

Spanning Cancer: Cancer as an Episode in an Individual Life Story

Richard Freadman¹

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Abstract This article discusses ways in which autobiographical writing of cancer experience can be used by non-professional writers living with the disease or its aftermath, and has been used by professional writers in published cancer memoirs, to help find meaning in cancer experience. It also considers wider sociological dimensions of cancer experience in contemporary western culture.

Keywords Cancer memoir · Narrative therapy · Illness life writing

When Dianne Clifton invited me to give this lecture, she laid down two – and only two – conditions: one was that it should allude to the power of story-telling; the other was that it should make some mention of liminality. In one way of another, the entire lecture is about the power of story-telling, and I'll come to liminality presently. But first, a brief outline of what is to come.

The lecture, which falls within the large interdisciplinary field called the Medical Humanities, will be in three parts. Part One, “Illness and identity stories”, introduces some of the lecture's key ideas and some of the ways in which these ideas are connected. I discuss, in turn, technologized modern medicine and psycho-oncology; psycho-oncology and autobiographical narrative; autobiographical narrative and the workings of our ‘who I am’ identity narratives; identity narratives and their response to life-threatening illness. I illustrate these points by reference to the cancer experience of a fictional character named Rob whom I have invented for the purpose

of the lecture. I thread Rob's narrative through the lecture, starting with his initial stirrings of unease at what might be a cancer symptom, through various diagnostic stages, treatment, his remission experience, and finally to the point at which he is moved and assisted to start writing his cancer story.

Part Two maps some of the many cultural, sociological and personal factors that may influence the experience of cancer that a given individual – say Rob – has, and also some of the modes, plots and techniques which our culture makes available – even in some instances prescribes – as narrative options for those who wish to write their cancer stories. Since autobiographical writing, of whatever sort and however ‘individual’ in voice and technique, must inevitably avail itself of some of these already-existing, culturally-provided narrative resources, it would be naïve to think of Rob's narrative as *just Rob's story*. Thus Part Two is entitled “Not just Rob's story”. His cancer story will be indebted to cancer stories of and by others, and to cultural templates and expectations pertaining to this genre of story-telling. As he writes he becomes another voice in a now rich and various field of non-fictional narrative that I call *illness life writing*.¹ I illustrate some of these points by noting several of the important scholarly studies about

✉ Richard Freadman
R.Freadman@latrobe.edu.au

¹ 46 Bordeaux Street, Doncaster, Victoria, Australia 3108

¹ In her path-finding study, *Reconstructing Illness: Studies in Pathography* (West Lafayette: Purdue University Press, 1993), Anne Hunsaker Hawkins uses the Freudian term ‘pathography’ for illness narratives by patients and carers. G. Thomas Couser, in another fine book, *Recovering Bodies: Illness, Disability and Life Writing* (Madison: University of Wisconsin Press, 1997), suggests using the term ‘autopathography’ to differentiate first-person illness narratives from third-person ones. In one of the foundational books in the field, Arthur Kleinman uses the less forbidding term ‘patient narrative’. See Arthur Kleinman, *The Patient Narratives: Suffering, Healing and the Human Condition* (New York: Basic Books, 1988). I prefer the similarly non-technical term *illness life writing* because a term like ‘pathography’ is too reminiscent of the cool scientific ethos that patient and carer writers often critique. Indeed *illness life writing* is often motivated by the desire to critique that very ethos.

illness life writing that have appeared over the past thirty-five or so years, and with reference to a number of important cancer memoirs published during that period.

Section Three sketches a form of narrative therapy I wish to propose and which I call *reparative writing*. This approach draws on some existing forms of narrative therapy, but derives principally from narrative work I have done over the years with individuals living with cancer, from narrative work I do under the auspices of a fine organization called Eastern Palliative Care, from years of teaching the techniques of autobiographical writing at university level, and from my own practice as an autobiographical writer. I suggest that *reparative writing* may, in conjunction with other ‘interventions’, assist someone like Rob to tell a cancer story which, as well as being valuable to others, may help him to integrate sometimes traumatic cancer experience into the larger ‘span’ of his life-narrative.

