces can be had in any order being tied up back and forth, in and out fore and aft like an innaresting (sic) sex arrangement. This book spill off the page in all directions, kaleidoscope of vistas, medley of tunes and street noises, farts and riot yips and the slamming steel shutters of commerce, raged squawk of the displaced bull head, prophetic mutterings of brujo in nutmeg trances, snapping necks and screaming mandrakes, sigh of orgasm, heroin silent as dawn in the thirsty cells, Radio City screaming like a berserk tobacco auction, and flutes of Ramadan fanning the sick junkie like a gentle lush worker in the grey subway dawn feeling with delicate fingers for the green folding crackle...

This is Revelation and Prophecy of what I can pick up without FM on my 1920 crystal set with antennae of jissom...Gentle reader, we see God through our arseholes in the flash bulb of orgasm... through these orifices transmute your body. The way OUT is the way IN... Burroughs quoted in (Grauerholz, 1998:173).

The words attach, slip past and intersect both each other, and meaning, in a current that is sometimes poetically smooth, sometimes disjointed, stunted and chaotic. Structural narration gives way to drug-like mania, a bodily gush and flow. Language here, is in the process of being digested or injected into our veins.

Lygia Clark, Ritual without Myth

There is a strange correlation between the work of William Burroughs and that of Lygia Clark. While Burroughs 'digests' language and meaning in written form, Clark does so with the language of representation.

The Brazilian artist's career demonstrates an increasing use of 'instability' as a structural element in her work. She embraced a state of perpetual 'precariousness', (Dezeuze, 2003: 227). In practice this means that the meaning of the artwork, it's very material, as well as how it acts on the experiences, even the bodies of both artist and spectator, is in a constant state of intentional flux, each element imprinting on the other without hierarchy. Her oeuvre places emphasis on incompleteness. It is up to the viewer to 'complete' or activate the work through engagement, (Morgan, 2003: 17, 18).

Burroughs' fluency in 'precariousness', especially in relation to the body, developed through his experiences as a junkie. For Clark, familiarity with volatility, uncertainty and 'precariousness' come from the external world. Brazilians lived through extreme economic fluctuations, major social upheavals and brutal military dictatorships during the twentieth and twenty first centuries, (Dezeuze, 2003: 227). Despite her turbulent context, or maybe because of it, Clark has said 'I am better off within myself', (Lygia Clark MoMA Interview, 2014). She retreated into art making.

Clark insisted on the importance of art outside the traditional notions of production and display, (Morgan, 2003: 13). Representational language is infected with implicit power relationships. Spaces associated with art, be it gallery, museum or learning institution, create an ideological and physical distance between viewer and artwork which seem static, aloof and impenetrable. Her works were not articulated as an end product, the accumulative final stage of an artist's vision, but rather a spring board for the viewer's personal psychological response to the work, (Morgan, 2003: 13).

Her work has been described as allowing for 'ritual without myth' (Morgan, 2003: 12). In her manifesto, published in 1983, she proclaimed to 'reject representative space and the work as passive contemplation', (Morgan, 2003: 17). 'Ritual' refers to the physical engagement with the artworks. Clark's pieces invite touch. Desires and fears are released in an entirely subjective engagement between participant and piece. In this way, the work is potentially therapeutic. 'Myth' can mean any

implicit expectation or idea about a practice or person. For instance, in Clark's case, 'myth' could imply the traditional role of the artwork as not being touched, the idea that its principle purpose is to be looked at and the idea that art only happens in a gallery.

Both Burroughs and Clark manipulate traditional language as a means to enter into and even alter the spectator's subjectivity. While Burroughs's project is distinctly nihilistic, Clark's work is intended to be healing. She believed in the 'transformative effects of art', (Morgan, 2003: 13). This transformation acts on both artist and spectator and the relationship between them, (Morgan, 2003: 16). Like the art therapist, Clark acts as a 'mediator' rather than creator of the artistic experience, (Morgan, 2003: 12). For this reason it is more appropriate to describe those who interact with her work with the inclusive egalitarian term, 'participants' rather than the implicitly hierarchical standard, 'viewer'.

In 2014, I visited the retrospective exhibition of her life's work at the Museum of Modern Art in New York. At the centre of the principle exhibition space there was a large mat for sitting on, scattered with several objects. I sat for a long while with a middle aged man whom I did not know, or share a word with, squashing and releasing a plastic bag full of water, seeing how it responded to having a large stone placed on it, passing it from one to the other.

These 'propositions' or 'relational objects' resemble Winnicott's ideas of transitional objects, (Morgan, 2003: 39). Her chosen objects were always common place, string, pebbles, stockings and so on. They were activated as meaningful artworks only by the 'spectator-manipulator', (Morgan, 2003: 37). As within traditional therapeutic practices, the transitional object can stand for the lost mother's breast or any other body part signifying loss, pain or desire, (Morgan, 2003: 39). The person manipulating the object could release repressed emotions through engagement with the object through an emotionally charged symbolic process.

Her 1973 work, *Baba Antropofágica*, for example, involves one person lying down at the centre of a group of kneeling people who slowly unwind spools of thread contained in their mouths, letting the spit coated coils fall on the prone body and then lifting the seething mass together. (Dezeuze ,2013: 243)

Clarke's interest in art therapeutic techniques coincided with a general criticism of biomedical psychiatric practices involving confinement and force. The traditional straight jacket symbolically represents the imposition of will through the physical power of a person or persons, institution and ideology onto a subject. Clark designed *Camisa de forca* or *Straight Jacket* to subvert this. Complex

systems of nets and weights were intended to promote a heightened experience of the body rather than a frightening constricted one, (Lygia Clark MoMA Interview,2014).



Figure 1, *Camisa de força*, (c.1969)

She argued that many of her contemporary ‘body artists’ simply replaced the traditional art object with their own bodies. Artists such as Hsieh and Wilke, could arguably be used as examples of this statement. Comparatively, Clark’s work seeks to fundamentally destabilise the relationship between the artist’s art work and the viewer. Her works emulate, but do not strictly resemble, bodily interiors.

The work insists on being played with. It may be joyful or traumatic depending on the individuality of each participant. They are the barest playgrounds in which meaning may or may not be generated.

The lack of symbolic, narrative or theoretical structures encourage the participants to 'insert their own myths' (Lygia Clark MoMA Interview,2014). In keeping with Kleinman's emphasis on storytelling, these processes are empowering and infinite in their ability to renegotiate and recreate bodily experiences within the specific personal and cultural needs of those who choose to play.

Introducing the ‘half-light’

William Burroughs and Lygia Clark present very different solutions to the artistic challenge of representing pain in a language which is non-restrictive in interpretation, that tells a sensory experiential story, rather than a literal one. Their works do not ‘communicate’ in the traditional sense. They refuse to ‘perform’. Words and images are not attached definitively to a single referent. Signification is partial and dispersed. Here I wish to re-imagine these practices within the metaphor of a ‘half-light’ in preparation for the discussion of my practical work.

Disease is often invisible and inexplicable. It does not always present itself as something which can be seen, labelled, understood. Medical language’... is nothing more than a syntactical reorganization of disease in which the limits of the visible and invisible follow a new pattern; the abyss beneath illness, which was the illness itself, has emerged into the light of language’, (Foucault, 1973: 242). The ‘abyss’ represents the place where language cannot go. Ill-fitting diagnoses and labels lightly plaster over this void, offering a partial and uneasy sense of safety from this darkness. Disease is given legitimacy within society only when it presents a surface on which light can fall. It must present itself visually for classification so that it can be integrated into society’s conception of itself and its boundaries.

My work seeks to inhabit the shadowy place between the abyss and language. My introduction touched on my frustration with the symbolic implications of this ‘surface’. Is retreating into abjection, and the isolation it allows, a way of hiding away from the prodding, poking, classifying, reclassifying and control exercised on the surface? Or can it be a space of resilience? If abjection is the social psychological construction of demarcating that which is unwanted from itself, how can this be a healing space to inhabit artistically? If the abyss represents the place where language cannot function, how can this be a position from which my work speaks?

