Introduction

PETER L. RUDNYTSKY

"Chance and the prepared mind." This aphorism favored by the psychologist Henry Murray best captures the serendipitous set of circumstances that led to the conference on "Psychoanalysis and Narrative Medicine" I organized at the University of Florida on February 19–22, 2004. A long-standing interest in psychoanalysis prompted me to propose a conference on this topic to the Thomas H. Maren Foundation, which responded with a munificence that allowed me to build my field of dreams without cutting any corners.

If my yoking of psychoanalysis and narrative medicine had in it an element of pragmatism, since a conference on psychoanalysis alone would not have been compatible with the mission of the Maren Foundation, this improvised theme now seems to me in retrospect to have been a stroke of genuine inspiration. It was after I had announced the title of the Gainesville conference that narrative medicine made its splash in the popular media in October 2003 with an article in *The New York Times* and a feature on National Public Radio. The conference, moreover, proved to be a "first" in two important respects. Not only was it the first conference ever on narrative medicine with an open call for papers, but it was also the first time that narrative medicine had been conjoined with psychoanalysis, thereby creating the opportunity for a new interdisciplinary dialogue. By bringing together individuals with backgrounds in psychoanalysis, the humanities, and the health care professions, the conference in Gainesville can be said to have forged a new intellectual community.

In designing the program, one of my primary objectives was to get away from the status consciousness that is too often the bane of the academic world. Although my budget permitted me to invite an extraordinary list of featured speakers—Rita Charon, Sander L. Gilman, Bennett Simon, Jody

Messler Davies, Mark Solms, Abraham Verghese, Jeffrey Berman, Norman Holland, David B. Morris, Lynn Gamwell, Geoffrey Hartman, and Frans de Waal—I also set up seminars, each of which was co-directed by two of the invited speakers. In these seminars, all the conference participants who wished to offer papers could have them discussed in a small-group format. The papers were posted on our Web site as they came in, assigned to a seminar several weeks before the conference, and members were asked to read the other papers in their group before arriving in Gainesville. Unfortunately, a family emergency prevented Jody Davies from attending at the last minute, and her place on the program was ably filled by Vera Camden, whose paper had initially been slated for inclusion in one of the seminars. Excursions to the Harn Museum of Art, led by Lynn Gamwell, to see a special exhibition of photographs of Freud's apartment at Berggasse 19 taken in 1938 by Edmund Engleman, shortly before the emigration of the Freud family from Vienna to London, rounded out the bill of cultural fare.

Besides receiving financial support from the Maren Foundation, one further way in which chance merged with design is that the conference was sponsored jointly by *Literature and Medicine*, co-edited by Rita Charon and Maura Spiegel, and *American Imago*, of which I am the editor and Vera Camden is a co-editor. In this cooperation between our respective journals, both of which are published by The Johns Hopkins University Press, I again discerned an emblem of the interdisciplinary synergy I hoped to achieve; and five of the papers included in the present volume—those by Lisa Schnell, Fred Griffin, Neil Scheurich, Terrence Holt, and Geoffrey Hartman—as well as an earlier version of this introduction, first appeared as a cluster in the Fall 2004 issue of *Literature and Medicine*.

Although I am not a scholar of narrative medicine, I believe that in proposing a conjunction with psychoanalysis I was inviting this exciting new discipline to claim an insufficiently acknowledged portion of its own history. For whereas narrative medicine arose from a desire to bring "literary competence" (and the benefits of literary study generally) within the purview of the medical school curriculum, it is, of course, psychoanalysis that is known as the "talking cure," and thus distills the essence of what narrative medicine is all about. From the standpoint of psychoanalysis, conversely, an alliance with narrative medicine offers the prospect of basking in the reflected glory of this revival of humanism within the bastions of science, and thereby strengthening its own position both intramurally within the mental health profession and in American culture at large.

