IN SEARCH OF A POLYPHONIC COUNTERNARRATIVE: COMMUNITY-BASED THEATRE, AUTOPATHOGRAPHY, AND NEOLIBERAL PINK RIBBON CULTURE

by Sarah A. Senff

This thesis uses practice-based research to explore possible interventions into the traumatic impact of illness upon breast cancer survivors’ voices and the role of neoliberal pink ribbon culture in compounding their silencing. The interdisciplinary research pulls from the fields of applied theatre, critical pedagogy, materialist feminism, narrative analysis, social movement theory, medical sociology, and dialogue, disability and performance studies. Reflecting upon process and praxis relating to a regional tour of Susan Miller’s My Left Breast as a means to engage a community of survivors, advocates and the general public, this thesis asks: Can a community-based theatre event focused on exploring breast cancer counternarratives provide both a therapeutic space for survivors to tell their stories as well as encourage the audience to think more critically about how culture works to influence narratives emerging from breast cancer culture?
A THESIS

IN SEARCH OF A POLYPHONIC COUNTERNARRATIVE:
COMMUNITY-BASED THEATRE, AUTOPATHOGRAPHY,
AND NEOLIBERAL PINK RIBBON CULTURE

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DEDICATION

For Kelly

Who continually inspires me to live hard and to love harder.
I’m holding you to that promise you made to wait for us at the Tree of Life.

For Allie

Who is so very much more than one single story.
Life is opening up a beautiful new chapter for you. May God give you joy.
…and a spare bedroom where I can visit.

For Nick

Who is my brother from another mother,
with strength that was called upon too soon and more still untapped.
Remember our pact!

For Erica

Who climbs mountains both literal and metaphorical.
I’d climb beside you any day.

and

For Jim

Whose sunny smile never dimmed as he fought breast cancer
in a world that didn’t support him nearly enough.
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INTRODUCTION

Statement of Problem

Unfortunately, most breast cancer survivors’ journeys to restored health do not end with a designation of remission. A number of survivors experience a loss of voice as a direct result of the trauma of illness, compounded by the critical gaze and dominant narrative of a breast cancer culture rooted in gender-based expectations and neoliberal consumer-based philanthropy. In order to relieve some of these pressures, I point to the dual ability of storytelling to disseminate information and serve as a therapeutic outlet. Using Susan Miller’s *My Left Breast* as a means to engage a community of survivors, advocates and the general public, I ask: Can a community-based theatre event focused on exploring breast cancer counternarratives provide both a therapeutic space for survivors to tell their stories as well as encourage the audience to think more critically about how culture works to influence narratives emerging from breast cancer culture? In order to answer this question, I will: 1) problematize the narratives emerging from breast cancer culture, 2) establish the therapeutic benefits and limitations of performed illness narratives, using *My Left Breast* as an example, and 3) analyze the results of the community-based theatre workshop in order to demonstrate audiences’ meaning making.

Significance

Much of my interest in this research stems from deep personal investment in public perceptions of individuals with cancer. The loss of a dear cousin to pediatric cancer was a formative moment in my life, both personally and as a young scholar. Throughout her years of alternate illness and remission, I watched her cede more than health to disease. Her identity was overwritten until she was perceived as something less than the dynamic and complex young woman she was; as her illness progressed, others reduced her to a two-dimensional sad story of ‘the cancer girl’ in order to distance themselves from fears of their own mortality and preemptively avoid grief at her loss. Similar misappropriations of identity left her family struggling to maintain their own distinct individualities apart from her illness and untimely death. Because these challenges are not unique to my family, I find myself considering how performance
might mitigate the negative impact of public perceptions of illness upon patients, survivors, caregivers, and their loved ones.

G. Thomas Couser calls illness and disability “the most widespread form of marginalization” (13) because it crosses cultural, racial, geographical, gender, sexuality, age, and class lines. While illness and disability may affect groups disproportionately,\(^1\) they are obstacles for virtually any social identity group imaginable, and can compound issues of marginalization for already-minoritized individuals. Arguably the most-discussed illness in America today, breast cancer affects millions\(^2\) of women and men living in various stages of post-diagnosis, as well as their loved ones and caregivers. This adds up to too many Americans in direct conflict with ‘the breast cancer wars,’ (Lerner) and even more whose tax dollars and charitable giving flow into research funding; the potential impact for interventions into breast cancer’s impact on culture is vast. My study seeks to deepen knowledge regarding the various responses to a community-based theatre event that engages a hotly contested issue, the existence, function and performativity of breast cancer culture, and public perceptions of breast cancer and awareness.

The theatrical event serves as a strong forum for such an inquiry because it can capture performances from both the actor and the audience. It asks, “How does the body perform in space?” and “What meaning can be made from audience reactions to that performance?” It can also create an empathetic response between performer and audience that stimulates action, which may be as simple (yet important) as a shift in their own thinking. Theatre also has an inherent ability to draw a crowd that can create a space for dialogue, an especially important asset in community-based theatre, which places prime importance upon active audience input. Community-based theatre is an interdisciplinary applied theatre field distinct from ‘community theatre,’ which is, simply put, amateur theatre. Community-based theatre scholar Jan Cohen-Cruz defines it as a field in which artists, collaborating with people whose lives directly inform the subject matter, express collective meaning. … an unwieldy field, seemingly contradictory. It spans performances committed to social change along with those whose purpose is the conservation of local cultures, sometimes both at once. Its

\(^1\) e.g. Higher incidences of: Autism Spectrum Disorders among Caucasians (Autism), deafness in men
\(^2\) In 2011, there were more than 2.6 million breast cancer survivors in the US. (breastcancer.org)
practices range from grassroots oral storytelling to formal techniques created by professional artists. Its theories build not only on ideas about art, but also on concepts from education, therapy, sociology, anthropology, the emerging field of dialogue studies, and community organizing. (Local Acts 1)

Limitations of Research

The research is primarily limited by demographic underrepresentation at workshops, which were overwhelmingly attended by middle class white women. And though self-identified breast cancer survivors attended each performance, they totaled only seven across five performances. Timing constraints proved a further challenge. In a prescribed two-year Master’s program, I necessarily set upon a thesis topic early, well in advance any fieldwork, which limited the amount of possible direct input community partners might have had in the scope of the inquiry. Academic timeframes further constrained engagement with the community in advance of the performances. In contrast to some community-based practitioners who spend two years or more developing projects with their target community, my five-month timeline was atypically brief. The scope of my review of dramatic literature was limited to women and cancer in the last quarter of the twentieth century. Finally, the data collection was limited by its real time handwritten transcription in place of audio or video recording. Because such recordings would have resulted in IRB requirements for workshop participants to sign written informed consent forms, it likely would have resulted in a lower rate of participation, especially considering most audiences’ conditioning to passive reception of theatrical performance.

Five performances and accompanying workshops took place in three separate venues (chosen for their accessible community locations) over three months. The 65 patrons in attendance on November 8, 2012 made for a sold-out opening night in the modestly-sized studio theatre on Miami University’s regional campus in Hamilton, Ohio. Miami-Hamilton and the surrounding community are composed primarily of the students and working and middle class individuals common to a small post-industrial midwestern town struggling to assert a new identity. Two more performances followed in the same

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3 Though a signed consent form was not required, participants were informed of their rights as research participants in advance through both a curtain speech and printed material in their playbills, as well as on an ongoing basis via verbal instructions given throughout the workshop.
venue with audiences of 46 and 55 on November 9 and 10, 2012, respectively. Nearly three months later, a one-night-only engagement on January 26, 2013 at the Oxford Community Arts Center in Oxford, Ohio for an audience of 44. The OCAC is located in a converted nineteenth century dormitory, with a well-used flexible theatre space. The OCAC enjoys a fairly broad audience base, from the Oxford elite to middle class families to students from the nearby main campus of Miami University. The regional tour closed on February 2, 2013 to a small audience of 29 in a storefront community gathering space in downtown Hamilton.

**Terminology**

For explanations of important terms not elsewhere defined, see Appendix Item I.

**Methodology**

The thesis is a manifold study of neoliberal breast cancer culture and performed autopathography, culminating in a practice-based research event in the form of a community-based theatre performance and workshop that toured regionally. The heart of my methodology is drawn from applied theatre, a family of several diverse forms with a common interest in social intervention. From Theatre of the Oppressed to Theatre for Development to community-based theatre to theatre in health education and beyond, each contains a utilitarian urge toward education, community development, or social change. In *Applied Theatre: International Case Studies and Challenges for Practice*, Monica Prendergast and Juliana Saxton characterize the field as self-consciously political, asserting that “applied theatre works overtly either to reassert or to undermine socio-political norms… to reveal more clearly the way the world is working” (8). Applied theatre’s revelatory intent parallels my quest for critical thinking; the community-based grounding of theatre in health education (THE) serves as both my methodological and theoretical home. Prendergast and Saxton note that THE focuses on “issues of health, safety and well-being” (87), “often addresses difficult [publicly taboo] topics” (88), and “is about raising awareness and changing behavior” (89). They continue: “THE's community-based process reminds us that health is not limited to individual choices and
behaviors, but is a larger social responsibility. Health is contextualized by the culture, values and social, political and economic conditions of a community” (88).

The workshop serves as arts-based participatory research using personal narrative, so IRB approval was secured for the protection of the human subjects. It was designed using methods from Augusto Boal’s *Theatre of the Oppressed*, Michael Rohd’s *Theatre for Community Conflict and Dialogue*, and John O’Neal’s story circles.

Data was collected primarily through research notes, rehearsal reports, reflective journal entries and email communication with community partners and production staff. Workshop data was collected in the form of transcriptions by two note-takers at each performance, each of whom had completed IRB training on research with human subjects. In addition to their closest approximation of participant commentary, when possible these note-takers also included observations about audience composition, body language, vocal quality, gender, and the general environment of the workshop. Raw data were analyzed qualitatively, primarily through narrative analysis, and secondarily as part of a coding process based in grounded theory.

**Theoretical Frameworks**

As a theatre thesis located within the emerging interdisciplinary of medical humanities, the diversity of theories integrated herein reflect the complexity of the field, which the University of California – San Francisco School of Medicine describes as:

an interdisciplinary and interprofessional approach to investigating and understanding the profound effects of illness and disease on patients, health professionals, and the social worlds in which they live and work. In contrast to the medical sciences, the medical humanities – which include narrative medicine, history of medicine, culture studies, science and technology studies, medical anthropology, ethics, economics, philosophy and the arts (literature, film, visual art) – focus more on meaning making than measurement.

To this list, I would especially add: dance, music, performance studies, sociology, psychology, and, of course, theatre.

Three overriding metaphorical concepts carry through the entire work of the thesis: the wounded storyteller, the phantom note and the polyphonic counternarrative. Arthur W. Frank’s *The Wounded Storyteller* explores the loss of voice that individuals
may experience following catastrophic illness and suggests that storytelling can serve as a therapeutic outlet to achieve its restoration and make meaning out of the experience.

Tessa W. Carr’s 2007 dissertation “Recovering Women: Autobiographical Performances of Illness Experience” applies Frank’s work to My Left Breast and other plays. Though there are certainly parallels in our theorizing of his work, I build upon hers by focusing on performed illness narratives within the specific framework of applied and community-based theatre as a strategy to prompt audiences’ own acts of autobiography.

Performance studies scholar Jill Dolan speaks of a ‘phantom note,’ a fleeting performative moment with “community resonance and social implication” (18) as a metaphor for considering with what cultural ideas or norms we consciously or unconsciously resonate. I extend her musical metaphor to seek a ‘polyphonic counternarrative’ to the current dominant narrative in pink ribbon culture, which functions primarily as a monotone. It may be sung beautifully, but it is only one voice, unchanging. Like the multivoiced polyphony of choral ensembles, such narratives of resistance would range the spectrum in tone of voice. They act in harmony together, then strike a dissonant chord, vibrating with tension, clashing and then resolving. They rest silently from time to time. They make room for a solo, providing a steady beat and support before the soloist blends in with the ensemble once more. There is give and take, ebb and flow, and the song ends and changes as necessary. Such polyphony in breast cancer narratives would involve making room for all of the experiences of the disease, both those that follow the master narrative and those that counter or complicate it.

Poststructural materialist feminism serves as primary theoretical lens. This multifocal lens of woven theories advocates gender equality (Aston; Sulik; hooks; Lorde), assumes social construction of identity and culture, and interrogates the complex and shifting power structures (Foucault) and socioeconomic factors (King; Ehrenreich) between hegemony (Gramsci) and resistance.

Performance studies springs out of the discourse of poststructuralism to reject essential reality and offer up theories on how we perform, or ‘do,’ our identities: gender, race, etc. Performance studies examines the meaning made from performance, from acting, from doing, regardless of the performative act’s origination from a human or inanimate object. “Essentially, performative is an adjective that describes someone or
something as being constituted in, through and by performance; that is, actively, presentationally, in embodied and often fictive ways” (Prendergast 61). Of particular importance to this thesis are the performance studies theories regarding performativity of disease (Auslander; DeShazer; Carver; Kanter) and the body (Diamond; Pitts; Schneider), utopian performatives (Dolan; Prendergast), scriptive things (Heidegger; Bernstein), and communitas (Turner). The concept of communitas emerges from the anthropological wing (Turner; Schechner) of performance studies, which evolves into an intersection of performance and social science. At this intersection, frame analysis and social movement theory (Goffman; Snow and Benford; Poletta; Animating Democracy) examine cultural performances.

Finally, the theatre in health education framework is informed by multiple theoretical disciplines. As an applied theatre (Boal; Rohd; Prendergast and Saxton; Prentki and Preston) subgenre, its roots are located in Augusto Boal’s *Theatre of the Oppressed*, which applies the critical pedagogy (Freire; Giroux; Marcuse; Boal) outlined in Paulo Freire’s *Pedagogy of the Oppressed* to participatory theatre methods. Critical pedagogy is “the educational movement, guided by passion and principle, to help students develop consciousness of freedom, recognize authoritarian tendencies, and connect knowledge to power and the ability to take constructive action” (Giroux, Lessons). And because of its inclusion in THE’s community-based theatre methods (Cohen-Cruz; Cocke; O’Neal; Sullivan; Ellis) which emphasize audience input, an increased understanding of civic dialogue through dialogue studies (Bakhtin; Romney; Ellis; Freire) is vital. Finally, THE emphasizes the importance of cultural, economic and sociopolitical context, therefore drawing upon medical sociology’s (Frank, Sulik) studies of illness and medicine within society.

**Historical Context: Breast Cancer Treatment And Advocacy**

Though its primacy among public health concerns is a relatively recent phenomenon, breast cancer itself is anything but new. “Breast cancer is an ancient disease. There has been no period in recorded history in which it cannot be found” (Leopold 23), with the earliest descriptions dating back to 3,000 B.C.E. (Leopold 15). Treatment has come a long way, but its history is violent and marked by secrecy about
the disease. The history that follows provides a trajectory of breast cancer treatment and advocacy, noting the historical events and cultural influences that shaped it. From an era when they lived as the property of their fathers and husbands to one of burgeoning bodily autonomy, women experienced a significant shift in agency that impacted their medical choices. And while today’s mastectomy, radiation and chemotherapy are often critically referred to as “slash, burn and poison” as a call for improved treatment protocols, when viewed in historical context, they are undeniably significant advancements. Seen over time, it becomes clear that culture alternately reflects and/or intervenes in the experience of breast cancer and its treatment.

In *The Breast Cancer Wars*, Barron H. Lerner provides a comprehensive history of treatment from its earliest days. He cites one 1811 patient account of mastectomy reveals that the incredible pain patients bore in the days before anesthesia: “Yet when the dreadful steel was plunged into the breast… I began a scream that lasted unremittingly during the whole time of the incision… so excruciating was thy agony… I then felt the Knife [rack]ling against the breast bone- scraping it!” (16). In 1882, William Halsted began using the radical mastectomy now named for him, expanding upon techniques he learned from German surgeons. He removed the cancerous breast, surrounding skin and fat, axillary lymph nodes and the pectoralis major (Lerner 17-20). The procedure left women with “a deformed chest wall, hollow areas below the clavicle and underarms, and, at times, persistent pain at the operative site and arm swelling known as lymphedema” (Lerner 33). Nonetheless most of his patients expressed positivity and gratitude for his intervention. Other contemporary procedures removed varying amounts of tissue, but Halsted’s radical mastectomy became the undisputed standard of care for advanced breast cancer for decades to come.

It wasn’t until the 1920s and 30s that some surgeons began to consider Halsted’s methods too extreme, and radiation was introduced as a less invasive treatment option (Lerner 34). By the 1930s, higher education was affordable and accessible as never before, with the increase in doctors and researchers leading to advancements in treatment at faster pace. The decade saw the founding of the National Cancer Institute to fund research regarding causes and treatments for cancer, as well as the Women’s Field Army by the American Society for the Control of Cancer (later renamed the American Cancer
Society). They aimed to engage in “trench warfare with a vengeance against a ruthless killer” (Lerner 43) by raising public awareness about cancer, which the American College of Surgeons had recently pronounced curable. This warfare language was a sign of things to come. The first formulation of chemotherapy arrived in the 1940s as a direct result of the chemical warfare introduced in World War I. With some slight modifications to mustard gas, nitrogen mustard impeded cell division and was used as the first chemotherapeutic agent (Weisse 127).

In the post-World War II America of the 1950s, aggressive treatment of breast cancer peaked as surgeons returning from the violence of war “went radical and then superradical” (Lerner 75). In contrast to the more conservative radiation-based therapies of the 1920s and 30s, surgeons began removing even more tissue than Halsted’s radical mastectomy. Jerome Urban’s method involved the removal of 4 additional sets of lymph nodes, including the supraclavicular nodes and the internal mammary nodes; in order to remove the internal mammary nodes, Urban removed several ribs and used a chisel to split the sternum, finishing the process with a skin graft (Lerner 80). At the same time, breast self-exam was becoming very popular, with an array of instructional pamphlets and films made widely available to the public. Yet women resisted even this simple and basic method of detection because a discovery of cancer resulted in disfiguring radical mastectomy (Lerner 55-58). For the predominantly male surgeons steeped in the sexism of the ‘50s, the breast was a “nonvital and functionless gland” and “one of the most dispensable parts of the body” (Lerner 89). It comes as little surprise then that one step mastectomy prevailed. After anesthetizing women for a biopsy of breast tissue, surgeons commonly removed the breast without waking or informing the patient if the biopsy was positive. Women simply awoke in the recovery room to find that they no longer had a breast. This is perhaps the best example of the paternalism and patriarchy that marked both the medical profession and culture at large at the time. Their failure to inform the patient or offer choices regarding her treatment became the basis of resistance to medical hegemony in future years.

In 1954, after her own experience with one step mastectomy, J.K. Lasser founded Reach to Recovery. They visited women who had undergone radical mastectomy in the hospital, providing a temporary prosthesis, medical information their doctors may have
failed to share, advice on what to expect in their recovery, and a letter to the husband on how to help their wives continue to feel sexually desirable. (Lerner 143). Over time and after some opposition that called it interference between the patient and her doctor, Reach to Recovery become mainstream and their efforts led to a beginning recognition of the psychological effects of breast cancer.

In the 1960s, mammography was introduced as a screening tool, though it didn’t become widely used until the 1970s. Its usefulness at detecting smaller nonpalpable tumors helped physicians to detect cancer earlier, leading to the acceptance of lumpectomy as a viable treatment option for women in early stages of the disease. The advance was a huge step in reducing the numbers of unnecessary mastectomy and improving the quality of life for women following surgical intervention for breast cancer. Hot on its heels in 1974 came the advent of adjuvant chemotherapy (i.e., chemotherapy following surgery) as a treatment tool that increased survival rates (Devita and Chu).

The 1970s also birthed a new discourse surrounding breast cancer. In his 1971 State of the Union address, President Nixon launched the so-called War on Cancer, declaring his intention to earmark an extra $100 million to launch an intensive campaign to find a cure for cancer, and … whatever additional funds can effectively be used. … [He said,] The time has come in America when the same kind of concentrated effort that split the atom and took man to the moon should be turned toward conquering this dreadful disease. Let us make a total national commitment to achieve this goal" (National Cancer Act).

In October 1971, an Army biological warfare facility was converted to the Frederick Cancer Research and Development Center and in December 1971, President Nixon signed the National Cancer Act into law.

In contrast to Nixon’s mainstream efforts, countercultural resistance to authority marked the American cultural climate; from civil rights protests to anti-war rallies to the rise of second wave feminism, Americans were actively questioning the establishment, and medical hegemony was not exempt. Stemming from the vociferous debate on a woman’s right to choose and to control her own body, the women’s health movement begun in the 1960s gained new ground with the 1970 publication of Our Bodies,
Ourselves, the Feminist Women’s Health Centers that sprang up, and the formation of National Women’s Health Network. As a result, the medical hegemony common to breast cancer treatment came under scrutiny that lead to improved relationships between women and their doctors, and several high profile women went public about their own experiences with breast cancer. Most notable were then-First Lady Betty Ford, whose disease was highly publicized, and journalist Rose Kushner, who published an extensive and influential account of her treatment entitled *Why Me? What Every Woman Should Know About Breast Cancer to Save Her Life*. Their openness lent a personal face to breast cancer and was crucial to its destigmatization (King xiii). Lerner, however, highlights some contention between the two. Kushner was one of the first to take a public stand against one-step mastectomy and had struggled to find a surgeon who would allow her to undergo only a diagnostic biopsy before making her own informed decision regarding mastectomy. She urged Ford to decline the one step mastectomy, as such a choice by the nation’s First Lady would empower other women to follow and demand improved treatment protocols. The First Family responded that “the President has made his decision,” leaving Kushner to protest it as “the all-time sexist declaration of no-woman rights” (Lerner 179). Their disparate views exemplified the spectrum of those held by breast cancer advocates of the polarized era.

The 1980s saw the beginnings of our current neoliberal model of breast cancer advocacy as world leaders like Ronald Reagan and Margaret Thatcher pushed neoliberalism to the forefront of their public policies. British chemical company Zeneca (now AstraZeneca) launched National Breast Cancer Awareness Month (NBCAM) in 1985, its primary goal to establish early detection through mammography as the best defense against breast cancer. With the increasing openness of the medical community and increase in women’s bodily autonomy, breast cancer self-exams and mammography were on the rise as women began to fear the impact of treatment less. The combination of improved treatment options and increased awareness led to the beginning of a steady decline in US breast cancer mortality rates since the late eighties. In 1986, the National Alliance of Breast Cancer Organizations (NABCO) was founded as a coalition of organizations seeking to provide resources to breast cancer patients and women at risk.
and to begin challenging the federal research agenda to mirror the success of the AIDS advocacy movement (King xv).

The debate over Medicare coverage for mammography marked the first part of the 1990s (1989-92). “The provision passed, overturned, then reinstated after a revolt by several congresswomen against their own Republican party” (King xv). The National Breast Cancer Coalition, founded in 1991, was the first major Washington-based feminist lobbying group with hundreds of grassroots organizational members. The NBCC launched an extensive letter writing to campaign to congress urging their commitment to breast cancer research. It seems no coincidence that the President’s Commission on Breast Cancer was launch in the same year, notably chaired by Susan G. Komen.

In 1992, a determined 68 year old with a family history of breast cancer, Charlotte Haley began making peach colored ribbons to send with a card that read “The National Cancer Institute annual budget is $1.8 billion, only 5 percent goes for cancer prevention. Help us wake our legislators and America by wearing this ribbon” (King, xxiv-xxv). Her campaign caught the attention of Self magazine and its guest editor, Evelyn Lauder of Estée Lauder, who were planning their NBCAM issue. They had been seeking a ribbon to distribute at cosmetics counters nationwide, hoping to replicate the success of the red AIDS ribbon, and asked Haley for the rights to hers. Fearing commercialization of her little peach ribbon, she refused, and Self responded by proving her right: after consulting their legal team, they realized that they didn’t need her at all. They had only to change the ribbon’s color to appropriate its message, and thus the pink ribbon was born.

As it increasingly became a hot political issue, government spending on breast cancer research rose from $155 million in 1992 to $400 million in 1993, and the National Cancer Institute began allocating more research dollars for breast cancer “than for prostate, ovarian, colorectal and liver cancers combined” (King xvi). And when Bush declined to support legislation that would transfer $210 million in defense spending to breast cancer research, the backlash launched it into an issue in the 1992 presidential race, with Gloria Steinem campaigning for Clinton in response (King xv). The increase in public attention and funding coincides with the rising neoliberal influence on the cultural discourse of breast cancer. From the early nineties until now, the primary form of breast cancer advocacy increasingly shifted from grassroots political and individual action to
philanthropy through consumerism. Pink ribbon merchandise proliferated at shocking rates and created a whole new sector of the cancer industry.

In the late 1990s, voices arose to critique NBCAM for its reactive rather than proactive nature, saying it asks “How do we detect and breast treat cancer once a patient already has it?” when a better question might be “What causes breast cancer and how do we stop it?” They objected to NBCAM’s leading sponsor AstraZeneca, the manufacturer of Tamoxifen, a drug commonly used to treat estrogen-resistant breast cancer tumors, who was found to have been a leading producer of pesticides that were deemed probable human carcinogens by the United States Environmental Protection Agency (Ehrenreich 52). The very company that founded NBCAM may have been complicit in causing cancer while profiting from supplying the chemotherapeutic agents for its treatment, making them a prime example of the self-perpetuating cycle of the cancer industrial complex.

The United States breast cancer mortality rate was 1.8% from 1989 to 1996, unequal across race. The most drastic differential is the thirty percent more deaths among African American women than white women, though the rate is consistent with overall health inequalities (King xviii). Critics claim these disparities exist in part because of a cultural focus on funding research rather than access to or payment for treatment. Breast cancer incidence has consistently risen in recorded history, from one in twenty-two in the 1940s to one in seven today (King xvii). Breast Cancer Action and others point to increase in the breast cancer rate as a result of increased exposure to known carcinogens such as radiation and synthetic chemicals while the American Cancer Society and NCI hold that increased screening and improved technology mean that smaller cancers are detected now that went unnoticed previously (King xvii).

The contemporary debates parallel the criticism leveled at NBCAM, settling along lines of screening versus prevention. Mammography remains the heavily relied-upon primary screening tool despite protestations of its unreliability (Ehrenreich). The 1994 and 1995 discoveries of BRCA-1 and BRCA-2 revealed that these genetic mutations, accounting for five to ten percent of all breast cancers, drastically increased a woman’s lifetime risk of breast cancer from around twelve percent to more than eighty percent. With this discovery, breast cancer screening entered a new, more complex and expensive realm.
Generally not covered by insurance, the $4,000 cost of genetic testing to screen for BRCA mutations repeats old inequalities that allow wealthy women better care options. A recent development should begin to change this reality shortly. Myriad Genetics patented BRCA genes shortly after their discovery by independent researchers not associated with their labs. Myriad’s “insistence that it was the only entity that could do the test and its aggressive efforts to shut down anyone else” (Reardon) meant that they garnered all of the profits from the lucrative new industry. Falling in line with the neoliberal discourse of breast cancer culture, they view everything, including the building blocks of the body, as assets subject to the market. But in 2009, “a coalition of plaintiffs including the ACLU, Breast Cancer Action and a number of scientific organizations, researchers and patients sued Myriad, claiming that it had no legal right to hold patents on the BRCA genes” (Lessy). In a landmark decision on June 13, 2013, the Supreme Court agreed. The most immediate impact of the case will be lower costs and availability of second opinions as other testing options become available. Still, a positive result to the test forces women to face the difficult decision between palliative double mastectomy or living with the heightened risk. The debate over palliative mastectomy rages hot, as critics name it unnecessary medical violence against women while others caution against interfering in medical decisions contingent upon women’s bodily autonomy.

My Left Breast: Women’s Cancer in the Late Twentieth Century

Winner of the Obie Award in Playwriting and Susan Smith Blackburn Prize, My Left Breast is a solo performance by playwright and real-life breast cancer survivor Susan Miller. The work takes the audience on a journey through her memories. Both funny and heart-breaking, Susan shares moments in her life as mother, as lover, as cancer patient, and as survivor. As a “one-breasted Jewish Lesbian Bisexual Mom” (11), she grapples with the loss of her breast, her child, and her romance as she deals with the indignities of side effects from treatment that were worse than the disease itself. Through it all, she seeks to draw the audience into her confidence, like old friends catching up over coffee. She finds the ‘cure’ for cancer in the simple joys of life, like little league with her son. As the lights dim at the play’s close, she shows the audience her mastectomy scar because, she says, “a scar is a challenge to see ourselves as survivors, after all. Here is the
evidence. The body repairs. And the human heart, even after it has broken into a million pieces, will make itself large again” (31).