Medical language marks the body in pain out as ‘abject’. Paradoxically, the body is doubly inscribed as such if it does not present itself for classification. Not only is it irregular, but also unknown and menacing. This doubly abject figure is that of the monster which lurks in the darkness. In terms of the metaphor of the abyss, perhaps it is necessary to operate with in a ‘half-light’. This opens up a symbolic space which is neither entirely confined by the strictures of language nor cut off from all

communication in the depths of this abyss. The half-light then, is a 'half- language'. It tells a partial story, communicates only up to a point while insisting on privacy within its subjectivity.

When the connections between words or images and meaning become unstable, the potential combinations between each become limitless. Unconfined by the laws of language, imagination can produce effusions of image and idea that reflect an internal reality that is conventionally inexpressible. In the imaginative product, issuing from the half light of the entrance of the abyss, communication, through image or word, has been fundamentally undermined. A sense of experience may be discernible, through the choice of imagery and use of materials, but the specifics will be entirely ungraspable.

My Practice, Re-enchanting and Re-engaging

...in isolation, pain 'intends nothing; it is wholly passive; it is 'suffered' rather than willed or directed. To be more precise, one can say that pain only becomes an intentional state once it is brought into relation with the objectifying power of the imagination; through that relation, pain will be transformed from a wholly passive and helpless occurrence into a self-modifying and, when successful, self-eliminating one, (Scarry, 1987: 164).

My struggle with the various doctors and institutions with whom I interacted while seeking diagnosis and treatment, was in many ways, a struggle with language itself. My bodily irregularities refused to conform to classification. To exist outside language results in terrible uncertainty and loneliness. Outside language stretches the abyss of abjection.

Abjection is at once hyper visible and unseeable. It is hypervisible in terms of the proliferation of images of otherness, behavioural, medical, cultural that represent that which is not normal. Paradoxically the object is so threatening because it looms, unseen and insidious, on the edges of experience. The former is indubitably a response to the fear of the latter. Images of horrific otherness are thrilling because they illuminate momentarily a small reprehensive vignette of the vast unknowable horror we sense is out there.

After many years I was finally 'made sense of' with a dual diagnosis, Pelvic Pain and Celiac Disease. These terms provide all the comfort that operating inside language can bring. I felt like I had been accepted back into the fold. However, depending on the specialist, chronic pain can be either a final diagnosis or simply a symptom of something else. The stability these terms offer is always under threat, always at the risk of being dismissed or replaced, constantly reinvented in diagnostic language in terms of partial, misinterpreted or all encompassing explanation. Language here is the solid ground beneath one's feet, which may, at any moment, begin to bubble and burn, or turn to quick sand and swallow one up.

The 'half-light' is the in-between space, before being re-embraced by language. Meaning is only ever partially shared. Imagery, when definable is ambiguous, lines outline nothingness in equal measure to somethingness. Unrestricted by the signifying laws of language yet not yet immersed in the all absorbing nothingness of complete abjection, this space can be a playground for the imagination.

Work from the 'half-light' is an invitation to interpret, to identify, though inevitably abstractly. This 'invitation' materialises through the indefinite, unanchored use of imagery and line. Like Clarke's playful objects, this allows any viewer to emotionally imprint themselves onto my images.

The body, before being inscribed by language, does not make sense. Communication is not neat. The pre-language of the body gurgles, squelches and oozes like a piece of Burroughs' prose. There is no reason why this should be ugly though language has created an aura of shame and silliness around these aspects of the body. Language sits on the surface, like badly applied make up.

My experience of my body became 'disenchanted'. Everything experienced became reducible. Every element of my life was documented, explained away. I was not 'struggling with coming to terms with life in a body which I could not control', I was 'Depressed'. Before I was acknowledged as a Celiac, I found myself dumped in the overcrowded and incredibly vague category of 'Irritable Bowel Syndrome'. The sense of the unknown was quickly methodically dispelled by proliferations of unstable scientific explanations, (Barnett, 2014: 22). A sense of mystery has no place in this paradigm.

I like to see my work as a process of re-enchantment. Re-engaging a sense of mystery seems to me, paradoxically, to facilitate the reclamation of my body from the prosaic all-seeing realms of science. The irregularities that my body and self constantly presented, were systematically sheared off in order to reach the point where I could make sense within medical language. My practice has been, in part, to lovingly re-gather these 'differences', allow them to speak, see what they say.

This reclamation is, in part, an attempt to rediscover a sense of bodily unity which is threatened through the literal and figurative dissecting of medical processes. The body becomes experienced as a set of systems rather than a unified whole, (Barnett, 2014: 27).

In terms of the Bio-psychological Model of healing, storytelling can help restore a sense of unity. I wrote the following short stories making use of imagery generated during art therapy sessions. They attempt to express my subjective pain in a 're-enchanted' symbolic language.

Art Therapy works by tapping directly into your subconscious through a process of automatic image making. Out of my subconscious trouped creatures, creature after creature, Noah's ark in reverse. The creatures were mystical, mundane, vulnerable, threatening, silly and sometimes sinister. They came to represent me, my mother, my father, my brother, my lovers, or more abstractly, my fears, my desires, bits of me that I had kept repressed.

These creatures began to enact scenarios that metaphorically represented aspects of my life. They provided a lexicon of symbolic images which comprise a personal, psychological mythology. They were creation myths, coming of age sagas, personal parables and allegorical misadventures in self-discovery.

Directing the wild animals from my imagination into clear narrations is an act of agency and reclamation in response to the passivity imposed by chronic physical pain. The 'objectifying power of the imagination' allows pain to act in a 'self-modifying' and even 'self-eliminating' capacity, (Scarry, 1987: 164). *The Farmer and the Apocalypse*, *The Lighthouse at the End of the World* and *The Monkey*, are three of the more poignant and coherent of these narrative experiments.

The Farmer and the Apocalypse

The new cockerel was born under a strange star. Within a week all the chickens were pregnant. Six months later there were more chickens than the farmer knew how to deal with. Too many for his humble needs, too many for the dinner plates of the small neighbouring desert town, too many for any imaginable use of chicken for every person he had ever met and their families. Too many for the small coop behind the house, too many for the precarious extended barbed wire contraption assembled above and beyond the original. Too many for the kitchen and bedroom and bathroom. Too many.

In his backyard, the farmer re-assembled an ancient and gigantic oil tanker to house the chickens. The various bits had been picked up from all the scrapyards in truckable distance. Here and there, he improvised. At night, when he closed the iron door, the farm was chickenless.

The small TV and the dusty week old newspapers told of flood after flood. 'From a distance one can see it all clearly,' he said to himself. At night he dreamt of monstrous bodies of holy wet vengeance.

The Lighthouse at the End of the World.

Lighthouse keepers had long ago become obsolete. Nobody really believed that anything ominous was going to appear from out of the great darkness beyond the 'edge'. However a few superstitious weirdos were still known to be posted in lighthouses along the edge of the abyss, forever gazing out into nothingness. Towns and cities were located far inland due largely to the belief that living near the edge unhinged people, that somehow the boundary pulled one hopelessly towards it, enticed one to throw themselves into the black infinity. The great deep dark, never a star, a mist or a bird.

One day a lighthouse keeper of great great age, after decades of looking, deciphered, or thought, or imagined he saw a grey-white-silver blur in the middle distance. The kind of smudge or haze an old cornea can create in contrast to uniform black, the kind of trick the eye can play when one looks too long and too hard. Also the kind of impression given by many things, flying together, not yet decipherable.

The shock of the sudden something stopped the old man's heart.

The Monkey

Last night a monkey stole my head. I recognised him from a drawing I had done a while ago. He had no place in this particular drawing which was a brainstorm for a story about a witch, a cat and a clock. But there he was, with his menacing yellow face and pink bandy body. And there again last night. Recently I was reading Italo Calvino's *If on a winter's night a traveller*. In a short story, a character experiences vertigo when she arrives at the edge of what the writer has written, which she describes as a terrible void which suddenly sprung up before her, (Calvino,1981:82). Luckily for her, the writer writes a bridge over the void, the story continues to unfold.

But what happens to characters an artist or writer invents, maybe entertains for a while, and then forgets about. Do they experience the same sense of being on the edge of a void or nothingness? And what happens when a particularly resilient character, for instance a menacing pink monkey, finds his way back from the edge to take revenge on the creator which abandoned him?