Illness and Identity Stories

Let’s start this Annual Lecture in Psycho-oncology by briefly considering psycho-oncology in the context of modern technologized medicine. Psycho-oncology obviously sees cancer as *both* a physiological and a psycho-social phenomenon. In this sense it is an attempt to heal a still widely-occurring conceptual and therapeutic rift in modern medicine which construes mind and body as fundamentally different orders of reality; physical illness as a matter largely sealed off from the psychological life of the patient; and the ill body as essentially a machine in need of repair. Many of you will be aware that this picture of mind/body relations in general, and mind/body relations in medicine in particular, owes a lot to the influence of the seventeenth-century philosopher, René Descartes. Whilst I share often-expressed concerns about the impersonality and dehumanizing effects of this Cartesian medical ethos, I do also think it important to acknowledge that its intense commitment to objective scientific investigation and its very high levels of expert specialization have played a major part in rapid advances in medical treatment, including treatment of many forms of cancer. So the history is complex and I see psycho-oncology and related uses of narrative in cancer therapy as a *re-balancing of cancer care*, indeed as a necessary correction from a too-limited focus on technological methods of cancer *cure* to the broader and more empathic notion of medical *care*.

Care in this sense entails attention to the ill individual in his/her broader life-context. It tends to rest on a further distinction between *disease*, understood as physiological dysfunction, and *illness*, where the latter term refers to the *meanings* that a given disease has or might have for a particular patient within the broader span of that person’s autobiography; especially their ‘who I am’ identity story. So psycho-oncology sees cancer as occurring within a biographical context, and to a creature – the human being – in whom there are

multiple, subtle and reciprocal relations between mind and body. Crucially, the mind of this creature, sometimes referred to by anthropologists and others as The Story Telling Animal, is deeply – though not of course wholly – narrative in its organization. Even those who are not writers possess impressive narrative skills. We constantly use narrative to orient ourselves in complex worlds; to narrate our experiences to others; we dream, gossip and fantasise in narrative; we use it to make projections of the future, to chronicle historical events; we employ it in various practical contexts like job applications, descriptions of how we’re feeling to our GPs; and of course narrative is fundamental to many forms of psychotherapy.

I want to stress that here and hereafter in this lecture, I do not use the term ‘story’ as a synonym for ‘fiction’, and that the term ‘narrative’ can refer either to fictional or non-fictional stories. The story-telling under discussion here is an attempt by people who have experienced cancer to narrate their stories as truthfully as they can, and even though the vagaries of human memory and the complexities of language make it impossible for anyone to tell a story of any complexity that is indisputably one hundred percent ‘true’, such patient writing can achieve a very high degree of narrative reliability. I should also point out that the account I give below of the relationship between the ‘self’ and identity narrative differs fundamentally from certain postmodern views which see the self as in some sense fragmented and/or overwhelmingly scripted from without, and from existentialist views which see radical ruptures in personal identity narrative as desirable, even as necessary precursors to the exercise of true human freedom.

I’ll focus now on that narrative activity that enables the Story Telling Animal to carry around a ‘who I am’ identity narrative in its head. This isn’t a universal capacity among human beings and a decent society will extend empathic and supportive care to those who for reason of illness, disability, injury or lack of opportunity do not possess it. Miss Havisham in *Great Expectations*, the old lady who, having been long ago jilted at the altar, sits withered and ‘corpse-like’ in her faded wedding dress, her stopped clock and watch emblematic of ‘the arrest of everything’² in her life, is a remarkable fictional evocation of a catastrophically maladaptive reaction to trauma which tries to stop the ‘who I am’ story dead; to kill off the self’s psychological life as a being in time. But where the ability does have opportunity to flourish we know that it involves *both* the establishment of an ‘I’ narrative, and a process of revision through which this narrative changes as it registers new experiences, insights, input from others, and so on. This revision process helps explain how it is that, quite remarkably, during the process of what psychologists call *identity formation*, our identities are able to change across time whilst remaining in some fundamental senses the same. We might

² Charles Dickens, *Great Expectations* (Hammondsworth: Penguin, 1965), 90.

give the name of *assimilation* to the process by which we incorporate new, disruptive, even deeply threatening events and feelings into our existing ‘I’ narratives. The process is assimilative in that it can absorb the new *without decimating the person’s sense of narrative coherence*. Peg Levine’s term *recalibration*³ captures very precisely the fact that the process can involve readjustments all the way along the arc of individual narrative, from past to projections of the future.