As the first popular American play about women and cancer and the first such play since British playwright Louise Page’s 1978 *Tissue, My Left Breast* marked the beginning of an era of honest dramatic representations of breast cancer. The autobiographical solo performance as political statement gained popularity in the nineties, and Miller’s play runs in that vein. Her 1994 play gives voice to underrepresented factions in the breast cancer narrative, that of the lesbian and the young woman, and she positions her illness as one among multiple vital personal losses rather than give the disease primacy in her identity formation. Miller further upends the traditional narrative structure of a breast cancer story by using an episodic plot and non-linear structure that denies the voyeuristic pleasure of witnessing her moment of diagnosis. And even though *My Left Breast* was an important feminist play that problematized many strands of the dominant narratives of breast cancer culture, Miller’s conclusion allies itself with its discourse of hope.

**In Comparison with Other 20th Century Cancer Plays**

The first popular breast cancer play of note, Louise Page’s *Tissue* (1978) premiered at the peak of the women’s health movement and three years after Rose Kushner’s groundbreaking book, serving a similar consciousness-raising function. *Tissue* takes its audience on an admirably complex journey that bravely faces the ugliness of both the medical, emotional, and interpersonal ramifications of breast cancer treatment. Its structure calls for three actors to play a myriad of roles, mirroring the complex and shifting formations of identity found in the lived experience of a breast cancer survivor.

Linda Park-Fuller’s *A Clean Breast of It* (1993) followed hard on the heels of the establishment of the pink ribbon as the icon of the disease. The play is an autobiographical solo performance written with a tri-fold activist intent: educational, sociopolitical and performative. Frequently performed by the author in hospitals, community centers and on college campuses in conjunction with an informative post-

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4 Linda Park-Fuller’s *A Clean Breast of It* was written in 1993, but was typically performed within a paradigm of grassroots activism rather than commercial theatre.
show talkback, Park-Fuller’s specific intent is to undermine the silence and cultural mythologies surrounding breast cancer, searching for rediscovered agency as she struggles out of the role of patient-victim. Park-Fuller’s performance and workshop contrast its neoliberal historical moment through a valuation of education and community and rejection of consumer culture. Maxine Bailey and Sharon M. Lewis’ Sistahs (1994) stands out as the only breast cancer play written specifically for a black multinational cast. Set in the kitchen of a Toronto home as five strong women prepare a meal together, the hostess struggles with her cancer and tries to set up a good home for her teenage daughter in the face of fears of her own death.

Frank Vickery’s A Kiss on the Bottom (1995) is the only breast cancer play written by a man that I’ve been able to uncover. The award-winning black comedy with an all-female cast puts a magnifying glass up to the historical denial of agency for breast cancer patients in their treatment. Set in a Welsh cancer ward, its three female inhabitants turn to laughter and mischief to cope with their situations, even as the hospital staff and family members keep the whole truth of their conditions from them.

Another dark comedy, Lisa Loomer’s The Waiting Room (1996), centers on the interaction of three women from different nations and periods of history, addressing ways in which women have always been victims of their cultures’ ideals of beauty, the inhumanity of the medical establishment and the corruption of the American pharmaceutical industry, echoing Audre Lorde’s objection to the reduction of breast cancer to a cosmetic issue in her 1980 memoir, The Cancer Journals. Andrea Green’s For Tiger Lilies Out of Season (1998) examines the struggle of one woman to maintain autonomy in the face of pressures from her doctor, her peers and her family. Her eventual refusal of treatment altogether is an extreme step, but certainly one which allows her to firmly grasp her own agency and write the ending to her own story rather than allowing the dictates of medical protocol to write it for her.

Finally, though Margaret Edson’s runaway hit Wit (1995) centers on a woman with ovarian rather than breast cancer, it captured both critical and popular attention after its eventual move to New York’s MCC Theatre in 1998 and encouraged other illness stories to spring up in its wake. Winner of the 1999 Pulitzer Prize for Drama, Wit tells the story of Vivian, a brilliant but cold professor of metaphysical poetry who is confronted
with metastatic ovarian cancer, and must learn how to live and die with kindness and grace. *Wit* departs from the earlier cancer plays mostly in its tone. Often called ‘grueling,’ it is an unflinching, intermissionless look at Vivian’s lonely and painful experience of treatment from diagnosis to death. This intensity confronts audiences with the knowledge that although medicine has come a long way, treatment for both ovarian and breast cancer is still typically far worse than the disease itself, violent and dehumanizing. Issues of ethics in the practice of oncology come to the fore as the young resident doctor who was once her student treats her with startling unconcern. Vivian “The Brilliant Academic” is medicalized and reconstituted as a research object incapable of human emotion or pain. As a result, *Wit* is frequently performed within medical schools’ medical humanities programs as a starting point for conversations about bedside manner, deeply ethical research on human subjects, empathy and other physician training exercises. The play was a cultural phenomenon that became the darling of regional companies’ seasons, with several high-profile productions nationally, spawning an Emmy-winning movie and a 2012 revival that was also its Broadway premiere.

These plays ask: How does culture support or undermine survivors? What is the role of the caregiver in the experience of breast cancer? Where and how can physicians locate the line between pushing the bounds of research and maintaining ethical and humane practices? What is the role of theatre in reflecting and intervening in culture? To address this final question, I respond with more: Can *My Left Breast*, a play deeply situated in its historical moment, maintain relevance in 2012? I believe it can by resituating the play within our current neoliberal context, primarily through discussions in the post-show workshop. Why choose *My Left Breast* in combination with community-based techniques? According to Cohen-Cruz, community-based theatre is about stories. Because *My Left Breast* is a true story of illness and one of my goals was to prompt audiences’ own acts of autobiography, community-based theatre’s emphasis on story and direct community input parallel my own.

**Chapter Overview**

Chapter One, “Material Concerns: A Challenge to Neoliberal Pink Ribbon Culture Through Community-Based Theatre,” is an analysis of the possibility of community-based theatre to create a polyphonic counternarrative to rewrite the dominant
narrative of pink ribbon culture. I define community-based theatre and position my own work along a continuum of case study examples. Through a materialist feminist lens, I problematize pink ribbon culture, examining the ways in which patriarchy and neoliberalism produce and reproduce it.

Chapter Two, “Telling Through Troubled Territory: The Politics of Performed Autopathography in Susan Miller’s My Left Breast,” is an examination of illness narratives performed with goals of social change. Using textual and performance examples from My Left Breast, it explores the struggle between the therapeutic goals of autopathography for the individual and the goals of feminist performance to resist silences, colonization, and socio-political norms, and challenge the objectifying gaze that focus on broader communities. In it, I present Arthur W. Frank’s concept of ‘the wounded storyteller’ that uses stories to recover a lost voice, along with the narrative strategies used to accomplish that goal. Pushing from the page to the stage, the chapter also examines the role of performativity and embodiment in meaning making. The chapter concludes with an outline of the challenges and limitations of autopathography.

Chapter Three, “Pushing Toward Praxis: Reflections on Process in a Community-Based Theatre Production of My Left Breast,” posits my work as a kind of pedagogy and argues that participants’ learning was facilitated by a synthesis of meaning making derived from the workshop structure and the performance itself. Exploring the critical pedagogy underpinning of community-based theatre, I transparently examine the process of creating, executing and making meaning from the performance of My Left Breast and its accompanying post-show workshop. Discussing each activity in detail, I use an aesthetic education framework to assess the audience’s learning.
Works Cited


CHAPTER ONE

Material Concerns: A Challenge to Neoliberal Pink Ribbon Culture
Through Community-Based Theatre

“We are all actors: being a citizen is not living in society, it is changing it.”
-Augusto Boal

Community-based theatre is one applied theatre form with great potential for sparking civic dialogue regarding public perceptions of breast cancer and investigating ways in which audiences think about and perform philanthropy and citizenship, but facilitators face challenges in the application, as I discovered through my own recent workshops. Effective community-based theatre facilitators must be cognizant of the cultural influences that construct their moment in history, as suggested by French Marxist philosopher Louis Althusser:

[D]ealing with the ‘heart’ of a problem entails the artistic practitioner's profound knowledge of his moment in history, an understanding of the unresolved social and cultural contradictions that provide the backdrop for which the artistic creation itself helps to serve as antidote and also a presentation of a theoretical frame of reference (albeit tentative and subject to change) for future practice. (Kowsar 3)

Althusser suggests, in effect, what some would consider simply good theatre: work grounded in historical context that reaches toward the intersection of theory and practice. In addition to the history of breast cancer treatment and advocacy previously explored in the introduction to this thesis, ‘an understanding of the unresolved social and cultural contradictions surrounding the experience of breast cancer in contemporary America must take into account the impact of pink ribbon culture and its associated neoliberal philanthropy. In order to develop the concept of a polyphonic counternarrative, I must first fully understand the how culture is working on and through dominant narratives.
Defining Community-Based Theatre

Community-based theatre is an interdisciplinary applied theatre field containing a broader range of forms than its simple name implies. Distinct from ‘community theatre’ which is, simply put, amateur theatre, community-based theatre is “a field in which artists, collaborating with people whose lives directly inform the subject matter, express collective meaning” (Cohen-Cruz, *Local Acts* 1). The form encompasses a wide range of practices and intentions and influences:

- Its practices range from grassroots oral storytelling to formal techniques created by professional artists. Its theories build not only on ideas about art, but also on concepts from education, therapy, sociology, anthropology, the emerging field of dialogue studies, and community organizing. (Cohen-Cruz, *Local Acts* 1)

A commitment to making art with direct community involvement binds all of these together, though even the level of community input exists along a spectrum among artists.

At a deep level, artists immerse themselves in a community, living with and observing community interactions much in the manner of anthropological fieldwork. Tordis Landvik’s 2005 project focused on the Nordic community of Björkevatn who were distressed by the erosion of the local Samic language and culture. Landvik’s two year residency built upon the anthropological research and a script that two locals had already begun, using storytelling and the actors’ own memories to draft a work that celebrated Björkevatn’s Samic history and interrogated its loss. Landvik’s task was “to work alongside” the playwright and “to listen to the actors stories and direct them into the script and scenes” (7). The entire cast spoke only Swedish, but they learned South Samic for the performance of *Vattufall*. As a result, many locals began to want to learn ‘the old language,’ and all Samic Theatre productions will be performed in South Samic for the local Björkevatn community.

Other community-based theatre artists may engage with local community organizations to frame a message and sketch out plans before visiting the project site for a residency during which they develop the work to its culmination with direct input from the community. The artist may simply serve as facilitator/director, assisting community members in developing and performing their own content. This was the case of
Bournemouth Theatre in Education’s 1997 play *Undercliff and over Heath*, which was written and performed by a group of teenage boys and community members under the guidance of facilitators, who in turn consulted with the boys’ teachers (Horitz 71-72). Their play celebrated the town’s history and was performed for the town’s general public at the local art gallery and museum. By contrast, Liz Lerman Dance Exchange develops the work with community members, but professionals edit, shape and perform it publicly (Korza, Bacon and Assaf 181).

Finally, artists may seek to gain traction in a given community by partnering with local community organizations with common goals, using a pre-existing text to explore an issue and spark civic dialogue following the performance. This was the goal for my workshops, and is the model that artist/activist Rha Goddess follows. “Beginning long before each performance, Goddess identifies key community organizations that fit with her mission so that she can collaboratively plan and offer activities and provide services and information to audiences” (Callahan 2). After securing this collaboration, Goddess performs her own one act show, *LOW: Meditations Trilogy Part I*, which examines the myths and stigma of mental illness. She follows up the performance immediately with a workshop, hoping:

> to create a safe space for audiences right there in the theater to confront issues around mental health that might not happen in another context. By having professional counselors lead these discussions and researchers document and evaluate their effectiveness, Goddess also hopes to create greater collaboration among mental health professionals, artists, and eventually those who might want to replicate this effort in their own communities. (Callahan 3)

It is the advance partnership with local organizations and the follow-up workshop that asks the audience for their direct input and connects them to local resources that keeps this model in the realm of community-based theatre. Depending on how it is positioned within the community and along this spectrum, community based theatre artists work with greater or lesser amount of explicit political motivation.

In the community-based theatre model that I follow, engaging a specific dramatic text is not the chief end of the performance event. In reality, the focus is on the interactive post-show workshop or talkback. “The emphasis on follow-up being equal to,
or more important than, performance positions audiences as witnesses rather than spectators *per se*, with an invitation to participate…” (Cohen-Cruz, *Engaging Performance* 81). The repositioning of the audience gives them both more power and more responsibility to engage and become part of the work accomplished in the performance. Anne Ellis says, “The focus is not on understanding theatrical craft or appreciating the skill of directors and designers, but rather on the potential for communities to express their own anxieties and hopes” (91-92). Certainly, delivering an excellent product is important, but that product’s importance is reimagined as a means to gather a community with both common and diverse experiences with which to dialogue. Ellis describes this process artfully: “Using performance not as an object of art to be studied and appreciated but rather as a catalyst for dialogue about issues of particular interest to an audience, community-based performers are engaging audiences in startling conversations precipitated by performances” (92).

Using the model Ellis describes creates room for movement along the continuum of impact suggested by Animating Democracy. They suggest that social movements progress from new knowledge (awareness) to a change in discourse (deliberation, media), which leads to new attitudes (values, motivation, vision), which create new capacities (leadership, creative skills, civic engagement), which prompt action (participation, mobilization) and results in a policy change (systems, conditions, access, equality). Individuals within the audience entered the performance space at different places along this continuum of impact relative to their relationship with and knowledge of pink ribbon culture. They respond to the work of art and the following dialogue from their own position, hopefully advancing along the continuum.

At its heart, Cohen-Cruz says, community-based theatre is “a field grounded in story” (*Local Acts* 1) with “an emphasis on participation and access” (“Ecology” 10) and its source “is not the singular artist, but a ‘community’ constituted by virtue of a shared primary identity based in place, ethnicity, class, race, sexual preference, profession, circumstances, or political orientation” (*Local Acts* 2). I would also dare add ‘disability’ to the list. The experience of catastrophic illnesses or disability as a ‘primary’ site of identity in terms of lifelong personhood, such intensely acute experiences can serve as an important locus of identity for some individuals. So while perhaps not ‘primary,’ breast
cancer survivors’ common experience of illness may serve to constitute a temporary kind of community. Common experiences of disability and illness do not connote a universality of identity or experiences within the disability community any more than the common ground found among other minority groups, and some breast cancer survivors may well reject identification with disability. Cohen-Cruz also draws a line between other multidisciplinary applied theatre forms and community-based theatre, saying that those “practices grounded in education or therapy are community-based theatre’s cousins, not siblings” (Local Acts 6).

**Utopia and Contradiction**

Theatre for social change and community-based theatre often spring from artists’ utopic urges. In her work *Utopia in Performance*, Jill Dolan’s utopia is admittedly idealistic, but also self-aware and critical, and her resistance to proscription falls in line with the core philosophies of community-based theatre which emphasize agency and self-determinacy in the hands of each audience member. She describes it as a fleeting performative moment, similar to the overtones⁵ (what she calls “phantom notes”) experienced in music. When a chorus sings with perfect harmony and resonance in an acoustically sound space, their resonance creates a phantom note that can be heard; it is not sung by the choir, rather the resonance itself creates this phantom at intervals above the fundamental notes being voiced. For Dolan, utopian performatives are “phantom notes with community resonance and social implication” (18). These implications may be limited in scope, seeking only to have an impact upon one’s immediate audience for therapeutic reasons relating to a specific life event, or they may cast a wider net on a larger public stage regarding broad societal concerns.

The oft-identified problem with utopias is that one person’s utopia may well be another’s dystopia. They are fraught with contradiction. In a 1968 student revolt in Paris, students of the Sorbonne demanded “Be realistic, demand the impossible!” (Levitas 83), wholeheartedly meaning both clauses of their chant. They “demand, realistically, what this system declares to be impossible” (Levitas 83). Herbert Marcuse argues that “art was

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⁵ For more information on the construction overtones and harmonics in music, see “Harmonics” in the *Grove Music Online* database.
the primary site for the articulation of utopian desire” (Levitas 84). Community-based theatre expresses the weaving of utopian desire, art, and conflict in its ability to both celebrate and critique culture at the same time. Cohen-Cruz calls it, “an unwieldy field, seemingly contradictory. It spans performances committed to social change along with those whose purpose is the conservation of local cultures, sometimes both at once” (*Local Acts* 1).

Asking Dolan’s question, “What am I consciously or unconsciously resonating with in culture?” proceeds from Erving Goffman’s frame analysis question, “What is going on here?” Frames are organizational structures that help individuals make meaning out of their experiences of society. Polletta and Ho say that, “Frames matter. The ways in which political actors package their messages affect their ability to recruit adherents, gain favorable media coverage, demobilize antagonists, and win political victories. The ways in which ordinary citizens think about gains and losses shape their political preferences…” (188). Frames matter because they tell us what phantom notes people are resonating with. They matter because in order to promote change, advocates must be able to understand their own framework and that of rivals. “Since ignoring rival frames puts a group at risk of seeming off-topic or evasive, movement groups often find themselves forced to counter, debunk, co-opt, or conform to opponents’ frames in their own public statements” (Poletta and Ho 193). So then, we must study both the resonant and dissonant frames (or phantom notes) in order to truly understand the multiple experiences of breast cancer. In this case, the rival frame is the dominant narrative of pink ribbon culture, but even mainstream culture has its part to play in a social movement. At a certain point, every social movement reaches a tipping point when it will either be picked up or absorbed into popular culture, or it will die out (Gladwell). Community-based theatre both reflects that culture back at audiences and offers opportunities for glimpses of possible utopias, of better futures for communities to move toward.

**The Pink Ribbon and Neoliberalism**

Any workshop facilitator hoping to address the experience of breast cancer must be cognizant of challenges stemming from the cultural baggage that informs and shapes
the experience as individuals resonate with the ‘phantom notes’ of a pink ribbon culture that is deeply rooted in neoliberalism. Neoliberalism may be defined as:

a philosoph[y] that sees market values as permeating all aspects of life, including not only the economic, but also religious, ethical, political, personal, and educational dimensions. The neoliberal sees all reality as a series of market transactions and places a value on all human endeavors, from philosophy to health care, from religion to law, in terms of quantifiable deals that can be assessed objectively. (Sukys 1).

The economic and social policies of Margaret Thatcher and Ronald Reagan gave rise to neoliberalism, and the world has not been the same since, with grand ideas of economic theory ‘trickling down’ into the way many Americans frame what it is to be ‘a good citizen’ or a socially conscious individual. This marked a significant shift in the way Americans thought about citizenship and philanthropy in the latter part of the twentieth century. Frequently, especially in terms of breast cancer activism, this manifested through a focus on consumerism or funding on a large scale, with less focus on patient recovery, support to family members, locally-based initiatives, or any number of other altruistic concerns. Within a framework of neoliberalism, everything imaginable is for sale so long as consumers are willing to pay. Critiques of neoliberalism come from multiple fronts. They often note its application in efforts toward globalization and privatization that homogenize diversity and target anything that ‘interferes’ with the free market, including laws that frequently provide vital protections for minoritized or socially vulnerable subjects. LGBT groups have not remained unaffected by the pervasive effects of neoliberalism. Queer and crip theorist Robert McRuer says that:

[A]ctivism on behalf of same-sex marriage often positions gay people as the perfect neoliberal subjects. … ‘the family’ takes on an increasingly important role as the provider of goods and services like caring labor for those who are young or elderly. Some gay marriage advocates have happily embraced the idea that gay

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6 One of the most readily visible examples is the popularity of and deep investment in the Komen Foundation’s Race for the Cure as a primary means to fight breast cancer.

7 For example, collective bargaining rights, the Civil Rights Act and the Americans with Disabilities Act have all come under fire from neoliberals claiming that they are outdated and interfere with businesses’ abilities to operate competitively within a globalizing free trade market.

8 Much in the manner that LGBT advocates have reclaimed the pejorative ‘queer’ for their own purposes, many in the disability studies movement work to reclaim ‘cripple’ through the use of ‘crip.’
people will take up these responsibilities for their newly formed families without asking anything more of the government than the right to marry. Such narrow campaigns for gay marriage do not support the right to develop a multitude of different kinds of relationships that might provide caring labor, nor do they support social responses, such as government-supported day care, to the question of who is to provide labor. In other words, when gay marriage is promoted in neoliberal terms, gay marriage activists are willing to accept and even promote privatized understandings of the need for care in exchange for mainstream ‘acceptance’ of gay relationships. (n. pag.)

Neoliberalism’s privileging of certain types of families reduces LGBT rights advocacy to a single issue of marriage equality, distracting from a myriad of other issues that require attention. McRuer goes on to talk about the ways that this thinking trickles through to the disability movement, which faces the same struggle with the choice between assimilation into the mainstream and fighting for broad societal change (or visibility versus invisibility, pride versus the closet). He says, “The good disabled subject is similarly the one most distanced from queerness (that is, the unruly kind of queerness that cannot so easily be domesticated). Similarly, [mainstream LGBT advocates seek to] deemphasiz[e] … issues that might more directly be comprehended as disabled: unemployment, homelessness, universal health care” (McRuer). This homogenizing swing toward the mainstream is a result of the globalizing and privatizing effects of neoliberalism that served to shift attention away from “a vibrant HIV/AIDS politics focused on exposing and countering institutionalized oppression, and toward a plea for marriage rights and recognition” where such “recognition and flexible incorporation into that world comes with the expectation of privatization and consumption” (McRuer).

The market drives all for the neoliberal, including philanthropy. Feminist scholars as well as a number of breast cancer survivors increasingly critique pink ribbon culture, both for its neoliberal threads and its gender-based identity politics. Part of the modern feminist criticism of the pink movement centers on the way it forces women into highly normative molds of femininity and acts to ‘pretty up’ what is ultimately an extremely ‘ugly’ disease. And while men and women with the best of intentions populate the movement, they are often unknowingly complicit in marginalizing and/or alienating the
very survivors they fight for. Cultural views of breast cancer and the men and women afflicted by it have shifted significantly over the last thirty years. From enduring stigma, to honored as brave for speaking out and creating awareness about the disease, all the way to being cast as “cancer heroes,” today’s survivors are seen as perpetually upbeat activists wearing pink and running endless Races for the Cure. Yet with a massive campaign⁹ that largely ignores minorities of any kind, where does everyone else fit in? Queer women, women of color, women whose budgets don’t include pink products at inflated costs, women who define their experience of femininity in non-standard terms, and men among others have been marginalized and largely ignored by pink ribbon culture.

Calm, soothing and pretty, the pink aesthetic plays into normative modes of femininity and perpetuates a kind of compulsory optimism that requires women to swallow their pain, despair, and rage in favor of a more socially acceptable and pliant attitude of hope. Renowned womanist scholar bell hooks sums it up nicely: "Pink is all about submission. I wanted to defy" (27). Brave souls who dare to speak up with a voice that differs from the status quo face severe backlash. This returns us again to the framework of local autonomy versus corporate control (paralleled by the emphasis on audience participatory input in community-based theatre compared to a traditional commercial theatre aesthetic). While hooks wrote about the color pink in a context apart from pink ribbon culture, her point remains germane. On one hand, pink ribbons have effectively conditioned our culture so that they easily command our attention and can be used to inform the public of previously unknown information. On the other, such a powerful icon can command can turn into manipulation or oppression in the absence of ongoing critical reflection. The pink ribbon is a ‘thing,’ in the Heideggerian tradition,¹⁰

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⁹ Government-funded breast cancer research for fiscal year 2013 is estimated at $805 million for the National Institutes of Health and Department of Defense at $120 million. According to year-end 2012 tax filings reported on charity vetting site CharityNavigator.com, its ranked breast cancer charities (i.e., public organizations with annual revenues in excess of $1 million reported for four years or more) brought in more than $457 million last year. The Susan G. Komen Foundation and the Breast Cancer Research Foundation accounted for $340 million and $53 million, respectively. This also accounts for neither large private foundations (like the Avon Foundation for Women and it’s $73 million annual average), nor the hundreds of charities nationwide who don’t currently meet the ranking threshold, nor charities who fund breast cancer initiatives as well as for other cancers.

¹⁰ For a complete introduction to thing theory, see Martin Heidegger’s *What is a Thing?* (1970) and Eugene T. Gendlin’s companion analysis thereof.
what cultural historian and performance theorist Robin Bernstein would call a ‘scriptive thing,’ that is, “an item of material culture that prompts meaningful bodily behaviors. … [It] reveals a script for a performance” (71). The gender-coded, socially-constructed aesthetic of the color pink is directly linked with cultural formations of ‘proper’ femininity: innocence, lightness, sweetness, softness, delicacy, childhood, and other similarly passive descriptors (Koller 405). The pink ribbon scripts heteronormative feminine passivity for the viewer. Bernstein notes that individuals may “resist, revise or ignore instructions” (71) from scriptive things, which accounts for the existence of non-dominant stories of resistance, but the endlessly repeated message of proper behavior has clearly been received by the community of survivors.

The Problem with Pink

Though breast cancer advocacy proudly claims roots in the women’s health movement, one of the most troubling aspects of pink ribbon culture is its unintended impact on the cancer victims it seeks to aid. Pink ribbon culture is most easily identified within organizations that focus on a primary outcome of awareness through a neoliberal paradigm of consumer-based philanthropy, though not all breast cancer activist organizations fall in this category. The most notable neoliberal influenced organizations are the Susan G. Komen Foundation and Breast Cancer Charities of America. Though each organization’s mission statement stipulates a commitment to research, their website front pages are dominated by hyper-feminine pink images and links to pink ribbon shopping opportunities. Evelyn Lauder’s 1992 appropriation of a grassroots movement’s peach ribbon so that the iconic pink ribbon could be distributed at cosmetics counters was perhaps the first direct connection of breast cancer advocacy as a salable commodity to the market, marking its neoliberal beginnings. Where the Komen Foundation exemplifies pink neoliberalism on the right through its emphasis on consumerism, Breast Cancer Action typifies grassroots advocacy from the left. They are actively involved in political lobbying and grassroots letter-writing campaigns urging corporations to cease pinkwashing practices. They created a list of “Think Before You Pink” questions urging consumers to actively consider the companies behind the pink ribbon products they purchase.
1. Does any money from this purchase go to support breast cancer programs? How much?
2. What organization will get the money? What will they do with the funds, and how do these programs turn the tide of the breast cancer epidemic?
3. Is there a “cap” on the amount the company will donate? Has this maximum donation already been met? Can you tell?
4. Does this purchase put you or someone you love at risk for exposure to toxins linked to breast cancer? What is the company doing to ensure that its products are not contributing to the breast cancer epidemic? (Think Before You Pink)

Between these poles, more than a thousand breast cancer charities currently operate in the US that fall along the pink continuum; the following are a few such notable examples. Despite her involvement in the pink ribbon’s contested beginnings, Evelyn Lauder founded the Breast Cancer Research Foundation, one of today’s leading breast cancer charities. And even though the BCRF predictably employs the pink ribbon in its literature and shopping for pink ribbon products is available on its website, these things are secondary to the preventative research that it funds (About BCRF). In 2009 ‘Out of the Shadow of Pink,’ ‘The Brandon Greening Foundation’ and Herb Wagner of ‘A Man's Pink’ joined forces to establish a Male Breast Cancer Awareness Week” (Male Breast Cancer). Finally, Brides Against Breast Cancer sells wedding gowns, both new items donated from designers and gently used ones from newlyweds, to raise money for free programs for cancer patients, their families and caregivers. It can be difficult to navigate through these hundreds of breast cancer charities to distinguish the ones most deserving of support. While many are excellent choices, some fall short due to inefficient wasting of funds while a few have sadly proven downright predatory, and sound-alike charity names can make it even more difficult to sort through the pile. CharityNavigator is one great web-based resource to help consumers choose charities with transparent and ethical business practices. In combination with Breast Cancer Action’s “Think Before You Pink” questions, would-be donors can make better-informed choices.

