

AUDRE LORDE'S *THE CANCER JOURNALS* AND THE PSYCHOSOCIAL
REBUILDING OF THE TRAUMATIZED SELF: AN ERIKSONIAN-
INFLECTED APPROACH TO AUTOPATHOGRAPHY

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Introduction

The prospect of death captures our individual and social imaginations, both fascinating and terrifying us. Much of the charged emotion surrounding death, both intellectually and practically, stems from the configuration of death as an event that is altogether unknowable. In her article, “Driving Death Away: Death and Freud’s Theory of the Death Drive”, Liran Razinsky surmises that “[the] arrival of death transcends our usual mode of thought, which seeks out motivations and reasons” (398). Indeed, much of humankind’s anxiety surrounding the process of dying comes from the inherently indiscriminate nature of death itself as a process which can strike any living being at any given time. Barring the occurrence of extraordinary circumstances, there exist few observable measures of an individual’s ultimate time and mode of demise. In cases of extraordinary circumstances that may appear to foretell a person’s imminent death, such as the sufferance of terminal illness, those involved—the terminally ill and their affective network—must often endure a painful internal process in which they face the dissolution of their identities. During these traumatic periods, some individuals with terminal illnesses have taken to transcribing their personal socio-affective world onto the page. Some such works of autopathography, otherwise known as first-person illness narratives, have gone on to achieve both critical and popular acclaim, earning their accolades through their viscerally personal handling of humankind’s death anxiety. Certainly, a commonality shared by many publicly successful autopathographical works is the intimate nature of their narrative. Many of these autopathographical works, for example, draw their contents from personal correspondences, as is the case with *Notes Left Behind*, where the narrative is stitched together almost wholly from fragmented messages left by a six-year-old intracranial tumour patient to her loved ones

(Desserich and Desserich), or from diaries, as is the case with Audre Lorde's *The Cancer Journals* (2006), where the author's private journal entries from the time she underwent cancer treatment form the foundation of a narrative on social justice and identity reformation. Indeed, the latter publication will be used as the principal case study for examining this thesis's described analytical methodology for studying autopathographies.

The reflectively interrogative nature found in most autopathographical writing coaxes from both the writer and his or her audience a plethora of wide-reaching humanistic considerations. Indeed, John S. Stephenson writes in the opening chapter of *Death, Grief, and Mourning*, "Being dead is very different from dying, which is the process of living" (2). Stephenson brings to attention with this statement the vast existential and definitional distinctions between dying and death. As saliently displayed by many autopathographical works, most individuals who are near death are still very much conscious, still contributing to their internal identity through their experiential sociality and shaping the world around them as a result. Indeed, many such individuals who may be suffering from either serious or terminal illnesses, such as cancer, could be said to be more alive during their illness than the norm, insofar as the acute experience and expression of visceral emotions is part of the underlying foundation of being human. In tandem with such authors' self-experiences of trauma, the affectively compassionate responses that audiences display towards successful autopathographical authors and their works socially reaffirm experiential humanity on the greater scale. Extending Martha Nussbaum's neo-Aristotelian model of compassion, Jeremiah P. Conway writes, "Compassion arises from the recognition of a shared humanity—that we are frail, vulnerable creatures who depend in many ways for our well-being upon circumstances not fully under our control" (285). Contextualized in reference to the affective dynamics of autopathographical works, Conway's

supposition infers that the compassion expressed by the autopathographer towards his or her social sphere becomes bilaterally modulated in a social feedback loop as readers encounter the humanistic spirit of the autopathographer in his or her time of trauma reflected within their own selves as they traverse the text. Engaging in autopathography either as a writer or a reader is, therefore, intimately engaging in the process of humanistic living. In this way, the experience of trauma and the writing acts it produces are, in large part, socially modulated.

To this end, many robust models, supported by sound postulations, already exist which help in explicating the social dynamics of trauma and autopathography. The internal world of the autopathographer in his or her experience and modulation of trauma through the act of writing, however, has been left largely unconsidered. Since the experience of any written work is intrinsically bilateral, with meaning being formed in the social space created between the audience and the writer, this emphasis on only one side of the experiential equation has left an undesirable vacuum in the current understanding of autopathographical works and their authors. The following discussion aims to begin rectifying this issue. It will provide a functional, author-oriented method for critically analyzing autopathographical works. In doing so, it also hopes to foster a deeper understanding of how the authors of such works both modulate, and are modulated by, their experience of trauma while completing their writing acts.

The opening chapter begins the discussion by summarizing and expanding upon the major contemporary trends in thought regarding the sociality of trauma and autopathography. Primarily focusing upon the co-witnessing model for working through trauma, this chapter weighs how socially inflected models of trauma are implicated in perceptions of the internal self, both during and after an individual's traumatic experience. Chapter Two expands the foundation laid by the preceding chapter: it considers philosophical and psychological conceptions of trauma

as an abrupt disillusion of an individual's self-identity. Incorporating aspects from both of these approaches, it then provides an Eriksonian-inflected model for critically analyzing autopathographical works for markers of their authors' working through of their trauma. In Chapter Three, a proof-of-concept case study is performed where the method outlined in the previous chapter is applied in a reading of Audre Lorde's *The Cancer Journals*. This reading intends to serve both as a model for future applications of the method to other works, as well as a further investigation into *The Cancer Journals* as an autopathographical work itself. The Conclusion of this study finishes the discussion by examining possible limitations of the method as described and performed, while also suggesting directions for further study. General discussion of the method, its groundwork, and its outcomes is conducted in this section.

Chapter One:

The Sociality of Trauma and the Autopathographical Experience

Works of autopathography generally exist in a paradoxical space between private and public in terms of their mode, straddling the boundary between the intimate and the communal. Indeed, the very popularity of autopathographical works derives from the sense of interconnectedness that the audience feels with the author in his or her time of hardship. As a result of the highly salient nature of the social aspects regarding not only autopathography, but even the process of dying itself, much of the existent literature on trauma, illness, and death has focused on examining and explicating the factors surrounding traumatized people in their relations to the greater social whole. In their seminal reference work, *Reading Autobiography: A Guide for Interpreting Life Narratives*, for example, Smith and Watson extend the views of G. Thomas Couser in expressing the observation that “[autopathographic] narratives [are] often... [born out of] the impulse to depathologize one’s condition’ [in a critique of]... social constructions [of illness]” (187). In regards to the overlapping genre of autothamatography, which is essentially autobiography concerning the author’s death, Smith and Watson agree with Susanna Egans in claiming that such writing constitutes a ““complex claiming of agency”” (188) over how authors wish their selves to be perceived through their work. Aside from their nuances, both definitions come from the vantage point of sociality, in which the author is seen as using his or her writing act to respond to and re-articulate the pre-existing constructions of the world external to themselves. Under these types of frameworks, the traumatized author’s internal self is predominantly ignored. Any internal development that the author experiences as a result of enduring trauma is only perceived as fundamentally a secondary effect of his or her primary interface with the social world. The author’s claim of agency or working through of personal

trauma does not come to fruition from within the self, but, rather, his or her efforts must be germinated through a third party, a person whom Mieke Bal, following Dori Laub, terms a “confirming witness” (x), hereafter referred to as a co-witness. According to this construction, a “memory [proper]... is not confined to the individual psyche, but is constituted in the culture in which the traumatized subject lives” (Bal x). Due to this relational dynamic, such conceptual frameworks do not place the traumatized author in the role of the active agent in the working through of his or her trauma. He or she becomes merely the vessel whence the traumatized self originates and whither the mended self is ultimately returned. The resolution of trauma occurs in the social space that is created when the co-witness offers to confirm the truthfulness of the traumatic experience itself.

The decidedly social direction of contemporary trauma theory literature can be traced to the birth of modern socio-psychiatric conceptions of traumatic experience. Starting roughly from the early 1950s and continuing until the mid-1970s, a multitude of marginalized social groups, chiefly headed in North America by feminists and war veterans, began their “‘consciousness-raising’ [social support] groups” (Degloma 106). By sharing their traumatic narratives amongst themselves, the members of these groups discovered that their personal psychological difficulties could be attributed to a relatively reducible set of specific experiences. This belief that trauma was largely an issue which could be understood from a generalized perspective, as the outcome of widely familiar circumstances, drove them into concerted efforts to “make their psychological problems into social ones” (Degloma 106). Prior to their work, the persistent cluster of anxieties and symptoms experienced by trauma victims was commonly ascribed to some generalized weakness of innate personal character (Smith and Pear 2). Indeed an article published in 1940 in the *Canadian Medical Association Journal* attributes the development of “war neuroses” in

soldiers to their individual “intellectual [and moral] inferiority”, insinuating that such soldiers merely suffered from “cowardice” (Boyer 54-5). Fighting against the damning historical perception of traumatic disorders, the reframing of what is contemporarily termed Post-Traumatic Stress Disorder (PTSD), allowed for marginalized groups to reclaim some of their social dignity in the face of a formerly indifferent or hostile public and politic. This inspirational thread of sociality has been carried into the overarching milieu of analytical frameworks existing within the field of trauma theory, insofar as the social space in which the traumatized author resides has become, at once, the ultimate source of the author’s trauma, the direction towards which the author’s articulation of his or her trauma is seen, and the mode by which the author’s trauma may be alleviated.

As practical evidence towards the claim that contemporary trauma theory focuses primarily on the socio-political aspects of traumatic experiences, one needs only to briefly review the current literature. The majority of such literature includes notions of “the diffusion of affect” through social circles, referencing abstractions of “trauma carrier groups”, which are said to “work to expand the category of traumatic experience to include more events of different types” (Degloma 109). This socially charged perspective bleeds into contemporary readings of literary works; in the contemporary academic environment, autopathographies are interpreted through a lens of social feedback relativism, whereby the authors are seen as near-exclusively a product of their chaotic, external social reality. For instance, Robina J. Khalid’s “Demilitarizing Disease: Ambivalent Warfare and Audre Lorde’s *The Cancer Journals*” devotes extensive effort to analysing how the “metaphor of warfare [is often] appropriated in narratives of disease” (698). Khalid’s theoretical reading of Lorde’s work is predicated on the concept that the author’s trauma resolution comes about primarily from her realization that she can overcome the patriarchal

linguistic “conspiracy”, which seeks to confuse and bind her as she attempts to articulate her trauma (698): “The militarized language [Lorde] has at her disposal is not the language her body actually speaks” (700). Although this present discussion will not specifically conjecture on the merits of these types of interpretations, it is clear that Khalid is socially oriented and focused on Lorde’s transmissive act itself rather than on the internal content of Lorde’s expression. She argues that Lorde’s expressive act is hampered by being unconsciously filtered through the dominant, yet cognitively alien, lens of modern Western medicine. Khalid’s line of argumentation is that Lorde’s method of re-articulation, thus, must be supported by a self-realization that her internal self and language must be liberated from the confines of a persistent socio-linguistic establishment, one which seeks to draw her ever-further away from her authentic self. Although such a claim is internally valid, the framework whereupon it rests remains fundamentally socially inflected, insofar as investigations into Lorde’s interactions with her external world are privileged over attempting to understand how her autopathographical act itself helps her to work through her traumatic experience. In regards to Khalid’s reading, the practical result of such a strong social inflection is that the author of the autopathography and her expression become pacified, being reductively interpreted as either ultimately muzzled by the dominant social ideology or simplistically overcoming social subordination under a plainly evil enemy. On the macroscopic scale, the social leanings of trauma theory at large ignore the inner world of those affected by trauma, casting them as secondary actors who must contend on the greater social stage.