In tracing the psychoanalytic genealogy of narrative medicine, three prominent names come to my mind. The first, inevitably, is Freud. Freud's fun-

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damental theoretical contribution is to have elucidated the influence of unconscious mental processes, and the defenses against them, on the whole of human life, while his greatest invention is of a new kind of human relationship—that between analyst and patient—in which people can seek a "soul-cure" through exploring the meaning of their often painful experiences with a trained professional in a secular context. Although Freud was himself a neurologist before he became a psychotherapist, he insisted that "psychoanalysis is not a specialized branch of medicine" (1927, 252), but rather belonged to psychology; and that the education of future analysts should "include branches of knowledge which are remote from medicine and which the doctor does not come across in his practice: the history of civilization, mythology, the psychology of religion, and the science of literature" (1926, 246).

Without Freud, there would have been no psychoanalysis, but in at least one important respect he impeded rather than abetted the contemporary rapprochement with narrative medicine. I refer to his notorious recommendation that the analyst should cultivate an "emotional coldness" and model his technique on that of "the surgeon, who puts aside all his feelings" (1912, 115) while performing an operation. Whereas it has been a principal thrust of narrative medicine to encourage physicians genuinely to listen to their patients, and in doing so to learn to look upon them not simply as a bundle of symptoms but as fellow human beings, Freud's own espousal of a surgical model of psychoanalytic therapy paradoxically steered his movement in the opposite direction, a wrong turn from which it is only now finally being rescued.

The other two psychoanalysts who can be regarded as progenitors of narrative medicine, Georg Groddeck and Michael Balint, are central figures in the relational tradition that has, in my understanding, succeeded in rectifying many of Freud's mistakes, including his minimizing of the need for genuine compassion and empathy on the part of the analyst in order for emotional healing to take place in the patient. Both Groddeck and Balint were closely associated with Sándor Ferenczi, Freud's great Hungarian disciple, who—as Paul Stepansky (1999) has shown in his study of the vicissitudes of the surgical metaphor in Freud's work—effected the "only bona fide transformation" (89) in Freud's conception when Ferenczi redefined the analyst not as a surgeon but as an obstetrician:

> The doctor's position in psychoanalytic treatment recalls in many ways that of the obstetrician, who also has to conduct himself as passively as possible, to content himself with the post of onlooker at a natural proceeding, but who must be at hand in the critical moment with the forceps in order to complete the act of parturition that is not progressing spontaneously. (1919, 182–83)

While reserving the right to use the "forceps" of active intervention as a last resort, Ferenczi exhorts the analyst to adopt a stance of wise passiveness,

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though this should not be misunderstood to mean being aloof or devoid of human sympathy.[1]

Ferenczi's admonition was heeded by Groddeck, the maverick director of a sanatorium in Baden-Baden who cheerfully called himself a "wild analyst" and who in his masterpiece, *The Book of the It* (1923), recounted how, in 1909, he "took over the treatment of a severely ill woman who compelled me to become an analyst" (264). Because the patient "saw in me the mother," Groddeck gradually came to renounce the practice of "authoritative, infallible, fatherly suggestion" that he had learned from his mentor Ernst Schweninger, and instead of being an "active, meddling doctor" he sought to become "a passive tool" who placed himself at the patient's disposal (266–67).

As a result of this conversion experience, Groddeck discovered that he himself was being healed by his encounter with his patient: "Then suddenly I stood before the odd fact that I am not treating the patient, but that the patient is instead treating me; or to translate it into my language, that the It of my neighbor seeks so to transform my It, indeed so transforms it, that it becomes serviceable to its purposes" (267). Groddeck summarizes his emphasis on the mutuality of the relationship between analyst and patient, which makes him a founder of contemporary relational thinking, with the affirmation that "it is not the doctor who is the essentially active partner, but the patient. The doctor's chief enemy is hubris" (1926a, 126). And because in every healing relationship there should come "a strange turning point where the patient becomes the doctor and decides himself what he is to do with the doctor's services and even whether he wants to accept them at all" (1928, 215), it follows that if the therapeutic process breaks down for any reason, "the doctor will have to tell himself: I have made a mistake; what matters then is to find out what kind of mistake it was and to discuss it honestly with the patient without any embarrassment or attempt at apology" (1926b, 225–26).