11 The National Breast Cancer Coalition is one of the country’s largest and most reputable breast cancer charities. Long Island-based Coalition Against Breast Cancer, however, raised nearly $10 million from donors but spent only about $48,000 to combat the disease. A recent lawsuit resulted in a $4.6 million judgment against them. Grand larceny and fraud charges are still pending, along with a civil suit (Associated Press).
Further problematizing the impact of pink ribbon culture upon survivors is the deluge of pink products with pink ribbons that began with Estee Lauder Cosmetics in 1992 and steadily expanded since then. From t-shirts and bumper stickers to cat food, yogurt and hammers, it seems that no product is exempt from cause-based marketing that targets a demographic of people who care about breast cancer. Though such marketing does succeed in raising money for cancer research and charities, many survivors are angry at what they identify not as companies out to genuinely support them and their cause, but rather as corporate greed that is actively exploiting the disease and working to make a buck off of their pain. Jeanne Sather is a metastatic breast cancer survivor and author of the blog “The Assertive Cancer Patient” who has lead an annual boycott of NBCAM since 2008. In an interview with *The Boston Globe*, she said, “For those of us with breast cancer, it’s like getting hit in the face… The companies are making money off my disease- even if they’re giving an amount to charity, they’re making so much more in profit” (Frieswick). In a comment posted to the 2011 article “I Don’t Need the Color Pink to Remind Me of Breast Cancer” on the Care 2 Make a Difference website, user “Tami M.” stated, “I hate the color pink now. When I see it, cancer, chemo, radiation, it all jumps out in my face… I want nothing pink around me again.”

The practice of ‘pinkwashing’ further complicates reactions to sales of products to raise funds for breast cancer research. Pinkwashing can be defined as “a practice whereby corporate actors seek to legitimize their products via the creation of language and imagery that obscures the often harmful nature of some consumer products while simultaneously producing a positive corporate image” (Lubitow and Davis 141). These may be products that contain carcinogens, contribute to environmental pollution (which many now believe to be a primary cause of the disease), or increase risk factors in another way. Yoplait’s pink-lidded yogurt contained rGBH, a hormone linked to increased risk of breast cancer, until anti-pink activist group Breast Cancer Advocacy’s campaigning resulted in its removal, with competitor Dannon following suit soon after. Car manufacturers churn out pink vehicles whose polluting emissions contribute to a more carcinogenic environment, and even Susan G. Komen, the most trusted name in pink, recently released a fragrance which contains hazardous toxic chemicals that are not
even listed within the product’s ingredients. Komen has since promised to reformulate (Think Before You Pink, 5).

Other survivors see the pink as a means to infantilize them and decenter their power. The proliferation of pink stuffed animals, Barbie dolls, cookies, candies and more makes a mockery of the incredible struggle of surviving breast cancer. User “Miranda L.” comments on the aforementioned article: “Many adult women resent having their experience with cancer infantilized a with all the pink ribbons and pink balloons and pink teddy bears and pink ad nauseum.” Friends and family who purchase such products do so in the belief that they’re not only contributing toward breast cancer research, but also acting in solidarity with their ill loved one, when they may also be making it more challenging to escape an already difficult reality. The sad truth is that these products contribute to an emerging trend of American ‘slacktivism’ through social media. That is, a minor act requiring little effort on the part of the ‘slacktivist’ that is represented to perform some social good. For example, the recent deluge of “Kony 2012” videos calling for the removal of Ugandan warlord Joseph Kony posted on facebook allowed users to feel good about ‘doing their part’ in helping to prevent more child soldiers’ recruitment into the guerilla warfare he leads. The act of posting the video itself is not a negative thing; the danger lies in that it has little impact yet fulfills the urge to be a part of a cause and prevents the slacktivist from feeling the need to engage in more materially impactful action later. This goes hand in hand with the trouble of campaigns such as that of the pink ribbon movement who focus on awareness as the central goal with no clear action item for message consumers to follow.

**Pink’s Deadly Consequences**

Many survivors and patient advocates claim pink ribbon organizations focus on ineffective strategies; they are determined to find the *cure* rather than the *cause*, and that their focus on mammography reinforces the status quo rather than pushing for advances in treatment options. They beat their drums for “awareness,” but fail to specify what exactly that means; furthermore, their message remains fundamentally unchanged in the last twenty years. It was very effective in its early days. The push for awareness found significant success in undermining the stigma of the disease, got women talking about
their health, and pushed them to be better self-advocates in their relationships with their doctors. Unfortunately, the pink ribbon movement has failed to build upon that success by adjusting their course to continue gaining new ground. The narrative of optimism that began as a liberatory means to free women from shame and stigma shifted from its subversive beginnings to become the mainstream narrative over time, so much so that it now tends to shut out stories that deviate from this new norm. Social movements run in cycles, so when one arrives at the final goal of improved policies/ equality/ access, etc. indicated by the continuum of impact, the job is not done. Culture continues moving and shifting, sometimes forward, sometimes back, so activists find themselves constantly starting back at square one in order to maintain tapped into the heartbeat of the social will. The static state of pink ribbon culture may actually act as a roadblock to further political and scientific progress:

Bathing our landscapes in pink is lovely, but it does not demand change: pink does not force corporations to account for the realities of a toxic environment that causes cancer; pink does not challenge medical procedures that disfigure women while keeping open the possibility of recurrence, nor does it halt the ‘treatments’ that cause substantial illness and pain; pink does not question government policies or pharmaceutical companies that push dubious, if not dangerous, drugs; and pink does not demand fundamental changes in the health care system. In short, the consensus movement built around pink works, in fact, as a blockage to real political action. (Elliot 529)

‘The consensus movement built around pink’ pivots on a self-help discourse that distracts from corporate responsibility and a focus on broad, systemic change and places the onus of wellness on individuals.

Neoliberalism finds its roots in individualist objectivism. The individualism is clearly seen through an emphasis on self-reliance readily illustrated by the American Dream. Individuals are responsible for their own destinies, for pulling themselves up by their own bootstraps. And despite the utopian kernel embedded in the American Dream, it (and it’s individualist underpinnings) deny the cultural forces at work that ensure that

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12 For further reading on objectivism and neoliberalism as global concepts, see “Social Construction of International Society” by Timothy Dunne.
the playing field is not level for everyone. Race, class, gender, sexuality and/or disability can serve as major obstacles to the social mobility that individualism promotes. A subset of individualism, objectivism is a philosophy currently enjoying resurgence in popularity thanks to high profile politicians on the far right\(^{13}\) espousing loyalties to the writings of objectivist icon Ayn Rand. Rand’s most notorious tenet is “the virtue of selfishness.” She says, “The pursuit of [man’s] own rational self-interest and of his own happiness is the highest moral purpose of his life” (Rand). In this framework, corporate executives are morally bound to pursue profit for themselves and their shareholders by any means necessary.

Pinkwashers have a vested interest in keeping public focus on pursuing a cure rather than a cause; if we were to instead take notice of their complicity in the crisis by creating products laced with carcinogens or engaging in production methods that damage the environments of the communities they’re headquartered in, they would stand to lose significant profits from the turn in public goodwill. And when corporations do step into the realm of prevention research, it is often so that they have a hand in influencing the scope of such studies and therefore limiting their findings. “Prevention studies sponsored by corporate dollars that focus on women’s individual behavior (drink less wine, lose weight, have babies early) fail to address the root causes of this disease because [they] are inextricably connected to corporate practices and profit cycles” (Jaggar). These studies spin the corporate narrative into one that they hope will resonate with a culture of self-help and individual responsibility in order to blame the victim for lifestyle choices and shift the focus from their dubious activities. Barbara Ehrenreich, feminist, women’s health activist, biologist, and breast cancer survivor, wrote a scathing article for Harper’s Magazine in 2001, warning readers of the dangers of undervaluing the threat of environmental causes, saying that such action creates “dupes of what could be called the Cancer Industrial Complex: the multinational corporate enterprise that with the one hand doles out carcinogens and disease and, with the other, offers expensive semi-toxic pharmaceutical treatments” (Ehrenreich 52).

\(^{13}\) Notable examples include 2012 Vice Presidential candidate Paul Ryan, and libertarian demagogue Ron Paul, who so admired Rand’s work that he named his son, Rand Paul, after her.
“Early detections saves lives” is the predominant message of many breast cancer charities; they inform women of the prevalence of the disease and then urge them to get screened. Cultural forces do their job extremely well; consumers hear this so frequently and with such little variation that they overemphasize mammography as the sole trusted solution. This message is dangerously reductive, and Breast Cancer Advocacy Executive Director Karuna Jaggar recently wrote that it “is literally costing us lives.” It provides false hope and fails to acknowledge significant limitations to mammography. “At best the evidence for the salutary effects of routine mammograms -- as opposed to breast self-examination -- is equivocal, with many respectable large-scale studies showing a vanishingly small impact on overall breast-cancer mortality” (Ehrenreich 51-52). She goes on to note that mammography results in as many as four false positives for each actual cancer it detects, thereby causing countless healthy women to unnecessarily undergo the terrifying process of biopsy and awaiting confirmation of results. Other oncological experts have said that mammography’s benefits "are not well established; if they do exist, they are not as great as many women hope," and that it may in fact be "one of the greatest deceptions perpetrated on the women of the Western world" (Ehrenreich 52).

And while pink ribbon culture deceives women, it leaves male breast cancer out of the equation nearly altogether. More than 2,000 men are diagnosed each year (breastcancer.org), and the pink movement ignores the impact of breast cancer upon their lives, particularly devastating since such men don’t have access to the same support structures as women. The prevalence of pink reinforces the falsehood that breast cancer is a woman’s disease; experiences and identities which fall outside the pink norm result in erasures with devastating and deadly effect. Men are exponentially less likely to recognize or promptly seek treatment for symptoms. This delay in means that men are generally diagnosed in the advanced stages of the disease, and once they have gathered the nerve to ignore the stigma and get help they often receive suboptimal care lacking sufficient research to implement an effective treatment protocol. 31 percent of diagnosed men die each year compared to 20 percent of women (Perkins and Middleton 239-40). The ocean of pink sends them the message that they must fight the battle on their own, handling the betrayal of their own bodies at the same time they must fight against a
gender-based cultural stigma that emasculates and demoralizes them. This is especially ironic since the pink ribbon movement initially sprang forth to work against the stigmatizing dominant narrative at the time.

**Why Community-Based Theatre?**

Community-based theatre functions as a particularly effective strategy in rewriting the dominant pink narrative because: 1) it parallels the participatory culture of neoliberal philanthropy, encouraging civic action, and 2) it resists generalizing and values the local over universal myths and formulaic narratives. I seek the emergence of a polyphonic counternarrative that opens a space for audiences to unmake cultural myths surrounding breast cancer, and community-based theatre makes this possible because it is “both about building and reflecting community in recognition of the fluidity and multiplicity of identities” (Cohen-Cruz, *Local Acts* 4). Gayle Sulik’s extensive and insightful work *Pink Ribbon Blues* is an important voice in critiquing the dominant narrative of pink ribbon culture in which she engages its pervasive optimism and resultant mythologies. She marks the emergence of the “she-ro,” “a feminine hero with the attitude, style, and verve to kick cancer’s butt while wearing 6-inch heels and pink lipstick” (16).

This emphasis on the hero/ she-ro has had a profound impact upon the language surrounding breast cancer, and Ehrenreich’s postmodern evaluation of the discourse that emerges from what she termed the breast cancer ‘cult’ (an interesting hyperbolization of ‘culture’) proves enlightening. Once again, almost all of the language surrounds the ‘survivor,’ and the admonition that ‘you’ve got to think positively.’ Mentioned less frequently is the woman currently undergoing treatment, though a sufficient label for her is more difficult to ascertain. ‘Patient’ is too medicalized, and ‘victim’ receives heavy censure for its darkness and negativity. These women are assigned verbs instead of nouns. They are ‘battling’ cancer. This battling may be modified by an adverb, but the lack of solid identity conferred by a noun remains, indicated by the warfare language surrounding the phenomenon. This lack of a noun is no simple resistance to labeling; it is another erasure, a denial of the struggle during the period when it is most real. Once this
noun-less figure reaches remission and conforms to the hero narrative, only then is she
gifted with the title of survivor and granted full access to the community of survivorship.

Even worse, women who ‘lose the battle’ do not receive the dignity of identity
even in death. “In the overwhelmingly Darwinian culture that has grown up around breast
cancer, martyrs count for little; it is the ‘survivors’ who merit constant honor and
acclaim” (Ehrenreich 52). In the discourse mandated and trademarked by the Susan G.
Komen Foundation, ‘hope for the cure,’ spawns ‘run for the cure,’ ‘bike for the cure,’ and
‘shop for the cure.’ Tellingly, the emphasis here is upon the easily commodifiable cure
rather than upon the individual women battling the disease. American culture glorifies
youth, health and beauty; age, illness and disfigurement seem only to enter the
conversation when the focus is upon an individual who has overcome them as obstacles.
Sulik further states that this model undermines the traumatizing experience of diagnosis
and:

creates the impression that diagnosed women should feel proud of the experience
and use it for transformative purposes. Pride and transformation require optimism,
the cornerstone of survivorship. …Optimism translates to a brand of social
support that almost demands commodification of the illness and a model of
survivorship focused on acquiescence to mainstream ideals. (16-7)

When a culture refuses to entertain or deal with death or disappointment in any realistic
manner, what is left but a focus on optimism and survivorship?

Samantha King’s *Pink Ribbons, Inc.* has become the manifesto of resistance to the
commoditization of breast cancer. She says that “participation in consumer-oriented
philanthropic activity represents a yardstick against which the capacities of individuals to
become ‘proper’ Americans are measured” (xxix), and despite philanthropic citizenship
proponents’ claims that it is “something we can all support and participate in regardless
of our social location or political leanings… such renderings rely on the erasure of power
relations that undergird charitable works and [deny]… the deeply class-structured,
racialized, and gendered deployment of philanthropic practices as an idea of citizenship”
(xxx). If consumer culture provides the way to become a good citizen, but individuals
have no discretionary dollars to contribute to causes they care about, then by this model,
they are neither good citizens nor proper Americans, regardless of whether they may have found other non-monetary ways to benefit the cause.

Consumer-based philanthropy marries the public’s desire to feel good about themselves through altruistic gestures with the Randian objectivist ideal of getting something in return. When shoppers buy pink ribbon-branded products, their purchases perform on multiple levels. Along with the physical merchandise, they receive the warm glow of self-activated altruism from their perceived role in the manufacturer’s donation to a breast cancer charity (regardless of the reality of how shockingly low the donation is from each of these products). They also get to cash in on the added benefit of publicly performing their good deeds. Bright, eye catching and splashy, pink products from water bottles to t-shirts and cars demonstrate over and over again consumers’ implied generosity to the breast cancer cause to all who may see them. Exercise-based fundraising follows a similar model. Runners for Susan G. Komen’s ‘Race for the Cure’ bathe themselves in pink kitsch as they run through the race routes on what are generally high visibility downtown streets. News crews cover these events locally, allowing individuals and the events’ corporate sponsors to demonstrate their philanthropy to a larger audience and realize a gain in public goodwill, a fiscally quantifiable asset to record on their profit and loss statements.

*My Left Breast: Community-Based Theatre and Neoliberalism in Context*

Between November 2012 and February 2013, I facilitated a series of workshops in Hamilton and Oxford, Ohio following performances of Susan Miller’s *My Left Breast* designed to engage the audience on matters relating to illness, loss, and breast cancer.14 Writing at a time when discussions of breast cancer were still very taboo, Miller’s 1994 play makes a political statement about the experience breast cancer and mastectomy. She provides the audience a view of a woman who shunned the role of ‘cancer hero’ and recalls a range of emotions and experiences with stunning vulnerability in order to get audiences talking and undermine the stigma associated with the disease. *My Left Breast*’s construction around a central theme of loss expands the relevance of the work to a broader audience, maximizing possibilities for civic dialogue through the identification of

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14 While I begin discussion of the workshops here, please see Chapter Three for in-depth analysis.
different types of loss: her lovers, her infant son, and her son’s growing independence. It seems that Miller recognizes that most in her audience will never have lost a breast or an appendage, so she positions the breakup with her longtime partner and love of her life as the symbol of that loss; it is the nearest she can come to describing the emotional impact of mastectomy to someone who has never experienced it.

Following each of five performances, audiences participated in a workshop rooted in community-based theatre techniques addressing their own experiences with illness and loss. Drawing on methods from Augusto Boal, Michael Rohd, and John O’Neal, I designed the workshop to allow multiple voices and experiences to speak at once, both through speech and embodiment. As each workshop unfolded, many of the audience members participating in the workshop demonstrated conflicting ideas about the problem of breast cancer culture: a personal and active voice of resistance to a singular dominant narrative on the one hand, and a neoliberal paradigm of breast cancer activism through consumerism on the other. Workshop attendees participated as they felt comfortable throughout each activity, and a decided majority chose to engage rather than simply sit and listen. This could be interpreted as a desire to be part of something greater than their individual selves. At the same time, some participants responded in ways that reinforced neoliberal ideas of consumer philanthropy, which are rooted in self-interest. When prompted to agree or disagree with a series of statements intended to situate participants in terms of both life experience and opinion regarding cancer, at least half responded positively to the statements “I have run a Race for the Cure or something similar” and “I ‘buy pink.’” Those who responded positively demonstrated a sense of pride in their actions, likely stemming from an interpretation of these activities as a positive meaningful way for them to enact their citizenship in a community of breast cancer patients and survivors.

In a word association workshop activity that followed, one group responded to the word ‘awareness’ as a prompt with the following list: ribbons, campaign, breast cancer, pink, marathons, walk-a-thons, fund-raising, and personal responsibility. Their associations clearly fall directly in line with commoditized notions of breast cancer.

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15 Because the workshops were created with the intent to be used as research, approval was obtained from Miami University’s Institutional Review Board to ensure the protection of the human research subjects.
action. This is hardly surprising in light of ‘awareness’ standing as the primary message of corporate breast cancer advocacy groups. Also note the final contribution of ‘personal responsibility.’ While many of the previous words in the list have connotations of masses of people and public good (dare I say welfare?), neoliberalism’s individualist autonomy of self sneaks back in to literally have the final word.

**Conclusions and Challenges for Practice**

So what is a community-based theatre practitioner/scholar who wants to engage an audience regarding breast cancer to do? I cannot argue that consumer-based forms of philanthropy are totally without merit; they are prevalent because they are both lucrative and well-attended as those impacted by the disease seek a community of mutual experience and a means to take control in an area of helplessness. Many members of my target audience may have significant emotional investments in this kind of community, some to the point that it becomes a major part of their identities. And even as true as this may be, pink ribbon philanthropy is unavoidably problematic. In short, I cannot avoid the problem or the complexity of audience response. I must tackle it head on, but I cannot allow my opinions a place of privilege in the workshops or it undermines the critical pedagogy foundation of community-based theatre. Michel Foucault provides insight into the role of the scholar/artist as expert/facilitator:

> The role of an intellectual is not to tell others what they have to do. By what right would he do so?...it is, through the analyses that he carries out in his own field, to question over and over again what is postulated as self-evident, to disturb people’s mental habits...to dissipate what is familiar and accepted, to reexamine rules and institutions and on the basis of this re-problematization...to participate in the formation of a political will...(265).

I do indeed wish “to participate in the formation of a political will,” but it is the role of the post-show workshop or talkback to trouble or to question, and to prompt civic dialogue surrounding an issue of importance, not to herd participants toward a desired answer. Indeed, it is to be expected that no simple answers will be reached in so short a time following a performance, but if dialogue is sparked, then one goal has been met, and
the seed has been planted. If audience attitude changes as a result of dialogue, then we have moved together through a full half of the continuum of social movement impact.

Working as a community-based theatre artist means growing comfortable with ambiguity, with unanswered and unexpected questions, and with never quite arriving at the ‘utopia’ hoped for. Dolan points out that the word ‘utopia’ literally means ‘nowhere,’ and suggests that:

Thinking of utopia as processual, as an index to the possible, the ‘what if,’ rather than a more restrictive, finite image of the ‘what should be,’ allows performance a hopeful cast, one that can experiment with the possibilities of the future in ways that shine back usefully on a present that’s always, itself, in process. Such a view of utopia prevents it from settling into proscription, into the kind of fascism that inevitably attends a fully drawn idea of a better world. (13)

As much as I may be attached to my ideas, they are limited by my experience, perspective and privilege, and to replace one hegemonic ideology with another is counterproductive at best. To act in a self-serving manner is to reify objectivism and through it the neoliberalism I reject. Despite Rand’s protestations, altruism is neither evil nor sainted; it is simply a necessary function of a just society.

While the role of a community-based theatre facilitator has potential for sparking civic dialogue surrounding social issues, it is evident that there are also challenges and limitations. What it can do is pose questions, provide an open forum for meaningful dialogue, present opportunities for marginalized groups to speak, identify and strengthen the common bonds that form a community, uncover oral histories, and function as a therapeutic outlet. What it can’t (or shouldn’t) do is impose the answers to the questions it asks or focus only on immediate results, a significant challenge since many practitioners are activists at heart with a desire to see real change occur. The problem with such a focus is that it can prompt “a view of art as a commodity[,] subject solely to operations of supply and demand in the marketplace, while limiting, if not denying, the constitutive role of the arts as political speech in the life of a democracy” (Medvecky). Sometimes simply making room for all parties to speak is enough of a political act, and lasting change can come at achingly slow paces.
In the end, community-based theatre proves useful for sparking civic dialogue regarding public perceptions of breast cancer and philanthropic citizenship. By its nature, community-based theatre requires a commitment to thinking beyond binaries and operating in the greys found when we move beyond simple theory into praxis. Each new audience is a new uniquely positioned community, and reconciling the diversity of their experiences requires comfort with the undefined, the incomplete, and the problematic. In my own recent experiences, I found conflicts not only between audience members collectively, but evidence of dissonant competing ideologies within individuals. Race, class, gender, and generational differences prompted testimonies from various audience members that were no less true for their directly contradictory statements; individuals resonated on multiple frequencies with multiple phantom notes at the same time. All of this provokes deeper preparation for facilitation: I must know the form and be comfortable with all of its quirks, its benefits and challenges. I must know the target community and the complexities of the issues that face them with sociopolitical, economic and historical context, performing the balancing act of honoring their values while troubling problematic ‘socio-political norms,’ and developing a “profound knowledge of [my] moment in history.” Then and only then can I hope to intervene in the troubling and complex nature of neoliberal pink ribbon culture.
Works Cited


CHAPTER TWO

Telling Through Troubled Territory:
The Politics of Performed Autopathography in Susan Miller’s *My Left Breast*

“...life writing about illness and disability promises to illuminate the relations among body, mind, and soul.” - G. Thomas Couser

A close look at representations of catastrophic illness on the contemporary stage reveals many examples of disease’s capacity to overwrite identity and silence individuals. While any number of plays address a character’s illness in a traditional narrative structure (Edmund’s tuberculosis in Eugene O'Neill's *Long Day's Journey into Night* or Prior’s AIDS in Tony Kushner’s *Angels in America*, ad infinitum), performed autopathography\(^\text{16}\) is an emerging form that bears closer investigation. Theory around autobiographical illness narratives suggests that they contain therapeutic potential for their authors, making room for the restoration of identities and subjectivities undermined by the experience of illness. And while this restoration is certainly a desirable goal, it focuses upon a therapeutic outcome for a single individual in performance. As a community-based theatre practitioner, I cannot help but wonder: is there a way to navigate the difficult balance between the therapeutic goals of autopathography for the individual that can be at times at odds with the goals of feminist performance to resist silences, colonization, and socio-political norms, and challenge the objectifying gaze that focus on broader communities? Susan Miller’s autobiographical *My Left Breast* is a strong example of an autopathographic text that manages both as it enters into a dialogue between the author’s own experiences of breast cancer and cultural perceptions thereof.

A review of dramatic literature regarding women and cancer in the last quarter of the twentieth century reveals a decided trend of taking back control. Over and over again, women with cancer take center stage, seizing control of their previously untold stories. The protagonist of Margaret Edson’s *Wit* dominates dialogue to such an extent that the play is actually primarily composed of monologues directed to the audience. She remains

\(^{16}\) Autopathography is a form of writing that contains “autobiographical accounts of illness, injury and disability” (Auslander 163).
onstage for nearly the entirety of the play as she leads us, with the help of a supporting cast, through one vignette of her battle with ovarian cancer to another. Although their protagonists don’t directly address the audience, Louise Page’s *Tissue* and Andrea Green’s *For Tiger Lilies Out of Season* employ similar dramatic structure to *Wit*. The cancer-afflicted protagonist remains onstage for virtually the entire play while other characters come and go around them, often with multiple characters played by the same actor. Others, such as Linda Park-Fuller’s *A Clean Breast of It* and Susan Miller’s *My Left Breast*, use autobiographical solo performance to ensure that their voices are heard by removing others from the stage entirely. In each of these plays, the protagonist breaks the fourth wall and addresses the audience directly, demonstrating a desire to connect with the audience to tell her own story rather than allow supporting characters to perform a mediated recreation. The need to tell their stories in their own words is the driving force throughout.

**Illness Narrative Strategies**

Arthur W. Frank’s own brush with cancer led to his theorizing the reason for this drive in his influential work on illness narratives, *The Wounded Storyteller*. In the preface to the work, he links the physical wound to a psychological one:

> Seriously ill people are wounded not just in body but in voice. They need to become storytellers in order to recover the voices that illness and treatment often take away. The voice speaks the mind and expresses the spirit, but it is also a physical organ of the body. The mystery of illness stories is their expression of the body; in the silences between the words, the tissues speak. (xii)

In this framework, simply writing down one’s story is insufficient as a restorative act; embodiment and speech are necessary, as nonverbal communication issues forth from and partners with dialogue, one informing and affirming the other. The body performs its own important text, so performed illness narratives may contain further potential for restoration of voice and agency beyond written ones. “A medical sociologist by training, Frank is especially interested in the ethical significance of patient testimony – in relation to, though not contained by, medical practice” (Couser 13). His work expands upon that of narrative medicine pioneer Rita Charon. Narrative medicine’s emerging
interdisciplinary pedigree and goals echo those of medical humanities. Emerging in response to a neoliberal health care system that prioritizes corporate concerns over patient welfare, according to Charon, narrative medicine is:

medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness. … [By placing] events in temporal order, making decisions about beginnings, middles, and ends… We seek connections among things using metaphor and figural language. … [Doctors] are more ably recognize patients and diseases, convey knowledge,… and accompany patients through the ordeals of illness (vii).

Charon’s narrative medicine is primarily a diagnostic tool written by physicians with input from patients. Frank’s illness narratives free themselves from clinical constraints and place narrative ownership back in the hands of the patient. The goal of The Wounded Storyteller is to “shift the dominant cultural conception of illness away from passivity – the ill person as ‘victim of’ disease and then recipient of care – toward activity. … As wounded, people may be cared for, but as storytellers, they care for others” (xi-xii).

Frank identifies three primary types of illness narratives: restitution, chaos, and quest. “The plot of the restitution has the basic storyline: ‘Yesterday I was healthy, today I’m sick, but tomorrow I’ll be well again’” (77). They “attempt to outdistance mortality by rendering illness transitory” (115). Frank cites the common cold medicine commercial as one easy example of this narrative: ‘Yesterday I was a sporty and attractive person, today I’ve caught a miserable cold, but when I take this convenient pill I will feel well again. At the opposite end of the spectrum, chaos narratives “imagine life never getting better. Stories are chaotic in their absence of narrative order. Events are told as the storyteller experiences life: without sequence or discernable causality” (97). Where restitution narratives “attempt to outdistance mortality,” chaos narratives are about drowning in the anxiety of unintelligible life. “Quest stories meet suffering head on; they accept illness and seek to use it. Illness is the occasion of a journey that becomes a quest. What is quested for may never be wholly clear, but the quest is defined by the ill person’s belief that something is to be gained by the experience” (115). Quest narratives are further divided into three sub-types: memoir, manifesto, and automythology. Memoir is “interrupted autobiography” (120), a broader life story that is disrupted by illness and
vice versa. Writers of quest manifestos feel a sense of social responsibility and an urge to tell an untold truth about illness. “They want to use suffering to move others forward with them” (120-1). Quest manifestos create meaning out of the betrayal of one’s own body and transform the trauma and pain of catastrophic illness into a tool for social change and public welfare. Finally, automythology draws on the metaphor of the Phoenix “reinventing itself from the ashes of the fire of its own body [to describe]… the totality of self-reinvention following massive trauma or catastrophic illness” (122).

Automythologies are about being reborn rather than simply surviving. Each of the preceding narrative types is an effective communication strategy to allow survivors who are wounded in voice to speak. Next, I will consider some of the factors that enforce silence.