I don’t want to idealize this process because, clearly, identity stories and the identities that depend on them are never completely integrated. We all struggle with conflicting or jostling identity facets and self-understandings, and when these struggles become too acute the resultant psychic strain can be enormous. Nevertheless, the assimilative capacity is an essential, impressive and often efficacious aspect of our narrative lives and one of my arguments tonight is that at times of great psychic duress it can be augmented by various kinds of assisted narrative activity.

I can’t think of a metaphor that adequately expresses the complexity of what happens when an identity story recalibrates in response to new experiential data. Marcel Proust’s *Remembrance of Things Past* is the most elaborate and brilliant literary representation of this process that I know and only a really great writer can even begin to do it justice. However we might schematically liken one dimension of the process to an unceasing, quantum, shuttle-like movement between ‘zones’ of past, present and future, dispersed along a shifting chronological axis. We all do such shuttle-like narrative work, often unconsciously, all the time; but a crisis like a life-threatening cancer diagnosis can send the process into overdrive in response to acutely urgent existential needs.

In his superb memoir of Multiple Myeloma and its incapacitation of his kidneys, *Love Letters from Transylvania*, Hugh Kiernan writes that ‘the still-echoing percussion, the synchronized train wrecks of cancer and kidney failure ushered chaos into my life’.⁴ Chaos, we might say, is the absence of narrative (though Arthur Frank includes among his designations of illness narrative ‘chaos narrative’),⁵ and *reparative* narrative work of the kind I’m proposing here is intended to assist people to undertake a form of narrative activity they have been practising, often unawares, for years in lower-key-ways, but now in a more conscious, targeted, crafted and emotionally efficacious manner, in order to reassert narrative coherence where chaos has done its disorienting work.

In her fine breast cancer memoir, *The Red Devil*,⁶ American publisher and journalist Katherine Russell Rich recounts some shocking encounters with emotionally incompetent

oncologists. Eventually though she meets one – a woman – whom she greatly admires. This outstanding physician tells her:

Once treatment ends, people try to isolate the disease, to make it into an episode, into something that just happened. They think that’s the best way to defend themselves. They think they can put cancer into an aluminium box and store it in a far corner of the room, and it’s painful to watch them try. They say, ‘Now I can get on with my life’, and I want to answer, ‘You can’t. This is your life.’ (97–98)

Based partly on work I’ve done on Holocaust experience and testimony, I want to qualify this generalization by saying that not everyone does better by telling their story. For some, I believe, the aluminium box does best. But Rob the carpenter, whose narrative I’ll now sketch, is not one of these.

This right-handed master builder learnt many of his fine skills as an apprentice on building sites from his emotionally reticent father, also a master tradesman. In his ‘who I am’ identity story Rob figures – and with good reason – as a thoroughly decent Australian man in middle age. Two of his signature qualities, which are constantly reinforced by the way others respond to him, are that he’s unflappable, a great ‘copper’, and kind – despite his slightly gruff ‘man of few words’ exterior, he ‘has a good heart’. Other important aspects of his identity story include: he has an excellent physical constitution and hardly ever gets sick; he’s got good genes – elderly parents, no cancer or heart disease in the immediate family; he and his wife June have great travel plans for their retirement; and his skill as a craftsman constitutes a major source of self-definition and self-esteem.

So when this coping guy who has a high level of confidence in his own body thinks that a mole on his right arm might have changed a bit in recent months, he’s none too bothered. But he’s heard too many cancer stories in the media and elsewhere, especially about sun-related cancers, to be completely immune to cancer fear. He shows the spot to his usually avuncular GP who unsettles him somewhat by suddenly looking less avuncular than usual and booking him in for an immediate appointment with a general surgeon. Following a biopsy which confirms melanoma, and another booking, this time for immediate surgery, the usually unflappable Rob finds himself in an unfamiliar state of high – sometimes searing – anxiety. The shuttle-like identity-story process in his mind goes into overdrive, his present situation precipitating great swooping imaginative probes into the past, and also the imagined future; prompting agitated, sometimes novel questions: *What sort of a life have I really lead? What does it all mean? How much of it might be left? What would – what should – I do with what is left if I’m going to die in middle age?*

³ Dr Levine suggested this term during question time after the lecture.

⁴ Hugh Kiernan, *Love Letters From Transylvania* (Melbourne: Michael Hanrahan Publishing, 2015), 156.

⁵ Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995), 97–114

⁶ Katherine Russell Rich, *The Red Devil: To Hell With Cancer – and Back* (New York: Crown, 1999), 97–98.