Initially, I intended to illustrate these stories in continuation with the final project of my Honours year which also focused on the healing power of imaginative storytelling in the treatment of pain. The series *Piglet and the Terrible Adventure* follows a small unassuming piglet character on a 'journey' through the body. The stages of this journey represent different body parts depicted as vast threatening landscapes. They metaphorically represent various bodily afflictions associated with my illness. This process was at the time cathartic and restorative. The book allowed me to re-interpret ugly everyday indignities into something beautiful and mysterious.

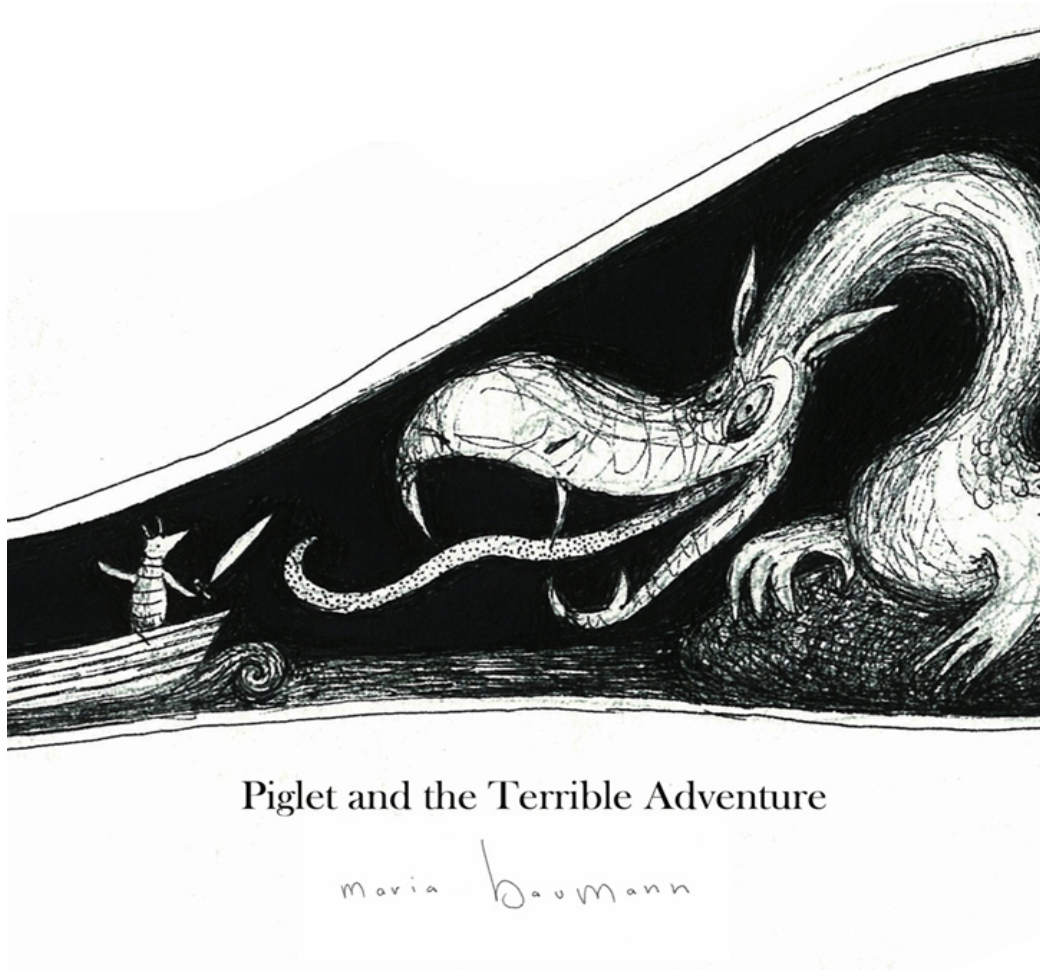


Figure 2, Baumann, M. *Piglet and the Terrible adventure*, (2013)

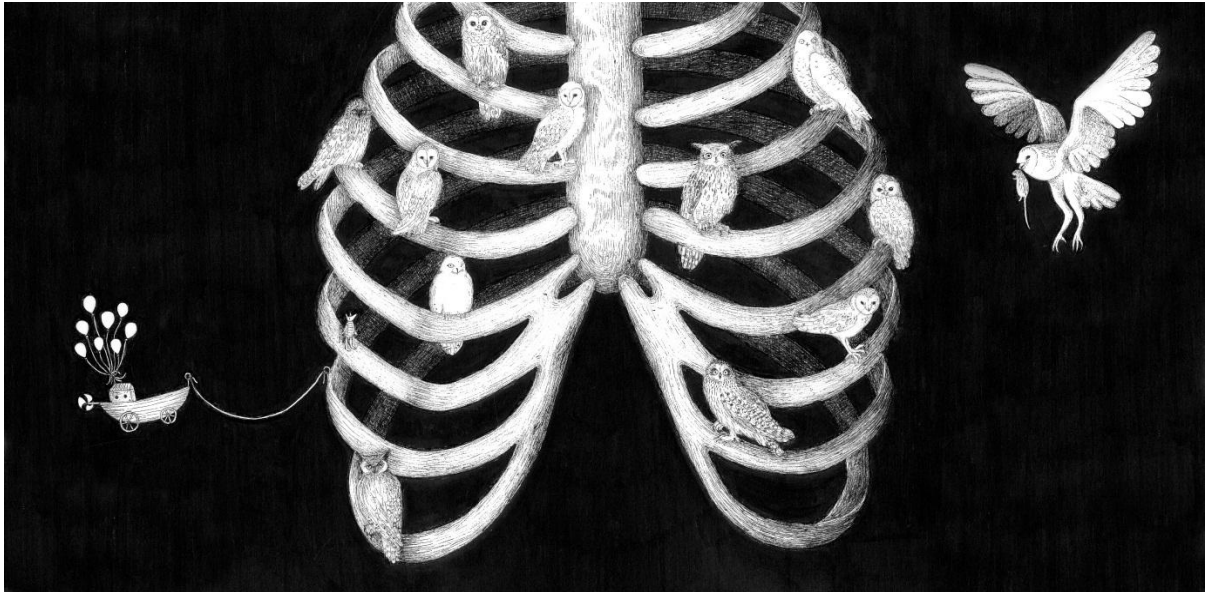


Figure 3, Baumann, M. *Neurosis*, (2013)

I quickly realised that literal renderings of *The Farmer and the Apocalypse*, *The Lighthouse at the end of the world* and *The Monkey*, were no longer meaningful. After a few aborted efforts to 'illustrate' these stories, I realised that I was finding the restrictions of narrative invasive. Rather, I became interested in illustrating what was conceptually and emotionally apparent in each. The stories each deal with the threat of the unknown, in terms of the symbolic language I have been using, the abyss of abjection. They respond to this threat alternatively with humour, fear and even desire. The stories ceased being frameworks that I needed to fill but rather points in a creative process. My work slowly became looser both in symbolic readability and style.

During the first year of my Masters, I produced dense pen drawings reminiscent of the Piglet series though less easily 'readable'. Some drawings were simply careful re-renderings of messy works I had created in art therapy sessions. Others were imaginative interactions with the characters that most frequently emerged in these drawings. All display, in one way or another, a conversation with the unknown.