In the history of psychoanalysis, Groddeck is best known for the concept of the "It," that primal source of the psyche-soma, underlying even the unconscious, of which the "I" is no more than an inescapable mirage or symptom. In German, Freud's "id" is also called *das Es*, while his "ego" is *das Ich*, but James Strachey's decision to translate these ordinary German words into English with their Latin equivalents, rather than as "it" and "I," accurately captures the difference between Freud's pseudoscientific structural theory and Groddeck's unabashedly subjective vision of the power of the It to shape human life.

Whereas I revere Groddeck both for his attempt to deflate the hubris of physicians—whether they be psychoanalysts or medical doctors—and for his appreciation of the unconscious dimensions of physical illness, he is attacked by the late Susan Sontag in *Illness as Metaphor* (1978) precisely because he

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ascribes diseases to internal causes and thereby seems to hold the patient responsible for his or her own suffering. "Such preposterous and dangerous views," she rails, "manage to put the onus of the disease on the patient and not only weaken the patient's ability to withstand the range of plausible medical treatment but also, implicitly, direct the patient away from such treatment" (47). Ironically, despite her own eminence as a writer, Sontag's critique of Groddeck reflects her inability to appreciate the positive contributions of either psychoanalysis or narrative medicine. For the main thesis of her book is that "illness is *not* a metaphor, and that the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphorical thinking" (3). Contrary to Sontag, however, it is not necessary to lay down the potent weapons of Western biomedicine, or, in Lou Andreas-Salomé's words, to look upon "the sick man as a criminal to be punished" (Freud and Andreas-Salomé 1966, 138), to recognize that even a physical illness will be given unconscious meanings by the person who suffers from it, and that the metaphors one fashions are likely to affect the outcome of the psyche-soma's efforts at self-healing. In her resistance to seeing illness as a metaphor, Sontag in effect counsels patients supinely to entrust themselves into the hands of their supposedly godlike physicians, and thereby spurns what there is to be learned not only from Groddeck but also from both Freud and Rita Charon.

Unlike Groddeck, who was Ferenczi's friend and contemporary, Balint was his most outstanding pupil; and when he left Budapest for London in January 1939, six years after Ferenczi's death, Balint provided a living link between the Hungarian and British schools of psychoanalysis. Together with W. R. D. Fairbairn, D. W. Winnicott, Marion Milner, John Bowlby, and others, Balint became a mainstay of the Independent tradition in British psychoanalysis, which is the most fertile seedbed of contemporary relational thought. Balint's theoretical contributions include a refutation (1937) of Freud's misguided notion of primary narcissism, and the elaboration of his own model of the "basic fault" (1968); but his most important achievement in the present connection is to have pioneered in introducing psychoanalytic principles into the practice of general medicine. He developed his ideas out of group seminars conducted in the 1950s at the Tavistock Clinic, and his book, *The Doctor, His Patient, and the Illness* (1964), inspired a far-flung movement of "Balint groups" that continues to the present day.

Written in nontechnical language for practicing internists, who are seen as mediating between the patient and the specialist, *The Doctor, His Patient, and the Illness* is founded on the premise that "by far the most frequently used drug in general practice [is] the doctor himself," yet "no guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself" (1964, 1). Among the many valuable insights in the book is that "in general practice the real problem is often the illness of the whole

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person" (39), and diagnosis constitutes a movement from an "unorganized" to an "organized" state through a process in which patients "*offer or propose various illnesses* . . . until between doctor and patient an agreement can be reached, resulting in the acceptance by both of them of one of the illnesses as justified" (18). As Balint stresses, "*if you ask questions, you get answers—and hardly anything else*" (133); and the doctor must therefore above all simply "learn *to listen*" (121). This ability, he adds, "*is a new skill, necessitating a considerable, though limited, change in the doctor's personality*." By learning to listen to what may be unconscious in the patient, moreover, "the doctor will start listening to the same kind of language in himself." In the psychoanalytic terminology that Balint introduces only in his appendices, the doctor is being encouraged to monitor his or her *countertransference* to the patient. As a practical matter, a cultivation of the ability to listen entails shifting the doctor-patient relationship away from the "pattern of a physical examination" because such an objectification of the patient "inactivates the processes [the doctor] wants to observe as they can happen only in a two-person collaboration" (121).