This whirr of narrative activity is largely stymied by what turns out to be a big operation, and then by precautionary chemotherapy which, despite Rob's generally robust constitution, absolutely flattens him for some months. After the operation the surgeon, a personable enough but busy man whom he hardly knows says:

It was Stage Three. Not ideal, but you should be okay. I think we got it all, but if there are any sinister little alien cells lurking about elsewhere the chemo should blow them out of the water. I had to take a lot of tissue to get a decent margin around the thing, so you won't like the look of your arm when the dressings come off it.

When this master craftsman whose professional identity matters so deeply to him asks about his future working life the surgeon replies rather jauntily:

Well, you're going to be a pensioner or a left-handed carpenter. Could be better. Could be worse.

And when after the chemo friends ask Rob how he's doing he replies with the following brief, phlegmatic autobiographical snippet:

Well, I'm back from the Planet of the Zombies. I don't know where those months went – they're a fucking great black hole – but the doctors say I should be right now and that the chemo should have destroyed any rogue cells left over after the op, and that's good enough for me. When I asked the surgeon about work he said I'd have a choice between the pension and carpentering with my left arm. No way am I taking this lying down!

Despite his apparently confident assertion to the contrary, Rob knows deep down that he's entered a new phase of life; one in which his medical future, and therefore the shape and meaning of his entire autobiographical narrative – past, present, future – has become uncertain. As Arthur Frank has argued, this new life-phase is largely a creation of technologized modern medicine. Rob is now living in 'remission'. He has become a citizen of what Frank calls the 'remission society'.⁷ Miles Little et al. have characterized the remission state as a form of liminality, in-betweenness; a neither-one-nor-the-other place in which the person is neither categorically ill nor categorically well; where the old self is back to some extent but can't quite be as it was before; where the past looks slightly unfamiliar and the future uncertain; and where anxiety haunts even the most determined resolutions to live well.⁸

⁷ Frank, *The Wounded Storyteller*, 8.

⁸ Miles Little, Christopher FC Jordens, Kim Paul, Kathleen Montgomery and Bertil Philipson, "Liminality: A Major Category of the Experience of Cancer Illness", *Social Science Medicine*, Vol. 47, No. 10, 1485–1494.

American cancer survivor-authors, Glenna Halverson-Boyd and Lisa K. Hunter, liken this state to a kind of 'limbo', and their deliberately upbeat title is *Dancing in Limbo*.⁹ But right now Rob isn't so much dancing as trudging. When nine months later he tells his GP that despite the triumph of learning to carpenter left-handed he's feeling flat, anxious and irritable, the GP, seeing a strikingly changed man, refers him to the eminent psycho-oncologist, Dr Dianne Clifton who, in addition to the clinical work she does with him, suggests that he might like to try some assisted written narrative work as well. When he responds with interest to this idea she refers him to someone like me – in fact, coincidentally, to me in particular.

Not just Rob's Story

Though Rob's cancer, like his identity narrative, is unique in various respects, he does nevertheless experience cancer in a cultural context that inevitably influences the cancer experience he 'has'. Noting some important scholarly discussions and cancer memoirs as we go, let's briefly map some of the cultural influences that may be in play here.

a. Cultural belief systems

Does Rob process his cancer experience as a religious person who may see it consolingly as an aspect of Intelligent Design, perhaps promising an after-life; or does he process it, perhaps less consolingly, in terms of say popular Darwinian evolutionary assumptions which envisage no ongoing life for the individual after death? Orthodox Jewess and Torah scholar, Deborah Masel, writes in her fine breast cancer memoir, *Soul to Soul*, that after her first treatment, 'it was Torah that sustained me', and that at such times 'Atheists hanging by their fingernails from the sides of jagged cliffs may experience an overwhelming desire to make promises to a god in whom they never believed....I can't not believe in the holiness that vivifies the world, both in its sunlit places and its terrifying shadows.'¹⁰ Renowned atheist and public intellectual, Christopher Hitchens, however feels no such 'overwhelming desire' when diagnosed with oesophageal cancer, and writes: 'My chief consolation during this year of living dyingly has been the presence of friends.'¹¹

b. Cultural conceptions of wellness and illness

⁹ Glenna Halverson-Boyd and Lisa K. Hunter, *Dancing in Limbo: Making Sense of Life After Cancer* (San Francisco: Jossey-Bass, 1995).