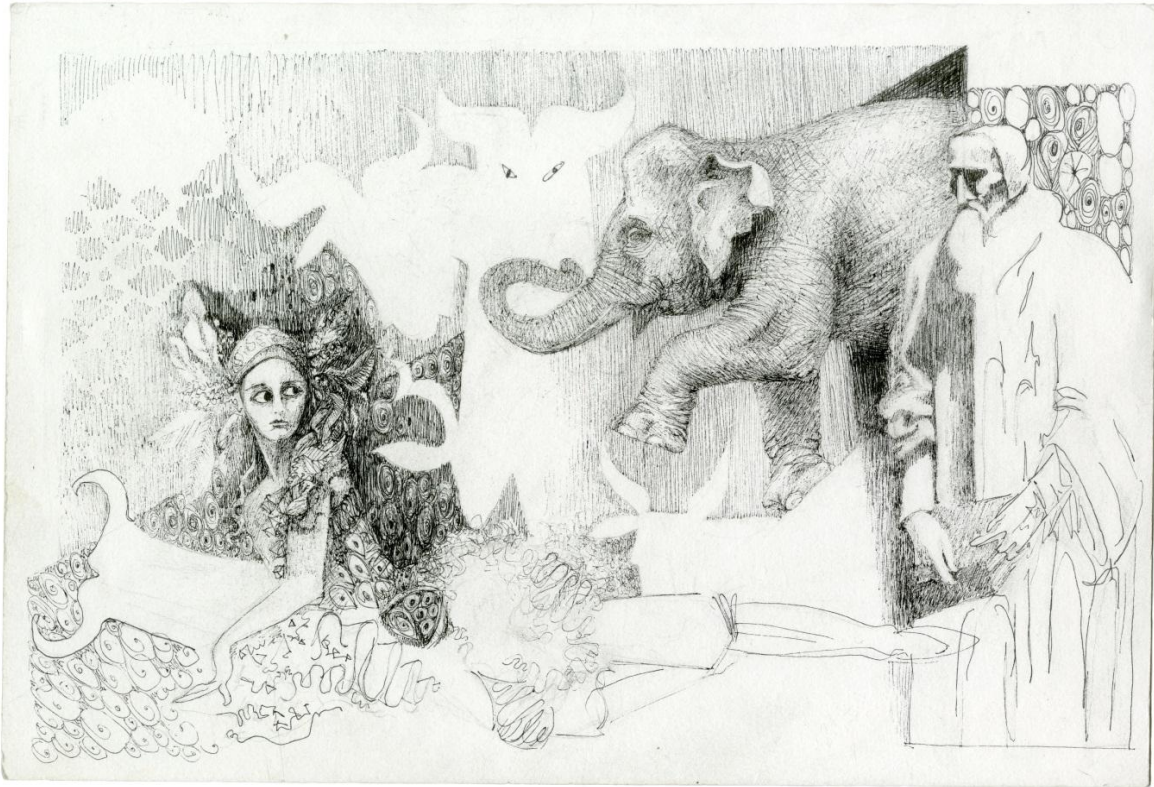


Figure 4, Baumann, M. *Untitled*, (2013)



Figure 5, Baumann, M. *Tummy Guernica*, (2013)

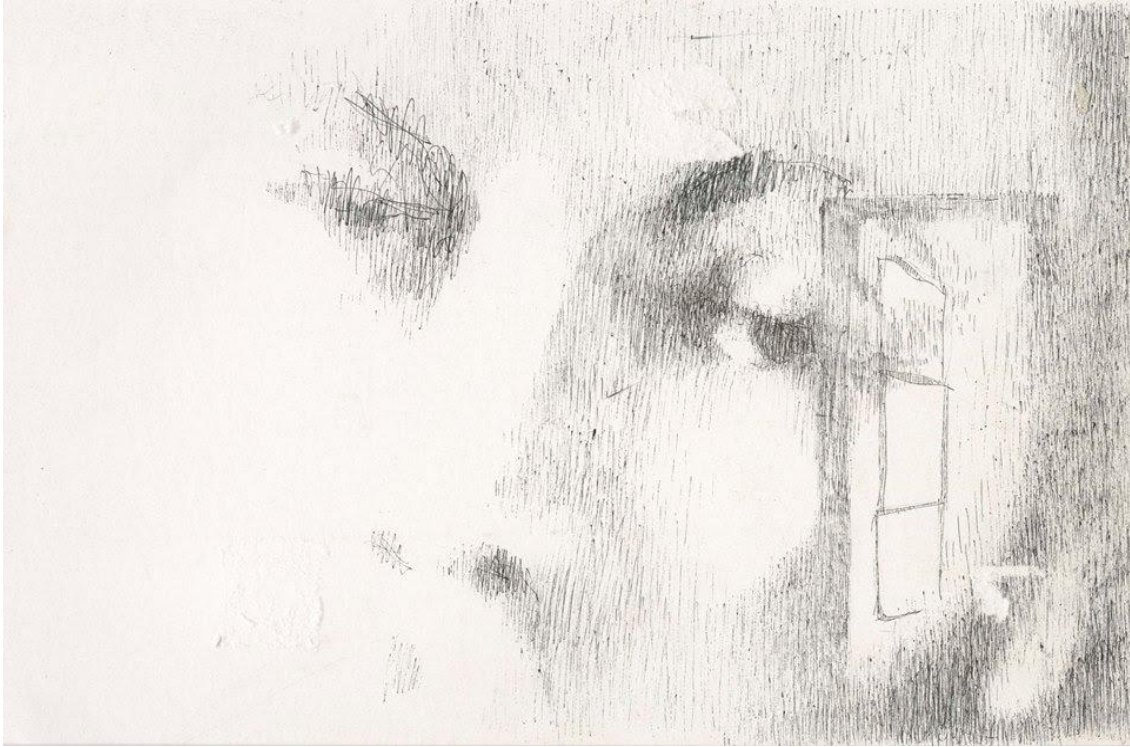


Figure 6, Baumann, M. *Skype* (2013)

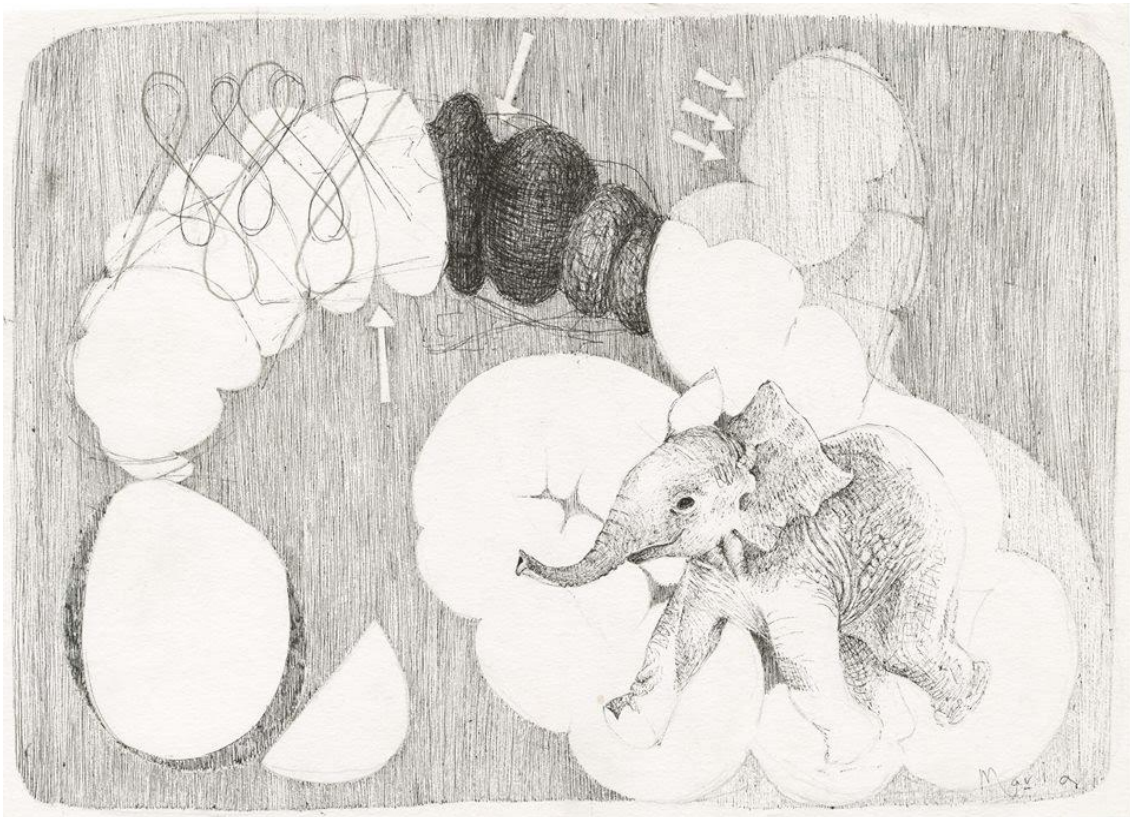


Figure 7, Baumann, M. *Bad Elephant*, (2013)

In retrospect, and in art therapeutic terms, I now recognise that these tight lines and 'illustrative' imagery reflect a neurosis and need for control, both psychologically and in terms of my art making process.