While this discussion wishes to suggest that there may be more to the process of working through trauma by means of autopathography than that which is considered from the social feedback model, it does not want to be misconstrued as advancing the idea that the sociality of

trauma is either non-existent or not important. Since all individuals interact as simultaneously the products and producers of various social spaces, neither social effects on individuals nor individuals' effects on social spaces can be ignored if a holistic understanding of the dynamics of trauma is to take place. Indeed, the essential definition of Post-Traumatic Stress Disorder found within the clinical *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association includes the idea that the disorder can be brought about through “experiencing repeated or extreme exposure to adverse details of [actual or threatened death, serious injury, or sexual violence]”, although such exposure does not officially include those from non-work related encounters with “electronic media, television, movies, or pictures” (271). Regardless of the official distinction that the American Psychiatric Association creates between first-hand and relayed experiences, however, contemporary neuropsychological findings offer strong evidence that any consumed experience is imparted with only superficial differences in regards to its practical effects on the psyche: those born without limbs are, for example, shown to have activation of their own motor systems while watching videos of others' limbic movements (Rizzolatti and Fabbri-Destro 182). In short, commonsensical and academic cross-disciplinary substantiation points to the fact that the experience of trauma is, in large part, socially modulated. This discussion will not seek to prove otherwise. Rather, it will aim to foster a consideration of the autopathographer's internal world. It will seek to better understand the internal world of the traumatized, and in so doing describe possible mechanisms by which the internal selves of such people ultimately re-establish their validity and refocus towards the social realm.

In attempting to uncover how traumatized authors' selves are rebuilt through acts of autopathography, this discussion does not break entirely new ground even within the discourse of trauma theory. In “Life Writing and Illness: Auto/Bio/Theory by Eve Sedgwick, Jackie Stacey,

and Jill Bolte Taylor”, Franziska Gyga argues that, “since the... subject in [an autopathography]... is the narrator [retelling his or her personal experiences,]... a specific kind of authority may be attributed to [him or her]” (291). Such a configuration of autopathographical authors deriving a unique authority over the veracity of their narrativizations of their personal experiences handles two primary considerations. Firstly, it mitigates the conceptual problems that inherently arise from attempting to consider the narrative as a “truthful” document—a quasi-clinical window into the psyche of the traumatized—because it confirms that source emotions are intrinsically valid due to the impracticality of measuring them through objective analysis. Secondly, it confirms that the source narrative, in the state it is delivered to the reader, remains the only non-conjectural means of analyzing the author’s traumatic experience. In that sense, any philosophical suppositions of problems relating to the actual narrativization of the experience into a document can be automatically dismissed as outside the realm of inquiry. Beyond handling epistemological contentions, the placement of the author as the ultimate authority on his or her own experience of trauma reaffirms that the author should be seen as the central locus around which a generative understanding of his or her trauma can be built.

From a vantage point where one disregards theoretical contentions of source correctness, the volition of the autopathographical author as an active participant in his or her working through of personal trauma can be appropriately recognized and analyzed. Indeed, contemporary psychological findings provide evidence towards the notion that those engaging in autopathographical acts can assist themselves in the working through of their own trauma, independent of any co-witness dynamics. Clinical findings have shown that engaging in autobiographical writing can lead to “feelings of greater psychological well-being[, as well as improvement in markers of physiological healthfulness, within the long-term]” (Baikie and

Wilhelm 339). Specifically in regards to patients with Post-Traumatic Stress Disorder, the act of autobiography can lessen feelings of “anger and tension”, being correlated with “a trend towards less depression” overall (Smyth et al. 91). In a profoundly practical way, Gygax’s belief that “narrative [can act] as a strategy for survival” (295) is largely confirmed in the lab. Writing about their trauma, for example in an act of autopathography, allows the traumatized at least some measure of relief from the terrors of their past. The traumatized derive a sense of agency from actively expressing their trauma into the external world; they become more than simply passive entities that must wait for a co-witness to share in their trauma.

Since it is now understood that individuals suffering from trauma may, indeed, possess an active role in the internal working through of their traumatic experience, outside of any direct co-witnessing relationships, an extended internally oriented model for conceptualizing the experience of trauma must be constructed. In the section that follows, such a preliminary framework for re-orienting the conceptualization of trauma as an internally active search for identity on the part of the traumatized will be explicated. Both literary and psychological facets will be considered in creating a view of the working through of trauma as a process that is actively controlled by the traumatized person.

Chapter Two:

Trauma as the Active Search for Identity

Within the contemporary dominant discourse of trauma theory there exists an essential framework which favours the conceptualization of experienced trauma as a type of proto-social, viral entity. In “Expanding Trauma through Space and Time: Mapping the Rhetorical Strategies of Trauma Carrier Groups,” Thomas Degloma notes the concept that “Post-traumatic individuals... can spread the impact of trauma to [others in their surroundings]” (110), indirectly alluding to a socio-viral conceptualization of trauma. According to this perspective, owing to a compulsive need to have their traumatic memories legitimized, the traumatized tend to spread experiences of their trauma under the auspices of social contact. Viewing the situation from within the framework of contemporary trauma theory, one can come to understand that the traumatized ultimately engage in the social dispersal of their traumatic experiences in the hopes of finally fulfilling their need for a co-witness, so that they may integrate their experience into their external social world. It is only after meaningfully externalizing their trauma that the traumatized, under this theoretical framework, can internally begin to comprehend their trauma and integrate their estranged past. Indeed, Dori Laub writes of Holocaust survivors that “there is... an imperative need to *tell* and thus to come to *know* one’s story, unimpeded by ghosts from the past against which one has to protect oneself” (63; emphasis in source). On a practical level, the principal therapeutic effect of retelling is said to stem from the transmission of the trauma to the co-witness; the traumatized person’s act of telling to the co-witness results in the reception of knowledge by the co-witness. In this sense, the mending of the traumatized psyche occurs unidirectionally, insofar as the co-witness must be present in order to complete the therapeutic

feedback loop. This social feedback model of trauma assumes, therefore, that there are universally graspable experiential “truth[s]” (Laub 65) that are, for the traumatized person, highly salient, uniquely known experiences. The anxiety caused by the traumatic experience is, at its core, caused by an overwhelming feeling of socio-affective isolation. The act of expression alleviates some anxiety because it results in a profound uncovering of “Truth” for the benefit of both the greater social whole and the self.

On a cursory examination, the viral social feedback model of trauma does appear to satisfy inductive logic, insofar as it accounts for the intrinsically social nature of the human species. A contention arises, however, when one considers that any social feedback loop which involves a co-witness necessitates at least three acts of transcoding.¹ First, the unprocessed psycho-sensory data derived from the experience must be translated into a transmissible form. This initial translation is an internally active process, whereby the traumatized individual works from within his or her understanding of the current sociality to approximate the meaningfulness of his or her experience in a form that can be understood by others. Upon receiving the translated experience from the traumatized person, the co-witness must then actively attempt to interpret the traumatic experience, using his or her own understanding of the current sociality—this creates another level of theoretical ambiguity. It is only after this process that the co-witness can offer his or her social feedback, which itself must be understood by the traumatized person.

¹ Wald Godzich summarizes this fundamental idea of semiotics in stating that, “Sign and meaning never coincide” (389). Any single communicative act can be seen as a unidirectional process in which the communicator transmits various intentional signs (words, gestures, etc.) to his or her audience. Upon receiving the communicator’s signs, the audience must perform an act of “transcoding” (391), inferring the intended meaning of the signs via their own cognitive schemata. An individual’s schemata for inferring meaning are constructed of the sum of their lived experiences and frames of reference (Evans and Levinson 438). As such, the audience’s understanding of the communication will never match the communicator’s actual intent. Boroditsky et al. illustrate this phenomenon on a practical level, finding that the linguistic gender of words alters people’s understanding of linguistic content. In German, where the word for “key” is masculine, they found that subjects commonly associated keys with adjectives evoking masculinity, such as “heavy”, “serrated”, and “metal”. In Spanish, where the word for “key” is feminine, they found that subjects were more likely to associate keys with adjectives evoking femininity, such as “tiny”, “intricate”, and “shiny” (70; emphasis in source).

Overall, any social feedback loop inherently introduces multiple layers of social modulation and transcoding, causing the ultimate meaning of social messages to shift in “unexpected ways” (Eyerman 50). This dynamic of instability in meaning creates a situation where a universal rendition of “the truth” becomes practically impossible to achieve. Indeed, Laub himself alludes to the difficulty of telling of the Holocaust, lamenting that survivors’ experiences are “inherently incomprehensible” (65), and “cannot be fully captured in *thought, memory, and speech*” (63; emphasis in source). Given that a traumatic experience cannot be fully captured in transmissible form, the externally focused model for working through trauma collapses. Since meaning is neither static nor unequivocal, the truthfulness of any message is compromised as it is projected externally.