¹⁰ Deborah Masel, *Soul to Soul: Writings from Dark Places* (New York: Gefen, 2011), 96.

¹¹ Christopher Hitchens, *Mortality* (Allen&Unwin, 2012), 54.

The phenomenal upsurge in patient narratives, particularly since 1950s,¹² is partly attributable to the fact that modern medicine in first-world societies has become so expert at curing or containing many hitherto deadly illnesses that we now tend to see wellness as the norm. Life-shortening illness is thus perceived as horrific and undeserved bad luck and/or as a catastrophic disruption – even rupture – in the patient’s identity narrative.

c. Demographic factors:

Cancer experience, and expectations of wellness and illness, can of course vary enormously according to demographic factors such as race, gender, class and ethnicity. Alas for very good reason, indigenous Australians will generally have lower expectations around all aspects of illness and wellness than most white Australians. Perhaps the greatest exploration of such factors in woman’s cancer memoir is *The Cancer Journals* by American poet, Audre Lorde. Lorde insists that the ‘work’ involved in surviving breast cancer is inseparable from the political ‘work’ of gender, race and class emancipation. She challenges her reader: ‘Perhaps for some of you...I am the face of one of your fears. Because I am a woman, because I am black, because I am lesbian, because I am myself, a black woman warrior poet doing my work, come to ask you, are you doing yours?’¹³ The British sociologist, Simon J. Williams, gives a fine-grained account of how demographic differences can mediate expectations and thus experiences of chronic illness and its impact on the biographical narrative of the patient. He also suggests that certain ‘biographical disruptions’ in individual narrative that result from widely-occurring conditions in modern society can actually (help) *cause* some forms of chronic illness.¹⁴

My own neck of the woods, the Anglo-Australian middle-class Melbourne Jewish community, is I think rightly not renowned for its stoicism in matters of illness. A standard telegram from this demographic might read: ‘Not feeling my usual self. Still I’ve had a good run. No need to call.’

d. The ways in which particular diseases are mythologised and metaphorised in the culture

Susan Sontag’s *Illness as Metaphor*,¹⁵ which explores our use of metaphors to describe cancer and other serious illnesses, has been highly influential in inspiring later studies of illness life

writing and in drawing attention to cancer metaphors that may be misleading and may have injurious consequences. Military metaphors which portray chemotherapy as ‘heavy artillery’ that will ‘blow alien cells out of the water’ are staples of our communal cancer stories; yet they attract sharp criticism in many cancer memoirs, including one of the finest and most important of all: Arthur W. Frank’s *At the Will of the Body: Reflections on Illness*. As his title suggests, Frank rejects battle metaphors, in part because he finds that the cancer patient must *work with* the body and is to a large extent in the hands not just of medical treatment, but of the body’s ‘will’. Of his testicular cancer he writes:

*The tumors may have been a painful part of me, they may have threatened my life, but they were still me. They were part of a body that would not function much longer unless it changed, but that body was still who I was. I could never split my body into two warring camps: the bad guy tumors opposed to the naturally healthy me. There was only one me, one body, tumors and all. Accepting that I was still one body brought me a great sense of relief.*¹⁶

And yet to reject battle and other possibly misleading metaphors is not, as Sontag proposes, to reject all use of illness metaphor. Even if this were possible – and it is not – the use of personally apposite metaphors remains, as we shall see, one of the most necessary and powerful resources available to illness life writers.

e. Narrative templates

A particular culture will provide the Story Telling Animal with templates for story-telling which perform positive and necessary functions. Templates assist the author to tap into existing forms of cultural intelligibility and to make narrative order out of existential chaos. Templates, though, might have negative effects – for instance, by implicitly deeming certain topics, or certain ways of talking about such topics, inadmissible in public narrative. Or a template might reproduce and reinforce ideological prejudices – for example, a prejudice about which groups in the community have the most right to speak and to do so with most authority. One of the beauties of authentic autobiographical writing is that, historically, it has refused many of the existing cultural boundaries around story-telling and so helped to liberalize attitudes towards the discussion of hitherto proscribed or veiled topics. Breast cancer narrative has not only eroded unofficial censorship of conversation about say mastectomy; it has also helped liberalize attitudes to writing about women’s bodies in general.

Plot structures are perhaps the most obvious example of narrative templates. Frank’s discussion of illness

¹² Hawkins, *Reconstructing Illness*, 4.