Breast Cancer and Silence
As discussed in Chapter One, a troubling aspect of the current cultural moment with regard to breast cancer is the imperative of optimism. Despite the fact that the medical community has now largely discredited the idea that positive thinking or emotional well-being have a material impact one way or the other upon cancer patients’ prognoses, the idea persists popularly and has a decided impact upon some women’s ability to speak openly about their experiences. Sociologist and breast cancer survivor Dorothy Broom calls it the “relentlessly optimistic narrative of courage… we are assured that breast cancer ‘can be beaten’, that we can be supplied with prostheses that will be indistinguishable from real breasts and that life will soon go back to ‘normal’” (250). Broom’s experience is all too common. Over and over again, throughout breast cancer counternarratives, women demonstrate a sense of frustration with the fact that this compulsory optimism ignores and/or denies their moments of anger, despair, fear and deep struggles with their own mortality. Miller’s protagonist, Susan, says, “…I wanted to talk about this but it made people uncomfortable” (24). It may be unlikely that either Susan or other survivors have been explicitly told that the darker side of their stories is

18 Counternarratives are those with revise or reject the dominant narrative. Obviously the strongest counternarrative would be one that rejects dominant culture, followed by a continuum of those that revise it to a greater or lesser degree.
unwelcome, but they were clearly able to read this message through subtextual and contextual clues and felt frustrated and silenced as a result.

Indeed, even at the moment of diagnosis, the newly pathologized woman is granted only a certain amount of socially sanctioned time within which she is allowed to openly dwell upon her body’s betrayal. “[S]he is permitted to express initial distress, shock or horror, the time and space for which such a reaction is severely circumscribed—she must very soon resume her ‘social duty’, be seen to brave ‘unpleasant treatments with courage and humour’, and then apparently return ‘to living a normal life once again’”(Wilkinson 270). There are few moments in which one is as deeply aware of one’s own body as in the moment catastrophic disease is confronted, and yet breast cancer patients are given very little time to sort through the complexities of emotion that spring forth from such an event. Many women discuss the disorientation that they feel after diagnosis and during treatment as unexpected complications arise, and Susan is no exception. She discovers that a side effect of her treatment has weakened her bones, and she translates the loss into a larger symbol of her new world: “…the bone densitrometry shows a significant… bone loss. Is the structure of everything dissolving? I can’t count on whatever it was that help me up, supported my notions, my exertions. Osteoporosis. It’s hard to say the word. … It’s the antifeminine” (Miller 17).

A woman with breast cancer is expected to navigate the treatment process with as little fuss as possible before re-entering society as a newly-dubbed ‘survivor’ who never hesitates at the idea of wearing a prosthesis or undergoing reconstructive surgery following mastectomy, seemingly magically made ‘whole’ again. She is a hero to be admired and emulated but never examined too deeply. One of the main problems with this, according to womanist writer and breast cancer survivor Audre Lorde, is that “[i]t encourages a woman to focus her energies upon the mastectomy as a cosmetic experience, to the exclusion of other factors in a constellation that could include her own death” (58). It is a reductive version of the experience of breast cancer.

Only the victorious woman who has conquered all is granted recognition. Western consumerist ideals run deep in breast cancer culture, and as in the capitalist paradigm, the American Dream reigns supreme. The individual who pulls himself up by his bootstraps from a lowly place from poverty to wealth (or illness to health) is granted a place of
honor. Success is all that matters. In cancer culture, illness narratives uphold a hero who moves in a direct line from diagnosis to treatment to cure. “In contemporary Western culture, we are encouraged to think of our lives as coherent stories of success, progress and movement. Loss and failure have their place, but only as a part of a broader picture of ascendance” (Stacey 9). Women whose choose to voice experiences differing from this model are ostracized. Once relegated to ‘other’ status, their testimonies can be safely discounted and maintenance of the status quo reinforced. Lorde experienced this bias at the hand of a nurse in her own doctor’s office shortly following her mastectomy. The nurse, who had previously been very supportive of Lorde, chastised her for her failure to wear a prosthetic to camouflage her missing breast. Overtly expressing her disapproval, the nurse commented, “we really like you to wear something, at least when you come in. Otherwise it’s bad for the morale of the office. …[Unfortunately it was] only the first such assault on [her] right to define and to claim [her] own body” (60-1). Lorde’s conformity to standards of beauty and optimism were framed as more important than the truthful experiencing of her own body, and the validity of the knowledge of her physical self denied.

Mainstream stories of illness reflect this through value system through their emphasis “on the heroic overcoming of loss and failure” (Diedrich 137, italics mine); tidy stories of ‘happily ever after’ are more important than the creation of a body of narratives that more accurately reflect the diverse experiences of breast cancer patients. It matters not that the lived experience of cancer patients rarely travels so tidy a path. Treatments fail; tumors regrow and metastasize; medical bills cripple patients’ future even if they do make it to the promised land of remission. Nonetheless, these experiences threaten the militant optimism of pink, so the women who have lived through these events are told that their stories are not welcome.

The Politics of Performing Autopathographies
While Frank references illness stories’ “expression in the body,” his focus as a medical sociologist leaves his theorization of embodiment and performativity underdeveloped. I revise his work using feminist performance theorists to fill in the void.
Through the work of Elin Diamond, we see that the moment Susan takes the stage, her body immediately takes on multiple meanings:

The body, particularly the female body, by virtue of entering the stage space, enters representation—it is not just there, a live, unmediated presence, but rather (1) a signifying element in a dramatic fiction; (2) a part of a theatrical sign system whose conventions of gesturing, voicing, and impersonating are referents for both performer and audience; and (3) a sign in a system governed by a particular apparatus, usually owned and operated by men for the pleasure of a viewing public whose major wage earners are male. (Diamond 89)

Taking the stage becomes a political act, one Miller extends by undermining the taboo of speaking openly about her experiences with breast cancer. While outing oneself as a breast cancer survivor is much in vogue in today’s cultural climate, it was not so very long ago that severe stigma was attached to the disease and doctors were revered as demigods. It wasn’t until the women’s health movement gained ground alongside the feminist movement in the 1970s that women dared to speak publicly about breast cancer. “Historically, women have been socially conditioned into silence, or have been taught that they must speak quietly. We are taught not to shriek or be shrill. We are taught not to express anger” (Aston 51). My Left Breast works to unmake this cultural conditioning, and Susan does (sometimes gleefully) the very things a lady ‘must not’ do.

In the ‘personal is political’ paradigm of second wave feminism, the simple act of speaking so candidly about her experience with breast cancer in a public arena in 1994 underscores the work with a decidedly political air. “By the very nature of the performance, an autobiographical performer takes an authoritative stance, a literal and figurative space traditionally occupied by men’s voices and bodies” (Carver, “Risky” 15). Taking it one step further, the autopathographic performer dually takes control of the representation of her identity even as the chaos of illness disrupts notions of a stable, coherent identity’s existence in the first place. So autopathography also contains “a performative struggle for agency… and situates personal narrative within the forces of discourse, the institutionalized networks of power relations, such as medicine…” (Langellier 135). Miller’s body in autopathographic performance experiences tremendous performative weight. Simply by stepping into the spotlight, her body all at once disputes
patriarchal dominance, renders identity unstable, struggles toward personal agency, and multiply signifies within the theatrical sign system.

**Disidentification**

As any other woman with breast cancer, Miller cannot escape the conscription of her body and identity into a patriarchal pink ribbon-based sign system that constitutes the ideal breast cancer patient as a middle-aged white heterosexual woman of restored health who values reconstructed appearance (i.e. not a current patient, but a survivor who has made her illness invisible once again). In response to the increasingly problematic narrative emerging from mainstream pink ribbon ideology, Miller counters her body’s medical colonization, working both with and against pink. Disidentification allows minoritized subjects to controvert harmful ideologies without throwing out the baby with the bathwater. José Esteban Muñoz’ influential work provides some valuable insight:

Instead of buckling under the pressures of dominant ideology (identification, assimilation) or attempting to break free of its inescapable sphere (counteridentification, utopianism), this ‘working on and against’ is a strategy that tries to transform a cultural logic from within, always laboring to enact permanent structural change while at the same time valuing the importance of everyday struggles. ... [The] ‘disidentificatory subject’… tactically and simultaneously works on, with, and against a cultural form. (25-26)

Through disidentification, Miller works ‘on, with and against’ the dominant narratives of heteronormativity, patriarchy, and pink ribbon culture. She take the ideology as a whole and recycles it into something good. Her work “thrive[es] on sites where meaning does not properly ‘line up’” (Muñoz 78). Susan’s identity as a queer woman problematizes her as a speaker for breast cancer awareness in contrast to the ideal heterosexual breast cancer poster child. According to Muñoz, “to perform queerness is to constantly disidentify” (78).

In perhaps the most readily identifiable disidentificatory moment of the play, Susan demonstrates the impact breast cancer has had upon her, rendering her illegible even to herself at times. She says,
Because, I want to say, when you're a hurt and leaky thing, all definitions are off.
… You are shorn of image. You are waiting to eat again and to speak in a
language with meaning. You are not gay. You are not a woman. You are not. And
by this, you are everything your former self defended against, apologized for,
explained away, took pride in. You are all of it. None of it. (8)

This contrast of things she both “defended against” and “took pride in” typifies
disidentification, which embraces the possibilities inherent in both/ and kinds of thinking
over either/ or. She at once celebrates and defies. Despite the fact that she has clearly
identified herself as invested in several important sites of meaning-making within her
self-conceptualization (lesbian, Jewish, mother, cancer patient), she also refuses
definition altogether.

This combined celebration and defiance occurs at another moment early in the
play when Susan shows her prosthesis to the audience. She says, “Here's what I wear
sometimes under my clothes. [She shows her prosthetic breast to the audience.] Don't
worry. I've got a spare” (6). She performs a basic function of breast cancer:
awareness-raising, speaking frankly about one of the realities for women following mastectomy. At
the same time, she defies cultural expectations about proper behavior for a breast cancer
survivor by speaking the open secret of prosthesis and refusing to allow the markers of
her illness to remain invisible. This part of her body is at once synthetic and explicit, and
“‘critically engage[s] ways of seeing’ to reverse the male gaze and be able to see for
[herself], rather than merely being seen by others” (Carver, “Staging” 396). Despite the
medical violence involved in her need for prosthesis in the first place, she
is tongue in cheek about it, creating a light-hearted moment by making a joke. She wraps up all of
these complexities into disidentification, recycling the good and the bad into something
more.

Bearing Witness
The act of performing autobiography also implies an audience to receive them,
and in so doing, empathetic audiences bear witness in another sense, bearing the weight
of the performer’s tale, the act of sharing lessening the load. “For the testimonial process
to take place, there needs to be a bonding, the intimate and total presence of an other – in
the position of the one who hears” (Felman and Laub 70). It is here where empathy is generated that *My Left Breast* begins to find the balance between the therapeutic goals of autopathography and the political goals of social change performance. The connection between performer and witness constitutes a teller-listener contract upon which the pairing of these disparate goals hinges. Miller’s storytelling fulfills her therapeutic need to be heard, and the audience listens to a story of political importance that controverts multiple socio-political norms (i.e.- breast cancer stigma & culture, heteronormativity, medical hegemony, etc.). Initially established during the performance, the sustained teller-listener contract provides opportunity for meaningful dialogue following the performance.

Susan’s experience of marginalization as a result of her race, gender, sexual orientation and disability make her storytelling even more overtly political. “Personal narrative performance is especially crucial to those communities left out of the privileges of dominant culture, those bodies without voice in the political sense” (Langellier 129). She proudly claims, “I am a One Breast, Menopausal, Jewish, Bisexual Lesbian Mom and I am the topic of our times. I am the hot issue. I am the cover of Newsweek, the editorial in the paper” (11). Miller retains control of meaning-making in her own story through her use of the monologue, which allows her to control when and how the others who are part of her story are represented and how she views herself from multiple subject positions as mother, lover, lesbian, Jewish, etc. The personal becomes the political and the small becomes larger as she performs her story in the public eye. “Embodied identity work shows that the individual body’s smallness and immediacy are deceptive, that the individual body can be made larger through its participation in a collective discourse and through dialogue with social forces” (Pitts 82).

**Quest and Chaos: A Dialectic**  
In order to achieve a ‘dialogue with social forces,’ *My Left Breast* contains elements of both quest and chaos narratives. “The quest narrative affords the ill person a voice as a teller of her own story, because only in quest stories does the teller have a story to tell; chaos narratives focus on the absence of self due to the turbulent experience of illness, while restitution narratives cast medicine itself as the hero” (115). *My Left*
Breast zeroes in on the manifesto facet of Frank’s quest narrative. This desire to connect with an audience and act as experienced sage significantly marks the play’s tone. Miller weaves experiences of illness with those of motherhood, romance, and daily life as she takes the stage.

Many quest narratives, in their aim to create meaning and find triumph at the end of the story, reify the image of what medical sociologist Gayle Sulik calls the breast cancer “she-ro,” “a feminine hero with the attitude, style, and verve to kick cancer’s butt while wearing 6-inch heels and pink lipstick” (16). Miller creates a strong image of resistance to this idealized cancer heroine. She places Susan in an archetypical moment of feminine domesticity, ironing her son’s shirt, juxtaposing it with the jarring act of snorting two lines of cocaine from the ironing board. A moment later she says:

Mothers have no business doing cocaine. Mothers have no business being tired all the time or sick from chemotherapy. …

There were powerful drugs in her body. But the one she took through her nose kept her from knowing what she knew. Kept her from the ache of caring. In her dreams she could smell the truth. Cocaine- sharp, thrilling. The cancer drugs, acrid and sere. Terrifying. A toxic taste in her mouth.

She had control over cocaine. She administered this to herself. In a breath. There were no needles, no invasion. It was a ritual of pleasure and retreat. It blotted out the anxiety of the waiting room.

And finally, it destroyed what was healthy and cured nothing at all. The woman ironing her son's shirt felt ashamed. She was not the cancer heroine she'd hoped to be.

Some people would say, this woman is doing the best she can. And that's all anyone can do. But, I think that's just another moral loophole. She can do better. She will do better. (15-16)

Miller’s cocaine confession is a moment of startling vulnerability that shows both the fear and pain of her experience as well as the impact of the pressure to appear as though she has it all together, the pressure to be the ‘she-ro.’ Some writers face temptation to construct a story in which the ‘she-ro’ gets the happy ending she ‘deserves’ in order to give hope to their audiences who may contain individuals only just beginning treatment,
or worse be back in treatment all over again. Disability and performance studies theorist Philip Auslander identified this tension, which he calls “even more exigent for performed autopathographies than written ones” (163, original emphasis), in his study of the autopathographic monologues of performance artist Spalding Gray:

Although the mere existence of an autopathographic narrative suggests that the author was healthy and able enough to write it and thus implies a happy ending, the drive toward resolution that characterizes life writing is problematic with regard to chronic conditions that are systemic, or degenerative and may not lend themselves to being recounted using a convention that implies resolution. (163)

The unfortunate reality is that sometimes treatments fail and patients die, and possible long-term and late side effects of breast cancer treatment through chemotherapy and mastectomy include a laundry list of significant health issues: lymphedema, infertility, neuropathy, cardiac damage, osteoporosis, lymphedema, and increased risk of other cancers (“Cancer Survivors”). The optimistic imperative embedded in quest narratives doesn’t always make room for this part of individuals’ experiences of breast cancer.

Miller’s work avoids this pitfall both by disrupting the linearity of Susan’s storytelling and including elements of the chaos narrative. “Chaos stories remain the sufferers own story, but the suffering is too great for a self to be told. The voice of the teller has been lost as a result of the chaos, and this loss then perpetuates that chaos” (115). Tessa W. Carr examines Miller’s text in her own work on autobiography and illness experience, pointing to the “tension between the accounts of loss and disability and the rebellious resilience to carry on illuminates the personal narrative of cancer that cannot be positioned as simplistically triumphant. Miller’s work is… poignant and unflinching in examining this paradox” (114). Miller uses chaos to resist the cultural myth that we can be made whole again. As a reflection of the human experience, theatre consumes culture and reflects it back at its constituents. Within a paradigm where ‘the willing suspension of disbelief’ is a functional part of the aesthetic, theatre makers are freed to explore and unmake myths. To do this, Miller shares moments when events did not move in a straight line from diagnosis to treatment to recovery, when diagnoses were missed, treatments failed, and fear and anger rose to the forefront of her experience.

Following these moments, however, she often returns immediately to the quest to create
order and make meaning out of the chaos. As she moves back and forth through these moments, a dialectical tension emerges between chaos and quest that results in deeper understanding of her experience. Her protagonist, Susan, spends a paragraph explaining to the audience that “nothing can save you,” and immediately follows it up by recreating a conversation that exemplifies the manifesto: “A man I know said to me, lesbians are the Chosen people these days. No AIDS. I said, lesbians are women. Women get AIDS. Women get ovarian cancer. Women get breast cancer. Women die. In great numbers. In the silent epidemic” (10). She follows this moment by returning to the chaos of her repeated misdiagnosis from multiple physicians on both sides of the country; this fear and dislocation was deepened by the moment in which she recognized menace from her oncologist and his nurse, and the belief they were trying to kill her. She transgresses. She grasps her agency by whatever means available to her. She never goes back to complete her treatment following the incident. Following all of this, she steps up onto her soapbox once again with a speech that directly questions the audience:

There are those who insist that certain types of people get cancer. So I wonder, are there certain types of people who get raped and tortured? Are there certain types who die young? Are there certain types of Bosnians, Somalis, Jews? … And are one out of eight women -- count 'em folks -- just holding on to their goddamned anger? (11)

It is following these moments of great conflict and vulnerability that Susan turns most distinctly to the audience, as if to urge them to action, or to encourage them to act as witnesses to her rage and resistance.

More than a means to balance what might otherwise become a reductive progress narrative, especially in reference to her treatment at the hands of medical professionals, Miller’s inclusion of chaos also acts to resist the medicalization and colonization of her body. As feminist counternarratives aimed at reconstructing and reclaiming ruptured identities, “women’s performance of cancer narratives [such as My Left Breast] participate in feminist decolonization” (DeShazer 81). They act in resistance to the medicalization of their bodies by questioning the absolute authority of medicine and positing women’s experiences of their own bodies as a valid alternate epistemology.
In *My Left Breast*, this is seen when Susan tells us that it was her lover (not her doctor) who found the lump (10), when her intuition leads her to discontinue chemotherapy from a malicious oncologist (11), when she declines to fill a prescription from a waffling gerontologist, (23-24), and when the cure for cancer is nothing more than little league (32). Miller’s ‘little league cure’ strikes can be seen as a deus ex machina moment of forced optimism, reaching for a cheerful and coherent conclusion to a story she is actually still living and for which she has a vested interest in a happy ending:

[B]ecause having ‘had’ cancer almost always means being susceptible to recurrence, being constantly vigilant—the retrospective closed-end autobiographical narrative is always some how false. … The desire of the breast cancer patient as mortal individual may be to wrap up the story, encapsulating the malignancy and preventing it from infiltrating the entire life… (Couser 41)

Nonetheless, in each of these instances, Susan positions her experiences and knowledge of her own body as a truth to transgress patriarchal medical hegemony.

The autopathography that may have begun as nothing more than a breast cancer survivor’s search to find her voice and her agency again suddenly takes on a deeper importance as she makes the leap from page to stage, turning the corner from therapeutic to transgressive. “Inevitably, when women study their own lives and those of other women, they encounter issues of containment and regulations, and in order to expose those restrictions they necessarily breach boundaries and create their own rules” (MacKay 157). And while some women’s autopathography may reside comfortably in the borderlands between the therapeutic and the socially engaged, Miller’s work is decidedly feminist. Susan continues to challenge women’s historical social conditioning through more than simple speech. She lets loose a primal scream of fear and frustration, freeing her voice in the most fundamental of ways. “That was good,” (18) she says, but follows it up with this speech about all of the imagined destruction she wrecks:

I have destroyed so much property in my mind. In my mind, I have smashed so many plates against the wall, ripped so many books from cover to cover. In my mind, I have trashed apartments, taken all the guilty parties to court. Done damage for damage done. But I'm the accommodating patient. I move on. Get over it. Exercise restraint. I am appropriate. (18)
Miller beautifully demonstrates the tension between her real desires and societal expectations of appropriate expressions of proper adult femininity.

Immediately after this outpouring of emotion and subsequent restraint and repression thereof, Susan comes unhinged when a doorman dares to eat her pizza, screaming at him and swearing like a sailor: “You ate it? You fucking ate my pizza. You fucking murdered my child, you fucking destroyed my career, you fucking robbed me of my youth, you fucking betrayed me, you fucking know that? You fucking fucking idiot!” (18) And while the scene may appear to be a simple bit of comic relief in a text that deals with weighty issues, Miller has wrapped up a great deal in that one pizza incident. In *The Explicit Body in Performance*, Rebecca Schneider discusses the trouble we run into here: “[T]he explicit body in much feminist work interrogates sociocultural understandings of the ‘appropriate’ and/or the appropriately transgressive – particularly who gets to mark what (in)appropriate where, and who has the right to appropriate what where” (3). Schneider’s intentional use of both the adjective and verb forms of ‘appropriate’ demonstrate the ways in which we conflate ownership and propriety. The one who owns the right to define Susan’s body is the one who gets to decide how and where it is properly presented. More than just her lunch, the pizza is a symbol of comfort which the doorman has taken from her, and he suffers her displaced anger, fear and frustration with her doctors and the betrayal of her own body as she unleashes it upon him in what is perceived as a more socially ‘appropriate’ setting than her doctor’s office.

Susan’s speech isn’t the only thing explicit about *My Left Breast*. In the final moment of the play, she unbuttons her blouse and reveals her mastectomy scar to the audience. Because of the absence of her breast, her partial nudity may or may not be read as such. Does this make the exposure more or less political, more or less transgressive? Much is wrapped up in this scar; it is her very history of her self, and the act of exposing a piece of herself rich with so much text functions as one of the benefits of the embodiment of performed illness narratives over written ones. Her exposure is a speech act, a moment in which she exposes the life story literally inscribed upon her body, though it is often characterized as unfulfilling. Noting its position at the end of the play in combination with the staging choice of dimming the lights as the scar is revealed, Carr calls it “ultimately disappointing as a statement of feminist reclamation” (124), but in so
doing may overlook the existence of multiple goals for the performance. Certainly, within the framework of Frank’s ‘manifesto,’ one of Miller’s aims is to bring about social change, but one must also consider the initial therapeutic goal in which Susan is ‘the wounded storyteller,’ allowing her tissues to speak and recovering her personal voice. Assuming Miller herself is the performer, protesting Susan’s act as not ‘appropriately transgressive’ may run the risk of claiming ownership of the choices she makes regarding her own body, compromising what is already a contested site of meaning. Revealing her scar to a public who cannot look away is an act of reclaiming the right to define her own body. “Reclaiming discourse presents the body as a potential site of symbolic resistance to oppression. Reclaiming or resistance ideology implies that social inscriptions on the body can be rewritten, and the body – especially the female genitals and breasts – can be reclaimed” (Pitts 71). In this moment, Susan reclaims the power of self-authorship, “determin[ing] the explication of [her] body, what and how it means” (Schneider 3, original emphasis). She rewrites her scar from disfigurement to something altogether more complex, saying

It's a mark of experience. It's the history of me, a permanent fix on the impermanence of it all. A line that suggests I take it seriously. Which I do. A line that suggests my beginning and my end. I have no other like it. I have no visible reminder of the baby I lost. Or the friend. No constant monument to the passing of my relationship. There is no other sign on my body that repeats the incongruity and dislocation, the alarm. A scar is a challenge to see ourselves as survivors, after all. (31)

The scar functions as embodied memory incorporated into identity, as lived histories inscribed into and upon her body. By absorbing them into her self, she asserts final control over her narrative, making an intelligible sign system out of formerly uncontrollable trauma. Miller reconstitutes her most painful moments as useful for provocation of social change. She at once issues a challenge to audience members to tell their own stories and prompts them to reconsider preconceived ideas of what breast cancer survivorship is or should be, again marrying autopathographic and activist goals.

This exposure of her ill self, both literally and metaphorically, collapses the idea of art requiring aesthetic distance to function.
Challenges and Limitations of Autopathography

While I certainly believe that autopathography can be a powerful tool for reclamation of voice, I am cautious of overstating its benefits. My own recent foray into autobiography proved illuminating to me as a research practitioner seeking to provoke audiences’ own acts of autobiography. With Miller’s *My Left Breast* serving as inspiration, I set out to write an autoethnographic solo performance that explored my own experiences with catastrophic illness and loss. Recalling the illness and subsequent deaths of two particularly close family members, I used my own journal entries, blog posts, emails, photos, and letters as artifacts. As each experience appeared on the page, I began to understand that careful separation between autopathography and autoethnography may be necessary for some storytellers. Autopathography has few rules; it is simply a person’s tale of illness. Autoethnography on the other hand has a richly explored lineage and range of methods relating in part to its emergence from the field of anthropology. Miller’s play is a successful example of both, but in my own experience combining ethnographic methodologies with writing about difficult personal histories verged on retraumatization as I mentally relived various moments in search of anthropological thick descriptions of each.

This process has led to a focus on the ethics of my methods as a facilitator of community-based theatre workshops on storytelling and cancer. The last thing I want is to retraumatize the very audience members I seek to aid, but retraumatization becomes a real possibility when insufficient time has passed, or if facilitators fail to sufficiently prepare participants. “A considerable balancing act is required between supporting narratives about the traumatizing life phase and simultaneously holding back so that the narrators do not unexpectedly delve too deeply into their sufferings and in the talk or thereafter find themselves overwhelmed by traumatic memories” (Rosenthal 3). In *Reading Autobiography: A Guide For Interpreting Life Narratives*, Smith and Watson caution against unguarded extollations of public acts of autobiography:

Lest we too easily hail the metaphorics of coming to voice as a self-liberating gesture, we might keep in mind that testimony also involves telling stories that put the narrator in jeopardy because what is told is in some sense publicly
‘unspeakable’ in its political context. That is, the personal experience out of which a narrator ‘speaks truth to power’ is fraught with risk: public condemnation and ostracism or threats to family members. Acts of witness also risk psychic injury. Acts of telling can trigger retraumatization, invite shaming in public exposure, [or] address unsympathetic listeners. Moreover, …the markets for stories of suffering\(^{19}\) influence and constrain whose story can be heard and what kind of story can be told. (85)

Their work prompts many questions: When is autopathography useful and for whom? When can it retraumatize? When can it endanger? Though a great deal of work has been written about the benefits of storytelling from various disciplines, it’s important to avoid asserting it as universally beneficial, especially across cultures. “Talking about trauma may only be useful at a particular time for a particular individual, and it may be countertherapeutic to encourage the traumatized person to relate his or her story when time and/or context are inappropriate” (Stein et al 33).

Autopathography is at its core a story of trauma, which contains its own set of difficulties. Talking about trauma is a paradoxical attempt to name the unnameable, the rupture in identity that occurs as a result of the traumatic event. Dramatherapist James Thompson describes traumatic incidents as ones that “overwhelm the memory-making facilities of the person to create a numbness close to the event and then an uncontrolled revisiting at periods sometimes long after… the most extreme moments of horror, loss or violence that disturb unusual patterns of memory to create affective memory traces that may appear unpredictably in the future” (Thompson 50). The traumatic event interrupts memory, identity, and leads to what Arthur W. Frank terms “narrative wreckage.” Coherent, consistent, linear narratives are unlikely to issue forth from autopathography. Performed autobiographies expand the possibilities present in written ones because of their potential to speak through silence. The actor need not speak words that limit him to predefined meanings, but can also use the movements of his body in space to create meaning through composition and gesture. When the unspeakability of trauma becomes a

\(^{19}\) The “markets for stories of suffering” link us back to the neoliberalism of breast cancer culture in which anything and everything is for sale, which puts autopathographers at risk for exploitation or even distort their reasons for telling the story in the first place. Constraints upon what and whose stories can be told further connect to the compulsory optimism of pink ribbon ideology that controls the dominant narrative and suppresses stories that are less than victorious restoration narratives.
barrier, such expression is a ready and useful outlet. As Frank says, “in the silences between the words, the tissues speak” (xii).