Beyond the problems associated with the traumatized attempting to project their experience of trauma externally towards a co-witness, there are compounded issues inherent in the role of co-witnessing itself which arise from the complex structure of most trauma narratives. The narratives that trauma victims attempt to share are, as Judith Herman characterizes, necessarily “emotional, contradictory, and fragmented” (Obourn 222), not only because of the difficulties that the traumatized face in transmitting the truthfulness of their experience towards the co-witness, but also because of the difficulties faced by the co-witness, who must on some level identify with the meaningfulness of the traumatized’s dithered expression of his or her trauma. Given that traumatic experiences are inherently indescribable and largely individualistic, this process of meaningfully responding to the traumatized becomes a Herculean task. In “Navigating Life Review Interviews with Survivors of Trauma,” Mark Klempner describes the difficulty he faces while acting as a co-witness for Holocaust survivors: “I go blank and numb, not knowing how to respond to suffering of such magnitude. I feel cheap somehow” (67). Unlike

the traumatized individual, who may have acquired stopgap coping mechanisms to psychically contain his or her trauma, the co-witness often enters the relationship unprepared for the inexorable psycho-affective assault. The immediate result is that the co-witness may become paralyzed by the acute experience of trauma. This, in and of itself, destroys the therapeutic benefit of the co-witnessing since it forces the co-witness out of the role of receiving and re-articulating the expression of trauma in a meaningful way. Further, outside of their immediate reaction, the possibility exists of other potentially destructive feedback arising from the co-witness unconsciously forming defensive responses to the trauma. For example, the co-witness may begin to deny the veracity of the trauma victim's account (Klempner 80) or displace their outrage, anger, and indignation onto the trauma victim (Klempner 78). Certainly, neither of such reactions is therapeutic; in some cases, negative co-witness reactions can exacerbate the feeling of trauma for the traumatized, who is likely to be approaching the act already apprehensive over the idea of sharing his or her trauma. Speaking practically, the act of co-witnessing is, thus, fraught with difficulties for both of the parties involved because of the difficulty in expressing and understanding the veracity of a traumatic experience.

Regardless of the subjective veracity of any co-witnessed traumatic experience, each act of externalizing one's trauma still alters the collective social whole. Degloma argues that "traumatic events disrupt the collective and interpersonal processes of socialization" (112). Following the experience of a traumatic event, individuals within a society simultaneously transmit their own experience of trauma towards the greater social whole through sharing their individual experience of trauma with other community members. This results in a situation in which, as a result of the multitude of discordant experiences of trauma transmitting amongst the individual members of the society, the very groundwork of the society proper destabilizes. Since

the process of making meaning is inherently socially inflected, a destabilization of the external social world has the top-down effect of simultaneously subverting the pre-established internal configurations of meaning within each individual actor of the society. In due course, an individual trauma potentially results in the traumatizing of an entire society, so that the only recourse is a process of “re-narration of the myths and beliefs which ground [the conceptions of meaning within the] collective” (Eyerman 49). The current discourse on this mechanism by which trauma transfers socially is predominated by models that focus chronologically on the long-term. Ron Eyerman, for example, uses such a model to explain the intergenerational transference of the trauma of slavery amongst African Americans. However, as a socially modulated experience, the transference of trauma does not limit itself to culturally macroscopic chronologies. Since the negation of meaning brought about by trauma occurs within each individual social actor, such negation begins within the individuals present at the traumatic locus, rippling continually outwards in both the social and temporal dimension. Ultimately, the factor which is currently lacking in the majority of trauma theory discourse is an appreciation for this on-going negotiation of meaning that occurs during the working through of trauma, which is undertaken not just by the co-witnesses that are external to the traumatized, but also by the traumatized in their externalization of their trauma. On both the individual and social level, multiple reconstructions of meaning in the social transference of trauma occur, so that “traumas are not[, in practice,] things, but processes of meaning making and attribution, [which involve] various individuals’ and groups’ struggle[s] to define a situation and to manage and control it” (Eyerman 43). The act of making meaning happens bilaterally between the individual and his or her greater society. As such, equal attention must be paid to the internal workings of both parties in their struggle to reach a satisfactory re-interpretation of their post-trauma world.

In terms of the internal state of the individual in his or her experience of trauma, Sigmund Freud postulates in his early work, “The Psychic Mechanism of Hysterical Phenomena”, that “the memory of a [past] psychic pain may later call forth tears. *The hysteric suffers mostly from reminiscences*” (5; emphasis in source). This single, embryonic idea of the experience of trauma as static and reoccurring for the traumatized appears to have been taken in isolation and reiterated throughout the dominant discourse of trauma theory. Indeed, in terms of the orientation of the field on the internal self, past traumas are assumed to be “transported in whole form to the present... [, determining] symptomatic behavior” (Piers 543). According to contemporary trauma theory, the static experience of trauma is continually relived by the traumatized, which is what necessitates the co-witness in the role of the interpersonal re-integrator of the “disassociated” trauma into the traumatized person’s psyche (Piers 543). By interpreting Freud’s genesiacal ruminations non-contextually, however, one not only ignores the authority of Freud’s more developed theoretical frameworks over their natal conceptions, but also grossly misinterprets the foundation of the Freudian canon.

Towards this point, in his later work *Beyond the Pleasure Principle*, Freud revisits his previous conclusions, citing them directly, before unequivocally stating, “I am not aware, however, that patients suffering from traumatic neuroses are much occupied in their waking lives with memories of their accident” (7). Especially in light of the fact that Freud himself offered a recantation of the suggestion that traumatic reminiscences may be psychically static, trauma theory can no longer afford to cling onto the notion that the traumatized continuously relive their experience of trauma in a static fashion. Instead, if the field wishes to continue to employ Freudian theory, its interpretations must be restructured to reflect Freud’s updated positions. To this end, the thoughts that Freud offers in “My Views on the Role of Sexuality in the Etiology of

the Neuroses” provides fertile ground for such a re-conceptualization. Within the discussion he provides an updated framework for the understanding of trauma; he claims that, in the case of psychosexual trauma appearing to originate from a patient’s infantile years, “Confabulations of memory[,]. . . which were mostly produced during the years of puberty[,]. . . are raised up and over the infantile memories, and. . . immediately transformed into symptoms” (189). If one contextualizes this line of thought more generally toward the formation of traumatic memories on the whole, it is clear that Freud argues in favour of a reinterpretation of traumatic memory as dynamically influenced by more immediate experiences. In Freud’s reappraisal, traumatic memories are not seen as static; they are inflected by experiences following the traumatic event. This view of memory as universally fluid is further backed by modern psychological research that finds memory to be functionally reconstructive. More specifically, it has been shown that, upon remembering, the mind uses schematic associations and deductive reasoning to create a new interpretation of the past. As such, each time a past experience is remembered, it is created anew and invariably “[altered]” from any previous recollection, transformed by the totality of the current conception of the self (MacLeod 38). Freudian theory and contemporary psychology are in concordance: traumatic memories can be spontaneously altered by both internal psychological factors and passive external social influences, which exert continuous, reforming pressure upon the psyche.

Given that most sufferers of trauma are not paralyzed by unintegrated re-experiences of their trauma, a more complex mechanism must, then, be uncovered to explain their observable symptoms. To this end, Abram Kardiner, an American psychoanalyst and a relative contemporary of Freud, provides a thought-provoking theory. Kardiner posits that, in the experience of gross psychological trauma, a prolonged psychological “regression” occurs towards “certain phases. . .

of early childhood”; in the most extreme of cases, portions of the patient’s self-identity can be thrown back into the state that they “[existed in] at birth” (115). To support his theory, he mentions the observation that, in the course of a reasonably routine life, normally functioning adults can nonetheless be momentarily stupefied into a quasi-paralytic state, as if suffering from trauma: “The type of reaction we see in infantile fascination persists throughout life, under conditions where [psychological] mastery is impossible. One can lose oneself in a given object or act” (153-4). Taken from this perspective, the symptom of what Freud terms traumatic mental and physical “enfeeblement” or paralysis in *Beyond the Pleasure Principle* (6), which trauma theory typically attributes to an inability to move forward from the original point of trauma, is instead described simply as a period of intense and active fascination with the unfathomable circumstance. Rather than being traumatized into a passive, overwhelmed state, those suffering from trauma have simply become over-engrossed in their traumatic experience, as they attempt to understand its implications. Indeed, following the initial ostensible suspension of activity, the traumatized may appear to engage in what trauma theory generally labels as, passive “re-enactment[s]” of their traumatic experience (Caruth viii). Following the line of reasoning provided by Kardiner, however, one comes to understand that what appears to be “re-enactment” is actually active “imitation, *i.e.*, mastery by way of identification” (153). The process of continuously “re-enacting” the traumatic experience, thus, occurs not in the psychic past of the traumatized, but is rather simply the result of the traumatized’s conscious, cyclically repeated attempts, occurring in the present moment, to comprehend the currently unfathomable. From this perspective, Dominick LaCapra’s postulation that the “necessary acting-out of trauma in victims... should not be seen as foreclosing attempts to work through the past and its losses” (699) appears to functionally agree with Kardiner’s psychoanalytic theory. Traumatized

individuals are not “re-enacting” their traumatic experience, trapped within a cycle of powerlessness. Rather, they are “acting-out” their trauma repeatedly in the hopes that, by doing so, they may eventually come to understand its inherently incomprehensible facets.

Contemporary research in the field of clinical psychiatry appears to allude to the idea that sufferers of Post-Traumatic Stress Disorder can experience “problems with affect dysregulation, aggression against self and others, dissociative symptoms, somatization, and character pathology” (van der Kolk et al. 394-5). This cluster of symptoms suggests that such patients are ultimately affected by “a disturbance in identity formation” (Piers 546), insofar as well-formed, consolidated identity would be indicated through an outward show of calm purposefulness, and an “intrapsychic experience of subjective self-sameness” (Mann 216). Taken together with the theoretical psychoanalytical evidence, this research puts forth a universal mechanism of action that would explain how engaging in autopathographical acts helps one to work through trauma. Engaging in autopathography must, in some as-of-yet undescribed practical manner, assist in the in re-formation of a robust self-identity within the autopathographer.

Prior to investigating how the act of autopathography itself assists in re-building a robust self-identity within traumatized individuals, however, it is important to note that writing about personal trauma is already a known as a probably beneficial method of therapeutic self-reflection. On the holistic level, externalizing one’s thoughts into a transmissible, socially inflected, linguistic form “requires the simultaneous interplay of cognitive and emotional actions” (Harris 179), as one translates the “disorganized and... chaotic” (Lyubomirsky et al. 693) discordant modalities of the mind into a clearer form. Indeed, the psyche stores and processes information in an enigmatic manner which defies unary explication from a functional standpoint. Internally to the thinker, the process of thinking itself often simply occurs without

conscious intervention; certainly, the precise substrates that bind thought and memory are indescribable. In order to externalize his or her internal world, the thinker's thought itself must be tied to transmissible concepts—broadly relatable and concrete representations of sensorial data—that must then be bound to some conception of relative experiential chronology. Of all the linguistic modalities, writing, as a process, arguably encompasses the most restructuring of thought into a transmissible form. Its product is inherently chronological and reductive in its signifiers. That is to say, the process of writing forces one's thoughts, which may otherwise be represented through an infinite number of psychic methodologies, into a limited number of words that must then be structured by common syntax into a meaningful form. From practical studies done on traumatized subjects, it appears that this structured quality of writing is responsible for the majority of its therapeutic effect: the frequency with which individuals use “causal (*because, reason*) and insight (*understand, realize*) words” in their self-reflective writing is positively correlated with “improved health” (Kerner and Fitzpatrick 336; emphasis in source). Writing about one's past assists in creating meaning and a sense of psychic coherence from otherwise arbitrary self-historical data.