Despite the burgeoning interest in narrative medicine, I suspect that many physicians who may already be convinced of the need to listen empathically to their patients, as well as of the desirability of enhancing "literary competence" as a part of medical education, have not yet recognized the extent to which this symbiotic relationship between literature and medicine is triangulated by psychoanalysis. As a modest first step, I would encourage teachers of courses in narrative medicine to consider including psychoanalytic texts on their syllabi. Not only does the psychoanalytic literature contain classics well worth reading for their own sakes, but the theoretical framework of psychoanalysis provides a language for describing the experiences that occur in everyday life, but can be observed in heightened form in highly charged relationships such as those between doctors and their patients. And it surely would not be amiss to bring psychoanalysts into the ongoing conversations between humanists and health-care providers.

Although there is perforce some overlap in their concerns, I have divided the chapters in this book into four sections. The first, "Contextualizing Narrative Medicine," serves as a portal for the entire collection. Pride of place belongs to Rita Charon who, in "Where Does Narrative Medicine Come From? Drives, Diseases, Attention, and the Body," recapitulates both the origins and bedrock principles of this new way of honoring "the complexities of the self's relation to the body in which it lives." Describing how she was first "visited" by the phrase "narrative medicine," Charon notes that its "grammatical kinship to such names as nuclear medicine and internal medicine" allows her

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inspired coinage to "say with more directness than can a phrase such as 'literature and medicine' that this is a bona fide field of medicine in which you can specialize and still be a doctor."

Of particular interest to readers of this volume will be Charon's reflections on the similarities and differences between narrative medicine and psychoanalysis, particularly with reference to their relations to the body. It is certainly true, as Charon notes, that the work of the internist or surgeon requires "corporeal contact"—indeed, the inflicting of pain—in a way that is prohibited to the analyst, though Charon likewise stresses the degree to which communication between analyst and patient takes place through "the bodily experiences of passion and drives." From my relational perspective, I would question Charon's contention that "the goals of treatment start with freeing the patient's libidinal energy," while "emotional or existential" aims have only a secondary importance. Uninhibited sexual gratification, however great its intrinsic reward, is no guarantee of happiness in life, and it is not uncommon for promiscuity to be the symptom of an underlying "emotional or existential" conflict. Still, Charon's insistence on the body as an "integument" that at once connects us to and separates us from other human beings remains powerfully evocative, and her example of how "a shadow story of severe congestive heart failure" elicited by a physician's questioning contradicts a patient's protestations of being in good health shows the body to be an agent of unconscious communication in the most radical sense.[2]

As Rita Charon can be credited with having created the discipline of narrative medicine, so Sander L. Gilman has in his immensely productive and wide-ranging career carved out his own distinctive field as a literary and cultural historian of the representations of disease and pathology. In a *tour de force*, his "Desire and Obesity: Dickens, Endocrinology, Pulmonary Medicine, and Psychoanalysis" takes the character of Joe, the "Fat Boy" in Dickens's *Pickwick Papers*, as the nodal point for an investigation into the stereotype of obesity in the nineteenth and twentieth centuries. As Gilman shows, Dickens at once exploited and subverted the conventional "image of the stupid fat man," and his character remained a standard point of reference in the subsequent medical literature on obesity, especially in children. Gilman's paper is a feast of many courses, but perhaps the most delectable portion is the concluding section on Hilde Bruch, a German-Jewish physician who, after fleeing the Nazis, came to the United States, where she underwent a training analysis with Frieda Fromm-Reichmann and "popularized the diagnosis of anorexia nervosa." Citing Bruch's 1973 book, *Eating Disorders*, which offers a psychodynamic rather than an organic explanation for Joe's so-called "Pickwickian Syndrome," Gilman reminds us that issues of gender and race are never far from the surface in the readings and misreadings generated by this singularly persistent—and pernicious—stereotype.