I also encountered a strong challenge from the politics of autobiographical storytelling as I realized that my stories were not solely my own. The experiences of family and friends were so tightly interwoven with mine that they were inseparable; I could not tell my story without telling theirs as well. “This concept of relationality, implying that one’s story is bound up with that of another, suggests that the boundaries of an ‘I’ are often shifting and permeable” (Smith and Watson 86). With this in mind, representing others in the process of representing myself becomes ethically problematic. I was reflecting upon how the illnesses of people I loved left a lasting impact upon me, which is true; their deaths are much of the reason for the exploration of this thesis in the first place, even years after their passing. But how much of someone else’s story can I tell before it becomes cooptation? Do I need to obtain permission to tell those stories? If the person whose story I’m telling has passed away, who, if anyone, has the right to give me permission? Is changing names and identifying details enough to protect represented individuals when those who know me would certainly be able to see through the attempt to anonymize? Does any of this change depending upon whether the representation is positive or negative? Do these answers change when the story is told as a political speech act? The answers to these questions will change from person to person based on the intent behind the storytelling and their own priorities, but they are vital questions that must be answered before such stories are performed publicly. Despite goals to use stories for social change, storytellers must carefully identify and weigh potential risks versus benefits.

Conclusion
These questions and others continue to emerge as I step further into the land of performed autopathographies. In the end, I believe further research is required to ensure that the maximum benefit achieved by performed autopathography. Its therapeutic potential has been well-theorized by Frank and others, but its limitations deserve further close attention. *My Left Breast* does an admirable job of balancing the personal
therapeutic goals of autopathography and the broader public goals of social change performance.

Miller challenges cultural expectations of living with breast cancer that belied her own experience not through an aggressive attack upon the socio-political norms she contradicts, but by making herself vulnerable and inviting the audience in to hear her story. She resists the medical colonization of her body, speaks into the silence, and captures the objectifying gaze of the audience to turn it back on them so that they must see themselves in her. With elements of both quest and chaos narratives in her story, she restores her ‘wounded’ voice in a manner that blazed a trail for others to follow. Bearing these things in mind, a performance of My Left Breast designed to inspire audience’s own acts of autopathography while at the same time exposing them to a kind of breast cancer narrative they may not have heard before seemed ideal, the results of which will be analyzed in Chapter Three.
Works Cited


Pezzullo, Phaedra C. "Resisting ‘National Breast Cancer Awareness Month’: The Rhetoric of Counterpublics and Their Cultural Performances." Quarterly Journal


CHAPTER THREE

Pushing Toward Praxis: Reflections on Process in a Community-Based Theatre Production of *My Left Breast*

“Theatre is a form of knowledge; it should and can also be a means of transforming society. Theatre can help us build our future, rather than just waiting for it.”

- Augusto Boal

This chapter will engage the practical considerations and experience of designing, implementing and reflecting upon the post-show workshop in order to determine outcomes. In it, I will discuss decisions made in the interest of praxis based upon the theory introduced in previous chapters, explore the special challenges of self-production and of community-based theatre, and analyze audience response and other information gathered during the actual workshops. Because community-based theatre “emphasiz[es] process as much as product” (Cohen-Cruz, *Local Acts* 11-12, original emphasis), it is important to actively reflect on what that process looked like, what meaning audiences made from it, and how it might be improved for the future. Through an analysis of the process and the pedagogy involved in the creation of the workshop series of *My Left Breast*, I argue that participants’ learning was facilitated by a synthesis of meaning making derived from the workshop structure and the performance itself.

The Search for Praxis

As a young scholar new to teaching, I have spent a good deal of time considering how students make meaning out of what I present in my classrooms and workshops, with special attention paid to how theory informs practice. Critical pedagogue Paulo Freire “defines praxis as reflection and action upon the world in order to transform it” (Grady 73). For Freire, transformative action should be derived from the thinking we do; they are contingent one upon the other. And because there can be no praxis without reflection, it became a part of my process at every step along the way, not only in the planning stages, but also between activities with the audience, after the close of each workshop, and at the
conclusion of the series. Reflection must always lead to action, so I had to be reactive to the needs of the community in my planning and execution of the workshop.

With this in mind, several practical considerations were altered from their original plans in the interest of praxis. I hoped to mitigate some of the class-based obstacles associated with attending the theatre, so all performances were free of charge and performed in locations accessible to the public, such as community centers and a regional university campus. While ongoing public interest in National Breast Cancer Awareness Month might have made publicity easier to come by and audiences easier to build, I was concerned about the impact upon breast cancer survivors who experience ‘pink fatigue’ and retraumatization during the month of October when they are unable to escape constant reminders of their illness. In addition, I wanted to avoid complicity with the commoditization of the disease, so I chose to postpone initial October production plans to the months of November, January, and February. There was also discussion about taking donations for breast cancer charities, but I ultimately decided that such a practice would reinforce neoliberal ideas of citizenship. The search for true praxis can at times make for extra work logistically, but when working with traumatized or at-risk communities, simply meeting the bare minimum requirements for avoiding harm is not enough.

Framing Productive Partnerships
Mounting a successful community-based theatre production proves difficult and at times precarious. Obstacles arise before the project even gets off the ground: small budgets, gauging community interest and support, limited production staff, etc. Community-based theatre seems always to be seeking for ways to prove that it deserves a seat at the arts table by pointing to its usefulness and effectiveness, but [e]fficacy depends on a favorable constellation of unstable elements: people already engaged or engageable with specific issues, aesthetic strategies that are compelling to desired audiences, strong alliances with political or community organizations, sufficient material support, and synchronicity with the energy of the times. (Cohen-Cruz, “Motion” 95)

Freire notes two kinds of praxis: normative praxis (reflective doing) and "true" praxis (reflective ethical doing) (Allsup 162).
Self-producing left me with a great deal of latitude artistically speaking, free from concerns or protocol specific to Miami University’s Department of Theatre, but limited resources restricted some of my possibilities for design and venues.

In addition to the pre-existing target community, I sought a new community created through a moment of spontaneous communitas,²¹ the groundwork for which would be laid by the performance event and advance interactions which groups that may provide additional valuable insight into the workings of that community. Clearly framing partnerships and navigating the difficulties that arise through these relationships is one of the greatest struggles and highest achievements of community-based theatre. In the case of *My Left Breast*, I had hoped to work closely with two to three local women’s health or breast cancer advocacy groups in order to give the production deeper ties to the communities I chose to perform in. After tailoring presentations for several such groups, I received positive feedback from The Greater Cincinnati Breast Cancer Alliance (GCBCA) and Pink Ribbon Girls (PRG). I contacted these groups because their core values contained something more substantial and active than simple ‘awareness. The GCBCA is heavily involved in direct political advocacy, and PRG provides a necessary service by targeting their services to the underserved population of specifically young women with breast cancer. Though PRG obviously has some direct ties to neoliberal pink ribbon philanthropy, they do provide services beyond simple ‘awareness’ campaigns, as well as providing helpful literature with titles that did resist a monolithic narrative (i.e. “Anger and cancer — what to do with the difficult emotions”). Both PRG and GCBCA gave all appearances of being very excited about collaborating with me on *My Left Breast* following various emails, phone calls and face to face meetings, but communication was a struggle from the beginning.

As with many community organizations, both were run entirely by volunteers, so both correspondence and decision-making took a great deal more time than they may have with a fully staffed for-profit agency. These organizations count many breast cancer survivors among their high level staff. I planned to take advantage of their experiences

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²¹ “Spontaneous communitas can never be adequately expressed in a structural form, but it may arise at any time between human beings who are institutionally reckoned or defined as members of any or all kinds of social groupings, or of none. …it is expected best to arise in the intervals between incumbencies of social positions and statuses, in what used to be known as ‘the interstices of the social structure’” (Turner 137-8).
both as patients and as advocates through a talkback panel that would have taken place instead of the workshop following one performance. Unfortunately, both the planned opening night panel and the rescheduled January panel were canceled due to panelist illness. The unfortunate reality of breast cancer ‘survivorship’ for these women means that the cancer itself may be gone, but the lasting effects of the disease and treatment continue to have a noticeable chronic impact on their lives. I in no way begrudge them for missing these scheduled events, but it nonetheless affected my ability to forge deep connections with these organizations and their constituencies. Furthermore, I found myself softening my more overtly anti-pink inclinations as I designed the workshop. In partnering with organizations that valued a pink paradigm, how could I openly question some of their key philosophies and actions while maintaining a positive working relationship? Cohen-Cruz says that, “…the disadvantage is that these are traditionally conservative organizations that might not share progressive goals, though progressive artists usually hope that identifying shared concerns can create opportunities for radicalization” (“Motion” 100).

The middle ground I found came through opening up historical context to my audience and allowing them to decide for themselves. It was also through my interactions with these organizations that I began to shift my thinking beyond a binary of good or bad in relationship to pink ribbon communities. I allowed myself more room to allow for celebration of the good that pink has done and the space it has opened for some women to find support through their illness and recovery or palliative care. It was through this interaction that I began to seek not the overthrow of pink ribbon culture, but the improvement thereof. This shift in thinking was an important one that began to clarify the distinctions between community-based theatre, which puts the community at the center, and activist theatre, which puts the artist’s social change agenda at the center. Theatre for social change scholar Sonja Kufinec warns that “if not thoughtfully engaged, activist [or community-based] art may have the potential for neocolonialism (4).” She cites her interview with José Luis Valenzuela, “a UCLA theater professor and director who works mainly with Latinos in Los Angeles, point[ing] towards the danger of an artist ‘coming into a community that they haven't taken enough time to investigate and be inside of.’ He warns that ‘paternalism can exist, or the savior idea…” (4). So even though I personally
take a position in relation to pink ribbon culture, approaching my facilitation from a didactic point of view would have been problematic and paternalistic and in defiance of the critical pedagogy underpinnings I sought for the workshop. Marcuse believed that a “critical theory of art is thus a dialectical one, criticizing negative features and articulating positive ones. It analyzes art within specific social formations and develops utopian notions of art and liberation that show art can have emancipatory potential and effects within specific social conjunctures. Accordingly, Marcuse’s key analyses of art articulate defining and constitutive contradictions, ambiguities, and ambivalences of art…” (Kellner 28). Struggle with contradictions, complexities and ambiguities are an inherent part of community-based art.

Critical Pedagogy
Pedagogy lies at the heart of this community-based theatre model that uses a carefully designed workshop to engage an audience with a performance and to make meaning from it. “When one practices pedagogy, one acts with the intent of creating experiences that will organize and disorganize a variety of understandings of our natural and social world in particular ways. … pedagogy is a concept which draws attention to the processes through which knowledge is produced” (Giroux and Simon 239). An important goal of my workshop was audience conscientization regarding breast cancer culture. I hoped that the workshop would encourage critical reflection upon how their cultural knowledge was being produced regarding breast cancer, potentially leading to a shift away from the more problematic ideologies of pink.

In the process of reflecting upon the pedagogy, though, I found myself struggling for a means to assess audience members’ learning. While this is not a typical component of mainstream theatre production, community-based theatre’s focus on process values feedback and assessment, situating it closer to education than traditional performance. Such assessment is difficult in a non-traditional environment outside the classroom where my learners aren’t taking exams or writing papers to demonstrate what they may have

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22 Conscientization is the “process of developing a critical awareness of one’s social reality through reflection and action. Action is fundamental because it is the process of changing the reality. Paulo Freire says that we all acquire social myths which have a dominant tendency, and so learning is a critical process which depends upon uncovering real problems and actual needs” (“Conscientization”).
learned. In order to have some sort of basis for evaluating an arts-based pedagogy, I have found the capacities for imaginative learning defined by the Lincoln Center Institute for Aesthetic Education (LCI) to be particularly helpful. In an article titled “Aesthetic Education, Inquiry, and the Imagination,” Madeleine Fuchs Holzer of the LCI enumerates these capacities while embedding them in pedagogical theory from Maxine Greene and John Dewey.

The LCI’s capacities for imaginative are: noticing deeply, embodying, questioning, identifying patterns, making connections, exhibiting empathy, living with ambiguity, creating meaning, taking action, reflecting/assessing (Holzer 3). The LCI envisions these capacities in a scaffolding manner. The first three (noticing deeply, embodying, questioning) indicate a surface level of learning that gives rise to relational meaning making exhibited by the next three (identifying patterns, making connections, exhibiting empathy). These guide participants toward the next three (living with ambiguity, creating meaning, taking action) that require synthesis and application of knowledge, and the reflecting and assessing that the LCI recommends functions recursively throughout the process. LCI defines reflecting and assessing as “to look back on your learning, continually assess what you have learned, assess/identify what challenges remain, and … what further learning needs to happen” (Holzer 3). Using these capacities as my touchstones, I am able to gauge the depth of learning from my workshop participants by analyzing the workshop experience, both from reflections upon my perspective as facilitator and evidence based on audience participation.

Identifying Tensions

Defined by Giroux as “the educational movement, guided by passion and principle, to help students develop consciousness of freedom, recognize authoritarian tendencies, and connect knowledge to power and the ability to take constructive action,” (Lessons) Marxist critical pedagogy forms the heart of the workshop’s theory. Freire, Giroux, and Marcuse were instrumental in its development, so their ideas in contrast to

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23 These capacities are also consistent with Animating Democracy’s continuum of impact. ‘Noticing deeply’ and ‘embodying’ compare to the AD component of ‘new knowledge,’ LCI’s ‘questioning,’ ‘identifying patterns,’ and ‘making connections,’ to AD’s ‘discourse,’ LCI’s ‘exhibiting empathy’ to AD’s ‘attitudes,’ LCI’s ‘living with ambiguity’ and ‘creating meaning’ to AD’s ‘new capacities,’ LCI’s ‘taking action’ and ‘reflecting/assessing’ to AD’s ‘action’ and ‘policy change.’
Dewey’s critical pragmatism and Greene’s existential humanism result in some tension between the theoretical underpinnings of the workshop itself and my analysis of its effectiveness as a kind of pedagogy.

Dewey’s pragmatism has been critiqued as blind to issues of power (Kadlec 521), which tends to collide with the radical pedagogies of Freire and Giroux. His theories also espouse a positivism that can be at odds with Marcuse (Kincheloe) and Freire’s rejection of objective datum, claiming them as subject to interpretation (Politics 51). On the other hand, Dewey rejected the dichotomy between reason and experience (Dewey 239), which echoes in Freire’s similar rejection of the dichotomy between emotion and cognition (Teachers xviii). And where Freire’s pedagogy is practically based in achieving widespread literacy for the masses, Greene supports “a kind of distancing, an uncoupling from your practical interests” (Allsup 159). Her work also focuses on personal transformation while the others concern themselves more broadly with collective social issues. Greene’s pedagogy reconnects to theirs through its intent to enliven the imagination in order to promote dissatisfaction with the status quo and spur students to action. Where each of these noted pedagogues come together is their deep belief in the power of education to implement change, though the radicality of their approaches may differ.

Tension also exists between core values of community-based theatre and aesthetic education. Aesthetic education comes from a place that values high art and privileges the product. The aesthetic quality of the artwork being examined must be high. By contrast, community-based theatre values ‘communal expression’ over the aesthetic value of the final product. Cohen-Cruz talks about this tension in relation to her own fieldwork:

The profound art of people who lack craft but are overflowing with the need to express not only their own desires but also those of their communities challenges the dominant cultural paradigm that privileges individual over communal expression. My experiences in the field have spurred me to advocate for a broader conception of art that encompasses both extraordinary individual expression and extraordinary communal expression. Community-based fieldwork in the arts inevitably breaks out of a purely aesthetic frame into other subjective territories
that long to be acted out—indeed, lived out—reminding us of art’s ability to confront us with our deepest desires. ("Gown” 61)

Furthermore, community-based theatre uses authenticating conventions from local culture and history (Kershaw 193), privileging local specificity over the presumed universality of human experience traditionally sought by high art. Aesthetic education moves away from this tendency by embracing Greene’s emphasis on the viewer’s subjective perception as valid, no matter what it may be, rather than “uncovering some hidden meaning others have defined” (Greene 193). In addition, while I have structured my analysis of the workshop around aesthetic education markers of learning, I conceived it with community-based theatre’s values in mind. Liz Lerman’s “basic criteria for artistic merit [is] how committed and connected a person is to the movement [saying,] ‘And if I don’t see THAT onstage I’m bereft.’” (Cruz-Cohen, “Speaking” 223). Once again, the focus is on the process and community’s engagement rather than a perfectly executed performance.

**Practice: Analyzing The Workshop**

*Transitioning From Performance To Workshop*

Another challenge of this particular production was the transition from performance to workshop. My desire to use the workshop as publishable research required full review by Miami University’s Institutional Review Board in order to ensure the mitigation of any potential harms to my human research subjects. While such concerns are certainly necessary and admirable, the IRB application process forced the workshop into the parameters of an exercise in social science, creating new obstacles to overcome. A full page of text included in the playbill required lines such as, “You will not be asked to do anything that exposes you to risks beyond those you experience in a classroom discussion” and, “If you have questions about your rights as a research participant…” (Appendix II.2). These are not phrases that inspire confidence or comfort within the audience that I was attempting to convince to stay for the workshop after the performance. For the most part, contemporary audiences come to the theatre expecting to simply sit and passively take in a show, so getting them to participate in interactive theatre models can be something of a challenge in the best of circumstances. By and
large, they arrive at the theatre expecting to sit quietly in their seats, enjoy the show, and leave after the curtain call. Audiences were historically not always so passive. “First World audiences have become increasingly alienated and disconnected from and commodified by performance as they have been moved from involved patronage to uninvolved consumerism over the past 100 or so years. Watching film and television, for the many thousands of hours that we do, compared to the relatively few hours we devote to live performance, contributes to this passive ‘numbing down’” (Prendergast 131). Applied theatre practices challenge what audiences are accustomed to and comfortable with, so engaging willing participants takes a certain amount of trust in the facilitator to lead them through the new and uncertain territory. In addition, a lengthy scripted curtain speech that was essentially a condensed version of the text included in the playbill was required (Appendix II.1). I appreciate the IRB’s intentions in requiring this speech. Meeting their requirements did cause me to think more deeply about how any elements of the workshop might have been deemed coercive (again returning to the concerns of true praxis). Among other considerations, in an effort to minimize harm24 to participants, I revised the scope of my questions to inquire more broadly. In that manner, participants could give as much detail as they liked, but hopefully wouldn’t feel the need to talk about an experience that they found it difficult to discuss. I also paid special attention to the physical arrangement of the performance spaces, ensuring that there was an easy point of egress for them to use at any time. Nonetheless the text of the speech that was finally approved was rather mechanical and cold, with even the phrase, “I hope you’ll all choose to stay,” (Appendix II.1) deemed too coercive for inclusion. The IRB-approved speech to be delivered after my curtain call and before the workshop served to undermine some of the trust and connection built during the performance. This was not insurmountable, but it meant that I had to work hard to reestablish a constructive working dynamic with audience members who chose to stay and participate, and I believe it resulted in fewer participants overall. After delivering my speech, I allowed a few minutes for audience members not participating in the workshop to depart, and then launched into the activities with as little lull as possible so as to maintain momentum.

24 See Magolda and Weems for a discussion of the inevitability of harm in qualitative inquiry and ethical discussions on how to minimize it.
The workshop itself contained four main activities: values clarification, word association, image of the word, and story circles. In the writing that follows, I will explain and analyze what took place in each of these with a majority of my focus upon the story circles as they were conceptualized as the apex of the workshop event. Even though my focus rested upon the possibility of important voices emerging from the story circles that would end the evening, it was important to take time preparing the audience to get there using warm-up and bridging activities to guide their mental energy. Each of these activities was important, serving to create an atmosphere of trust and a culture of active contribution, as well as providing opportunities for different kinds of both spoken and embodied speech acts. Ultimately, however, the first three activities served as a launching pad to the storytelling portion of the workshop.

*Values Clarification: Clarifying Our Positions*

The first exercise, adapted from Michael Rohd’s *Theatre for Community, Conflict & Dialogue* (54), positions workshop participants and make them and the facilitator aware of the multiplicity of experience and viewpoints within the room, preparing them to listen and hear. Participants stood in a line and responded to the statements in the figure below by moving to the appropriate location. If they agreed, they took several steps forward, as space allows. If they disagreed, they took several steps back, and if they were unsure, they remained where they were. The original idea to have people line up and step forward or backward to indicate agreement or disagreement allowed for more clarity of people’s intensity of response, but was unwieldy and impractical for the space at the November 8 workshop. At the November 9 workshop, participants remained in the audience and were instructed to stand to indicate agreement and remain sitting to indicate disagreement. This worked better, but created a lack of clarity between those actively disagreeing and those who were simply choosing to watch and not participate. To resolve this, at future performances all who chose to participate were asked to raise their hands at the start of each question and to drop their hands to indicate disagreement or leave them raised to agree. The chart below shows the number of total participants in the activity at each workshop, followed by the number of positive responses to the indicated statements:
Values Clarification Statements

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of total activity participants</td>
<td>15</td>
<td>14</td>
<td>13</td>
<td>22</td>
<td>15-17</td>
</tr>
<tr>
<td>1. I have had a family member who was seriously ill.</td>
<td>15</td>
<td>9</td>
<td>11</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>2. Someone close to me has or has had cancer.</td>
<td>12</td>
<td>8</td>
<td>11</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>3. Breast cancer is an issue that I find personally important.</td>
<td>11</td>
<td>6</td>
<td>7</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>4. I have experienced a loss that marked me.</td>
<td>12</td>
<td>1</td>
<td>8</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>5. I have supported a breast cancer advocacy group.</td>
<td>6</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>6. I have run a Race for the Cure or something similar.</td>
<td>8</td>
<td>6</td>
<td>1</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>7. I “buy pink.”</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>8. I think a cure is coming soon.</td>
<td>9</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>9. I have felt put off by the amount of attention breast cancer receives over other cancers or illnesses.</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>10. I worry about the cost of healthcare or having insurance.</td>
<td>13</td>
<td>6</td>
<td>11</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>11. I think it’s important to make preventative care a priority.</td>
<td>13</td>
<td>9</td>
<td>10</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>12. I actively make it a priority in my own life.</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>12</td>
<td>7</td>
</tr>
</tbody>
</table>

As participants progressed through each statement, they were encouraged to look around and take in others’ agreements or disagreements with each statement so that they could better understand who was in the room with them. This activity hinged upon the ‘exhibiting empathy’ point of LCI’s capacities for imaginative learning. To exhibit empathy is “to respect the diverse perspectives of others in the community [and to] understand the experiences of others emotionally as well as intellectually” (Holzer 3). This was most clearly demonstrated during the reflecting and assessing period that followed this and each exercise. We followed up by discussing what they may have noticed or found surprising. They were drawn together by the fourth statement, “I have experienced a loss which marked me.”

Multiple participants mentioned surprise at so many having experienced deep loss, especially given the youthful median age of the primarily undergraduate audience; this seemed to begin a common ground for them to build upon. On the other hand, others were “shocked” (Nov 10) that anyone might be put

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25 Anonymous quotations from workshop participants throughout this chapter are my best **paraphrased approximations** of their statements based on notes taken by IRB approved note takers rather than word for word quotations. They are here cited by the date of the workshop.
off by the amount of attention breast cancer receives. One young woman responded that “it’s weird to see there’s not that same understanding or rallying behind other illnesses,” (Nov 9) specifically referencing her own study of mental health disorders. For some in the audience, this was the first introduction to the idea that any resistance to pink ribbon activism existed, leading some to question, or at least think more deeply about, their own investments in such activities.

**Word Association: Identifying Patterns**

The second activity was a simple word association exercise in which the audience was asked to shout out words or phrases that they associated with a given prompt. This activity provided a low-pressure opportunity for audience members to begin exercising their voice. All they had to do was shout out a word or two, and all answers were accepted and written on a board at the front of the workshop space. With no “right” or wrong answers, participants began to speak up more. While there was some experimentation between workshops in the number of prompts they were given, the most successful format used “survivor” and “awareness” as prompts with the audience choosing the third word based on some of the themes they saw arising either from the play itself or from results of the prior two prompts. Not only did this provide the opportunity to reassert the prioritization of community input central to the workshop, it also required them to identify patterns between categories. This was particularly effective at the Jan. 26 performance, which enjoyed the most active audience participation. They chose ‘scar’ as their third word, and generated a list of 38 words or phrases that they associated with it (in comparison to the lowest response of only 6 and an average of 16 responses to each prompt). Their list ranged from physical (stitches, healing, wound, cut, badge, visible, surgery) to emotional (personal, pain, flaw, memory, courage), and contained a number of value-based words (beautiful, ugly, mistake, flaw, not whole). They also seemed to view scars as scriptive things containing their own texts, offering up responses such as “story,” “story starter,” “badge,” “tip of the iceberg.”

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26 “Questioning: To ask questions throughout your explorations that further your own learning…” (Holzer 3).
27 See Appendix Item III
28 “Identifying patterns: To find relationships among the details that you notice, group them, and recognize patterns.” (Holzer 3)
this framework, scars become stories written on the body, just begging to be told. Arthur W. Frank’s words here echo: “in the silences between the words, the tissues speak” (xii).

Image of the Word: Embodying Our Storied Lives
The third activity of the workshop centered on Augusto Boal’s “Image of the Word” game (176-177). I chose three words from the bank of responses that participants provided in the word association activity, and a group of volunteers from the audience used their bodies to create images that represented their interpretations or reactions to these words. The activity allowed them to play with the words that arose out of their responses to both the play and their own lived experiences through embodiment. Boal’s exercise searches for additional meaning that might not be conveyable through words alone. He says, “images don’t replace words but they cannot be translated into words either- they are a language in themselves” (175). Images and words complement one another. Perhaps even more importantly, “[i]mage Theatre is based on the multiple mirror of the gaze of others- a number of people looking at the same image, and offering their feelings, what is evoked for them, what their imaginations throw up around that image” (175). The image-maker certainly has some idea of what he means to convey through his pose, but that meaning is not necessarily what is read by the audience, each of whom interpret the image based upon their own set of experiences and references, continuing the work begun in the Values Clarification exercise to perform the varied perspectives in the room. In this manner, multiple meanings are both welcome and validated, and no one person can claim ownership of the image. Boal’s multiple mirror pairs well with aesthetic education’s goals to “notice what there is to be noticed, and to lend works of art their lives in such a way that [viewers] can achieve them as variously meaningful. When this happens, new connections are made in experience: new patterns are formed and new vistas are opened” (Holzer 1-2).

Image of the Word was by far the most difficult activity for the audience. Volunteers were hesitant to step into the new vulnerability of embodiment, but after a bit of encouragement, between four and nine people actively participated in this exercise at each performance. They were asked to respond to words as simply embodied as

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29 “Embodying: To experience a work of art or other object of study through your senses, as well as emotionally, and also to physically represent that experience” (Holzer 3).
“strength” or “fear” as well as more abstract concepts like “change” and “pink.” Some participants had clear ideas of what they wanted to convey and did so quickly and clearly, while others struggled to generate ideas and used humor as a defense mechanism. After participants revealed their images for the word “change,” one participant said, “don’t judge me” (Feb 2) as audience members laughed. Their images for this prompts ranged from literal interpretations of changing one’s clothing or pocket change to a runner’s stance meant to be ‘racing for the cure’ to initiate change. One of the most powerful moments within this exercise sprang out of the January 26 workshop in which I allowed the audience to choose the third word they wanted to embody. They overwhelmingly voted for “scar.” As participants struck their poses, some held parts of their body protectively, indicating either surgical or self-inflicted scars. Others indicated emotional pain through posture and facial expression, and one stretched her arms wide as if to represent crucifixion.

At this point the workshop’s environment became electrified; the quiet became deeply contemplative and one woman wept silently. Those in the audience remarked upon the multiple interpretations of the same word and noted that none of the participants would look at another; they were all looking at their own ‘scars.’ One participant spoke of the different ideas about scars that had been put forth, both the ugly and the beautiful. She noticed that when we spoke of our own scars, we regarded them as flaws, as ugly things to be covered. It was only in others that most regarded scars as beautiful symbols of courage, as stories waiting to be told. In addition to the meaning made through embodiment, participants had to make connections and create meaning in order to arrive at the image they wanted to convey. They pulled from their personal knowledge and textual memory to connect ‘scar’ to their own appendectomy or to crucifixion and create an embodied image to represent that connections. The various connections made by the actively embodying participants travel out to the audience, whose own insights are sparked by the diversity of images represented.