For the traumatized, this process of forming coherence out of self-historical data is paramount as an initial step towards re-forming a stable self-identity. A study of breast cancer victims found that subjects who “create[ed] meaning out of the experience [and] focus[ed] on personal growth” (Hilton 51) reported that they were more “motivated” and had a greater “sense of control” (Hilton 46). According to the foundational principles outlined by developmental psychologist Eric H. Erikson, a subjective sense of volition and motivation is a prime conscious indicator of a robust self-identity. Describing such indicators more holistically, Erikson writes:

[The] conscious feeling of having a [self-identity] is based on two simultaneous [internal] observations: the immediate perception of one's selfsameness and continuity in time; and the simultaneous perception of the fact that others recognize one's sameness and continuity. (23)

In essence, Erikson's idea of the person with a robust self-identity embraces the notion of that person possessing a stable sense of self-history, whereby the sum of their self-historical data has been converted into a sort of internalized self-narrative, which informs not only their personal sense of self but is also projected outwards into their social reality. Contemporary socio-psychological findings appear to support this construction. In a study of Indian university students, for example, Dhar et al. report that those "who describe themselves relatively consistently in different roles or situations report higher levels of well-being than do individuals who have more inconsistent or fragmented self-concepts" (145). Reformulating arbitrary self-historical data into a coherent self-narrative appears to be the basis of identity formation. Naturally, then, possessing a stable self-identity leads to a subjective feeling of general well-being.

It should be evident that, if possessing a stable self-identity leads to a feeling of psychological healthfulness, then the psychological assault of a traumatic experience is brought about because of a destabilization of a person's self-identity. Indeed, in his seminal "Growth and Crises of the Healthy Personality", Erikson assumes such to be the case. Writing on soldiers returning from the Second World War, he outlines a model for understanding the etiology of what is contemporarily known as Post-Traumatic Stress Disorder: "Any loss of a sense of identity exposes the individual to... [*war*] *neuroses*" (93-4; emphasis added). He further solidifies his stance in "Ego Development and Historical Change", explaining that in the traumatized, "there is

a distinct loss of [self-]identity. The sense of sameness and of continuity and the belief in one's social role are gone" (42). From these lines, it is first clear that an Eriksonian model of self-identity development includes at once internal, intrapsychic components along with extrinsic, social components. Both internal and extrinsic factors work in tandem to produce and sustain the feeling of selfhood within the individual. As such, any understanding of psychological trauma must consider the issue from a similarly bilateral perspective.

To begin to come to an understanding of how autopathography may help trauma victims work through their experience, precise determinants of what creates a robust self-identity must first be explicated. To this end, Erikson provides a strong framework. He believes that individuals actively gain particular interdependent identity "virtues" as they progress through life by "successfully [resolving]" specific socially oriented crises that occur during each stage of human development (Brittian and Lerner 722). In sequence, the virtues that are thought to culminate in a healthy self-identity are: Trust (Erikson 55-65), Autonomy (Erikson 65-74), Initiative (Erikson 74-82), Industry (Erikson 82-88), "[Role-]Identity" (Erikson 88-94), Intimacy (Erikson 95-97), Generativity (Erikson 97), and Integrity (Erikson 98-99). Speaking broadly, Erikson's model in its classical form is certainly useful for investigating live patients who are undergoing therapy to work through any multitude of issues that may present themselves during a lifetime. However, for it to be most applicable to analyzing autopathographical works, which provide but a controlled representation of individuals as they rebuild their identity, some alterations must be made. Such alterations take into account several broad considerations that must be contended with when analyzing autopathography. From a practical perspective, for example, the observable reconstruction of the author's identity is limited to the fragments he or she pens onto the page. Obviously, unlike when attending to a live patient, the analyst in this case

cannot interrogate the subject for further details. The experiential representation of trauma is provided by the author in a finished state, and is not tailored to in-depth identity reconfiguration analysis. In a similar vein, assuming he or she has read the entirety of the text to be analyzed, the analyst responds then to the totality of the traumatized's expression. Therefore, the alterations to be proposed essentially relate to reconfiguring the Eriksonian model towards assisting with the literary analysis of trauma.

The primary alteration to the Eriksonian model of psychosocial identity development consists of removing a consideration of the strict demarcations of age for each of his life-stages. Doing this accounts for the reality of traumatized individuals and autopathographical works. Namely, although the traumatized may have suffered a dissolution of identity, they do not literally return to completely infantile state as a result of their trauma, insofar as most traumatized people still retain some expression of advanced cognitive development from their pre-trauma period. Further, Erikson himself admits repeatedly in his work that “[some] trend[s]... start much earlier [or later], especially in some [individuals]” (82). Additionally, both Erikson's forerunners and Erikson's successors have expressed doubts that specific qualities of human development can be concretely tied to an individual's chronological age. For instance, Victor Tausk, writing in 1919, expresses his belief that, ““The child discovers himself and that man must, throughout life, constantly find and experience himself anew”” (qtd. in Mann 212); Mali A. Mann writes in 2006, “Thoughts, feelings, impressions, relational patterns, concepts, theories, and beliefs... constantly and mutually influence one another and their social world” (212). Since the consideration of chronological age is inapplicable to this present discussion, and the consideration of chronological age itself when dealing with identity formation appears to be

of highly tenuous value, it can be ignored without losing either the model's practical utility or intellectual integrity.

The Eriksonian virtue of Trust is achieved as individuals become convinced that "they can trust the world and that they can trust themselves" (Erikson 56); it is brought about practically from "pleasant" impressions of collective experiences of others (Erikson 58). An individual who trusts himself or herself projects that internal trust outwards, as confidence in their external reality. This ideologically links the Trust virtue to the Intimacy virtue, whereby the individual readily seeks affective connections with the external world. Indeed, an individual who does not seek Intimacy is categorized by Erikson as suffering from Self-Absorption. This is a trait which is most clearly observed in the form of interpersonal "distantiation": "the readiness to repudiate, to isolate, and, if necessary, to destroy those forces and people whose essence seems dangerous to one's own" (95-6). Since both Trust and Intimacy result in similar collective expressions, this study proposes that they can be subsumed under a General Identity Quality (GIQ): Warmth. This is a qualification of how autopathographical authors describe both their intrapsychic and social affective valance. Certainly, the emotional states of both the trauma victim and his or her social network are important determinants for the re-formation of a robust self-identity. Writing about their experiences, traumatized African-Americans in a study by Tanya L. Sharpe and Javier Boyas "remarked that what was most paramount to their coping practices was... coming together [with those that they trust]" (863). Unsurprisingly, victims of trauma who are surrounded by the practical auspices of others' affective comfort and care report a lessening of negative symptoms. Together with a supportive external world, an affective belief in one's self as a wilful individual who may ultimately work through difficult situations—exemplified by the traumatized's employment of "positive reappraisal strategies" (Hilton 51)—

is also associated with improved subjective health during traumatic experiences. In general, individuals who feel good about themselves and their community will develop robust self-identities.

For Erikson, a central element of a stable self-identity includes aspects of meaningful work. To this end, the virtue of Autonomy is foundational. As is the case with all of the Eriksonian developmental virtues, Autonomy is modulated both inward, as part of the individual's self-concept, as well as outward, forming an interplay with the individual's social reality. Erikson writes, "From a sense of self-control without loss of self-esteem comes a lasting sense of autonomy" (68), suggesting that the type of autonomy which builds a positive self-identity is not necessarily one of free-reigned liberalism. Built upon having a strong sense of the virtues encompassed within Warmth, the individual must rather be exposed to environments that are at once challenging and psychically safe. If the individual experiences a loss of self-esteem while exerting self-control, they may internalize patterns of "shame and doubt" (68). In relation to their orientation in the external social world, a sense of Autonomy is achieved by individuals in social relationships that "[reaffirm] the [individual]'s essential dignity... [and foster a] high sense of autonomy and of self-reliance" (Erikson 73). The individual must feel competent enough to be trusted by others, while simultaneously protected by social auspices from unreasonable risk. Indeed, modern sociological studies have found that workers who are in positions involving "uncontrollable and routine work are at the highest risk for poor health and premature mortality" (Tokuda et al.1). Such findings correlatively suggest that Autonomy is important for psychosocial health.

As the virtue of Autonomy is gained, so too is Initiative. In regards to the latter concept, Erikson remains relatively vague and poetic, describing it clearest through a concrete example:

“[After learning to walk,] gravity is felt to be *within*, when [one] can forget that [one] is doing the walking and instead can find out what [one] can do *with it*” (75; emphasis in source). From this descriptor of where Initiative can be seen germinating, it is evident that the virtue entails the self internalizing a concept of resolution in manifesting its own destiny. Feeling supported in the external world, and having triumphed many challenges over time, the psyche imbued with Initiative faces less routine stress, not having to ruminate over its basic performance. Indeed, a self lacking Initiative suffers from an abundance of “guilt” (Erikson 74), presumably as it ruminates over its failures. However, assuming the psyche has minimal guilt regarding its past it is then free to concentrate on pondering what can be done with its newfound skills. In doing so, it begins to consider concepts of “sharing obligation, discipline, and performance [enhancement]” (Erikson 81), developing an increasingly social bent. The self receives increasing amounts of pleasure from thinking about the communal whole. Thus, Initiative is most practically tied to the virtue of Industry, which is expressed as a sense of “pleasure [in] work completion by steady attention and persevering diligence” (Erikson 86). A shortfall in Industry feeds the rise of feelings of inferiority, both in the self and within others’ intrapsychic opinions of the individual (Erikson 82). Ultimately, the continued cog-wheeling of this triad of virtues bolsters the development of the Role-Identity virtue. This is essentially a feeling of security and contentment with both the internal construct of one’s self-perception, as well as with one’s own operational role within the social whole (Erikson 88). The virtues of Autonomy, Initiative, Industry, and Role-Identity are interrelated insofar as they describe the components of a healthy self-identity that deal with an idea of feeling psychosocially capable. Each of these virtues is contingent on having a strong sense of self-purpose and direction, and is influenced greatly by “positive [self-] identification with those who *know* things and know how to *do* things” (Erikson 87; emphasis in

source). As such, this study proposes that they be subsumed under a General Identity Quality: Competency.