Increasingly, I have come to find partiality and instability a more meaningful model for storytelling. My later work speaks from the 'half-light' with more confidence, less need to be affirmed or even understood. In formal terms, the technique developed a synchronicity with the sense of insecure variability that I was trying to express. The ephemeral forms and loose use of watercolours describe a sense of bodily and social instability in a way that the tightly controlled pen drawings never could.

The earlier work also corresponds with a time of prolonged bodily difficulties in that strange in between space before diagnosis. Unwilling to 'perform' my pain, I isolated myself. This is reflected in the imagery I generated at the time, which is obstinately difficult to access in any way, save for the most abstractly emotional resonances. The imagery speaks loudly but in a language shared by one, a defiant oxymoron. My frequent use of my own hand writing as a visual element promises communication and then denies it. Only very few words are discernible in these messy scrawls. They seem to say 'there is so much going on here but I refuse to share any of it with you!'



Figure 8, Baumann, M. *Untitled* (2014)



Figure 9, Baumann, M. *Untitled*, (2014)

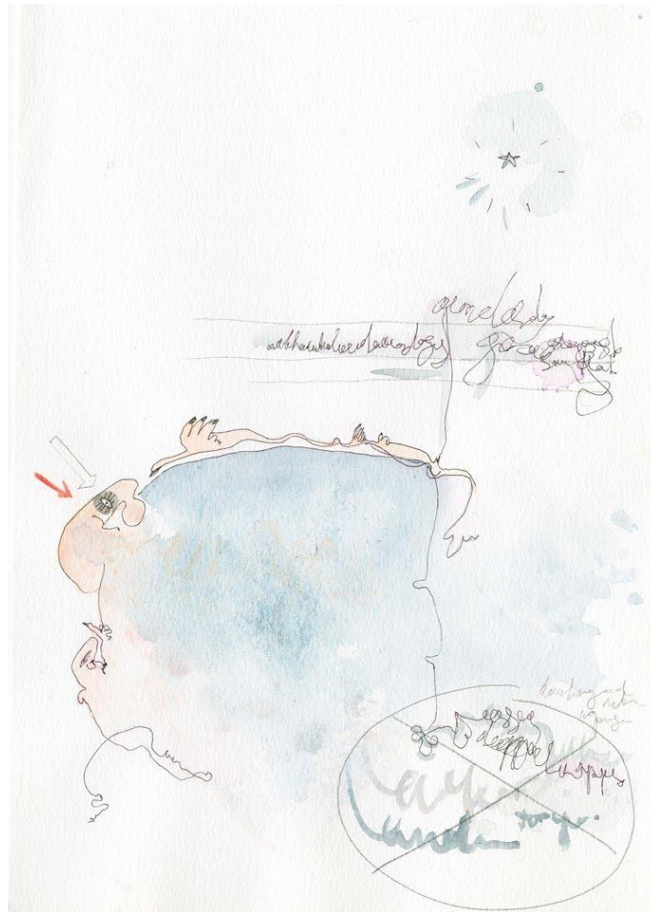


Figure 10, Baumann, M. *Humunculous*, (2014)

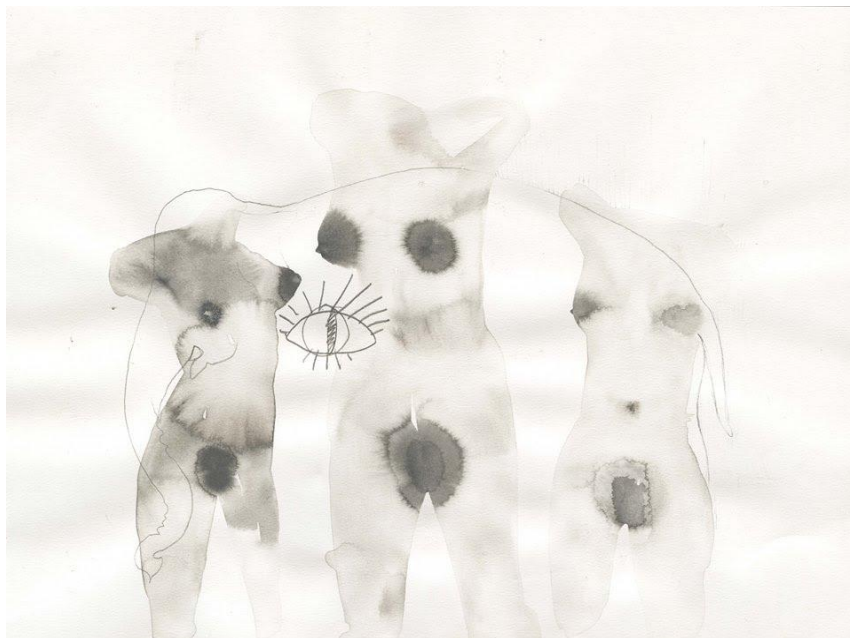


Figure 11, Baumann, M. *Untitled* (2014)



Figure 12, Baumann, M. *Untitled* (2015)

This phase was not destined to survive long. One has a responsibility to 'be part of the world'. Language is not intended for one. Getting better, getting diagnosed, isolating less, my work began tentatively to communicate. These later works includes imagery relating to the circus, show girls, early pornography and photographs of myself in which I am clearly performing or failing to perform a role. These works are not 'easily translatable', they do not offer up any literal explanation of themselves, and yet they communicate quite clearly a sense of the performative which is in some state of rupture; desperately over-acted, half-hearted, lonely, exhausted, or unalluring despite all efforts. The subjects struggle to maintain their performative selves against the glaring light of a metaphorical panopticon.



Figure 13, Baumann, M. *Untitled* (2016)



Figure 14, Baumann, M. *Untitled* (2016)



Figure 15, Baumann, M. *Untitled* (2016)



Figure 16, Baumann, M. *Untitled* (2016)



Figure 17, Baumann, M. *Untitled* (2016)

In terms of a final presentation, a set of booklets, each reflecting a different theme from my thesis, seems the natural accumulation of this process. Books imply intimacy, process and narrative rather than the spectacle and finality of a curated exhibition. The theory and practice of this process has been experientially inseparable. The booklet format allows me to represent this through the use of quotes and ideas as text which dissolve into emotive imagery.

These books are titled: *my story with celiac disease and chronic pain*; *pain and society*; *pain and performance*; *art as therapy* and *storytelling as healing*.



Figure 18, Baumann, M. *My Story with Celiac Disease and Chronic Pain*, cover (2016)

Figure 19, Baumann, M. *Pain and Society*, cover (2016)

Figure 20, Baumann, M. *Pain and Performance*, cover (2016)

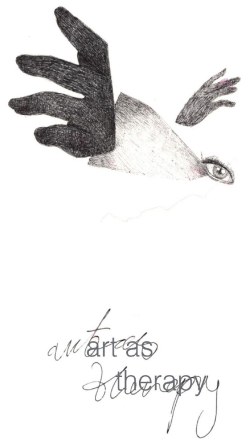


Figure 21, Baumann, M. *Art as Therapy*, cover, (2016)



Figure 22, Baumann, M. *Storytelling as Healing*, cover, (2016)



Figure 23, Baumann, M. *art as therapy, layout 9*, (2016)