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The depth and breadth of Sander Gilman's work find a worthy sequel in that of our two Holts. Richard Lewis Holt's "Pinel and the Pendulum" itself juxtaposes two Foucaults, J.-B. and Michel, and the pendulum suspended in 1751 by the former in the Pantheon with the metaphor of the pendulum as it pertains to the conflicting forces that bisect Holt's chosen field of psychiatry. Holt's chapter leads into an extended meditation on Philippe Pinel, best known for having in 1795 unchained the patients in his asylum Le Bicêtre, and a reading of Pinel's landmark text of 1801, *A Treatise on Insanity*. Although Pinel advocated the "moral" treatment of insanity, Holt makes it clear that this Enlightenment ideal was by no means "immune to empirical scrutiny and validation." And though Pinel not only unchained but also listened to his patients, and thereby introduced "the patient utterance as a legitimate object of study," his position at the apex of "both the physical and discursive spaces of insanity" exemplifies Holt's point that "it was an institution, the asylum, that gave rise to Pinel's novel psychiatric perception," as much as "a new way of looking at the mentally ill" can be said to have created "new powers and institutions." In thus using Pinel to demonstrate that "the modern medical gaze is as much about power as it is about knowledge," Holt circles back to Michel Foucault, whose *Histoire de la folie* he had in his pocket as he walked from La Salpêtrière to the Pantheon during his student days in Paris.

Terrence E. Holt first gained a PhD in English literature before qualifying as a medical doctor. Drawing on his scholarly training, Holt in "Narrative Medicine and Negative Capability" offers an incisive cultural history of narrative medicine. As Holt argues, its cultivation of confessional writing has antecedents in the New Journalism of the 1960s. Through its rejection of "Olympian objectivity," this "reinserting [of] the first-person singular point of view into journalism" risked indulging in "the voyeuristic pleasures of participation without any of the guilt." Yet, Holt contends, as a paradigm of "the mixed motives and shameful pleasures that accompany the most virtuous acts," such a "contradictory fragmentation of impulse" is "an inevitable part of ethical discourse" that paradoxically "offers a ground that actually enables a practical ethics of care."

Any examination of medical autobiographies, Holt continues, turns not simply on the doctor-patient relationship, but above all on the relationship with the audience that consumes these often harrowing tales of fallibility and even incompetence. For Holt, as one schooled in poststructuralism, narrative medicine is less a "response to contemporary pressures in medicine" than it is a "particularly revealing example of the fissures and paradoxes that necessarily result whenever we tell ourselves any story of the 'I.'" Fittingly, Holt concludes with an autobiographical vignette of his own about an occasion when, as an exhausted resident, he had ordered the discontinuance of a pump that had kept one of his cardiac patients alive. Reminded of his father's death a

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decade earlier under "nearly identical" circumstances, Holt sobbed to himself while simultaneously thinking about how soon he could get away for lunch and of the many other patients for whom he was also responsible. Far from being troubled by this "splitting," however, Holt experienced it as a truthful liberation that enabled him to respond in the moment of crisis both as a detached medical professional and as a human being united in grief with the dying woman and her family. Such a capacity for "entertaining two seemingly opposed responses" Holt attributes to his training "not as a doctor, but as a reader," and he equates it with what the poet-physician (and tuberculosis victim) John Keats two centuries ago called "negative capability."