Before this discussion continues, some attention should be paid to how a measure of Competency is informed by the existent literature. Since Competency incorporates elements of productivity, questions may initially arise as to how productivity is affected by trauma. Indeed, there are long-standing “popular ideas of overwhelming post-trauma maladjustment to the demands of work, and/or of workaholism” (Suedfeld et al. 251). In these conceptions, trauma victims are thought to turn compulsively to work as a means of self-destructive coping. Logically, if the internal conceptions of purposefulness in the traumatized have been commandeered to act as a sort of psychic opiate, then it may be counterproductive to incorporate purposefulness as a reconstructive aspect of self-identity. To this end, however, Suedfeld et al. found in a 219-subject study of Holocaust survivors—consisting of 115 survivors and 104 untraumatized comparables (246)—that there was “no evidence” supporting stereotypical manifestations of increased destructive workaholism in their traumatized sample compared to the norm (251). In fact, rather than supporting the popular notion that an abundance of work may be deleterious to a fragile psyche, there is ample evidence that productivity helps to improve the health of both traumatized patients and those around them. Studying patients post-acute trauma, Vestling et al. found, for example, that patients who returned to work reported higher subjective feelings of well-being overall compared to those who did not return to work. Socio-psychologically, the productive patients reported feeling better than the controls in every metric covered by the study, including “mood, energy, endurance[,]. . . self-esteem[, sexual intimacy, self-care, and a sense of being appreciated by their household]” (129). In essence, remaining productive in the aftermath of acute trauma appears to not only bolster the metrics of

Competency, but the effects also carry over towards the Warmth dimension. In this way, modern research dispels the popular notion that the traumatized may unhealthily sublimate their trauma towards their work.

Returning to Erikson's model of psychosocial identity development, this discussion can now investigate the remaining two virtues of a robust self-identity. The virtue of Generativity can be thought of as an internalized drive to look beyond one's own chronological space. Evidence of this virtue can be seen when individuals display "[an] interest in establishing and guiding the next generation" (Erikson 97). Those who are not generative ultimately succumb to an overwhelming sense of psychosocial stagnation. For those with terminal illness, the very presence of an autopathographical act in their history could arguably indicate a desire to be generative, insofar as the act itself entails distilling part of one's own frame of consciousness into a more enduring form beyond the self, an outer space which is more accessible to others. Beyond that, championing causes, mentoring others, and working towards a greater social good are all generative activities that aim to leave a lasting legacy of the self prior to passing by darning the greater social fabric. Related to this, Tokuda et al. report that, out of social "pleasure, [deep] engagement, or meaning", seeking "[deep] engagement with others... is now considered as the most important determinant [of sound psychosocial health within the literature]" (9). This is a sensible conclusion, given that the final Eriksonian virtue is Integrity; Erikson defines this lucidly as, "the acceptance of one's own and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted of no substitutions" (98). The Integrity component of a person's self-identity arises as he or she reflects on his or her life as lived up to the present, reminiscing with a feeling of peaceful contentment rather than anxious disgust over what has been accomplished. Perhaps most pertinent to the

autopathographer, Erikson also states that a fear of death is ultimately the product of such anxious disgust over one's conduct of life so far. Under such conditions, "despair" may be aroused as the individual grapples with the "feeling that the time [one has been given] is short, too short for the attempt to start another life" (Erikson 98). Both Generativity and Integrity are associated with the desire to have an impact on a world after the dissolution of the physical self. Both virtues have to do with positive self-reflection and legacy leaving. This study, therefore, proposes that they be subsumed under a General Identity Quality: Self-Transcendence.

In review, this discussion has isolated three inter-related General Identity Qualities which can be considered as the basis of a strong self-identity. These three qualities are: Warmth, Competency, and Self-Transcendence. While engaging in their acts, the autopathographers should show signs of unconscious, reflective contemplation regarding how their experiences of trauma and illness have affected them both internally and socially within these dimensions. As they reflect and write, the present framework posits that their act of writing should assist in making their fragmented self-historical data into a cohesive self-history. Restoring and internalizing a cohesive self-history, the autopathographer reforms his or her self-identity and effectively works through trauma. On a practical level, the literary study of autopathographical works should remain cognizant of the General Identity Qualities triad, investigating the way in which the author records, and interacts with, the external social world of others, as well as his or her own internal psychological world, within the three dimensions. The framework as outlined aims to be expressive, rather than reductive; it aims to provide a means of investigation through analytical reportage of autopathographical works, rather than assume a linear model of self-identity redevelopment. As such, it should be applicable to a great variety of autopathographical works, regardless of their length, style, or content.

In the following chapter, this study will provide an example of the presently outlined Eriksonian framework deployed to analyze Audre Lorde's *The Cancer Journals* as a proof of concept study.

Chapter Three:

Audre Lorde's *The Cancer Journals* and
the Psychosocial Rebuilding of the Traumatized Self

Civil and women's rights activist and poet Audre Lorde was initially diagnosed with breast cancer in 1978, during a decade when "breast cancer was considered a dirty secret, and the social ideal decreed that women endure [its treatment] without others finding out" (Thorne and Murray 148). While receiving treatment, Lorde kept a meticulous diary of her experiences in which she recorded her thoughts and emotions as she endured the physical and psychological upheaval of not only the cancerous metastasis itself, but also her eventual mastectomy. This diary forms the substrate of *The Cancer Journals*, published in 1980, which serves as a typical example of an autopathographical work. Evaluating Lorde's ultimate result, Jeanne Perrault concludes, "[It is] a writing of self that makes the female body a site and source of written subjectivity, yet inhabits that body with the ethics of a deeply and precisely historical, political, sexual, and racial consciousness" (Morris 168), referencing Lorde's acute, simultaneous awareness of both her self in her experience of traumatic illness as well as how that self informs and responds to elements of the greater social whole. These two co-dynamics on display in *The Cancer Journals*—the dual awareness of both self and sociality woven into a coherent "counternarrative" (Smith and Watson 261)—form the essence of autopathography. Beyond such a literal classification of Lorde's work, however, come far more important concerns regarding what clues it can provide on Lorde's personal psychosocial battle with breast cancer. Given that the experience of illness is, at its core, a socio-affective dialogue between the ill during their throes in traumatic illness and the external world, it becomes important to examine the dynamics of that relationship. Further, especially since the experience of illness, and thus also the penning

of autopathography are decidedly affective acts, one must consider the events of illness holistically, for their emotional valiance, rather than in a discrete chronological series. Following these two tenets, then, Lorde's psychological and physical working through of breast cancer can be successfully analyzed.

Immediately following her mastectomy, Lorde experiences circumstantial "terror and disbelief" in tandem with intense depersonalization events in which "another part of [herself] flew like a big bird to the ceiling of whatever place [she] was in, observing [her] actions and providing a running commentary" (30). This psychically disturbing paradox of experiencing simultaneous disembodiment and heightened self-awareness marks the acute beginning of Lorde's trauma. Even at first glance, this initial traumatic fissure of her self is decidedly damaging, insofar as it tests Lorde's own mental soundness. On a deeper level, this experience signals, what developmental psychologist Erik H. Erikson terms, "identity diffusion" (118). When approaching this critical state, an individual becomes maximally aware of his or her own self and identity before it swiftly dissipates and the "sense of inner continuity and sameness" (Erikson 126), which forms the basis of a coherent internal self-history, is lost. In this sense, the traumatized self is literally a psychically lost self in terms of its relation to the traumatized person; the traumatized person ceases to maintain an individual identity. Lorde's depersonalization event is the visceral manifestation of her identity diffusing in the face of unbearable trauma.

Having lost her sense of self from the intense trauma of her mastectomy, Lorde spends her initial recovery period in a "childlike" state of "quasi-numbness" (41); she recalls from this time, "Once I put a flower in my hair and walked through the halls looking for [my partner] Frances" (37). Lorde's account of psychological regression following her identity disillusion is

consistent with the model of trauma put forth by psychologist Abram Kardiner. Studying American servicemen recalled from duty by so-called “war neuroses” in the midst of the Second World War, Kardiner postulated that, following gross psychological trauma, psychological “regression” occurs towards “certain phases... of early childhood” (115). Taken together with the Eriksonian indicators which suggest that Lorde’s trauma began in earnest with the diffusion of her self-identity, Kardiner’s conceptions are logical: since Lorde is robbed of her sense of self by her acute traumatic experience, it follows that she then is left in a childlike state, affectively and socially infantilized. Her recollections of the initial period after her mastectomy bring to light how the experience of trauma is fundamentally an experience of a loss of self-identity. In this way, when working through their trauma, the traumatized must not just integrate their traumatic experience into a refashioned self-identity, but, rather, they must rebuild their sense of self altogether.

The formation of a robust self-identity is a complex task. Although the self-identity is developed internally through the individual’s own interpretation of personal experiences, those interpretations are moulded by pressures exerted by actors in the external world, such as peers and elders (Erikson 21; 87; 95). Due to this procedural involvedness, Erikson postulates that the years of adolescence, when one is likely to hold a reasonably well-developed self-identity yet few social obligations, serves as a time for the self to focus on development. He terms this rapid-development period a “*psychosocial moratorium*”, writing of its potential benefits as a period where the individual may “abandon the *kind* of work he [or she has] been doing without relinquishing the work *habit*” (104; emphasis in source). Contemporary research has provided support for Erikson’s postulations; in a study of male subjects at various stages of psychosocial development, researchers found that “moratorium status males held higher levels of moral

reasoning” (Adams and Shea 82). Providing a comfortable social environment for a critically developing individual to engage in intrapersonal activities may, thus, help to optimize and quicken identity formation by relieving him or her of many routine socio-cognitive burdens.