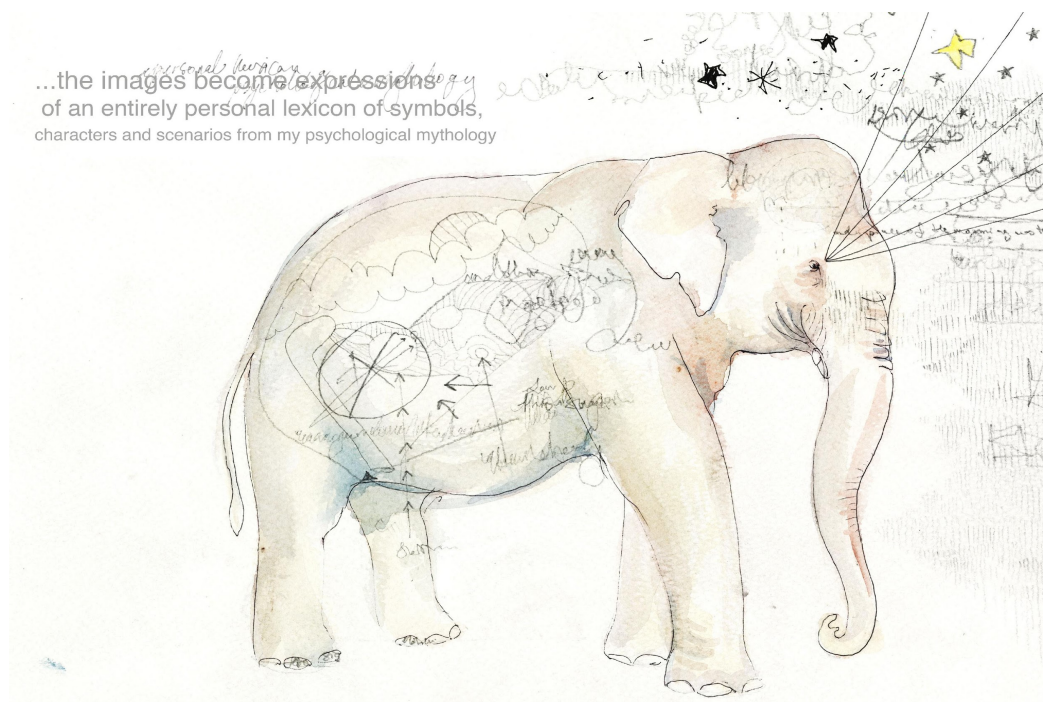


Figure 24, Baumann, M. *art as therapy, layout 6*, (2016)



Figure 25, Baumann, M. *my story with celiac disease and chronic pain, layout 3, (2016)*

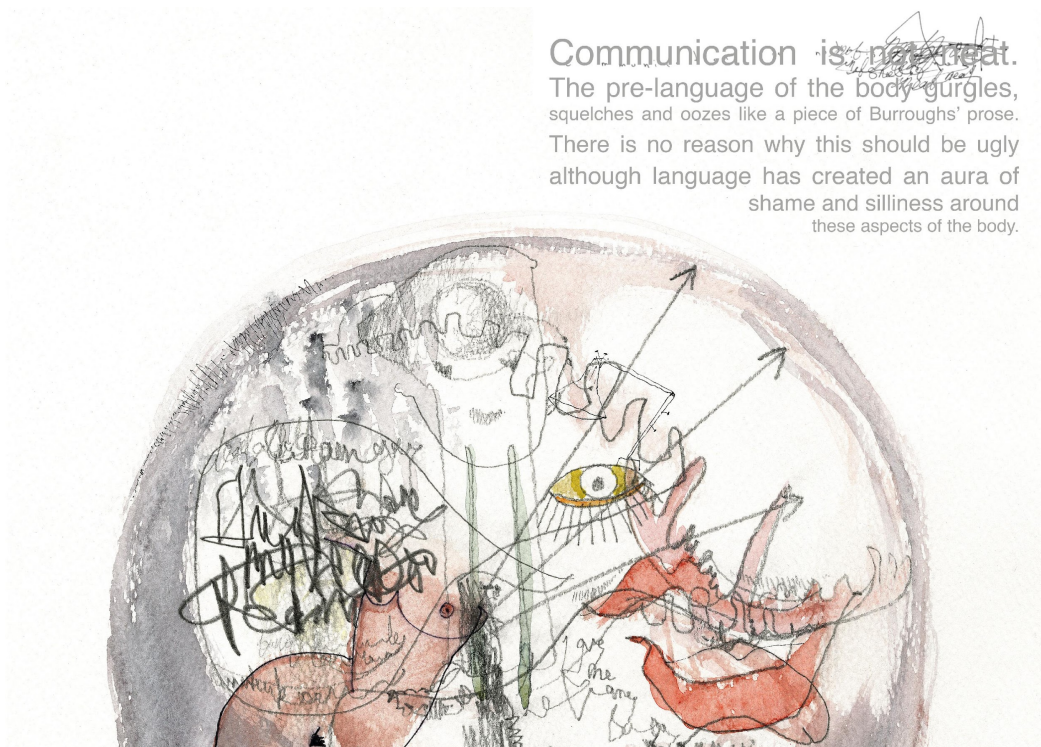


Figure 26, Baumann, M. *art as therapy, layout 4, (2016)*



How does one become part
of the world? or id?

Figure 27, Baumann, M. *pain and society, layout 2, (2016)*

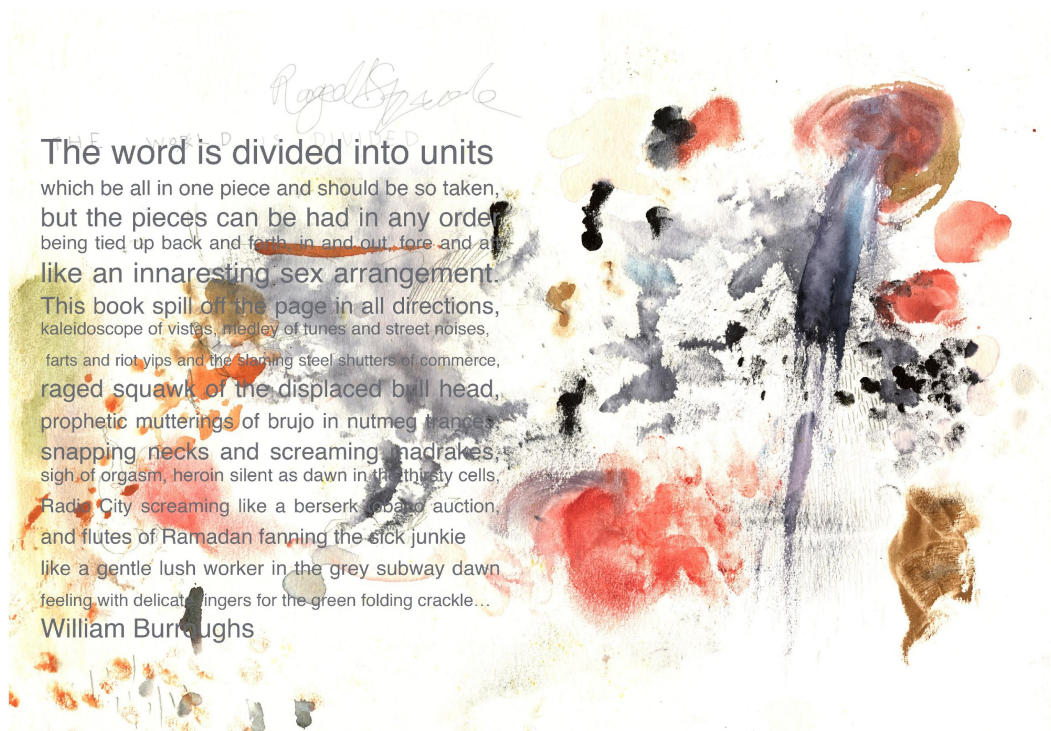


Figure 28, Baumann, M. *art as therapy, layout 8, (2016)*

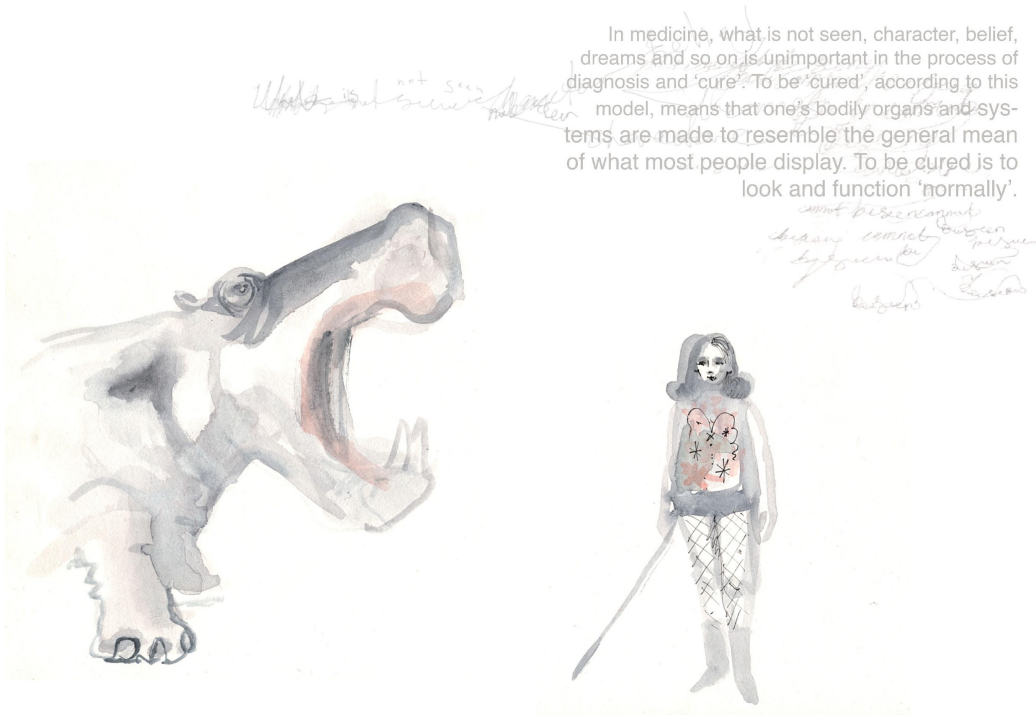


Figure 29, Baumann, M. *pain and society*, layout 12, (2016)