30 “Noticing Deeply: To identify and articulate layers of detail in a work of art or other object of study…” (Holzer 3).
31 “Making Connections: To connect what you nice and the patterns you see to your knowledge and experiences, to others’ knowledge and experiences, and to text and multimedia resources” (Holzer 3)
32 “Creating Meaning: To create your own interpretations based on the previous capacities, see these in the light of others in the community, and express it in your own voice” (Holzer 3).
Because of the success of this moment in launching momentum into the activity that followed, I attempted to recreate it the following weekend’s workshop, including “scar” as one of my given prompts and leaving open the third as ‘audience choice.’ While it did elicit a good response, it was not the deeply connected engagement with the word we had experienced in the previous week, likely because it did not spring forth from the audience’s own connections and meaning making. This incident reaffirmed Cohen-Cruz’s admonishment to “make it with whoever is in the room” (Local Acts 134). Though I had wanted to recreate the magical moment from the week prior, I was dealing with a different room full of people who had different experiences and responses. This was an important lesson for me as a facilitator. What resonates most strongly with one group of people is not necessarily what another group will connect with; it’s important to always remember to let the participants drive the discussion to where the dialogue is most fruitful.

*Story Circles: Searching for Responsive Understanding*

The final activity of the workshop was a simple storytelling activity partially based on a model of story circles promoted by John O’Neal of Junebug Productions that allows for “deep communication and exchange”(O’Neal) and equity of sharing within the circle. Each of the preceding activities was designed as a warm-up to prepare the audience for the connection and engagement of listening and telling their stories. O’Neal says that “…when people sit down to actually talk together we have the chance to look at the body language, listen to the tone of voice, to question if you're not clear about something or to challenge if you think that's in order.” All of these things work in concert to communicate a message from the teller to the listener(s) and vice versa. It was in this moment that I envisioned the emergence of the aforementioned polyphonic counternarrative I sought. It was here that it would become clear which cultural phantom notes participants were resonating with, and was the clearest forum for the restoration of voice to survivors of catastrophic illness as they began to dialogue within their groups.

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33 Other relevant models of differing methods can be found in the work of Dudley Cocke of Roadside Theatre or Suzanne Lacy. Other cultural and social justice workers (i.e.. feminist consciousness-raising, antiracist, etc) use storytelling as a consciousness-raising tool.

34 For a definition, refer to the Introduction or Appendix Item I: Glossary.
One can hardly mention polyphony and dialogue in the same breath without invoking the work of Mikhail Bakhtin. In “The Art of Dialogue,” Ann Romney positions Bakhtin among other dialogue theorists important in relation to civic dialogue. She says: For Bakhtin, the discovery of truth was not a focus of dialogue, nor was a specific outcome certain. Rather, he saw the goal of dialogue as ‘responsive understanding.’

Several of Bakhtin’s ideas are essential to a contemporary understanding of dialogue. First, dialogism encourages us to recognize and examine the many and varied perspectives that exist in most situations. The multiple voices and perspectives revealed are not framed as either-or choices, but are all viewed as potentially correct. There is not just one idea or two opposing ideas to be debated, but many ideas to be heard and considered. Therefore, dialogue leads not to one certain outcome but rather to many possibilities. (62)

This multi-voiced (or polyphonic), open-ended possibility is important in supporting multiple kinds of experiences and stories as valid and important, and goes hand in hand positively framing the idea of living with ambiguity. Furthermore, positioning the goal of dialogue as “responsive understanding” means that for true dialogue to be achieved, some change must come because of it. Bakhtin’s idea of ‘responsive understanding’ and Freire’s definition of praxis work together to mandate action. Responsive understanding means that the listener must respond to what she has heard and do something about it, as explored by the importance of bearing witness explored in Chapter Two. This is particularly useful in the moments when community-based theatre seeks to initiate change. In my workshops, I was looking for multiple voices and experiences to be heard and valued in order to resist neoliberalism’s influence upon culture that homogenizes perspectives. While the workshop is designed to accommodate any experiences of illness and loss, the hope was for the audience to hear new or lesser-explored stories of breast cancer survivors.

35 Another of LCI’s capacities for imaginative learning. “Living with Ambiguity: To understand that issues have more than one interpretation, that not all problems have immediate or clear cut solutions, and to be patient while a resolution becomes clear” (Holzer 3).
Concerns of Coercion

Though storytelling is both simple and powerful, it also contains the potential for harm. No matter how much the facilitator makes it clear that anyone may simply pass on their opportunity to speak at any time, some may feel pressured to share in response to the generous vulnerability of other storytellers in their circle. They may get caught up in the moment and share something that they later regret. For this exercise, I wanted to be careful not to harm the very people I sought to aid. Furthermore, Cohen-Cruz is careful to note that “[n]ot all storytelling is liberating. One might use personal stories to come to any conclusions. Personal story risks merely reproducing dominant ideology, as with a rape narrative through which the victim blames herself” (“Redefining” 109). Context is important, as is critical reflection of what is being reified in the telling.

Storytelling Praxis

As I transitioned from Image of the Word into Story Circles, I briefly introduced the audience to Arthur W. Frank’s idea of the ‘wounded storyteller’ in order to lay out my reasoning for the activity, and indeed for the workshop as a whole. Audience members were directed to sit in circles of three to four and share amongst themselves as they felt comfortable for 20 minutes regarding the following prompts:

• Tell of a time when you realized the value of your own health.
• Tell of a time when the way you saw yourself was drastically different than the way you found others to perceive you.

The first prompt was designed with the hope that cancer survivors would tell their own illness narratives, but allowed enough room for others who had experience the illness or loss of a loved one to connect as well. The second prompt was intended to broaden the scope of discussion for the younger undergraduate student audience demographic. It was my concern that they may not have a great deal experience with illness or loss at this point in their lives, so I added an alternate prompt that followed another important theme from My Left Breast. It was eliminated following the very first performance when it became apparent that even those who had no personal experience with catastrophic illness, nearly everyone had lost someone close to them. This provided enough traction to enable solid participation in the first prompt, which was the focus of the inquiry.
The initial movement of audience members to form groups was always hesitant and required a bit of urging. Once established, group sizes tended to be closer to five or six on average rather than three or four as instructed. Some of this may have resulted from a ‘safety in numbers’ impulse; it’s much easier to disappear into a larger group and avoid the vulnerability of telling one’s own story. Groups also tended to compose themselves of audience members who had come to the performance together, and this may have had an impact upon the stories they told. Based on the companion they arrived with, might they tell a story that was less revealing about themselves? Might they tell their story with less context or detail because their companion had already heard it multiple times? On the other hand, forcing separation of friends into different groups might sever a feeling of security that allowed some individuals to share in the first place. The November 10 audience initially declined to participate in story circles at all. This may be in part because it was the most sparsely attended workshop with only 13 in attendance who were spread throughout the theatre rather than grouped, making it more difficult to comfortably ‘hide’ in a crowd. When asked to gather into groups, no one moved. After a few failed attempts to encourage participation, I was ready to move on when a man asked if he could share with the whole group. After he spoke, five others went on to tell their own stories with the large group as well, and the exercise was by and large successful. In all of the other workshops, once the ball got rolling, however, people seemed very comfortable engaging and sharing freely with few exceptions.

When asked following the exercise how they felt while telling their stories, individuals at multiple performances said that they felt safe.36 One man indicated that the environment was “warm and caring,” (Nov 8) while another said that there was, “no risk” in the “safe space” (Nov 10). Though every attempt was made in the design of the workshop to achieve this, the work benefits from the raw honesty and vulnerability of Susan Miller’s text. Participants may have subconsciously reacted to the experience of watching Susan/me bare her/my soul and responded in kind. Based on their commentary, a few participants believed I actually was Susan despite my name listed as performer in all of the publicity materials and the full-page actor biography included in the program. The empathetic bond formed between actor and audience clearly carried through into the

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36 For a review of theories about safe spaces, see Öster et. al, Campbell et. al, or Holly and Steiner.
workshop. Another woman said, “It felt safe (Three people agree vocally agree with her, saying, ‘Yeah.’) because you’re laying the foundation for ‘It’s okay for you to share your most intimate things’ which doesn’t always happen. Because someone asks for those details it gives you freedom” (Nov 10). There is a powerful sense of freedom in telling a stranger. It seems as though there is less at stake in the telling; even if the stranger reacts negatively, the teller can simply choose never to interact with him again.

This theme of being ‘given permission’ arose throughout the workshop series. The very act of asking for their stories seemed to free certain participants (primarily women) from the “feeling that you’re not allowed to tell” (Nov 8). Another said, “It felt more freeing to get it off my chest,” (Nov 9) and another “felt at ease because everyone has their own story, so [he] had permission to tell it” (Jan 26). Over the course of the workshop series, seven people told their stories publicly for the first time. Others told their stories to colleagues or friends who hadn’t known them before.

An overwhelming proportion of participants mentioned a feeling of connection as they both told and listened to stories within their groups. Storytelling made them feel “not alone,” (Nov 8) “good to find someone who wears the same shoes,” (Nov 8) and that it is “amazing how connected we can be” (Nov 8). Others drew parallels from this feeling to the difference between knowing something and understanding it:

You know intellectually that others have been through experiences like yours. You know that other people have experienced loss just as deeply or more deeply than you have. But it’s another thing to have a visceral reminder of that and hear it. And even though you’re a stranger that’s a part of your shared identity. (Nov 10)

At the Nov 9 workshop, a surprising number of participants had experienced specifically stage IV melanoma in loved ones, and they spoke of how nice it was to be able to speak in shorthand. The others already knew about the disease, so they didn’t have to preface each part of their story with an explanation; their listeners already knew, already empathized with their situations. One woman said that it was freeing to get it off of her chest to someone who already understood because of a sense of responsibility she felt the listener. “You don’t have to give more background. I didn’t feel like I was burdening
anyone. Because sometimes you talk to your friends they’re always thinking, ‘What do I say to that?’ And you can see that in their face when you’re telling them” (Nov 9).

The teller’s interpretation of the listener’s desires became a recurring theme as others related experiences of previously telling their illness stories in their daily lives. One man spoke of his difficulty returning to everyday life following the death of his young daughter to cancer. He said that people became awkward and were unsure how to talk to him following such tragedy. “You learn how to read the person addressing you. You decide: do they really want to hear this story, or do they just want to console you?” (Nov 10). Another young woman spoke about frustration with the listener’s urge to console. Immediately following her father’s stage IV melanoma diagnosis, she spoke about her fears for his health with her mother-in-law, who immediately shared her own story of having skin cancer removed. She said, “‘Oh, it’s no big deal, it’ll be fine.’ But I’d already researched it. She had good intentions and was just trying to connect, but it was more like… it’s kinda nice to have someone just listen and absorb it. She was just trying to offer a fix to make me feel a little better. But sometimes that can be destructive” (Nov 9). These participants felt silenced by their listener’s inability to process or handle the information they were sharing. Another woman cried as she spoke of her “craving” to tell the whole story of losing her young daughter to cancer; she’s told bits and pieces to various people, but never the whole thing. She wants to be able to talk about both the tragic parts of her daughter’s illness as well as the laughter they shared even through treatment. She spoke of how frustrating it was to walk into a room following her daughter’s death only to have everyone suddenly become silent and sad; she had been reduced to the sad cancer mom instead of a whole person” (Jan 26).

That so many workshop participants spoke of being frustrated with their listeners indicates a betrayal of the understood teller-listener contract. “To enter into the confidence of this testimony draws the listener into an ethical relationship with the other. ‘Ethical,’ because: to become a listener or an audience member of testimony, is to encounter what Emmanuel Levinas describes as the infinite responsibility to the other person” (Fisher 114). It is no wonder that these participants seem frustrated; their listeners have either avoided or misunderstood their responsibility. The performance and workshop prepare participants to be responsible listeners by engaging their empathetic
response, first to ‘Susan,’ and then to one another by valuing the multiplicity of perspectives in the room. This is important to the creation of a polyphonic counternarrative because the various stories must be admitted and balanced among the others. As in choral ensembles, singers must constantly and actively listen to those around them, responding to changes in dynamics, tempo and pitch in order to blend as a cohesive unit. The danger for nondominant breast cancer narratives lies in a violation of the teller-listener contract, that even when room is made for a story to be told, there is no guarantee that it will be received.

A few participants did struggle with the storytelling exercise. Although every attempt was made to allow participants to decline the opportunity to share, some did feel pressure to contribute. These individuals tended to speak about their feelings about sharing in metaphors with vivid imagery. Their comments support O’Neal’s idea that “[s]tories conjure images that mimic the experiences to which they refer as opposed to ‘proving’ things through a series of logical exercises” (“Stinky” 125). One woman in particular stated, “I like having ownership so that my stories can belong to me. Sometimes I just want to share my story with the wind” (Nov 8). She explained that she was worried and embarrassed, wondering if what she was saying would be accepted. This hesitancy is certainly understandable when one reflects upon the gift that is autobiographical storytelling. “To tell one’s story is… a profoundly generous act and furthermore to be entrusted with this story places great responsibility on the… audience member” (Fisher 113). One young woman framed the experience with a metaphor, saying, “Telling your story is like giving away a piece of yourself, like you have this bucket of pebbles that make up who you are and with each story you hand out a pebble. [I feel] All at once light but more grounded” (Nov 8). This woman’s explanation of her experience indicates a connection to those in our temporary community that she envisioned lasting beyond the timeframe of the workshop. To give away (as opposed to lending) a piece of oneself is a permanent act, and one involving both trust and vulnerability. These metaphors also demonstrate O’Neal’s assertion that “storytelling rests on analogical – as distinct from logical – thinking” (“Stinky” 125). It’s through this analogical thinking that story circles connect to social justice; consciousness is raised and
participants move from oppression to awareness to action. Responsive understanding means that the listener must respond to what she has heard and do something about it.

**Special Workshop Demographics**

Self-identified breast cancer survivors were present at each workshop, and their experiences ranged from years in remission, to recently finishing treatment to having just begun after a recent diagnosis. They generally fell into the same general demographics that pink ribbon campaigns currently reach: white women who appeared to be middle class and range in age from 30s-50s. One of the most interesting interactions was with a survivor who was telling her story for the first time in public. Once she acknowledged herself as a survivor, though, she was one of the most active participants in the workshop with a great deal to say. She cried as she spoke about feeling silenced, “This is the first time I’ve ever said it out loud. You don’t know who you pass by that has it. Most women don’t talk about it. You just get your prosthesis and go about your merry business with your cute little wig on and your smile. And you don’t know who’s going through it. There are so many people who are surviving out there” (Nov 9). People responded warmly to her, telling her that this was the place and we were the people to hear it. She spoke repeatedly about her uncertainty and mistrust of the medical community based on her experience with repeated missed and misdiagnoses. Her voice got softer and more intense as she urged the younger women in her group not to rely too heavily on mammograms and to be their own advocates for their medical care. She and other survivors spoke about both the physical and emotional loss of their experiences. One woman said,

The part about loss, the losing of the breast, [is] that it’s not as much about physical but there’s much more to it. I’ve had two mastectomies and two reconstructions. When being diagnosed, it’s like ‘get this thing off of me,’ but then there is a loss that you feel, and it’s hard to describe. Mastectomy is amputation but no one thinks of it that way. (Feb 2)

This was echoed by another woman who identified deeply with Susan’s monologue to her therapist in which she describes being “shorn of image” (Miller 8). She said, the “part
that hit me… the hurt and leaky thing, how she’d lost her identity; that’s the thing that’s with me every day” (Nov 10).

And while the active contribution of these survivors was important and valuable, there were also others who were more quietly present. There were several audience members that I judged to be survivors based on their reactions to certain parts of the performance, a certain kind of connected eye contact or a knowing smile as I performed Susan’s story. Some of these women left after the performance, thanking me for the show, but declining to participate in the workshop. A few stayed for the workshop and simply sat and listened to others’ discussions. One woman only self-identified as a survivor after the workshop ended. As people were shuffling out, she came to speak to me and another survivor who had been present. She had only very recently been diagnosed, undergone lumpectomy and begun chemotherapy. The evening before, she had realized that her hair was falling out and asked a friend to shave her head. The performance of *My Left Breast* was the first time she’d ventured out in public with her wig, and the workshop gave her the opportunity to make some connections and find a community of survivors she was looking for. The temporary community of survivors I had set out to reach gained potential for lasting impact in a small way as they exchanged contact information and the survivor who was many years post-mastectomy shared some of her own experience and advice.

Another self-identified survivor who was mostly quiet during the workshop was engaged and took notes whenever I mentioned a resource for breast cancer advocacy or a book about pink ribbon culture. She was two months post-mastectomy and had been telling her story through a blog and spoke of how much she valued the sense of encouragement and connection she found through the comments people left for her. She said, "I put myself out there and found I was really happy with that. I found all kinds of people chime in and help out and you can find other people going through the same thing and get a sense of support… By sharing you have a community and support from that community" (Nov 10). Her public openness was contrasted by the survivor who had been telling her story for the first time publicly who talked about her own internet presence in relation to her illness. She said, “That’s funny because on my facebook nobody even mentions it. I won’t allow it. Until this, you really had to be in my circle to know” (Nov
9). She maintained tight control on who was allowed to know and how and when it was referenced in public because she was aware on some level of the ways that breast cancer performs within the public’s imagination as she experience the weight of their gaze upon her. Another survivor spoke about how the loss of her hair impacted her style. She said that when she was ill, scarves were difficult to find and people mostly wore bandanas when confronted with chemotherapy-related alopecia. So instead of focusing on the scarves she couldn’t find, she began to wear flashy earrings in order to show some of her personality. Again, her story focused on controlling the ways in which people perceived her, and acknowledging the phenomenological concept that “to be in the world is to encounter other people, and part of our awareness is an awareness that others perceive us, judge us, and set limits for us” (Fortier 41).

While breast cancer survivors and their stories were much sought-after as my target demographic for the audience, I did have some concerns about the potential for their positions as experts on the experience of the disease to silence other potentially valuable insights from other participants in the workshop. This can stem either from participants fears of saying something ‘wrong’ to someone who has lived through it, or simply through the intensity of focus shifted to a single person’s experience as ‘more valuable,’ leaving less time for other stories to be told. For the most part this was not the case in the My Left Breast workshop series. While survivors made active contributions, they were selective in what they chose to share, which opened the floor to all kinds of experiences to speak. There were two occasions when conversational dominance of a breast cancer survivor may have been due to the authority found in their roles as expert. The first was in a story circle composed of two undergraduate women and a breast cancer survivor and her husband, both of whom were in their early fifties (Nov 9). The woman and her husband took a decided lead in telling their stories, tending to speak as a cohesive unit at times. The survivor spoke of her experience, certainly, but also of their experience working through her illness together. Their unified front may have been intimidating to the younger women in their group, but it also may have had to do with the differences in their age. At the final performance of the series, one survivor began to dominate conversation simply by being the participant most ready with a response to my inquiries.
At that point in the workshop, however, we had shifted into the final debriefing moments before concluding, so most had already had a chance to say what they wanted.

Another group that was of special interest to me was that of the men who were present. As discussed in Chapter 1, because breast cancer is popularly considered a woman’s disease, and because the pink ribbon movement doesn’t really represent or make room for them, the majority of men tend not to invest as much time or energy in breast cancer advocacy. Because of this, I had hoped that some male breast cancer survivors might find their way into my audience, but none publicly identified themselves if they did. The men who did attend made up only about twenty percent of the audience composition. They were by and large students who were required to see the show for a course, or they were the significant others of these students or the breast cancer survivors who attended. Most of them looked to be in their early twenties, with a handful of middle-aged men as well. Several chose to simply remain as silent observers, though most did participate in the values clarification and storytelling exercises. While I did my best as a facilitator to make sure everyone felt welcome to participate, it seemed that in some cases the cultural baggage of the pink philanthropy was still scripting these men’s behavior. If breast cancer is a woman’s disease, then what right have they to speak about it?

There were notable exceptions to this who provided valuable contributions to the experience of the workshop. The first was the man from the husband/wife survivor team previously mentioned. He was actively involved in the storytelling with his wife, mostly likely because they framed parts of her illness as their experience, not simply hers (Nov 9). He already had ownership over his part of the story and was able to tell it freely. One young man was ‘dragged’ to the theatre by his girlfriend, but ended up really enjoying and participating in the work. He spoke about how comparing the stories in his group “made them seem like unifying threads” and said that Miller’s “comparison of the cure to [little league] was great since he grew up playing baseball” (Jan 26). Several men also connected with Susan’s breakdown at the moment when the doorman eats her pizza. One man positioned the loss of the pizza as the “loss of comfort” (Nov 10) and really seemed to understand the moment when things simply become too much and a person snaps and unloads on the nearest living being. It seemed at times as though the men were the most
impacted by the workshop in terms of consciousness-raising. Several spoke of being “surprised by the negative connotation with awareness,” (Jan 26) and had no idea that any such critique of pink ribbon culture existed (though this was true of some women as well). These reactions to Susan’s story and the others heard in the workshop demonstrate that “[w]hen we tell stories, we are sharing with each other how we put things together. When we share stories, we share whole parts of ourselves. Stories come charged with the spirit of the teller but have lives of their own” (Yuen 4). These stories’ lives ‘of their own’ are what form the basis of creating new phantom notes for individuals to resonate with; it’s easier to shift the pitch to a different frequency than to stop the vibration altogether.

For the most part, men did not dialogue directly with women while we were reflecting upon activities in the large group. They would speak up and offer opinions and insights, but almost never in response to something a woman had said. One exception to this arose when a man critiqued the moment in the play when Susan chooses not to fill a prescription from her doctor. Directing his question at me, the facilitator, rather than the audience at large, he said “Doesn’t it seem like she’s given up” (Feb 2)? A current breast cancer patient from the audience responded directly to him, saying, “I took it as she was taking control of her own body. Saying ‘I’m making a conscious choice to be in control of my own health’” (Feb 2). This was an important exchange that began to get at the dichotomy between medical hegemony and patient agency and would have been an opportunity missed had he not chosen to speak up. It may never have occurred to this young man of middle class privilege that a woman’s decision to ignore her doctor’s medical advice was inextricably linked to the desire for bodily autonomy, something many young men never have need to question for themselves. Susan’s decision was based upon the experiential knowledge and trust of her own body, and this exploration was made possible by the trust in the community of the workshop that had been built over the course of the evening. “Having laid a basis of mutual respect and listening, people can then approach points of contention and issues of injustice productively and with fresh perspectives” (O’Neal, “Stinky” 144).
Wrapping Up

After reflecting upon the storytelling activity, I gave the group an opportunity to speak more broadly about the experience as a whole. They were invited to discuss their responses to the play itself, and perhaps more importantly, what they were going to take away from the experience. In a workshop that encouraged living with ambiguity, clearly defined action was perhaps less visible, but certainly still present. Evidence of audience members taking action was most present in their changes in thinking. On woman said “that she didn’t realize how people have to live up to a cancer story, meeting those expectations for other people, [and] that the scene with the ironing shirts and cocaine opened her eyes” (Jan 26). For this participant, this was a very new idea. Another participant suggested an action item for me, saying, “Maybe you should do something like this for the medical profession to help them get some more humanity” (Nov 9). One young man was “shocked that one person opened [his] mind,” saying “I know about breast cancer, not about the personal, just medical facts.” The performance and workshop had given him a new empathy for patients and survivors. He promised to “pay more attention” to representations of breast cancer patients in the media in the future (Nov 8).

After everyone had the opportunity to have their last word, the audience was thanked for their participation and released, yet several people lingered at each performance. Most of these individuals were seeking deeper community. Some exchanged contact information and made plans to get together at a later date, while other continued swapping stories. This was especially true of breast cancer survivors, who tended to gravitate toward each other at the end of the event.

The Absence of Critique

The man’s reference to the moment he “didn’t like” (Feb 2) when Susan chose non-compliance with her medication was some of the only moderately confrontational reaction I received at all during the project. While I’d love to think that the performance and workshop were simply so well-designed and executed that there was nothing to critique, I know that this is not the case. There are any number of things that I would

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37 “Taking Action: To try out new ideas, behaviors or situations, in ways that are neither too easy, nor too dangerous or difficult, based on the synthesis of what you have learned in your explorations” (Holzer 3), i.e. in the workshop.
change to improve upon for the future, and analyzing critique can be an important part of the reflection process so important to community-based theatre. So what might this virtual absence of negative feedback mean? Some audience members’ choices to sit silently and not participate might be framed as one form of critique. It is possible that I put my critique of pink ribbon culture a bit too far forward. Resistance can often be a site of productive dialogue, so I find myself curious where the voices that echoed the dominant narrative of breast cancer culture were and what does their absence mean?

Given the inherent authority in my position as facilitator, some participants may not have felt comfortable voicing their disagreement with this. While it is impossible as human beings with opinions and positions of our own to remain totally neutral as facilitators, the best option may often be to put those opinions aside momentarily. “Sometimes this means suspending one’s own agenda as facilitator in order to allow the community to articulate its concerns. At the same time, in order to avert a kind of ethical relativism, [facilitators] should prepare to make choices and take responsibility for decisions that reflect their own social and political worldviews” (Armstrong 114). This balance between suspending one’s agenda while taking responsibility for decisions made about facilitating can be a difficult one to find. In this case, I found the line that I was comfortable with by recontextualizing the argument with myself in the audience’s shoes. If I were in the audience, how would a facilitator who had a clear agenda to undermine a philanthropic organization I hold dear impact me? How much criticism is good food for thought, and how much can I take before I shut down and start ignoring everything else the facilitator has to say? My goal as a facilitator is then to push at the boundaries of that line without crossing it and alienating my audience. My role is to get them to consider new perspectives by getting them to open to their fellow participants and listen deeply.

Another reason for this lack of critique may be the play’s subject matter. Even though Susan Miller’s writing flies in the face of the idea of the cancer ‘she-ro,’ the referents are still present. Because culture has deified the cancer patient, it becomes taboo to criticize either Susan or me, still functioning in the post-performance moment as her surrogate (Roach). The members of the audience who refer to me as Susan make it clear that to at least some of them, I am still functioning as her even after the transition from

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38 For more explanation, see Chapter One, or Gayle Sulik’s Pink Ribbon Blues.
play to workshop. This resistance to naysay the catastrophically ill was evidenced in part by Arlene Croce’s infamous non-review of Bill T. Jones’ *Still/Here*. Jones’ dance theatre piece incorporated footage of interviews with terminally ill individuals. Because of their integration into the work, Croce, who refused to see the work, called it “victim art,” “unintelligible as theatre,” and “beyond the reach of criticism” (16). All of this is wrapped up in the compulsory optimism of the pink ribbon movement. The very thing I hoped to critically engage makes it difficult to spark a dialogue. Perhaps this might have been less of an issue had someone other than the person who performed as Susan led the workshop.

**Conclusion**

The *My Left Breast* series of workshops that ran between November 2012 and February 2013 provided an opportunity for community members to learn about the experience of breast cancer in ways they may have never before considered. Using community-based theatre format for the workshop allowed them input and investment into the inquiry, grounding it in their own experiences to make it relevant to their own lives. Its focus on process and reflection allowed me to think critically about the meaning audiences were making as it was happening and enabled me to shift course midstream to be responsive to audience needs. Framing an evaluation of their learning around the LCI’s capacities for imaginative learning allows for a clear look into when learning is happening and provides insight into ways that activities might be more pedagogically-driven in future workshop iterations.
Works Cited


“Roadside Theater’s Story Circle Methodology.” Roadside Theatre. 1999. Web


CONCLUSION

“A woman should be able to say
I've become an Amazon,
Warrior woman minus a breast,
The better to shoot arrow
After fierce arrow”
-Alicia Ostriker

This practice-based research project varies in execution from the work of many creative theses, which often select a dramatic text to direct and focus upon, with dramaturgical analysis and reflections from a director’s point of view. By contrast, the focus of my work remains upon the post show workshop. The performance serves as a means to gather an audience with which to dialogue rather than the focus, so much choice of Miller’s My Left Breast was important only inasmuch as in engaged the audience’s empathetic response and prepared them to think about the issues to come in the post-show workshop.

The research leading up to the workshops prepared me to be a better facilitator. Althusser’s admonition for the artistic practitioner to have a “profound knowledge of his moment in history” (Kowsar 3) resonated deeply with my growing understanding of praxis, of the meeting of theory and practice leading to action. Most especially as an outsider to the community I focused on, context and historical understanding of the issue was vital. Insider or outsider, no understanding of the experience of the experience of breast cancer can be complete without knowing the history of its treatment and advocacy explored in the Introduction and Chapter One. And to understand what I asked of participants in my story circles, Chapter Two explores a deeper knowledge of the whys and hows of autopathography.