Providing Lorde with practical benefits similar to those of the adolescent psychosocial moratorium appear to be the periods of relative calm during her hospitalization: she writes of that time, “It was a 12 month reprieve in which I could come to accept the emotional fact/truths I came to see first in those horrendous weeks last year before the biopsy” (34). Noting the reservation that, naturally, she could not be entirely consciously happy under those circumstances—“the very bland whiteness of the hospital which I railed against and hated so, was also a kind of protection, a welcome insulation within which I could continue to non-feel”—the same “undemanding” environment (Lorde 46) became the one in which she could take the time to recollect, reflect, and write. The immediate physical and psychological neutrality of her mind in the hospital, which was allowed to explore itself unencumbered by extraneous stimuli, may have spurred Lorde into reflection while keeping her focused on her therapeutic act of autopathography.

Indeed, the physical experience of the self working through trauma plays an important role in terms of its influence on the successful resolution of that trauma. This is not only true in a practical, externalized sense, such as physical location, but also in a more psychic sense, such as the subjective sense of physical completeness. Lorde writes, for example, that “any amputation is a physical and psychic reality that must be integrated into a new sense of self” (14), alluding to how a self-identity finds its roots not either in the psychic or in the physical, but instead relies on the successful integration of both the psychic and the physical to form a cohesive whole. While it is arguable that any psychological trauma necessitates similar co-morbid physical manifestations,

amputations provide the clearest case for explication. For example, cases of phantom limb experiences, a common phenomenon whereby limbic amputees continue to experience sensation in “the body part that is no longer present” (Flor 182) illustrate the interconnectedness of an individual’s psychological and physical realities.

Although the precise cause of phantom limbs is unknown, researchers Ramachandran and Rogers-Ramachandran have developed a novel therapy to help amputees ameliorate the uncomfortable sensations caused by their phantom limbs. During the procedure, the patient places his or her limbs in a specially designed optical box, which reflects an image of the physical limb over the empty space occupied by the phantom limb, causing the illusion that both limbs are physically present. By then moving the real limb, many patients report that they can consciously control their phantom limb, feeling it move deliberately through physical space (380). Using this method, 80% of the patients studied reported “improvements in pain” (386), as a result of being able to reposition their phantom limb. Such findings provide strong evidence for Lorde’s idea that the physical and psychological sense of self are closely related; even when these two aspects of the self-identity are incongruent, the psyche still attempts to integrate them into a coherent whole. Further, reality reflects Jane E. Schultz’s postulation of self-identity and the feminist body politic, ““If one’s image is unrecognizable, one must find one’s way back to a notion of the self that can be accepted”” (DeShazer and Helle 9), insofar as facing the psychological trauma of illness is simultaneously facing a physical trauma of bodily reconfiguration. As Lorde discovers during her experience post-mastectomy, one cannot work through psychological trauma without addressing its physical manifestations.

Having now briefly considered both the etiology of Lorde’s trauma as well as the practical factors pertaining to her experience of that trauma and her active act of

autopathography, the discussion can begin exploring how various episodes detailed in her work may have impacted her self-identity reconstruction. To accomplish this, the principal factors in self-identity formation must be explicated. These three factors, termed by this discussion as General Identity Qualities (GIQ), as derived in distilled form from Erikson's seminal "Ego Development and Historical Change" are: Warmth, Competency, and Self-Transcendence. Warmth is a qualification of autopathographical authors' experiences of intrapsychic and social affective valiance. Competency is a qualification of how the autopathographical authors' sense of ability and industrious self-worth is modulated by the experiences they have detailed. Self-Transcendence is a qualification of how the autopathographical author expresses a desire to have an impact on a world after the dissolution of his or her physical self through positive self-reflection and legacy leaving. Since "the process of recovery is not linear" (Vogel-Scibilia et al. 406), this triad of GIQs may be analysed in each recorded experience, existing as broad qualifications of experiential valiance rather than quantitative markers.²

During her post-mastectomy period, Lorde develops a locus of concern regarding the use of breast prostheses. As previously shown, the trauma of mastectomy is, at once, psychological and physical as the patient reforms his or her sense of self. To this end, the majority of authorities whom Lorde meets during her recovery attempt to encourage her to don prostheses, ostensibly to ameliorate her sense of identity loss: "'You will feel so much better with it on,' [Lorde's nurse reasons with her]" (60). Medical authorities are seemingly quick to evaluate Lorde's melancholia as a problem primarily rooted in her physical loss, itself. Even on such a superficial level, however, breast prostheses fail to placate Lorde's consuming sense of loss. In fact, the artificiality of the prostheses exacerbates her feelings of disembodiment: she recalls "[The

² For an extended discussion of the rationale supporting this framework for analyzing autopathographical works, see Chapter Two of this study.

prostheses] perched on my chest askew, awkwardly inert and lifeless, and having nothing to do with any me I could possibly conceive of. Besides, [they were] the wrong color, and looked grotesquely pale through the cloth of my bra” (44). Most immediately, wearing the prostheses causes Lorde to further lose her sense of intra-psychic warmth, insofar as doing so makes her feel increasingly unlike her ideal conception of self. Indeed, the prostheses do not only feel foreign to her, by being in a practical sense “the wrong color”, they heighten her psychological awareness of her own mortality, by being “lifeless” and “grotesquely pale”. On a deeper level, since Lorde cannot identify with the prostheses’ cadaverousness, she actively rejects socially modulated attempts to impose a new self-identity aligned with death and victimization upon her self. In this way, her defiance signals the natal stages of a rebirth in her sense of self-competency; she begins to rediscover her own sense of self, one which can be clearly delineated from negative social prejudices and stigmas. This “feeling [of] one’s body as one’s own”, as Jay Prosser describes it, “is a core component of subjectivity, perhaps its very basis” (Chinn 193), and, thus, essential to the development of a robust self-identity. While the medical community insists that Lorde don the prostheses, diminishing her sense of warmth, her subsequent refusal of the prostheses signals an increase in her personal sense of competency.

Of arguably equal importance to considerations of how breast prostheses impacted Lorde on a personal level are more universal considerations of the social construction of breast cancer and breast prostheses. In this regard, the seemingly well-intentioned, yet functionally misplaced, insistence of the medical authorities that Lorde wear them for her own psychological betterment provides an entry point for discussion. Certainly, their doggedness in insisting that she wear the prostheses causes her at one time to feel entirely disenfranchised: she recalls, “It wasn’t worth the effort to resist... I knew I didn’t look any better [wearing the prostheses]. At home I wept and

wept and wept” (49). Ultimately, Lorde is able to mitigate the assault on her sense of warmth and competency through “[making] love to [her]self, endlessly and repetitively, until it was no longer tentative [that she remained a sensual being]” (49), reaffirming her budding self-identity and encouraging her own affective self-transcendence. The fact that she is able to overcome the negativity of the medical authorities does not, however, explain the root of their persistence since the dynamics of such persistence lies beneath the superficial. Other than asserting, for instance, that Lorde will feel better after wearing the prostheses, many medical authorities directly chide Lorde for her decision to forego prostheses, claiming that it is “bad for... [others’] morale”(52). Indeed, the social backlash that she experiences is not an isolated incident: Thorne and Murray cite a case where “a Canadian woman was terminated as a breast cancer volunteer when she opted to have her remaining breast amputated rather than continue coping with prosthetic efforts to appear two-breasted” (152).

The net social result of this insistence that those post-mastectomy augment their bodies with prosthesis for the sake of “[decency]” (Lorde 66) highlights a social attitude that, as Lorde herself succinctly states, “keeps the post-mastectomy woman in a position of perpetual and secret insufficiency, infantilized and dependent for her identity upon an external definition by appearance” (59). Rather than encourage those traumatized by breast cancer and mastectomies to reform and transcend their previous conceptions of their selves, reforming their self-identities, the general social construct actively hinders them from achieving any sense of self whatsoever. Functionally, research by social psychologist Jennifer Crocker has found that “basing self-esteem on external qualities such as appearance... is related to a variety of negative mental health outcomes” (148). Such negative mental health outcomes are further reflected in many interviews conducted with post-mastectomy patients. One woman interviewed by Lloyd et al., for example,

stated, “I don’t feel as if I’m a woman, or attractive [anymore]” (479), alluding to a reality where many post-mastectomy patients, having lost their self-identities, are then unable to divorce themselves from superficial social expectations, and come to terms with their trauma. Such negative feelings of self-warmth and competency are unaided by often equally negative experiences of external sociality; the same respondent recalls her husband’s reaction: “he [said something along the lines of], ‘Oh my God, what have you done, it’s awful, it looks terrible’” (Lloyd et al. 478). The experiential reality of those traumatized by breast cancer and subsequent mastectomies reflect Lorde’s theory of social dynamics. It is harsh and often vehemently unsupportive of encouraging such women to successfully transcend their former selves. Rather than support the identity reconstruction by offering external warmth and reaffirmations of their competency, many social factors attempt to actively hinder the development of a positive self-identity in those traumatized people.

This developmentally detrimental social ecosystem for post-mastectomy women remains a contemporary issue, even if the substrate itself may be better hidden. As in Lorde’s reality of the late 1970s, where the socio-political medical establishment appeared to actively discourage patients from claiming agency over their selves (Lorde 73-4), the socio-political actors of today also are producers and products of an oppressive reality for mastectomy patients. Even the language of a landmark 2003 study by Harcourt et al., in which the researchers showed that doctor-patient relationships in cases of mastectomy are often influenced by subtle prejudices that disempower women, displays a slant that objectifies women and prioritizes their appearance. In their introduction, the authors write, “women [post-mastectomy] face the distress and disfigurement caused by the loss of the breast in addition to the fear of a potentially life-threatening disease” (106), appearing to give precedence to the distress caused by physical

“disfigurement”, rather than the life-threatening nature of the disease itself. Indeed, the irony of the situation is apparent when the authors continue by denouncing the way in which many medical professionals may inadvertently frame treatment choices so as to prioritize patients’ physical appearance. They cite, for example, an interview with a patient, who reports, “[My surgeon said] he would have to do a mastectomy because of the size of [the tumour] and where it was[,] otherwise... [the procedure] would leave me very disfigured. And then he just said they would do a reconstruction there and then... otherwise [the procedure] would leave [my chest] deformed” (106). The fact that Harcourt et al. highlight the systemic tendency of those in the medical profession to contribute to the negative atmosphere surrounding the appearance of women post-mastectomy shows the cultural pervasiveness of such prejudices. Further, it suggests that the behaviour may not be motivated out of a conscious desire to objectify women.