Our four chapters in "Psychoanalytic Interventions" include three by practicing psychoanalysts with a profound literary sensibility, and one by a scholar with a deep knowledge of psychoanalysis. In "'The Past Is a Foreign Country': Some Uses of Literature in the Psychoanalytic Dialogue," Vera Camden takes off from Freud's references to Oedipus and Hamlet to contend that "narrative functions like the repressed core that will inevitably return, however disguised, to haunt the science of psychoanalysis." The heart of her paper is an extended case history of a deeply traumatized woman, haunted by the childhood memory of having had to drown kittens in a bucket of water and crying hysterically as she saw their excrement in the water. Mrs. F.'s analysis was flooded by anal material, including bouts of diarrhea that interrupted her sessions, and chaotic dreams that it was Camden's task to "clean up." Listening to Mrs. F. reminded Camden of L. P. Hartley's novel, *The Go-Between*, in which the narrator is similarly traumatized by the "foreign country" of his past. Although Camden did not divulge her countertransferential associations directly to her patient, they did inform how she worked with Mrs. F., and the changes they were able to effect together in her psychic landscape. It may not require being an English professor, as Camden is, to be a gifted psychoanalyst; but Camden's chapter is a model of how the "talking cure" is indeed on every level synonymous with narrative medicine.

The theme of trauma receives more general elaboration in Bennett Simon's "It's Really More Complicated Than You Imagine: Narratives of Real and Imagined Trauma." Drawing on his previous work on both tragic drama and ancient Greek thought, as well as on his experience as a psychiatrist and psychoanalyst, Simon defines traumas as events that "at once demand to be made meaningful, yet also resist understanding." Narratives, he explains, require the dynamism of "trouble," but overwhelming trauma is precisely "not symbolizable," and may thus be known "mainly by the uncanny or despairing affects in the patient or those induced in the therapist or both." Simon marshals research by neuroscientists and developmental psychologists to bolster his point that, unlike "ordinary autobiographical memory," traumatic experiences "are initially imprinted as sensations or feeling-states that are not immediately transcribed into personal narratives." The therapist who works

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with traumatized patients will thus find he or she "has stepped into a minefield without knowing it," and from a series of arresting vignettes Simon draws the conclusion that "the problem of sorting out true memories from fantasies" is "enough to drive the clinician *meshuge*."

Beginning, like Simon, with the phenomenon that "trauma evades narrative memory," Janet Sayers, in "Narrative and Feminine Empathy: James to Kristeva," focuses on the ineffable states of mystical transcendence to which the shattering experience of trauma is paradoxically akin. Whereas both narrative medicine and psychoanalysis tend to place their faith in the curative powers of speech, Sayers points to a countertradition, stemming from William James, in which it is rather the escape from language that can heal "the divided self." Sayers then explores how D. W. Winnicott, Wilfred Bion, and Julia Kristeva variously trace the roots of a "proto-narrative" capacity for empathy to the mother-infant bond. The psychoanalyst who, through reverie, assists the analysand in "digesting" otherwise inchoate data of experience—in Bion's terms, transmuting a "β-element" into an "α-element"—is recapitulating the role of the mother. To imbue experience with the resonance of a dream is likewise the task of art. In the context of her concerns with psychoanalysis and narrative medicine, Sayers's chapter brings together the questions of gender and religion, and she intimates that it may be possible to reconcile narrative with what lies before or beyond it, the wordless expanse captured in Henry James's image (invoked by Rita Charon) of the healer's "great empty cup of attention."

Our final chapter in this section, Fred L. Griffin's "The Fortunate Physician: Learning from Our Patients," expatiates on John Berger's *A Fortunate Man* (1967), a literary portrait of the life of an English country doctor, John Sassall, in order to convey in accessible language what a psychoanalyst has to offer to physicians "on the front lines of patient care." Griffin, himself a physician as well as a psychoanalyst, has recently co-founded a discussion group on narrative medicine under the auspices of the American Psychoanalytic Association, and he conceives of this chapter as a contribution to the "conversation" not only between psychoanalysts and primary care providers but also between the disciplines of psychoanalysis and narrative medicine. Without being influenced by Groddeck, Sassall concurs that "the forms in which disease are expressed are largely determined by the entire personality of the patient," and that the physician should give up a conception of himself as "a heroic figure" in order to be able to learn from his or her patients, while Griffin's own project of speaking to physicians about psychoanalysis without resorting to its esoteric terminology finds its prototype in Balint's Tavistock seminars.