Analysis of the workshop outcomes in Chapter Three demonstrates the discovery and/or strengthening of community between participants, who spoke of feeling ‘connected’ and ‘not alone.’ Returning to the central question of the thesis, using Susan Miller’s My Left Breast as a means to engage a community of survivors, advocates and the general public, this thesis asked: Can a community-based theatre event focused on exploring breast cancer counternarratives provide both a therapeutic space for survivors
to tell their stories as well as encourage the audience to think more critically about how culture works to influence narratives emerging from breast cancer culture? Based on my analysis of my own workshop series, I would say that a community-based theatre event can at least begin this work. The workshop provided a forum for breast cancer survivors to share their stories if they wished to do so, and several took the opportunity. How therapeutic the action actually felt for the survivor remains undetermined since I created no mechanism for individual follow-up because of IRB restrictions, but the space was provided and all were generally positive about the experience both during and after the workshops.

But did the audience begin to think more critically about breast cancer culture? Did the polyphonic counternarrative emerge? I believe the answer is yes to both. Participants entered the workshop with varying kinds of life experiences that positioned them in different locations along the ADI continuum of impact, but they all seemed to have moved some distance along it before the close of the evening. Some gained new knowledge about the added difficulty imposed by the dominant neoliberal pink ribbon cultural narrative upon breast cancer survivors; this was revolutionary information for some. Others engaged in discourse that allowed them to see the issue from multiple perspectives, some potentially heretofore unexplored, while others experienced a change in attitude on the issue.

While I’d like to think that the workshop urged them to progress along the second half of the continuum to developing new capacities, taking action and changing policies, I have no evidence that such a change occurred. ADI’s view of discourse hinges upon multiple perspectives being welcomed and explored, a concept that resonates well with LCI’s concept of living with ambiguity, which allows for multiple interpretations of issues, emphasizes that sometimes there are no easy or clear solutions to problems and embraces patience while searching for resolution. In this formation, living with ambiguity is not simply accepting complexity, but accepting it while continuing the search to resolve it, linking to Bakhtin’s idea of responsive understanding. His polyphonic view hinged upon action as a necessary element of dialogue, echoing Freire’s goal of transformative action through praxis. These converging frameworks yielded new perspectives and horizons for the audience, and for me a deeper understanding of the
importance and function of civic dialogue within social justice. The civic dialogue experienced in these workshops built upon the counternarratives begun by survivors such as Miller, Lorde, and Kushner.

Despite this guarded success, a great deal of cultural work remains. We are entering a new era of breast cancer treatment through the expanding practice of prophylactic mastectomy. Since the development of screening for BRCA-1 and BRCA-2 in the mid-1990s, many women who test positively for these genes have chosen preventative mastectomies in light of their drastically increased risk of developing breast cancer to around 80%. Hollywood royalty Angelina Jolie recently revealed her own decision to undergo double mastectomy and reconstruction in early 2013, leading to widespread debate about the practice. Proponents of prophylactic mastectomy say that it is about taking control of one’s own body and future and controlling both to the greatest extent possible, but opponents claim that especially with celebrity endorsement like Jolie’s, it can spin into a place of fearmongering where women are taking potentially unnecessary medical violence upon themselves. Wise advocates tread carefully about weighing in too heavily on one side or the other because ultimately it’s still a question of a woman’s bodily autonomy and making the decision she can best live with. So even as treatment and screening options improve, public discourse grows more complex, calling out for the polyphonic counternarrative to validate whatever choices a woman makes as best for her own body. Culture continues to shape and influence the discourse around breast cancer even as technological realities evolve, but civic dialogue created through participation in community-based theatre events can help individuals think critically about how it’s being shaped, by whom, and to what end.
Works Cited


APPENDIX
Appendix Item I: Glossary

**Autopathography**: According to Philip Auslander, “autobiographical accounts of illness, injury and disability” (16); see also ‘pathography.’

**Conscientization**: concept of critical consciousness-raising made popular by Paulo Freire’s *Pedagogy of the Oppressed*. According to the Oxford English Dictionary, “the action or process of making others aware of political and social conditions, esp. as a precursor to challenging inequalities of treatment or opportunity; the fact of being aware of these conditions.”

**Counternarrative**: positional narratives that reject or revise the dominant narrative, often with concerns of social justice as motivation.

**Image Theatre**: A tool used in Augusto Boal Theatre of the Oppressed that “consists of physical representation of thoughts and ideas through the raw expression of the body, an individual’s most fundamental artistic tool. In Image, participants explore issues of oppression by using nonverbal expression and sculpting their own and other participants’ bodies into static physical images that can depict anything concrete or abstract, such as a feeling, issue, or moment. Spectators are asked to observe these images and reflect on what they witness” (Thompson).

**Lumpectomy**: a surgical procedure in which early stage breast cancer tumors are removed while leaving as much healthy tissue in place as possible; a less invasive alternative to mastectomy.

**Mastectomy**: a surgical procedure in which varying amounts of breast and surrounding tissue are removed in order to prevent the spread of cancerous cells.

**Pathography**: According to the Oxford English Dictionary, “The study of the life of an individual or the history of a community with regard to the influence of a particular
disease or disorder.” More informally, it can simple be described as a story or account of illness.

**Phantom note:** Jill Dolan’s utopian concept of a fleeting performative moment with “community resonance and social implication” (18).

**Pink ribbon culture:** the customs, ideas, and behaviors that mark breast cancer advocacy. These include: a focus on consciousness-raising, research funding for a cure, neoliberalism, consumer-based philanthropy, gender-based stereotypes, individualism, and compulsory optimism, ability and heterosexuality.

**Polyphonic Counternarrative:** My own extension of Jill Dolan’s “phantom note” as a musical metaphor. It refers to the dominant narrative of pink ribbon culture as a monotone and suggests that the addition of a body of resistant narratives to that monotone could create a polyphony like that found in a choral ensemble. See an extended definition in the Introduction. See also: ‘counternarrative.’

**She-ro:** Medical sociologist Gayle Sulik’s conception of the breast cancer hero. She is stereotypically feminine superhero: untiring, always upbeat and always positive.
Works Cited


Appendix Item II: IRB Approved Informed Consent Process

The workshop’s facilitator will, following the performance of the play, deliver the following speech (number 1), and direct the audience to the following text which will be published within the playbill (number 2):

1. Text for Speech

Good evening and thank you all for coming tonight. In a few moments we will begin a workshop that I’d like to encourage you all to stick around for. This workshop is part of my research for my master’s thesis as a graduate student at Miami University, and it will touch on your own experiences with illness or loss using simple storytelling techniques and some theatrical games for non-actors. We are going to take a short break now, and during that time I’d like to refer you to page x for more information about the study. At this time you can make one of three choices: you can go, stay and listen, or stay and participate. It’s entirely voluntary and you can choose to participate or decline as you choose at any time for any reason during the workshop. It’s also important for you to know that there is a note taker in the room, but she will not record any information to identify you personally, nor are there any other recording devices in use. Everything that happens here tonight will be confidential within my research, but remember that full confidentiality cannot be guaranteed due to the other individuals participating in the discussion. Please respect each other’s privacy and honor the contributions made here tonight by not discussing them once we leave here. Please only provide information that you feel comfortable with others knowing. Again, you will have plenty of opportunities to depart, and you may opt out at any time. Also, if you are under the age of 18, please come to see me during the break. We’ll get going here in just five minutes.

2. Text for playbill

After tonight’s performance, you are invited to participate in a workshop that explores responses to illness or loss. You will be asked to respond both verbally and nonverbally to a series of prompts, as well as share your own personal experiences if you so choose.

The workshop will run approximately 45 minutes and participation is entirely voluntary;
you may discontinue participation and/or depart at any time for any reason, and you may decline to respond to any individual questions. This workshop is part of a Master’s thesis study that examines how to use theatrical interventions in the engaging civic dialogue for public health education. A note taker will be present to record the discussion and workshop here tonight, but no personal identifying information beyond your gender will be noted, and no other recording devices of any kind are in use. You will not be asked to do anything that exposes you to risks beyond those you experience in a classroom discussion. I will protect participants’ confidentiality within my research, but full confidentiality cannot be guaranteed due to the other individuals participating in the discussion. Please respect each other’s privacy and honor the contributions made here tonight by not discussing them outside the workshop. Please only provide information that you feel comfortable with others knowing.

Because of the nature of the research conducted this evening, participation is limited to individuals 18 and older. Minors may remain to observe if accompanied by a parent or guardian, but it is asked that you inform the facilitator of your decision to do so.

If you have further questions about the study, please contact me, Sarah Senff, senffsa@muohio.edu, or my thesis advisor Dr. Ann Elizabeth Armstrong at armstra2@muohio.edu. If you have questions about your rights as a research participant, please call the Office of Advancement of Research and Scholarship at 529-3600 or email: humansubjects@muohio.edu.

Your choice to remain and participate following the break at the end of the show signifies your agreement with the following statement:

I agree to participate in the study of storytelling as a response to illness or loss. I understand my participation is voluntary and that my name will not be associated with my responses. I further acknowledge that I am 18 years of age or older.
## Appendix Item III: Other Workshop Data Analysis

### My Left Breast Post-Show Data

**Word Association Grouped by Prompt**

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### Other Workshop Data Analysis

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1. **Appendix Item IV: Other Workshop Data Analysis**
   - **Survivor:** Nov. 8, 2012
   - **Awareness:** Nov. 9, 2012
   - **Cure:** Nov. 10, 2012
   - **Scar:** Jan. 26, 2013
   - **Cancer Culture:** Feb. 2, 2013
   - **Loss:** Nov. 8, 2012

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2. **Appendix Item V: Other Workshop Data Analysis**
   - **Survivor:** Nov. 9, 2012
   - **Awareness:** Nov. 10, 2012
   - **Cure:** Jan. 26, 2013
   - **Scar:** Feb. 2, 2013
   - **Cancer Culture:** Nov. 8, 2012
   - **Loss:** Feb. 2, 2013

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3. **Appendix Item VI: Other Workshop Data Analysis**
   - **Survivor:** Nov. 10, 2012
   - **Awareness:** Jan. 26, 2013
   - **Cure:** Feb. 2, 2013
   - **Scar:** Nov. 8, 2012
   - **Cancer Culture:** Nov. 9, 2012
   - **Loss:** Nov. 10, 2012

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4. **Appendix Item VII: Other Workshop Data Analysis**
   - **Survivor:** Jan. 26, 2013
   - **Awareness:** Feb. 2, 2013
   - **Cure:** Nov. 8, 2012
   - **Scar:** Nov. 9, 2012
   - **Cancer Culture:** Nov. 10, 2012
   - **Loss:** Jan. 26, 2013

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5. **Appendix Item VIII: Other Workshop Data Analysis**
   - **Survivor:** Feb. 2, 2013
   - **Awareness:** Nov. 8, 2012
   - **Cure:** Nov. 9, 2012
   - **Scar:** Nov. 10, 2012
   - **Cancer Culture:** Jan. 26, 2013
   - **Loss:** Feb. 2, 2013

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6. **Appendix Item IX: Other Workshop Data Analysis**
   - **Survivor:** Nov. 8, 2012
   - **Awareness:** Nov. 9, 2012
   - **Cure:** Nov. 10, 2012
   - **Scar:** Jan. 26, 2013
   - **Cancer Culture:** Feb. 2, 2013
   - **Loss:** Nov. 8, 2012
### My Left Breast-Post-Show Data
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Endless Thanks

My Left Breast
By Susan Miller

Produced by special arrangement with Playscripts, Inc.

Contributors:

Thanks to:

Suspendisse sagittis scelerisque elit.

Endless Thanks

My endless thanks to all of those who helped to make this production possible. I simply couldn’t have done it without you.

~ ~ ~

Miami University Department of Theatre
Miami University Hamilton Theatre
Oxford Community Arts Center

Miami University
Women’s, Gender and Sexuality Studies Program
Greater Cincinnati Breast Cancer Alliance
Pink Ribbon Girls
Bekka Eaton Reardon
Dr. Ann Elizabeth Armstrong
Dr. Paul K. Jackson
Dr. Elizabeth Reitz Mullenix
Dr. Caroline Crosswell
Dr. Susan Moser
Andy Lynn
Keith Arcuragi
Polly Heinkel
Lexi Marsh

Appendix Item IV: Playbill
**About the Actor**

Sarah Senff has a Bachelor of Arts in Theatre from Belhaven University and is currently pursuing her Master of Arts in the same from Miami University along with a graduate certificate in Women’s, Gender, and Sexuality Studies. Her acting highlights include the roles of Mother in *Ragtime*, Aunt Eller in *Oklahoma!*, Cathleen in *Riders to the Sea*, and Irene Adler in *Sherlock Holmes: The Final Adventure*. She has spent some time behind the scenes as well, serving as Director (*Guys and Dolls, The Memory Trilogy, I Dream Before I Take the Stand*) and Production Stage Manager (*Jenny Wiley Theatre, Kentucky Shakespeare Festival, Shattered Clay Drama Troupe*), among other roles. She toured nationally with Acquire the Fire and is a mezzo-soprano who sang for two seasons with the Columbus Symphony Orchestra.

Sarah’s current research focuses on applied theatre, theatre for social change, feminist theatre, and representations of illness on the modern stage, especially concerning women and cancer. Her master’s thesis focuses on the potential for autobiography and storytelling to serve as a therapeutic means to restore the voices of those who have experienced silencing or erasures of identity as a result of cancer and its treatment.
After the Show

After tonight’s performance, you are invited to participate in a workshop that explores responses to illness or loss. You will be asked to respond both verbally and nonverbally to a series of prompts, as well as share your own personal experiences if you so choose.

The workshop will run approximately 45 minutes and participation is entirely voluntary; you may discontinue participation and/or depart at any time for any reason, and you may decline to respond to any individual questions. This workshop is part of a Master’s thesis study that examines how to use theatrical interventions in engaging civic dialogue for public health education.

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A Note from the Actor

A friend once told me, “Sarah, you were destined to live your life on a soapbox.” I think she may have been right. The urge to make a difference, to talk about things that matter has never been far from me, and I believe deeply in the power of community-based theatre to intervene in issues that affect real communities.

Sometimes life conspires to make activists out of us; my moment of clarity came after watching family and friends with cancer. The struggle to survive the disease and its brutal treatment was difficult enough, but I watched as their identities seemed to disappear into a haze. They were no longer seen as individuals with interests and flaws and strengths and all manner of colorful personalities; they were the women with cancer.

This performance is about restoring the voice, the identity, that can be lost to cancer and other catastrophic illnesses. It’s about honoring the strength and perseverance required of those who go through treatment while remembering the spectrum of their identities in all their fullness. It’s about giving women permission to have moments when they angry or afraid or frustrated or weary. It’s about letting their family members be more than the little brother of the girl who died of cancer, or the mother that people avoid because they no longer know how to talk to her. It’s about undoing the medicalization of the disease and restoring humanity. “This was the cure for cancer.”

This performance is dedicated in loving memory: to Kelly, lost to ependymoma, but who loved the color purple, her pet hedgehog, and Project Runway. To Marsha, who fought the good fight against ovarian cancer for nearly ten years, who loved riding her bicycle through the hills of southern Ohio, and who baked the most legendary chocolate chip cookies on the planet. And in honor of Erica, who is living with verve and who rocked the post-chemo baldness at her wedding, in sickness and in health.

It is my hope that the work at hand will add complexity to the discourse around cancer and survivorship, because as the great bell hooks once said, "Pink is all about submission, and I wanted to defy."
Breast Cancer Timeline

1894 Halsted radical mastectomy (removes the full breast, surrounding lymph nodes and chest muscle) introduced as a treatment for breast cancer

1940–1960 Ovarian and hormone suppression found to improve breast cancer outcomes

1971 Less invasive mastectomy proven effective

1974 First studies of doxorubicin demonstrate that the drug can shrink breast tumors in women with advanced disease.

1975 Chemotherapy after surgery increases cure rates for early-stage breast cancer

1977 Tumor’s response to estrogen proven to predict risk of breast cancer recurrence

1977 Lumpectomy proves a viable option over full mastectomy for some women, allowing them to retain more healthy breast tissue

1977 FDA approves breakthrough drug tamoxifen

Late 1970s Growing use of mammography saves lives

Mid-1990s BRCA gene mutations linked to increased breast cancer risk. Bone-building drugs help reduce complications of breast cancer and its treatment

1996 Sentinel lymph node biopsy introduced to assess breast cancer spread

1998 Oral chemotherapy drug, capecitabine, approved for advanced breast cancer

1998 Chemotherapy before surgery helps more women benefit from breast-conserving treatment

2000 Breast cancer subtypes identified and treatment tailored to the genetic make-up of a patient’s tumor.

2003 Higher density, shorter term chemotherapy improves breast cancer survival

2004 New class of drugs that block the body’s estrogen production introduced

2005 Low-fat diet and exercise may reduce recurrence

2005 Digital mammography more accurate than standard mammography in younger women

2007 MRI screening recommended for women at high risk

2007 Declining breast cancer incidence linked to lower use of hormone replacement therapy

2007 Shorter course of radiation therapy is as effective as less frequent radiation therapy for early-stage breast cancer

2009 Preventive surgery confirmed to reduce breast and ovarian cancer risk in women with BRCA gene mutations

2010 Targeted drug denosumab helps prevent common bone-related complications in advanced breast cancer

2010 Removing fewer lymph nodes for some breast cancer patients does not impair survival

This timeline contains selected entries from Cancerprogress.net’s “Progress Against Breast Cancer” and was developed by the American Society of Clinical Oncology. Visit cancerprogress.net for more information about the above events and more.
Appendix Item V:
Sample Partnership Proposal Package

My Left Breast

A Presentation for Partnership
A regional tour of Susan Miller’s My Left Breast
in partial fulfillment of the Master of Arts at Miami University

Sarah Senff
4314 Oxford Reily Road
Oxford, Ohio 45056
(740) 571-1183
senffsa@muohio.edu
About the Play
Susan Miller’s *My Left Breast*

Winner of the
1995 OBIE Award for Playwriting
and
The Susan Smith Blackburn Prize for Best Play written by a Woman in the English language.

“A scar is a challenge to see ourselves as survivors, after all. Here is the evidence. The body repairs. And the human heart, even after it has broken into a million pieces, will make itself large again.” -from *My Left Breast*

**Synopsis**

*My Left Breast* is a solo performance by award-winning playwright and real-life breast cancer survivor Susan Miller. The work takes the audience on a journey through her memories. Both funny and heart-breaking, we experience moments in her life as mother, as lover, as cancer patient, as survivor. She takes us along for the ride as she grapples with the loss of her breast, her child, and her romance, as she deals with the indignities of side effects from her treatment that were worse than the disease itself. Through it all, she seeks to draw us in to her confidence, and shares her tales with the audience like old friends catching up over coffee. She makes us believe that there is a light at then end of the breast cancer tunnel.

“I want to tell all the women in the changing booths [being fitted for prostheses], that we are still beautiful, we are still powerful, we are still sexy, we are still here.” -from *My Left Breast*

**Critical Reception**

**The New York Times**

"A metaphor of resilience... done with a self-aware humor and a literary acuteness that make her hour on the stage an enlarging experience."

**The Cincinnati Enquirer**

"Her observations are always astute, usually wry and invite at least an inner smile of recognition. Some are laugh-out-loud funny."

**The Boston Globe**

"With self-effacing humor and gut wrenching honesty, she weaves a tale of personal loss and takes us on a spiritual journey that ends in redemption and rebirth. The laughter is as spontaneous as the flicker of recognition that passes through the audience. She's suddenly Everywoman, standing there for all of us-our mothers, our sisters, our daughters, ourselves."
About the Artist

Sarah Senff

Biography
Sarah holds a Bachelor of Arts in Theatre from Belhaven University and is currently pursuing her Master of Arts in the same from Miami University. She has extensive experience onstage (highlights include Mother in Ragtime, Aunt Eller in Oklahoma!, Cathleen in Riders to the Sea, and Irene Adler in Sherlock Holmes: The Final Adventure), as well as several behind the scenes credits as Director (Guys and Dolls, The Memory Trilogy, I Dream Before I Take the Stand) and Production Stage Manager (Jenny Wiley Theatre, Kentucky Shakespeare Festival, Shattered Clay Drama Troupe). She toured nationally with Acquire the Fire and is a mezzo-soprano who sang for two seasons with the Columbus Symphony Orchestra.

Sarah’s current research focuses on applied theatre, theatre for social change, feminist theatre, and representations of illness on the modern stage, especially concerning women and cancer. Her master’s thesis focuses on the potential for autobiography and storytelling to serve as a therapeutic means to restore the voices of women who have experienced silencing or erasures of identity as a result of breast cancer or its treatment.

Sarah’s Personal Connection

This research is more than simple theory for me. Having lost women in my family to breast and ovarian cancers, and pediatric ependymoma, these experiences birthed the drive to make a difference by any means. I hope to use theatre to partner with existing community organizations to improve the quality of life and mental well-being of survivors and their loved ones, as well as promote public health through education informed by the most current research.
A high quality of life for individuals affected by breast cancer

*My Left Breast* focuses not only on “Susan’s” experience with cancer, but on how she deals with loss. Far from imperfect, she is real and vulnerable and allows the audience glimpses into both her successes and failures and how she found her own personal “cure.”

Compassion for individuals affected by breast cancer

One message of the play is that it is possible not just to survive loss, but to thrive in its wake. “I want to tell all the women in the changing booths [being fitted for prostheses], that we are still beautiful, we are still powerful, we are still sexy, we are still here.”– from *My Left Breast*

Access to high-quality breast health care for all

These performances will allow the GC BCA the potential to reach many new groups that could benefit from further education.

Well-informed members who exercise their talents, skills and expertise to keep breast cancer issues a focus of public attention

I believe that we all have something to contribute in the fight against breast cancer. Even those without oncological expertise or deep pockets can use gifts within their own wheelhouse to make a difference. Theatre is special for its ability to forge connections, create community and foster well-being.

A diverse membership that demonstrates commitment to our mission

*My Left Breast* speaks to both mainstream and marginalized audiences, with specific appeal to the gay and Jewish communities.

Collaboration with other organizations devoted to breast health and breast cancer activities

I am deeply committed to working with local breast health advocates to enrich the experience and match audience needs with community organization resources. Theatre is a collaborative art whose practitioners understand the importance of synergy.

THE VISION:

This touring production of *My Left Breast* serves as a practice-based research for a Master’s Thesis in Theatre from Miami University. It will target audiences of breast cancer patients and survivors, family and friends, patient advocates, and health care professionals as well as the public at large. Community organizations will be invited to provide information and resources to audience members, and workshop will be offered following the performance for any who wish to participate. The workshop will begin with a discussion panel before moving on to a more interactive portion. It will use story circles and other theatre-based community-building activities to provide opportunities for audience members to tell their stories and explore their feelings regarding their own experiences as well as public perceptions of breast cancer.

THE PERFORMANCES (PROJECTED):

November 2012
~Miami University Hamilton

January – February 2013
~Oxford Community Arts Center
~Hamilton Downtown
~Columbus Civic Theatre

THE GOALS:

1. To provide a platform for the recovery of voices and uncover erasures of identity resulting both from the illness, its treatment, and the culture surrounding breast cancer
2. To partner with community organizations with common goals and match audience needs with community resources

HOW YOU CAN HELP:

1. Participate in a post-show discussion panel
2. Assist with promotion and publicity
3. Provide educational materials to provide to audience members
Appendix Item VI: 
*My Left Breast* by Susan Miller

With cuts marked as performed in the Workshop Series

LIGHTS UP: (I COME OUT DANCING. Then, after a moment:) The night before I went to the hospital, that's what I did. I danced.

(Indicates breasts) One of these is not real. Can you tell which?

(Beat) I was fourteen the first time a boy touched my breast. My left breast, in fact. I felt so guilty with pleasure I could hardly face my parents that night. It was exquisite. Well, you remember.

(Beat) I always wonder in the movies when the female star has to appear topless in a love scene and the male star is caressing her nipples, how the actress is supposed to remain professional. See, I don't think this would be expected of a man whose penis was being fondled.

(Beat) Anyhow, breast cancer.

The year it happened my son was eight. He looked at my chest, the day I told him. We had these matching Pep Boys tee shirts. You know -- Manny, Mo, and Jack. He looked at my chest and said, "Which one was it? Manny or Jack?"


"What did they do with it?"

"I don't know."

He starts to cry. "Well, I'm going to get it back for you!"

Now he is twenty and I am still his mother. I am still here. We are still arguing. He is twenty and I wear his oversized boxer shorts with a belt and he borrows my jackets and we wear white tee shirts and torn jeans and he says, "Why don't you get a tattoo?"

"A tattoo?"

"Over your scar. It'd be cool."

Here's what I wear sometimes under my clothes.

(Show BREAST PROSTHESIS to audience) Don't worry. I've got a spare. When you go for a fitting, you can hear the women in the other booths. Some of them have lost their hair and shop for wigs. Some are very young and their mothers are thinking: why didn't this happen to me, instead? And there's the feeling you had when you got your first bra
and the saleswoman cupped you to fit. Cupped you and yanked at the straps. Fastened you into the rest of your life.

(Beat) I miss it but it's not a hand. I miss it but it's not my mind. I miss it but it's not the roof over my head. I miss it but it's not a word I need. It's not a sentence I can't live without. I miss it, but it's not a conversation with my son. It's not my courage or my lack of faith.

(Beat) I miss it -- but it's not HER.

Skinnied on the left side like a girl, I summon my breast and you there where it was with your mouth sucking a phantom flutter from my viny scar.

We met at an artists' colony. One night at charades, (That's what people do there) when an outstanding short story writer was on all fours, being a horse, I sat on the floor and leaned against the sofa. I rubbed my back against what I thought was the hard edge of it. And realized after a minute that I was rubbing against Franny's knee.

"God, I'm sorry."

"Don't be."

"I thought you were the couch."

"It's the nicest thing that's happened to me all day," she said.

In town, one afternoon, we run into each other in the bookstore. It might as well be a hotel room. We might as well be pulling the bedspread off in a fever. We are in a heap. We are thinking the things you think when you are going to run away together. It is only a matter of time.

"You don't finish your sentences," she said.

"I've been told."

"I'm starting to get the drift, however. I know where you're headed."

I was headed toward tumult, headed toward breakage, headed toward her.

(Beat) It's been a year since she left me and how do I tell someone new? Even though it will probably be a woman. See, a woman might be threatened. A woman might see her own odds. She might not want the reminder.

I threw on my ripped jeans and a pair of — I pulled on my black tights under a short-black skirt — I threw on a white tee shirt and an oversized Armani Jacket — my hair was, well, this was not a bad hair day.
"I guess it's a date," I said to my therapist. "Two single gay women who don't know each other except through a mutual friend. I guess you'd call it a date."

"Do you realize you called yourself a gay woman? I've never heard you refer to yourself that way before."

"Well, it just doesn't seem to matter anymore. What I'm called."

"You mean, since Franny left. Interesting."

"You sound like a shrink."

"Why do you think it doesn't matter anymore," she says.

Because, I want to say, when you're a hurt and leaky thing, all definitions are off. What you were, who you told everyone you might be had a sheen, the spit of artifice. There was always something covert--But now, you've come apart. Like an accident victim in shock, you don't see who sees you and you don't care how you are seen. You are a creature, simply. You move or stop or lurch from side to side as you are able. You make a sound without will. Your former self, the husk of you, hovering near, looks on startled and concerned. But you are not. You are shorn of image. You are waiting to eat again and to speak in a language with meaning. You are not gay. You are not a woman. You are not. And by this, you are everything your former self defended against, apologized for, explained away, took pride in. You are all of it. None of it. You want only to breathe in and out. And know what your limbs will do. You are at the beginning.

Hey want to meet for a cappuccino at Cafe Franny? Gotta run, I'm off to the latest Franny film. Meet you at the corner of 83rd and Franny? How about Concerto in Franny at Carnegie Franny?--Was anything ever called by any other name? (Beat) Oh, you play the piano? Franny plays the piano. You say words in English. Well, see so did Franny. Uh huh, uh huh, you have hair. That's interesting because you know, she also had hair.

(Beat) Maybe I'm paying for the moment when I looked at her and thought I don't know if I love her anymore. Maybe she saw me look at her this way and believed what she saw, even though it was no more true than the first day when you looked at someone and thought, "She's the One." Thought, "I'm saved."

But nothing can save you. Not your friends, not the best Fred Astaire musical you've ever seen -- the grace of it, not your mother's beauty, not a line from a letter you find at the bottom of a drawer, not a magazine or the next day. Nothing can save you. And you stand in the moonlight and a sweetness comes off the top of the trees, and the fence around the yard seals you off from the dark and you can't breathe. It is all so familiar and possible. It is too simple that there is this much good and you don't know how to have it. And it makes you wonder when it was you lost your place. Then you catch a breeze, so warm
and ripe, it makes you hope that someone will come who also cannot save you, but who will think you are worth saving.