Since it is reasonable to propose that there may be more complex social processes at play than Lorde’s assumption that “the attitude towards prosthesis after breast cancer is an index of this society’s attitudes towards women in general as decoration and externally defined sex object[s]” (62), one does well to consider issues with a more macroscopic focus. In this regard, exploring Lorde’s interactions with others, outside of her being schematized primarily as a post-mastectomy patient may be useful, insofar as doing so allows for the development of a baseline upon which to judge her future interactions post-mastectomy. Immediately following her surgery, for example, when she is more directly a post-operative patient than a post-mastectomy patient, she nonetheless encounters hostility from the medical establishment: she recalls, “I remember screaming and cursing with pain in the recovery room, and I remember a disgusted nurse giving me a shot. I remember a voice telling me to be quiet because there were sick people here” (35-6). From Lorde’s anecdote, it is clear that the medical professionals in the recovery area view her

not as a person deserving of emotional warmth, but as an emotional and logistical problem that should be suppressed. On a functional level, such dehumanization of patients by medical professionals is not uncommon; a study by Kalliath et al., conducted on 465 medical professionals (39), found “emotional exhaustion as the core element of burnout [in the studied cohort], [with] depersonalisation as perhaps a subsidiary dimension” (46). Put simply, many in the medical profession suffer from emotional exhaustion, likely resulting from the affectively relentless nature of most patient-carer relationships. In turn, this emotional exhaustion leads to both an intrapersonal and interpersonal propensity towards depersonalization as a coping response. Given this information, it is clear that Lorde’s cold treatment in the hands of medical professionals, as well as the arousal of their contempt and disgust, was more reflective of their own internal psychological anxiety than being emotive states directed particularly at Lorde herself. The lack of interpersonal warmth she experienced was simply the ultimate result of her medical professionals being emotionally burnt out by the constant affective stress inherent in their lines of work.

With an understanding that many interpersonal reactions to others are internally rooted, the discussion can revisit the motivations of those who overzealously insisted that Lorde use breast prostheses for the benefit of public decency and others’ morale. On this front, research on coping responses, similar to those unconsciously employed by medical professionals suffering from burn-out, can provide some insight. For instance, the classic Freudian defence mechanism of projection, where people “reduce concern that they may possess feared [or undesirable] traits” by noticing and admonishing them in others (Schimmel et al. 976), helps to reduce personal anxiety. According to Schimmel et al., this behaviour is a “by-product of the hyper-accessibility of one’s undesired characteristics” (971). Since people tend to ruminate over their perceived

shortcomings, thoughts of those shortcomings become psychologically hyper-accessible, becoming negatively schematized to situations in the external world. Contextualized to Lorde's experiences, it is probable that her breastlessness provoked the ire of others not simply because they had been socially conditioned to see breasts as a source of female beauty and self-worth, but because seeing Lorde in such a state reminded them of their own insecurities regarding mortality and self-identity. Along with such projective defensiveness resulting from concerns of appearance and sexuality alone, there come the exceedingly high levels of generalized, "psychonoxious" anxiety (Fallowfield et al. 696) for those preoccupied with serious or terminal illnesses; the majority of breast cancer patients are "unable to sleep, due to worrying thoughts ricocheting around their heads all day and night[, finding themselves]... tense and unable to relax or concentrate and... extremely irritable" (Fallowfield et al. 698). Indeed, even in the case of breast cancer survivors, approximately 30% develop persistent post-traumatic stress disorders, which sometimes last decades after oncological remission. Additionally, up to 97% report lasting anxiety over the possibility of a reoccurrence (van den Beuken-van Everdingen et al. 1137). Overall, the social situations that Lorde found herself thrust into were doubtlessly charged with negativity, their actors already engrossed in their own anxious thoughts. In such stressful environments, Lorde's self-assuredness coupled with her refusal to follow the norm was likely seen as a threat to others in their already psychologically compromised state. In this way, such negative reactions were not directed at Lorde, herself for any true transgression; they were the ultimate manifestation of those others' psychosocial fragility.

Beyond relatively basic explanations relying on models of generalized stress and defensive coping, it is also important to consider factors unique to the psychological salience of

trauma and death. To this end, Mikulincer et al. provide a lucid summation of research on death anxiety and its functional manifestations:

[R]eminding people of their own mortality... [leads to] more negative evaluation of out-group members and those who threaten one's cultural worldview, increased estimates of social consensus for one's opinions, harsher punishment for moral transgressors, increased aggression against those who criticize one's cultural beliefs, increased conformity to recently primed cultural standards, and more reluctance to violate cultural standards. Importantly, heightened adherence to a cultural worldview following death reminders has been found among children as young as eleven. Moreover, these effects appear to be unique to thoughts about death. (21)

Extrapolating from these premises, it is evident that, regardless of her relative self-transcendence, and her internalized feelings of warmth and competency towards her status as a confident and sensual woman, Lorde was destined to receive a mostly negative response from those haunted by the trauma of cancer and anxious about death. Her non-conformist outlook clashed with the death-anxious drive towards socio-ideological homogeneity. That said, with the previous conclusions in mind, the fact that Lorde was non-conformist could be taken as signalling one of two possible scenarios: either she had already started recovering a sense of self, thus making her less death-anxious, or she was, indeed, conforming to her in-group ideals, which, for a life-long activist such as Lorde, would have included tenets on remaining strong-willed, intellectually independent, and respectful of the self. In either case, regardless of the proximate cause of her behaviour, she ultimately became the target of those with insecurities surrounding their own social position in a turbulent social atmosphere. More generally, Lorde's

experiences illustrate how the predominant social environments of those with trauma may functionally hinder self-identity reconstruction by limiting or even working against the re-establishment of positivity in the general identity qualities of warmth, competency, and self-transcendence which is necessary for successfully working through trauma.

Considering that social support favouring the positive development of the general identity qualities may be rare, then the source of such support for those who do manage to develop a robust self-identity post-trauma must be scrutinized. In Lorde's case, for example, while much of the wider social world may have been hostile to her non-conformity and confidence, those close to her—her primary social group—are characterized as markedly compassionate, supportive, and accepting. Lorde possesses strong and continually reassuring social ties which importantly buttress her with warmth in her times of need: she recalls such a time when she “woke up to the slow growing warmth of Adrienne's and Bernice's and Deanna's and Michelle's and Frances' coats on the bed” (28), finding that it had overcome the stark frigidity of the hospital in which she had fallen asleep. Thinly veiled in metaphorical prose within this passage is Lorde's acknowledgement of how her close-knit social circle helped to both protect her from harm in her periods of vulnerability and reaffirm her worth in her periods of self-doubt. Indeed, the general consensus regarding psychological recovery from traumatic stress involves receiving adequate “levels of perceived and tangible social support from family and friends”, which lessens the likelihood of “[experiencing] compromised mental health” from such scenarios (Sharpe and Boyas 857). Understanding the aforementioned social dynamics, wherein the environments frequented by the traumatized are likely inherently detrimental to the positive development of warmth and competency, it follows that this social support from the primary social group serves to counteract the psychologically injurious environment often created by the wider social world.

The chief function of a supportive primary social group in terms of rebuilding a traumatized person's self-identity is to insulate them from attacks on their intrapersonal and interpersonal perceptions of warmth and competency, so that they may find value in self-transcendence.

Along with reassurance from friends and family, a strong sense of industry and purpose is central to developing a sense of competency. For those traumatized by serious illnesses, there additionally exists a world outside of professional and interpersonal statuses, such being the world of being a candidate for the status of trauma survivor. Put plainly, the traumatized person must feel as though he or she understands the illness, so as to decrease encroaching feelings of "ambiguity" and increase his or her "sense of control" (Hilton 50). Functionally, a strong feeling of competency in regards to one's illness also increases the drive to consider information contrary to one's beliefs since, as demonstrated by Albarracín and Mitchell, "individuals who believe that they will effectively defend themselves may [more] willingly receive counterattitudinal information that succeeds in changing their attitudes" (1565). Those who possess strong belief in their own intellectual competency are more likely to seek out balanced sources of information. Lorde alludes to this idea herself when she states, "women need to face the possibility and the actuality of breast cancer as a reality rather than as myth, or retribution, or terror in the night... After surgery, there is a need for women to be aware of the possibility of bilateral recurrence, with vigilance rather than terror" (63-4). If one takes Lorde's statement together with the research on how individuals process information in times of emotional trauma, it becomes clear that a high level of subjective competency in relation to one's illness can help to improve one's overall psychological and physical state during every stage of illness. A sense of control and competency, in this way, largely alleviates anxiety over the unknown, increasing

active participation in the healing process, and improving the possibility of a robust self-identity post-trauma.

Naturally, the presence of serious illness and trauma does not exclude a developing individual from the need to obtain a sense of competency outside of being a possible trauma survivor. To achieve a robust self-identity, the traumatized must also develop a sense of social competency. This involves both a sense of interpersonal competency, which is closely aligned with feelings of warmth, and a sense of industrious competency, which is associated with self-transcendence. Lorde herself writes, “I really felt and wanted, and that was to live and to love and to do my work, as hard as I could and for as long as I could” (32), alluding to the interconnectedness of the dual tracks of social and industrious competency in terms of maintaining the internal drive towards self-identity development throughout psychologically trying times. A strong sense of social competency increases the traumatized individual’s sense of affective and realized self-worth by not only helping him or her understand that he or she serves an important contributory role in the lives of others, but the experience of working through trauma also gives such individuals a broader practical basis on which to evaluate the products of their social work. Indeed, according to a literature review compiled by Steven S. Coughlin, “When faced with pain, grief, or fear of premature death, people reach out to others for support and are reminded of how interconnected we are with others”, which in turn “improve[s] patient outcomes and... enhance[s] overall health and quality of life” (63). Certainly, this dynamic can also work inversely insofar as, if one reaches out and finds poor levels of external support, then the ability to positively qualify one’s own social self-worth evaporates, and the self-identity cannot be robustly rebuilt. The successful achievement of a sense of competency, therefore,

involves an on-going exchange, whereby the traumatized both contributes to and receives from their social groups in terms of intangible affectiveness and practical markers of productivity.