¹³ Audre Lorde, *The Cancer Journals* (San Francisco: Aunt Lute Books, 1980), 13.

¹⁴ Simon J. Williams, “Chronic illness as Biographical Disruption or Biographical Disruption as Chronic Illness? Reflections on a Core Concept”, *Sociology of Health and Illness*, No. 1, 2000, pp. 40–67.

¹⁵ Susan Sontag, *Illness as Metaphor* (London: Allen Lane, 1979).

¹⁶ Arthur W. Frank, *At the Will of the Body: Reflections on Illness* (New York: Houghton Mifflin Company, 1991), 56.

narrative plots in *The Wounded Storyteller* is still the most comprehensive one we have.¹⁷ I will restrict myself here to three widely-occurring – and sometimes intermixed – cancer memoir plot templates: first, *the triumph narrative*, in which the encoded message reads something like: ‘how I beat cancer and never looked back’; second, *the illness and personal growth narrative of remission or cure*, which in effect says: ‘I dreaded cancer, but now I see it more as an opportunity than a blight, because it enabled me to grow as a person in necessary ways that I couldn’t have achieved without it’; and third, *the chronic uncertainty remission narrative*, which often features a tone of anxiety, even lament: ‘I can’t feel secure, can’t trust my body, any more’; ‘once a cancer patient, always a cancer patient’; ‘I’m living in limbo’.

f. Clinical and experimental opportunities for cancer narrative

A culture like ours of course provides various settings which encourage the exploration and narration of cancer experience. Diverse forms of psychotherapy – not least under the umbrella of psycho-oncology – are cases in point. We also have online discussion and writing groups such as the Australian Expressive Writing Group for Adults Affected by Cancer (for this and other Australian online groups see <http://www.cancerconnections.com.au/index>).

In another key, there are specific methodologies designed to support written storytelling about illness and other sources of emotional distress. Perhaps the best-known of these is James Pennebaker’s practice of *emotive writing* which invites people to write, usually in bursts of about twenty minutes spread out over several days or weeks, about painful or even traumatic experiences. The experimental subjects, who are I gather usually students recruited from Pennebaker’s campus, are instructed to write with complete spontaneity, without any concerted processes of reflection or revision. Their writing is then compared with that of a control group who have been invited to write about non-disturbing experiences. Pennebaker’s research has attracted a lot of attention – much of it favorable – in part because, unlike most forms of narrative therapy, it is backed by quantitative research results. Having drawn blood before and after the writing process these results apparently show beneficial effects on the immune system, especially increased production of t-cells.¹⁸

¹⁷ Frank, *The Wounded Storyteller*. See especially chapters Four, Five, Six and Seven. See also Hawkins, *Reconstructing Illness*, and Couser, *Recovering Bodies*.

¹⁸ James Pennebaker, *Writing to Heal: A Guided Journal for Recovering from Trauma & Emotional Upheaval* (New Harbinger, Oakland, CA), 2004. See also Stephen J. Lapore and Joshua M. Smyth (eds), *The Writing Cure: How Expressive Writing Promotes Health and Well-Being* (Washington DC: American Psychological Association), 2002.

I’m agnostic as to these particular claims, but I do think that at the very least they help confirm the long-held belief that *expressive art in general*, be it writing (fictional or non-fictional), painting, music, dance or whatever, can have beneficial physiological effects. However, my conception of *reparative writing* does not rest on any such claims. I simply argue that it can be of assistance to some patients to write their cancer experience in a more sustained, reflective, assisted and mentored way than Pennebaker’s no doubt valuable method proposes. Such benefits, I believe, can be psychological and emotional, and can deepen and enrich identity stories. They can also help individuals to make the all-important transition from the status of ‘patient’, with its implications of passivity, its designation of a person to whom medical crisis and treatment ‘happens’, to that of an *active* someone who seeks to articulate meanings in illness experience by crafting a narrative artefact and communicating those meanings to others.

Whilst cultural factors, including some of those I’ve discussed above, will play their part in a given piece of cancer writing, there is an *irreducibly personal* dimension to any cancer experience. In this, as I believe in all areas of human experience, the importance of individual temperament must be acknowledged. Individual temperament is likely to play a big part in how a cancer patient reacts to say the shock of diagnosis, to the dizzying change in perspective it may occasion, and much else. Similarly, that person’s individual history – their specific autobiographical narrative, with its constituent ‘who I am’ story – will have a major bearing on how they interpret and process their cancer experience; whether they see it, for instance, as an outrageous ‘disruption’ of their life-narrative or as an expected and acceptable manifestation of life’s larger rhythms.