Some of the most deeply affecting chapters in this book are those in the third section, "The Patient's Voice." For as both narrative medicine and contemporary psychoanalysis have cultivated a more collaborative partnership

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between both members of the treatment dyad, so both modalities encourage the patient to share his or her own story as an integral part of the healing process. In "Learning How to Tell," Lisa J. Schnell combines the tale of the death of her daughter Claire at eighteen months from a horrifying neurological disorder with the tale of her own psychosomatic illness arising from an unconscious identification with her daughter's plight, and Schnell weaves this exceptionally poignant dual narrative together with arrestingly original meditations on psychoanalytic theory.

Although Schnell does not cite either Groddeck or Balint, her chapter, like Griffin's, makes a compelling case for their teachings. She comes to recognize that her physical symptoms are nothing if not metaphors, caused by her "inability to pronounce *da*—to tell, to imagine, the whole of my and Claire's story." In keeping with Balint's view of diagnosis as a process of negotiation between doctor and patient, Schnell explains that she "was looking for another story, one that I could own even if I couldn't control it," and that it was her "doctor's very refusal to tell his own story about my illness that allowed me to regain my health." She reads the *fort-da* game of Freud's grandson recounted in *Beyond the Pleasure Principle* as a parable about the origins of narrative out of an experience of primordial loss, and how the ability to mourn requires that one possess "an internal space of perception," which is tantamount to acknowledging the "cognitive distance" between a thing and its linguistic representation. Thus, "learning how to tell" becomes a matter of replacing hysterical imitation that does not allow for symbolic distance with a verbal *mimesis* that at once accepts and transmutes loss.

Whereas Lisa Schnell explores how her mental anguish expressed itself through physical symptoms, Ed Cohen in "Imagining Immunity" leaps across the mind/body divide from the opposite direction. Stricken with Crohn's disease in his early teens, Cohen recounts what it has meant to him medically, intellectually, and spiritually to have grown up "in thrall to a metaphor." While not denying the efficacy of Western biomedicine, Cohen indicts the professionals who treated him because they "didn't believe that metaphor had much to do with their practices," and he attributes his own astonishing recovery from near death to the activation of his body's innate healing powers, chiefly through trances in which he visualized "wrapping a band of warm light around the surgical incisions." Cohen joins Richard Holt in paying homage to Foucault for enabling him to understand how his own experience as a patient was "enmeshed in the institutional plays of power/knowledge," and his chapter likewise dovetails with Janet Sayers's reflections on the symbiotic relations between narrative understanding and intimations of transcendence.

What I find perhaps most impressive about Cohen's chapter, as about Schnell's, is its seamless transition from spellbinding autobiography to scintillating theoretical analysis. He traces the concept of "immunity" to its origins

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in Roman jurisprudence, showing how by the end of the nineteenth century its metaphorical power had displaced the earlier view of healing as "a natural manifestation of the organism's inherent elasticity" (and its connection to the universe as a whole) with a definition of medicine as "a powerful weapon in the body's necessary struggle to defend itself from the world." As Cohen argues, both the triumphs and the limitations of Western biomedicine can be understood in terms of the way the metaphor of immunity has supplanted that of healing, with the consequence that the patient is reduced to being a passive tool in the hands of doctors and researchers. Echoing my own critique of Susan Sontag's attempt to eradicate metaphor from medicine, Cohen asks us to imagine what it might mean "to affirm healing *as* metaphor." One dividend would be the rehabilitation of the "placebo effect," which, as Cohen notes, is ironically excluded from biomedicine "not because it is *not* effective but precisely because *it is*." For Cohen, in short, metaphor is a "transformational technology" that should open all of us to "a potentially productive kind of not-knowing, a kind of not-knowing that asks us to engage imaginatively with the organisms-that-we-are in the service of our vitality and aliveness."