A man I know said to me, Lesbians are the Chosen people these days. No AIDS. I said, Lesbians are women. Women get AIDS. Women get ovarian cancer. Women get breast cancer. Women die. In great numbers. In the silent epidemic. He said, I see what you mean.

The surgeon in Los Angeles said it was a fibroadenoma. "Someday you might want to have it removed," he said. "But no rush. It's benign." I watched it grow. Then in New York, I saw another surgeon. He said, "What have you been told?"

"Fibroadenoma," I say.

"Well, I'm concerned," he said. "I want to biopsy it."

You know how when everything is going right, you figure it's only a matter of time, until that bus swerves on to the sidewalk, or you finally make it to the post office to buy stamps and that's the day a crazed postal worker fires his Uzi into the crowd. Everything was going right for me. I had just won an Obie for a play at the Public Theatre. I had a contract for my first novel -- I was in the beginning chapters. And a new relationship.

It was Jane who found the lump. The gynecologist said it was a gland. When it didn't go away, she sent me to the surgeon who said it was something it wasn't.

All of this happened at the beginning of a new decade. When we would all lose our innocence. It was 1980. In New York. I heard the Fourth of July fireworks from my hospital bed. I was 36. I was too young. People were celebrating. And they were too young for the plague that was coming.

There were two positive nodes. I went through 11 months of chemotherapy and I had only one more month to go. But at my next to the last treatment, after they removed the IV, the oncologist and his nurse looked at me with what I distinctly recognized as menace. I thought, they're trying to kill me. If I come back again, they'll kill me. I never went back.

There are those who insist that certain types of people get cancer. So I wonder, are there certain types of people who get raped and tortured? Are there certain types who die young? Are there certain types of Bosnians, Somalians, Jews? Are there certain types of Gay men? Are there certain types of children who are abused and caught in the crossfire? Is there a type of African American who is denied, excluded, lynched? Were the victims of the Killing Fields people who couldn't express themselves? And are one out of eight women -- count 'em folks -- just holding on to their goddamned anger?
This is my body -- where the past and the future collide. 

I am a One Breasted, Menopausal, Jewish, Bisexual Lesbian Mom and I am the topic of our times. I am the hot issue—I am, the cover of Newsweek, the editorial in the paper. I am a best seller. And I am coming soon to a theatre near you. I am a One Breasted, Menopausal, Jewish, Bisexual Lesbian Mom and I am in.

My son is having symptoms. His stomach hurts. He feels a tumor in his neck. He injures his toes in a game of basketball and suspects gangrene. He says, "My organs are failing." He stands in front of the refrigerator opening and closing the door. "Can I make you some breakfast?" I want to do something for him. I haven't done anything for him, it seems, in awhile. I mean like my mother would do for me. But he isn't hungry, it's just a reflex, this refrigerator door thing. Some small comfort.

He walks into the living room and throws his leg over the arm of our formerly white chair. Sitting across from me, disheveled, morning dazed, he says, accusingly, "I think I'm dying."

"You're not dying."

"Maybe it wont happen for a year, but I'm dying."

"Honey, you're talking yourself into it. Why are you so worried about everything?"

"What if I have AIDS?"

That's something I didn't have to think about when I was 20.

"Everybody's going to die. You'll see. All my friends. It's going to happen."

"Talk to me."

He's a dark thing. His eyes match my own. He'll see a child, overweight, wearing glasses maybe—he'll notice a child like this somewhere, trying to make his way against the odds and it will seem to Jeremy heroic. "Stud," he says. And means it.

"Maybe I have spinal meningitis."

I try not to laugh.

"I'm serious."

"I'm sorry."
Things are breaking down.

He is twirling a strand of hair around his finger. We're in the Brandeis parking area, waiting to take our children to their dorms. It's an oppressive August day. Everyone has gotten out of his car, but Jeremy won't move. He's in the back seat, regretting his decision. There are no pretty girls. The guys are losers. This was a big mistake.

Suddenly I'm in another August day. I've just put my eight year old on a bus to day camp. He looks out at me from the window. A pale reed, he is twirling his hair around his finger. I watch him do this until the bus pulls away. What have I done? I go home and fall onto my bed. I lie there and mourn all the lost Jeremys. My three year old, my infant boy. I lie on my bed and have grim notions. What if something happened to me and he came home from camp and I wasn't there to pick him up? What if I had an accident? Who would take care of him? What happens to the child of a single parent who is kidnapped by a madman?

Then I imagine him lost. I see him twirling his hair, as it grows dark in some abandoned warehouse. He walks the streets of a strange neighborhood. I know that he is crying in the woods. He has gotten himself into an old refrigerator. He falls into a well. He is in the danger zone. He was wandered too far from me. I have cancer and what if I never see him grown. "I'll go and get it back for you, Mom."

By the time I have to pick him up from camp, I'm frantic. Somehow, we survived, until now.

We get to his dorm and unload. His room is in the basement. It is moldy and I feel homesick. This isn't right. Parents move toward their cars dazed and fighting every urge to run back and save their young from this new danger -- independence. When I get home, the sound of Jeremy not in his room is deafening.

THE PHONE CALLS: Mom. I'm all right. Don't get upset. Just listen, okay. I got arrested last night.

Mom, I'm all right. Don't get upset. Just listen, okay. I'm in the infirmary. The Doctor says it's pneumonia.

Mom, I'm all right. Don't get upset. I was playing rugby and I broke my nose. (That beautiful nose!)

"Mom," He calls from Los Angeles where he is visiting his girlfriend, on the day there is an earthquake that measures 6.6. "Mom, I'm all right, But I think LA. is gone."

He transfers to NYU and calls to tell me a car has driven into a crowd of people in Washington Square Park, but he's all right. He calls to say that the boy who was his catcher on the high school baseball team has jumped from a building. "I was walking
down his street, Mom. I saw the ambulance. I saw his feet coming out from under a blanket. I can't stop seeing his feet."

Once after Franny and I had a fight, Jeremy and I were out to dinner. He was 13. I must've looked particularly hopeless. Maybe it was my inattention. Whatever shadowed my face, it was enough for him to say, "Are you going to die?" Did he worry himself orphaned every day since I had cancer?

"No, honey, no," I say, shocked into responsibility. "I'm sorry. Franny and I just had a fight. It's nothing. I'm fine. I'm not going to die."

"You looked so sad," he said.

I want to report myself to the nearest authorities. Take me now. I'm busted.

He was 2 and a half days old the day he came to us. My parents drove my husband and me to the lawyer's office. We handed over a sweater and cap we had brought with us and a blanket my sister made. And we waited. We waited for every known thing to change. Jeremy says he remembers the ride back. The Pennsylvania mountains. And how it was to be held in my arms. How it was to be carried home.

A woman is ironing her son's shirt. The palm tree shivers outside the window. Gardenia wafts through though she can't smell it. It's 4 A. M.. She has laid out his button down oxford cloth shirt along with two lines of cocaine on the ironing board. She does them. After his sleeves.

Mothers have no business doing cocaine. Mothers have no business being tired all the time and sick from chemotherapy.

The surgeon said, "Don't join a cancer support group. It'll only depress you."

The drug of choice for most people undergoing chemo is marijuana. It's supposed to help the nausea. But, marijuana didn't work for me. I wanted something to keep me awake, to keep me going. Something I associated with good times, former times, something that assured me there was time.

Sleep, rest, these things were too close to the end of it all. I couldn't give in. If I stopped, the whole thing might stop.

The woman ironing her son's shirt was testing everyone. Who would stay after she'd pushed them away?

There were powerful drugs in her body. But the one she took through the nose kept her from knowing what she knew. Kept her from the ache of caring. In her dreams she could smell the truth. Cocaine -- sharp, thrilling. The cancer drugs, acrid and sere. Terrifying. They were Proust's asparagus in her urine. A toxic taste in her mouth.
She had control over cocaine. She administered this to herself. In a breath. There were no needles, no invasion. It was a ritual of pleasure and retreat. It blotted out the anxiety of the waiting room.

And finally, it destroyed what was healthy and cured nothing at all.

The woman ironing her son's shirt felt ashamed. She was not the cancer heroine she'd hoped to be.

Some people would say, this woman is doing the best she can. And that's all anyone can do. But, I think that's just another moral loophole. She can do better. She will do better.

Morning broke. Her son came running down the hall. Her lover called to sing her show tunes.

"I might lose them," the woman thought. "But not while I can still have them." She vowed to stop. "This will be my last time." And it was. Her son was very pleased with his shirt.

I didn't lose my hair, I lost my period. Chemo knocks out your estrogen, which knocks out your period, which puts you, ready or not, into menopause. So, at 37 I was having hot flashes and panic in the left hand turn lane. (Beat) It's like this. I'm driving and I'm in the left hand lane and when the light turns red before I can make the turn. This isn't good. This for me is a life threatening situation. My heart races. My hands and feet tingle. I hyperventilate. I'm a lot of laughs.

Sometimes this happens if I walk too far from my house.

Now, there are hordes of women out there who, even as we speak, are flinging open windows, ripping off their clothes and turning to say to a dining companion, a spouse, friends, and even total strangers, "Is it hot in here or is it me?"

Most of these women can win back the love of friends and family by taking estrogen. But you can't take estrogen in most cases of breast cancer. So years later, when the hot flashes are over and I can manage to sit in the left hand turn lane without calling the paramedics, Franny and I are visiting my parents and I take a swing at a golf ball. Oh, don't misinterpret. This is my parents' golf course. Their idea. But it's a beautiful day. And I tee off quite nicely. I'm feeling proud of myself, so I take my second swing and I get this sudden, searing pain accompanied by a kind of pop in my side. I've fractured a rib. A year later. Same swing. Same thing.

Then, another time, I reach out my side of the car to remove a twig from the windshield. Pop. My friend Brock runs up behind me, lifts me into the air with his arms around my chest. Pop. I sit the wrong way on a theatre seat. I bend and reach awkwardly for something I've dropped. My trainer pushes my knees into my chest. Pop. Pop. Pop.
The bone scan is negative, but the bone densitometry shows a significant demineralization— or bone loss. Is the structure of everything dissolving? I can't count on whatever it was that held me up, supported my notions, my exertions. Osteoporosis. It's hard to say the word. It's an old person's disease. It's the anti-feminine. It's the crone.

I go to see the doctor in Gerontology. The waiting room is full of old people. Naturally. They've come with their husbands. Or their grandchildren. With each other.

A few days after coming home from the hospital, after my mastectomy, I go to the movies in the middle of the afternoon.

I notice two older women arm in arm, walking to their seats. And I know what I want. I want to get old and walk arm and arm with my old friend to a movie in the middle of the afternoon.

What movies are you seeing, Franny? Do you still walk out in the middle? On the street, do you take someone's arm? Will you grow old with her?

The gerontologist consults with my internist who consults with an oncologist, who probably consults with somebody else. The rib fractures seem consistent with chemotherapy and the resulting loss of estrogen. But she'd like to run more blood tests. I especially love the one they call a tumor marker. And why are these things always given on a Friday? Have a nice weekend.

(Beat) Excuse me, I need to scream now.

(SCREAMS) That was good. But what I really want to do is break a chair.

(Beat) I have destroyed so much property in my mind. In my mind, I have smashed so many plates against the wall, ripped so many books from cover to cover. In my mind, I have trashed apartments, taken all the guilty parties to court. Done damage for damage done. But I'm the accommodating patient. I move on. Get over it. Exercise restraint. I am appropriate.

(Beat) Except for the day the doorman ate my pizza.

I was coming home from Chemotherapy with a pizza. Jane was trying to get me to eat right. Well, trying to get me to eat. So we had this pizza and when I got an urge for Lac Chocolat which was right down the block from where we lived, I gave the doorman my pizza and asked him to hold it for a couple minutes. When I got back, I asked him for my pizza. And he said, "I ate it."

You ate it? You fucking ate my pizza. You fucking murdered my child, you fucking destroyed my career, you fucking robbed me of my youth, you fucking betrayed me, you fucking know that? You fucking fucking idiot!
He offered to pay me for the pizza.

I walk home from Mt. Sinai, after the Gerontologist, down Madison across the park. Trembling. The possibility that there is something else, something more --

I walk around the reservoir. And I see a doorknob from my old house hanging on the fence.

Then a remnant of a child's blanket worn down to a sad shred. My wedding band. And messages no one has picked up. "Come home. All is forgiven." Gifts that came too late. The opal ring I gave Franny at Christmas. A page torn from Chekhov.

There's a black and white photograph. It's a group of friends. When everything was fine. Before the bad news. I walk farther and I see people testifying. Telling their stories. Here at the wailing wall. And then I see my pink suitcase.

I have this pink suitcase. I don't know how I ended up with it really. It belonged to my sister. I was given the powder blue set for high school graduation. And she got the pink. Well, anyway, it's mine now.

My agent said, "I'm sorry. There's nothing more I can do. Maybe if you spoke to the publisher yourself." I had gotten a year's extension on my novel. It was up now. I called the publisher. I said, "Look, I need more time. I've had this thing happen to me and --"

"I know," she said, "That's unfortunate."

"I've been writing, though. I have about 100 pages."

"I'm sure it's a wonderful book," she said, "Although I haven't read any of it, but we just can't give you any more time." She asked for the return of my advance. The Author's League gave me half the money. I paid the rest, put my novel in the pink suitcase and turned the lock.

It is all that is incomplete in me. The waste. My fraud.

While I'm waiting for the results of this tumor marker, I go with an old college chum to a gay bar. We had gone to the Expo in Montreal together with our young husbands. We deposited our children at the same camp. She's divorced and seeing a woman now.

The first time it ever occurred to me that I might make love with a woman, I was in bed with my husband and I thought, I wonder what it feels like making love to me. I don't understand the concept of this place. Everyone is cruising, but no one makes a move. All around me women are whispering, "Go on... talk to her. Now's your chance." It ripples through the narrow, smoky, room. "Go on. Talk to her. Now's your chance."

Two women kiss nearby. I halt. I cave. To see this.
The gay bar in Paris, it was Franny's first. The women were fresh and attractive and we danced to a French hit. The lyrics translated, meant the death of love, but we were far from dying. We were expressing ourselves in Paris.

A slave to love when she spoke French. A goner to her version of the Frenchman in America. The accent, the pout, the hands -- she had them down. I was seduced. Sometimes after a rough patch, I'd say, all you have to do is speak in French and I'm yours. In the middle of a fight, switch to it, take me.

I had four years of college French, but I could say only, "Have you any stamps" and order Grapefruit juice. "Vous avez jus de pamplemousse?"

She required me to say pamplemousse back in the United States, in our bed.

When will a French family struggling with directions on the subway fail to remind me?

We are mothers. We know the same thing. And sometimes it is too much to know. It drew me to her and it is the thing that would come between us.

She's a mother. I trusted she would take better care of things. A mother is a safe bet. A mother would not leave her children for someone else's children. A mother shows up. Stays put. She installs a light in the hall. Franny's a mother, I thought. She won't harm me.

It keeps coming back. What she said. The way she looked saying it. "We're not in the same place." WHAT DO YOU MEAN? "I don't think we'll ever live together." WAIT. DON'T. PLEASE. WAIT. "This is so hard," she says. OH MY GOD. HAVE YOU MET SOMEONE?

I can be standing in line for bagels. I can be punching in my secret code at the bank machine. It returns to me. A howl goes up.

"Well, you look fabulous."

"I'm a wreck."

"You'll see. People find that very-attractive."

Every room. Every way the light fell. Every room we walked. Every way we combined there. Every room you moved into and out of. Every absence. Every room of our inclining. Every tender routine. Every room and way I learned you. Clings.

Just two and a half months before Jeremy was born, my first baby died, and the doctor injected me with something so the milk in my breasts would dry up. My breasts became engorged. Hard and full to bursting. It's painful, this swelling of something that wants to come.
When I was pregnant, I took something called Provera. Later it was shown to cause birth defects.

So, when I got breast cancer I wondered, was it the time someone sprayed my apartment for roaches? Or too much fat in my diet? Was it the deodorant with aluminum, or my birth control pills? Was it the high wire lines. Or was it genetic?

"Here are your choices," the Bone specialist in L.A. said. "Pick one. A shot every day of Calcitonin which costs a fortune. I wouldn't do it. Etidronate which can cause softening of the bones. Or Tamoxifen, an antiestrogen that acts like an estrogen."

I really hate this arrogant, out of touch son of a bitch specialist, you know? But my internist concurs, and him I love. So, I take the Tamoxifen.

Side effects: Increase in blood clots, endometrial cancer, liver changes. Something interesting happens. My ovaries ache. I'm ...well, how do I say this... the juices are flowing. But I'm in L.A. working on a television show and Franny's in New York.

When I come home for good at Christmas, she tells me it's over. And I'm left to stew in my own juices.

I didn't call her the day I had a cold. I didn't call her on Friday because I wanted to talk to her so badly my throat closed up. I didn't call her the day before that around 15 times because I was trying to make it until Friday. I didn't call her one day because I was at the bookstore waiting and hoping. I didn't call her on Wednesday because it would have been a failure, so I swallowed the history of it down. I didn't call just now to save my life, because the instrument of rescue was already in my hands.

I go back to Mt. Sinai to see the gerontologist. All my tests are normal. "There's really nothing much to do about this bone thing. Except, increase the calcium in your diet. Maintain a consistent exercise program. Especially weight lifting."

Well, hey, I belong a health club. With TV sets. And I was starting to see some nice rips in my shoulders. But, then over a period of 5 months, I had three separate rib fractures. They take 4 to 6 weeks to heal, so how do I maintain a consistent exercise program?

The doctor is a gracious woman and she sees my frustration. And frankly is tired of hearing me whine. "All right, look, I know this sounds like I'm waffling, but I think I want to put you on Etidronate."

I don't think the names of these drugs are very friendly, do you?

"We'll follow you closely for a year." she says and gives me a prescription.

I haven't filled it yet.
When my baby died, I felt I had no right to talk about childbirth or being pregnant. I had a baby. I was pregnant. I had morning sickness. I bought clothes and furniture. I had a son. He lived three hours. He was born to me. I finally understood what women were. And I wanted to talk about this, but it made people uncomfortable. In some ways losing Franny is like that.

I want to remember a Scrabble game where we made up words and meanings and laughed until we were in pain. I want to express my affection for her Miro bag, which held my glasses, a half stick of gum. I want to talk about the vegetable stand at the side of the road where we left our money in a bucket and the invisible proprietor trusted us to love his tomatoes and his sweet corn and his zucchini and we did.

I want to talk about these things but I feel I don't have the right to tell the love story because it ended badly.

Okay, I'm in her kitchen and I grab wild for a knife and plunge it into my belly. She can’t believe it. She says, "But I had to cut your bagels for you." I say, "Well that stopped, didn't it?" And I die. Better, I huddle against a wall outside of her apartment. All night long. In the morning when she leaves for work, she sees me there. Cold. Unattended. The drift that I am. Her detritus. She drops her books and bends to me. "Susan? Susan?" Who, I strain is that. And the call. They call to say, oh this is from my friends, they call her. "Susan's dead." And they hang up.

My friends, these women with wild hair and good eyes, these women friends who engage my light and do not refuse me, dark as I am these days. These friends make room for disturbance. They have the wit to see it coming. This is who they are, these people who school themselves and event the city and construe fresh arguments and listen to the heart beat its woe. These friends are my history. What they know about me is in the record. Errors. Shifts. Defeats. Occasions of grace. They were there when I looked up from my hospital bed. They were there when I looked up after Franny left and couldn't see a thing. And these people, my friends, are taking out an ad. In the personals. "She's adorable. She's smart. And would you please take her off our hands? We can't stand it anymore!"

Maybe we're only given a certain amount of time with anyone. Or we can have the whole time if we remember on the days it is not going well, that these are not the days to measure by. The moment we marry is often so minor, so quotidian, that later we forget we've taken vows. When Franny walked to her study to write, I took my vows. When she asked me before sleep, if I wanted some magic cream on my cuticles and rubbed it into my fingers, I took vows. When I weeded her mother's garden, cleaned under her son's bed.

Is it there in the beginning? The thing that finishes us?

Out in the country with my friends, I wake in the morning to the sound of a wasp in its death throes. A screen door shuts and the dog's paws sound like a hot drummer's brush
across the floor. I walk outside to the buzz and the click and the hum. Suddenly, I feel bereft.

My favorite book in the Golden Book series was "The Happy Family". Imagine. Well, here's the picture. Beautiful clean cut boy and girl. Mother and Father. Crates arrive. Brand new bikes. They all go on a picnic. It was my touchstone.

He was dark and thin. She was dark and beautiful and not as thin. He, my father introduced himself to her as Frank Lamonica. And she was Judy Grey, a singer with her own show on the radio. "I'll never smile again, until I smile at you." He said, "We're going to come back here next year, married."

Isaac Figlin and Thelma Freifelder. My model for romance.

There was a war. He went. She was a bride. They wrote letters. She sent him a lock of my hair.

Now she is 74 and he is 83. My father says, "I've never been more in love with your mother than I am right now." On the night before my father has surgery to remove a kidney, my mother climbs up next to him in his hospital bed. We, my brother and sister and I turn our heads. Were they really ours? Who might we have become without these two people who said yes one mad summer in the Poconos and taught us how to dance and spell and drive a car. Taught us what was good. They were good.

After I lost my baby, I was taken back to my room. And I saw my parents standing there, in the doorway, waiting for me.

(Beat) So, I told them a funny story and made them laugh.

After my mastectomy, my father rubs my feet. My mother sings me a song. They do this for me and I let them.

House. It's a concept that cries out deconstruct. There is the universal notion of house and there is Susan's house. The house that longing built.

There was something important about Franny and me. I don't know. Maybe it was only that we tried.

We have children and we had to bring them up. We had to be their mothers. We would cry when we saw orphans arrive from Korea on television. But we had ours and they were still becoming and they had something to say about it. Now they are grown into that beauty of starting up.

The first time I went to Franny's house, I recognized the familiar aroma of boy's feet. Simon's sneakers were lurking under the coffee table. It reminded me of home.
Jody sang commercials and told me silly jokes. She is lovely, Franny's daughter. She is lovely and strong and difficult. She is Franny's daughter. Simon sits at the piano. "Hey, Susan, do you like this?" I do. I like what he plays. I like him. And so when I walk into the living room at the end, at Christmas and see him, I come apart.

They were 10, 12, and 14, when we started out. Nearly 8 years later, we'd lived through puberty and three sets of college applications.

"You bitch." "You're such a bitch." Our teenagers were not having a good day.

My son punches his fist through a wall. Her daughter stops eating. The oldest weeps his lost structure. How much of this has to do with us, I can't say, but we blame ourselves, each other, and sometimes who we are.

"I can't do this," Franny would say. "I don't know how to be a mother and a lover. Can't we just wait until the children are grown and find each other again?"

A family is the faces you see and know you will see whenever you look up. When Franny is on the phone and Simon is reading a book, when Jody's watching her soaps, and Jeremy is in the kitchen complaining there isn't anything to eat. When a person says, as casual as heartbreak, do you want a cup of coffee honey?

Here's what I did. I really did this. I rented a car and drove to the Howard Johnson's Motor Lodge outside of Woodstock. It was OUR place. We stayed there when we visited her parents. It seemed like every time we stayed at a cheap motel, there was child abuse going on in the next room. Perhaps it was only a haunting. Our own children tormenting us for the time we abandoned them at camp or wouldn't let them stay up late to watch some TV show or maybe they were just pissed off at us for having the bed to ourselves.

The motel is its orange self. Why do I weep? The air in the parking lot is hot and familiar. Somewhere close. Somewhere in the trees, around the bend, over the hill, she is. I can't breathe. It was in one of these rooms she asked me to make love to her. Her father had just died. And she needed this from me. I knew how to marry love with death. I knew if you kissed someone who needed you to live, you would live.

The day after I came home from the hospital, still bandaged, half crazy from residual drugs and fear, Jane and I made love. I didn't care if my stitches came free. Let them rip. I shouldn't have been able to move in the ways I moved to her, but I was powerful. The possibility of death nearly broke our bed. In a few days I would start chemo but that night, I was not in possession of the facts. I was a body in disrepair and someone was healing me.

I wanted to heal Franny. I wanted to swoop her up, take her in my jaws, protect this love. She kissed me with her teeth. I swallowed her loss down whole. Everything was streaked with us. "My love" "Don't stop." "Darling". I placed myself at the source. So lovely. So
known to me. And for awhile at the Howard Johnsons outside of Woodstock, we kept chaos at bay.

(Beat) I went to the town square. I didn't know where to walk exactly or where to set my sights.

I wondered if people could see me, or was I invisible because I didn't belong anymore? And if Franny actually came to town on this day, would she walk right past me? Turning a few feet away to look back as if there were something, a sensation she couldn't name, my scent more powerful than my substance, wafting through to catch her up short. I steadied myself against a store window and wished for a prop.

(Beat) There she was. On the other side of the street, her hands in her pockets, singing Rodgers and Hart. Or thinking about semiotics. Going on about her life.

(Beat) Just like I needed to go on about my own.

(Beat) Goodbye Franny. Goodbye my friend. Goodbye my left breast, Goodbye my infant son. Goodbye my period. Goodbye 35. Goodbye old neighborhood. Your doctor says "It's Positive." Your lover says, "It's over." And you say goodbye to the person you thought you were.

(Beat) I'm going to show you my scar. In a minute.

When you have a brush with death, you think, if I pull through this, I'm going to do it all differently. I'm going to say exactly what I think. I'll be a kind and generous citizen. I won't be impatient with my son. I won’t shut down to my lover. I'll learn to play the trumpet. I'll never waste another minute.

(Beat) Then you don't die. And it's God, I hate my hair! Would you please pick up your clothes! How long do we have to stand in this fucking line?

One day I'm sitting in a cafe and a man with ordinary difficulties is complaining. Our water heater is on the fritz. Just like that he says it. OUR something isn't working and WE are worrying about it.

I want to say -- Cherish the day your car broke down, the water pump soured, the new bed didn't arrive on time. Celebrate the time you got lost and maps failed. On your knees to this domestic snafu, you blessed pair, while you can still feel the other's skin in the night, her foot caressing your calf, preoccupations catching on the damp sheets. You twist, haul an arm over. While remote kisses motor your dreams.

The people who made love to me, afterwards: There have been three. Jane, of course who slept with me in the hospital, pretending to be my sister. David. And Franny. It's the way David said, "It's wildly sexy this body of yours that has given birth and given up a part."
It's the way Franny loved me more for my lack of it, this symmetry that other women have.

How do I tell someone new? Okay, help me out here. Say I've finally met someone I like. Do I tell her over the salad? Wait till dessert? Do I tell her when we're getting undressed? Does it matter? Would it matter to you?

(Beat) I miss it but there is something growing in its place. And it is not a tougher skin.

(Beat) The doctor says my heart is more exposed now. Closer to the air. You don't have any protective tissue, she says. I hardly need a stethoscope to hear it beat. I cherish this scar. It's a mark of experience. It's the history of me, a permanent fix on the impermanence of it all. A line that suggests I take it seriously. Which I do. A line that suggests my beginning and my end. I have no other like it. I have no visible reminder of the baby I lost. Or the friend. No constant monument to the passing of my relationship. There is no other sign on my body that repeats the incongruity and dislocation, the alarm. A scar is a challenge to see ourselves as survivors, after all. Here is the evidence. The body repairs. And the human heart, even after it has broken into a million pieces, will make itself large again.

My son did get it back for me. In a way. Not the year it happened. But the year after that and the year and the year and the year after that.

(Beat) It was little league that saved me. It was Jeremy up to the plate. It was Gabe Goldstein at second. It was Chris Chandler catching a pop fly. It was Jeremy stealing home. It was providing refreshments and washing his uniform. It was trying to get him to wear a jock strap. It was screaming," Batter. Batter. Batter. It was Jeremy pitching the last out with the bases loaded. It was the Moms. The Moms and Dads and the coolers. It was the hats we wore and the blankets. It was driving him home from practice. It was his bloody knees. It was the sun going down on us, watching our sons and daughters play and be well.

(Beat) This was the cure for cancer.

I miss it, but I want to tell all the women in the changing booths, that we are still beautiful, we are still powerful, we are still sexy, we are still here.

(I unbutton my shirt to reveal my scar as the LIGHTS FADE.)

THE END