One important variable here can be the sort of *coping style* the individual habitually adopts, with respect to illness and to other life challenges. A very fine and wonderfully readable exploration of this issue is John Diamond’s *C: Because Cowards Get Cancer Too: A Hypochondriac Confronts His Nemesis*. Declaring himself ‘the world’s least brave person’,¹⁹ Diamond describes various ways in which he in fact ‘coped’, sometimes failed to do so, and at times did so simply because there was no alternative. As in many cancer memoirs, much of the suffering Diamond describes is occasioned by iatrogenic illness – illness caused by cancer treatment itself. (Of course untreated cancer may occasion suffering that treatment, for all its possible side-effects, will often help assuage.) Let’s now return to the cancer experience of Rob – a man known for his emotional evenness and his ability to ‘cope’.

¹⁹ John Diamond, *C: Because Cowards Get Cancer Too: A Hypochondriac Confronts His Nemesis* (New York: Random House, 1998), 52.

Rob's Story and Reparative Writing

Whilst not all of the cultural/sociological factors I've mentioned above seem particularly applicable to Rob – he's been fairly relaxed and agnostic in matters of religion, for instance, and has high expectations of wellness and longevity despite being of the working-class – we might say that his cancer has shaken, even radically disrupted, his identity narrative on a number of fronts: this extremely healthy man has suddenly been life-threateningly ill; his once powerfully-muscled right arm looks withered and deformed; his laconic Aussie male self-image has taken a hit from acute cancer-related anxiety; this unflappable man has become very anxious and irritable; this individual who saw old age as a given now sees that he could be denied it; his brilliance at his trade is gone: left-handed he's still a competent tradesman, but not a brilliant one. Above all, there's what he thinks of as a 'black hole' lodged in his autobiographical story which doesn't seem to fit: he sees his cancer as a freak and frightening episode.

When at my encouragement he has his first go at writing his cancer experience, what he pens basically repeats what he had told friends upon the cessation of his treatment, but with a new beginning and a very upbeat ending:

My father was a master carpenter and he taught me the trade. He's a man of few words and I didn't really get to know him until we started working together. Then we got a lot closer and for the first time I came to see what made him tick and what made his marriage to my mother tick, too. Then I got crook with cancer – melanoma – and had an op and chemotherapy. It was like months on some Planet of the Zombies. I don't know where those months went – they seem like a black hole now – but my wife June was terrific through it all and the doctors say I should be right now and that the chemo should have smashed any alien cells that were left after the op. I'm back at work now – left-handed. I'm not what I used to be at the trade and I don't get as much enjoyment out of it, but I'm still pretty handy, and the cancer's a thing of the past.

But he's seeking help because in fact he's been feeling depressed, anxious, irritable and disoriented, and one way of assisting him might be to encourage him to develop, revise and expand this first draft of his cancer story so that it becomes less generic, more authentic; starts to issue from a deeper place. In the words of Havi Carel, author of a fine (non-

cancer) memoir which also includes excellent philosophical explorations of illness and death, he can start to write the subjective, textured 'phenomenology' of his illness experience.²⁰ Thus revised, his cancer story may have more power to heal the rift in his identity narrative that has been occasioned by his disease.

I propose a series of perhaps eight to ten sessions – a process that fosters vivid emotive writing, reflection, revision, and attention to the overall architecture of the narrative. Such a process can often bring a calm that comes with crafting an artefact, even one which chronicles personal pain. I would see the role of the narrative therapist as that of an empathic peer-type partner, rather like Carl Rogers' conception of the non-directive, humanistic therapist. The writing therapist's role would be to draw to Rob's attention narrative possibilities, both thematic and formal, that might not otherwise have occurred to him; to give him permission to emerge from old narrative ruts and to 're-story' his life in new and enriching ways.²¹ Here are four suggestions that might be made in response to Rob's request for guidance:

- Perhaps try switching some key metaphors, looking particularly at that hugely unproductive metaphor of the black hole, and also at those very conventional metaphors of rogue cells and heavy artillery chemo; perhaps look for metaphors that express how you're actually feeling now?
- Look for some emotional threads that connect that 'black hole' time with your earlier life. For example, you say June was 'terrific' through the tough times, so maybe track the way the marriage has evolved and taken this crisis in its stride, and where it is now?
- Try writing the changed feelings you have about work and the workplace now in a bit more detail: the loss of skill and enjoyment.
- Try writing in more detail the feelings you have about your changed body.
- Check to see that the plot you're using – it's basically a triumph narrative at this point – really expresses your feelings about living in remission. And be aware that you have options here, for instance, the *illness and personal growth narrative of remission or cure*, or some combination of this and other plots.