Figure 30, Baumann, M. *pain and performance*, layout 6, (2016)



Figure 31, Baumann, M. *pain and performance, layout 8, (2016)*



Figure 32, Baumann, M. *pain and performance, layout 3, (2016)*



Figure 33, Baumann, M. *storytelling as healing, layout 3, (2016)*

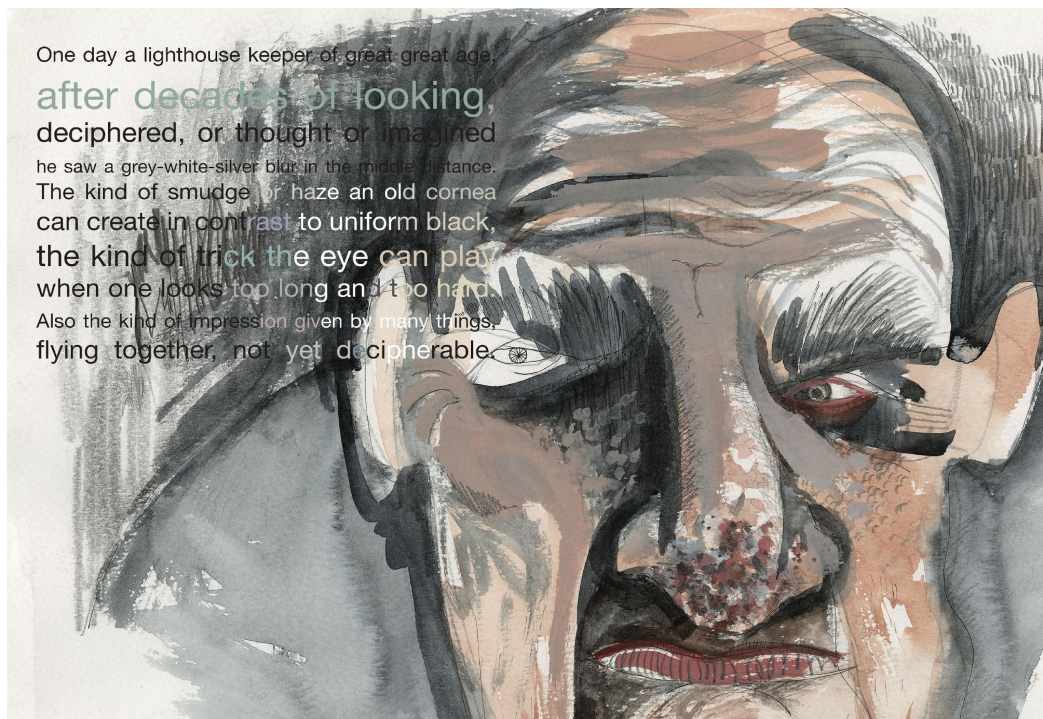


Figure 34, Baumann, M. *storytelling as healing, layout 8, (2016)*

My work experiments are with a 're-encharnted' visual language in relation to the sick body. The images are 'ritual without myth', signs without stable referent, talking without describing or instructing. They offer nothing more than the edges of a feeling, or perhaps at most, the feeling and renegotiation of the sense of an 'edge'.

Conclusion

This thesis, as a constant presence in my experience of life over the last few years, has been an illustration and embodiment of the all-consuming multidimensional nature of illness to which I have been referring to throughout my writing. It expounds on subjects to which I am instinctively drawn but also which I am most eager to avoid.

As someone completely immersed in an unusual bodily relationship to the world, I doubt that I could have spent three years meaningfully engaging with any other subject. At the same time, the reading and writing necessitated by this work has been unusually painful for an academic pursuit. People in pain tend to find ways to escape their bodily dilemmas. In my experience, this manifested in strange repetitive and compulsive habits which kept my focus distracted from the constant bodily pull to submersion in pain. This writing, and its practical counterpart, has been a constant process of engagement and disengagement, fascination and repulsion, intrigue and aversion.

The time it has taken to write has also been perforated by medical problems that have directly affected my ability to both draw and write. My diagnosis of Interstitial Cystitis was reverted to that of 'Chronic Pelvic Pain', the one leading naturally into the other. This process may be symptomatic of endometriosis. This has meant constant revision of medications. Pain medication, particularly seriously redefines how one's body relates to the world. For many months I was disorientated, excessively clumsy, prone to lose track of conversations and even my own thoughts. I could not concentrate or read even recreationally. Adjusting these doses to a level which has allowed me to function, while keeping the pain manageable, has been an on-going process which has certainly not concluded.

During this time I have suffered terrible guilt about my inability to 'perform' as expected. This has been both self-afflicted and imposed from the outside. Reporting on a period of inactivity, which are frequent both with chronic pain conditions and autoimmune diseases, is often met with open frustration, spoken and unspoken expressions of 'what, again?' The sense of 'fault' is constant and invasive. I have often felt like I am reporting on a hangover or some other self-inflicted shameful condition. I felt like a child who constantly knocked over precious things. For instance, I was accused

of faking a doctor's letter explaining my chronic pelvic pain condition. The accusation of 'faking' has been discussed in both chapter 1 and 2 in relation to the need for performance in making oneself socially viable. This type of accusation both emphasises the need for more convincing performance and expresses the constant potential for performative failure. It invalidates an all-encompassing subjective experience. Such an accusation is the constant fear and source of anxiety for anyone suffering an 'invisible' and chronic condition. The words are there, spoken by loved ones, colleagues and superiors, in the minds of the sufferer long before they are or are not uttered.

These reflections make use of my own experience as a case study for my theoretical argument. Biomedical medicine is reliant on a constructed binary between health and illness, normality and abjection. This binary is simultaneously disguised and naturalised by the notion that medicine is a science and not a discourse. For instance, the maintenance of a functioning capitalist society is subconsciously and communally maintained by a dependable work force which stigmatises illness and the lack of performativity it signifies. A culture of shame has been created around the body which cannot 'contribute to society'. Specific agendas and corrupt ideologies interwoven within the biomedical narrative are safely hidden behind the façade of 'scientific objectivity'.

Part of this scientific fallacy is that the visual is a direct reflection of reality. Since the scientific discoveries of the Enlightenment period, the visual has become the most celebrated and dominant diagnostic tool. For this reason, the binary implicit in biomedical thinking, is significantly maintained through visual representation. This emphasis is problematic on several levels. A single visual can be interpreted in many different ways, different specialists have different ways of looking. Many conditions are short on visual cues, in some they are non-existent. Sufferers of bodily maladies are expected to 'look ill' to justify their inactivity.

Chronic pain challenges the presumptions of biomedicine by existing entirely in the subjective, directly inexpressible in visual form. Its subjects often look entirely normal.

Performance is necessary for the person in pain to keep making sense within a community invested in biomedical binaries. Paradoxically, it is necessary to define oneself as outside normality, as 'abject', to translate meaningfully within the 'normal'.

My practical work experiments with ways to exist outside biomedical constructions of illness. Using a visual medium to destabilise the assumptions around the scope of the visual, I have created work based on the principles of instability. Communication is that of feeling before it has been reorganised by the mechanisms of language. As a creature, in many ways, brought into being by

language, and expressing itself through language, this claim may be overly ambitious. It does however, preside as an inherently unreachable artistic aspiration. Metaphorically, my work, inhabits a 'half-light', wishing to be 'seen', to communicate my experience, refusing to be illuminated by scientific or social scrutiny.