The practical markers of productivity that arise out of a strong sense of competency serve as a primary avenue for legacy leaving and, thus, a sense of self-transcendence. A self-identity that includes a strong component of self-transcendence looks increasingly away from the corporeal self as a means of achieving enduring social value. It refocuses its efforts, instead, more globally, with a drive to educate and secure those beyond the self. Particularly in cases of high death salience, such as in the case of traumatic illness, this drive assists in providing the self with a feeling of social continuity in physical incapacitation or after death. Psychological case studies of retirement home residents conducted by Germina Emily R. Rio, for example, show a commonality of efforts to transcend the self amongst the cohort. Writing of her experiences with a resident identified as “Mrs. E”, Rio recalls:

“I don’t want to be forgotten[,]” Mrs. E said]... She told me how she loved to crochet. She donated thousands of hand crocheted baby bonnets and little shoes to hospital nurseries. She never had children but she took care of a niece and nephews. She had so much to share with great affection. (3-4)

Individuals such as Mrs. E, who are successfully engaging in self-transcendence appreciate the greater social world outside of themselves, making concentrated efforts to extend their affective and practical influence beyond their corporeal self. Key to the positive orientation of this outlook—the reason it does not devolve into a crocheting compulsion for Mrs. E—is maintaining a sense of communal responsibility. Indeed, although Mrs. E may voice her fear of being forgotten, her acts of service stem not from self-centredness, but rather from a desire to “share” and “care” with “great affection”. In this way, true self-transcendence, which is central to a

strong self-identity, increases the exchange of affective and practical security in relation to both the traumatized and his or her social groups. Lorde, herself, touches on the social co-operation inherent in self-transcendence during a discussion with Charles H. Rowell: she says, “I want my poems—I want all of my work—to engage, and to empower people to speak, to strengthen themselves into who they most want and need to be and then to act, to do what needs being done” (Rowell and Lorde 62). Echoing the spirit of Mrs. E’s actions, Lorde too shows a marked focus on ensuring that her products not only leave a legacy after her passing, but also that they assist others in a positive manner. On a more theoretical level, this means that self-transcendence partially entails the distillation of the intangible aspects of a blossoming self-identity into a more tangible form; central values and personal axioms are passed on to the greater social whole as one transcends the self. This, in turn, feeds back into the qualities of warmth and competency by making one’s values and beliefs more clear to the self and others, leading to a cogwheeling of self-identity development.

Interpreting autopathographical works, such as Audre Lorde’s *The Cancer Journals*, with regard for the General Identity Qualities of Warmth, Competency, and Self-Transcendence provides greater clarity in terms of understanding how various social dynamics affect those working through trauma. For Lorde, a warm social environment translated into a sense of competency and self-transcendence which ultimately allowed her to rebuild her self-identity post-mastectomy as a cancer survivor and a sensual, strong-willed woman. Her experiences help to illustrate that many socio-political factors surrounding the seriously ill must be carefully considered for their impact on self-identity development; many such factors may, in fact, work against individuals in their attempts to come to terms with their illness and trauma. Although Lorde herself eventually came to “accept the existence of dying, as a life process” (24), she

reminds us of the interconnected, inherently social nature of a healthy self-identity, even if such a self-identity must be primarily formed through introspection. The experience of illness, and the autopathographical voice that comes out of illness, is therefore highly social, teaching us about our responsibility towards each other through our responsibility towards ourselves. Only by taking care of those around us can we, as individuals, live, love, and prosper in the security of co-operative ventures.

Conclusion

The present study attempts to further the understanding of the individual experience of trauma by examining autopathography on a functional level. Reconceptualizing the manifestation of traumatic illness as the product of a shattered sense of self, which must be rebuilt for the individual to successfully work through his or her trauma, it proposes a shift away from the contemporary trend to view trauma from a primarily social lens. Rather than relying on externalized co-witnessing dynamics, the traumatized are theorized to have a large degree of agency in terms of successfully resolving their identity dissolution during their post-trauma period. Along with this proposal to shift the ideological substrate of the field towards a consideration of the individual's experience of trauma, a practical method for analyzing autopathography based on Erikson's Stages of Psychosocial Development has been put forth. Under this framework, the General Identity Qualities of Warmth, Competency, and Self-Transcendence have been isolated as dimensions for analyzing autopathographical works and their authors' experiences of trauma. While this analytical method has been prepared with great effort to maximize both its theoretical utility and ease of deployment, the possibility of confounding factors still exists. Broadly speaking, such confounding factors arise out of either simplifications in the interpretation of the autopathographical process or generalizations in terms of how unique individuals experience trauma. Both of these aspects are conscious limitations imposed on the current models to aid in the theoretical intelligibility and practical viability of the frameworks and methods described by this study.

In Chapter Three, the analytical method described by this study was deployed in a reading of Audre Lorde's *The Cancer Journals*. Lorde's work was chosen for its prototypical

narrative in relation to autopathography as a genre. However, the ensuing literary analysis paid little attention to the fact that Lorde's diary was heavily modulated before its publication. Indeed, the majority of commercially successful autobiographical works are the products of "editing, selection of narratives, framing, chapter organization, and so forth", which aim to "[naturalize the works'] rhetorical strategies and ideological motives" (Cloud 119). In this way, the majority of commercially successful trauma narratives adhere closely to a particular plot progression, which includes certain expected themes, motifs, and genre tropes. According to McMullen and Solomon, these narrative expectations form "terministic screens", which reduce the complexity of narrated individual experience (Cloud 116). In terms of commercial trauma narratives, this simplification serves to increase readability and reliability for the audience, thus increasing potential saleability. Using such a deliberately modulated text as a corpus for analyzing individualized experiences of trauma may, however, prove unfruitful since the corpus in such a presentation would be engineered to express certain outcomes and motives over others. Specifically in relation to breast cancer narratives, for example, Emily Waples writes, "[Most] reinforce a uniform subject position—that of the survivor—and to emplot that subject in a familiar narrative", citing the tendency of these narratives to sentimentalize, and engage in "pinkwashing" of, unique experiences of breast cancer (49). As described, the current method for analyzing autopathography does not attempt to control for any such overt hegemony in authors' retellings of their experiences. However, given a large enough sample of generically related literary analyses employing the method, it may be possible to perform factor analyses on the sample's linguistic content to identify and cancel out the interference of terministic screens on individual works.

Beyond the external modulation of narratives for commercial reasons, writers generally also self-moderate their experiences while putting them to paper. On the most basic level, as Dana L. Cloud surmises, “even (self-authored) autobiographies construct selves and narrate lives as ‘critical fictions’” (119), essentially suggesting that, apart from external sources of narrative modulation, authors themselves self-edit as they write, consciously structuring their disparate recollections into a coherent narrative. Further, psychological studies have shown that a multitude of unconscious mechanisms determine what is recalled during memory reconstruction. The seminal experiments of Carl R. Rogers, for instance, show that individuals hold internalized ideal images of the self with which they strive to be “in congruence” (235). Extending this framework, Jerome Bruner postulates that individuals “develop a workable narrative ‘theory’ about how [their selves] developed” and will shape their memories to be in concordance with this grand narrative of the self (46), which usually emphasizes the expression of personal agency, even in the face of an oppressive reality (41-2). The unconscious selection and modulation of mnemonic content ultimately influences the events that the autobiographical author will relate to his or her audience—even if the work is for intrapersonal consumption—and affects the message he or she will attempt to ascribe to the experience in question. In order to recognize and control for the influence of an author’s unconscious self-conceptions, those performing literary analyses as per the described method should carefully consider their corporal content in relation to the author’s known personality, goals, and motives. Gaining such a comprehensive perspective on an author allows the analyst to study the author’s expression as arising from the author’s own greater experience of subjectivity.

The issue of subjectivity in relation to traumatic experiences also presents possible considerations in terms of the model’s theoretical framework. Most centrally, the model as

described assumes that the autopathographical author possesses standard psychosocial drives during both his or her traumatic experiences and the writing of his or her work. In the case of authors with pre-existing psychiatric disorders or authors who have been diagnosed with comorbid disorders post-trauma, the method, used as described, may suffer from reduced analytical effectiveness. In a myriad of personality disorders, including Avoidant PD, Schizoid PD, and Borderline PD, there is a marked reduction in social support seeking and an increase in the use of avoidant coping strategies (Bijttebier and Vertommen 854-5). Further, Taylor et al. find that individuals with Avoidant PD “seek to avoid all emotions, irrespective of valence” (591). These conclusions suggest that the qualitative analyses of writing by people with such disorders, especially on Warmth dimensions, may require framework reorganization. Such reorganizations would draw into question the end goal of working through trauma: specifically whether the traumatized individual’s pre-trauma self-identity should be used as a baseline for determining successful trauma resolution. These types of considerations are extremely complex and beyond the scope of the present discussion, but should be deliberated by the analyst where necessary. Indeed, there is some evidence that expressive writing “buffers the deleterious effects of [social] inhibition” in traumatized patients who also suffer from social inhibition (Merz et al. 348), so it may be that those with confounding psychiatric disorders represent a sizable minority of potential autopathographical authors.

Of relatively tangential note compared to the aforementioned considerations and limitations, are the pieces of counterevidence which suggest that expressive writing, in and of itself, is ineffective as a treatment for trauma. Since the present discussion is not an empirical study of trauma treatment methodology, it does not attempt to either support nor refute the validity of expressive writing as a practical treatment for psychological trauma. Nonetheless, it is

prudent to mention that a collection of studies, such as one by Jensen-Johansen et al. on 437 Danish breast cancer survivors post-intervention (1493), find no difference in improvement between those who write about their trauma and those who write on neutral topics (Jensen-Johansen et al. 1495). Craft et al. believe that the general “emphasis on narrative, or storytelling”, irrespective of the exact content produced, is responsible for the improvements in health for some subjects in such studies (313). Regardless of the practical therapeutic effects of performing autopathography, however, it stands that the products are culturally relevant and, thus, the analysis of such products and their production may yield insights into not only the individual psyche, but also into the stitching of human relationships on the whole. Indeed, the inherently qualitative slant of this study reaffirms the idea that human psychosocial experiences can have a sort of subjective validity all their own, deserving of increased awareness and academic study on that front.

To return to the introductory citation of Liran Razinsky, in which it is thought that “[the] arrival of death transcends our usual mode of thought, which seeks out motivations and reasons” (398), it is true that death itself is likely to remain humanly unknowable. Indeed, death is the very absence of thinking and knowing. However, while death is the absence of thinking and knowing, the experience of trauma which may precede death is very much the opposite. It is a time of intense personal introspection, where individuals consolidate what they think into what they know about both themselves and those around them. In this sense, any expressive act undertaken during the experience of trauma is likely to be a distillation of an individual’s psyche—his or her hopes, dreams, loves, and hates—and thus deserves the respect of our careful consideration. Only through considering those on life’s cusp can we as a species begin to understand the motivations and reasons for life that we so relentlessly seek.

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