Even though Rob is not highly educated and not a big reader (indeed this is partly why I chose him as an example), I reckon that if he really took to this, really got into what I call *the writing zone*, his narrative could take off in ways that would surprise him. It might well run to twenty, thirty, forty or more pages. On the way, the narrative would move through

²⁰ Havi Carel, *Illness: The Cry of the Flesh* (Durham: Acumen, 2008). Since Carel's entire outlook is phenomenological, references to the phenomenology of illness experience can be found throughout.

²¹ I know of no finer example of this sort of assisted narrative activity than the 'narrative therapy' of Michael White. See especially his *Maps of Narrative Practice* (New York, W. W. Norton and Company, 2007).

several stages, and perhaps in condensed form his next draft would look something like this:

My father was a master carpenter and he taught me the trade. He's a man of few words and I didn't really get to know him until we started working together. Then we got a lot closer and for the first time I came to see what made him tick and what made his strange, moody, up-and-down marriage to my mother tick as well. Then I got crook with cancer – melanoma – and suddenly this place, the building site where I'd blossomed and learned the trade I loved, became a dangerous place because that's where I probably got the cancer, sleeves rolled up to the summer sun.

Now I was a bundle of nerves stepping out the front door of a morning. Anxiety would fizz down my arms like chemo and there'd be ice cubes at the bottom of my belly. I know about chemo because I had a dose of it after the melanoma operation to help my immune system cope with any leftover cancer cells. Chemo was the toughest thing I've ever been through and sometimes I felt like a Zombie: sick, listless, flatter than I've ever been, not caring whether I lived or died. A lot of that's still a bit hazy now but my wife June was terrific, day-in, day-out, and it was almost as though we got the closeness of our teenage relationship back, care of the cancer. But my being cranky and flat now is throwing a wet blanket over that and we both want the caringness back. It's what the future should be about.

The doctors say I should be right now, but no one really knows. You've got to live with uncertainty. I'm carpentering left-handed now and pretty proud of that, even though I'm not the chippie I used to be. I get a nasty reminder every time I look at the withered, mangled arm that holds the nail as the left one swings the hammer. It looks like something from a shark attack. Sometimes I

can hardly recognize it as a part of me. I'm still learning to accept it back into my body.

The cancer was like getting lost in someone else's life for a while. I'm back now, but still finding my way.

Some of the narrative work involved here clearly resembles what Rob might do in say psychotherapy; but I suggest that the process of *reparative writing* I've sketched might help him to bring new narrative strategies to bear upon his disrupted and ruptured identity story, and to write more authentically; from a deeper, more healing, place.

I would like to think that *reparative writing* can make a useful if modest addition to the forms of assistance currently offered to people, including citizens of the remission society, who wish to find deeper meanings in their cancer experience and to share those meanings with others.

Richard Freadman received his degrees from Brandeis University and the University of Oxford and is a Fellow of the Australian Academy of the Humanities. He is an Emeritus Professor of English and former Director of the Unit for Studies in Biography and Autobiography at La Trobe University, Melbourne. In the field of life-narrative he is the author of books on autobiography and the will (*Threads of Life: Autobiography and the Will*, University of Chicago Press, 2001), a memoir about his father's life and their relationship as father and son (*Shadow of Doubt: My Father and Myself*, Bystander Press, 2003), and Australian Jewish autobiography (*This Crazy Thing a Life: Australian Jewish Autobiography*, University of Western Australia Press, 2007). He currently works with Eastern Palliative Care (Victoria), Alzheimer's Australia (Victoria), and Bapcare (Victoria), using life writing to assist people and their careers in palliative care and dementia care settings. This essay is based on the 2014 Annual Lecture in Psycho-Oncology delivered at the Michael Chamberlin Theatre, St Vincent's Hospital, Melbourne, Victoria, Australia.