Theory, experience and practice interdependently tell the same story. Language is our principle recourse to each other and the world. Language insists that we be translatable. Biomedicine translates us as either normal or abject. For many, this means inventing themselves in terms of this binary. This is a creative construct, albeit reiterative and subconscious. Inhabiting this creative space can be both healing and defiant when entered into with self-consciousness and self-preservation.

Bibliography

Books

1. Barnett, 2014. *The Sick Rose: Disease and the Art of Medical Illustration*. London. Thames and Hudson.
2. Benthall, J and Polhemus, T. eds. 1975. *The Body as a Medium of Expression*. London. Allen Lane.
3. Calvino, I. 1981, *If on a winter's night a traveller*. Great Britain. Minerva.
4. De Botton, A. and Armstrong, J. 2013. *Art as Therapy*. London. Phaidon.
5. Brodwin, P., Good, B. Good, M. and Kleinman, A. 1994. Introduction. In: Brodwin, P., Good, B. Good, M. and Kleinman, A. 1994. *Pain as Human Experience: An Anthropological Perspective*. Berkley, California. The University of California Press.
6. Brodwin, P. 1994. Symptoms and Social Performances: the Case of Diane Reden. In: Brodwin, P., Good, B. Good, M. and Kleinman, A. 1994. *Pain as Human Experience: An Anthropological Perspective*. Berkley, California. The University of California Press.
7. Droit, R, (ed). 2004 *Michel Foucault, entretiens*. Paris. Odile Jacob. p 95.
8. Gilman, S. 1987. AIDS and Syphilis: The Iconography of Disease. *October*, London. MIT Press. p. 87-107.
9. Gioni, M. 2013. 'Is Everything in My Mind' in *The Encyclopedic Palace, Bienalle Arte 2013*, Vol 1.
10. Good, B. 1994. A Body in Pain- The Making of a World of Chronic Pain. In: Brodwin, P., Good, B. Good, M. and Kleinman, A. 1994. *Pain as Human Experience: An Anthropological Perspective*. Berkley, California. The University of California Press.
11. Kleinman, A. 1994. Pain and Resistance: The Delegation and Relegation of Local Worlds. In: Brodwin, P., Good, B. Good, M. and Kleinman, A. 1994. *Pain as Human Experience: An Anthropological Perspective*. Berkley, California. The University of California Press.
12. Kafka, Franz. 1938, *The Metamorphosis, the Penal Colony, and Other Stories*. New York: Schocken Books Inc., 1988.
13. Kahn, D. 2001. *Noise, Water, Meat: A History of Sound in the Arts*. Cambridge. The MIT Press.
14. Kleinman, A. 1962. *The Illness Narratives: Suffering, Healing and the Human Condition*. New York: Basic Books.
15. Lupton, D. 1994. *Medicine as Culture: Illness, Disease and the Body in Western Societies*. London. Sage Publications.
16. MacLachlan, M. 2004. *Embodiment: Clinical, Critical and Cultural Perspectives on Health and Illness*. Berkshire, England. Open University Press.

17. Manderson, L. 2011. *Surface Tensions: Surgery, Bodily Boundaries, and the Social Self*. San Fransico. Left Coast Press.
18. Morgon, J. ed. 2003. *PULSE: Art, Healing, and Transformation*. Boston. The Institute of Contemporary Art.
19. Radley, A. 2009. *Works of Illness: Narrative, Picturing and the Social Response to Serious Disease*. London, England. InkerMen Press.
20. Scarry, E. 1986. *The Body in Pain: The Making and Unmaking of the World*. New York. Oxford University Press.
21. Sontag, Susan. 1978. *Illness and Its Metaphors*. New York: Farrar, Straus and Giroux.
22. Stafford, B. 1991. *Body Criticism: Imaging the Unseen in Enlightenment Art and Medicine*. Cambridge, MA, and London: MIT Press.
23. Van Djick, J. 2005. *The Transparent Body: A Cultural Analysis of Medical Imaging*. Washington, USA. University of Washington Press.

Journals

24. Breu, C. 2011. The Novel Enfleshed: Naked Lunch and the Literature of Materiality. *Twentieth Century Literature*, 57 (2). p. 199- 223.
25. Boudreau, D, Cassell, E. 2010. Abraham Flexner's "Mooted Question" and the Story of Integration. *Academic Medicine*, 85 (2).p. 378-383.
26. Cooper. D. 1996. Bob's thing. *Artforum International*, April. p. 74.
27. Dezeuze, A. 2013. How to live precariously: Lygia Clark's Caminhando and Tropicalism in 1960s Brazil. *Women & Performance: a Journal of Feminist Theory*, 23(2). p. 226– 247. Available at: <http://dx.doi.org/10.1080/0740770X.2013.825444> [Accessed 12 August 2014].
28. Frascina, F. 2014. Object/self. *Art Monthly*, April. p. 375. Available at: <http://go.galegroup.com/ps/i.do?id=GALE%7CA368525087&v=2.1&u=27uos&it=r&p=AONE&sw=w&asid=ee88b1f5f4d972b22b4fde8817650a3b> [Accessed 4 October 2014].
29. Gilman, S. 2012. Representing Health and Illness: Thoughts for the Twenty-First Century. *Medical History*, 55 (3). P. 295 – 300. Available at: http://journals.cambridge.org/abstract_S0025727300005299 [Accessed 2 September 2014].
30. Gilman, S. 2011. Seeing bodies in pain: From Hippocrates to Freud. *The International Journal of Psychoanalysis*, 92. p. 661–67.
31. Gooldin, S., 2003. Fasting Women, Living Skeletons and Hunger Artists: Spectacles of Body and Miracles at the Turn of a Century. *Body & Society*. 9: 27.
32. Havsteen-Franklin, D. 2008. The Composite Image: An Exploration of the Concept of the 'Embodied Image' in Art Psychotherapy. *International Journal of Art Therapy*, 13(2). p. 53-64. Available at: <http://dx.doi.org/10.1080/17454830802503438> [13 October 2014].
33. Janzen, J. 2010. Mind/Body, Subject/Object: Recent Trends in Medical Anthropology. *Reviews in Anthropology*, 30. p. 343-360.

- Available at:<http://dx.doi.org/10.1080/00988157.2001.9978291> [Accessed 12 August 2014].
34. Klein, L, Alter-Muri, S. 2011. Dissolving the Boundaries: Postmodern Art and Art Therapy. *Art Therapy: Journal of the American Art Therapy Association*, 24(2). p. 82-86.
Available at: <http://dx.doi.org/10.1080/07421656.2007.10129584> [Accessed 13 October 2014].
35. Naryvey, C. 2002. Venus ruined: photographs from Hannah Wilke's "Intra-Venus". *Resources for Feminist Research*, Fall. p. 133.
36. Park, R, Park, M, 1991. Goya's living skeleton. *British Medical Journal*. 303(6817). p. 1594.
37. Pollock, G. 2010. Hannah Wilke: Elective Affinities. *Art Monthly*, Sep. p. 34.
38. Porter, R. The Body Politic: Diseases and Discourses. *History Today*, October. p. 23-29.
39. Shapiro, K. 2014. CONFOUNDING SOLIDARITY: Singular, Universal and Particular Subjects in the Artworks of Tehching Hsieh and the Politics of the New Left. *Journal of the Theoretical Humanities*, 18 (4). p.195-210. Available at:
<http://dx.doi.org/10.1080/0969725X.2013.869020> [Accessed 3 October 2014].

Internet Sources

40. Assizes, C. 1870. Trial of the Parents of the Welsh Fasting Girl for Manslaughter. *The Tivy-Side Advertiser*, July 15.
Available at:< <http://www.welshlegalhistory.org/research-jacob-trial-report.php>> [Accessed 7 October 2014].
41. *Celiac Disease Foundation*.
Available at:< <https://celiac.org/celiac-disease/diagnosing-celiac-disease/>>.[14 August 2015].
42. Foucault. 1973. *The Birth of the Clinic*. [e-book]. London: Routledge.
Available at: <http://home.ku.edu.tr/~mbaker/CSHS503/FoucaultClinic.pdf> [Accessed 13 October 2014].

Videos

43. *Lygia Clarke MoMA Interview*, 2014, exhibition video. Museum of Modern Art. New York.