For Kimberly R. Myers, the journey chronicled in "A Perspective on the Role of Stories as a Mechanism of Meta-Healing" began somewhat later in life when, as a graduate student, she was diagnosed with inflammatory bowel disease. After what she calls "the fall (from health)," Myers found that the literature she had always appreciated "intellectually and philosophically" now took on a "new significance" in its visceral demonstration that she "was not alone in facing life-altering bodily change." Impelled by the need to "restore a sense of agency in the face of my loss of control," Myers borrowed from alternative medicine the notion of "meta-healing," which she defines as "a means of healing that occurs in observing the healing of others." In what was "probably the most vulnerable moment of my life," Myers admitted to the students in her course on literature and medicine that a pathography she had asked them to read was actually her own illness narrative, a revelation that transformed their communal bond and inspired the students to breakthroughs in their final projects.

Following her participation in a 2002 National Endowment for the Humanities Institute on "Medicine, Literature, and Culture," Myers issued a call for pathographies from academics in any discipline. The response was overwhelming. In her interactions with the more than ninety people who submitted illness narratives, Myers was faced not simply with the normal tasks of an editor but also with the ethical responsibility "to witness the stories." Despite her belief in "meta-healing," Myers—struggling with her own chronic illness—found "the sheer magnitude of fear and grief recounted within these pages" almost more than she could bear, leading her to compare herself to Holden Caulfield vainly "trying to catch everybody who was about to go over the cliff." Still, she did not allow her physical and emotional dis-

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tress to deter her from her commitment, which has borne fruit in a volume entitled *Illness in the Academy: A Collection of Pathographies by Academics*. As Myers writes no less wisely than courageously, "[T]he gift in simply being there is valuable not because it is *easy*, but precisely because it is so difficult. Venturing into the shadowlands full force is the gift one gives not only to another, but also to oneself."

Unlike the other contributions to this section, Jean S. Mason's "The Discourse of Disease: Patient Writing at the 'University of Tuberculosis'" is not a first-person illness narrative. Rather, in an impressive piece of scholarship, Mason sifts the largely overlooked archive left behind by patients at Saranac Lake, New York, the sanatorium founded in 1884 by Dr. Edward Livingston Trudeau, who had himself been diagnosed with tuberculosis before discovering the salubrious effects of this Adirondack Mountain locale. In its mingling of patients and practitioners, as well as its integration of "patient care, scientific research, medical training, and patient rehabilitation," what Mason denominates the "university of tuberculosis" became "an exemplary model of community-based health care." Given that the treatment of TB imposed "long hours of enforced idleness," many patients turned to writing as a means of passing the time. Their productions ranged from bare-bones diaries to published collections of poetry by such gifted authors as Herbert Scholfield, Adelaide Crapsey, and John Theodore Dalton, to the entrepreneurial gold mine of *Trotty Veck Messages*, collections of witty inspirational passages in prose and verse (named after a character in Dickens's "The Chimes") the sales of which increased from an already impressive four thousand copies in 1916 to an astounding four million copies fifty years later.

In addition to presenting these and other intrinsically interesting texts (including the aptly named *Trouble Book of Isabel Smith*), all of which attest to "the therapeutic power of writing" confirmed by up-to-date psychological research, Mason reflects on the ways that patient narratives combine with clinical records and scientific reports to describe the medical encounter from different perspectives. Each of these sources contributes integrally to "a multidimensional discourse of disease," though narrative medicine would encourage us to give priority to the "inherently metaphoric" writings of patients. Mason quotes Anne Hunsaker Hawkins, co-director of the NEH Institute that came along so opportunely for Kimberly Myers: "Not only, then, does pathography restore the phenomenological and the experiential to the medical encounter, but it also restores the mythic dimension that our scientific, technological culture ignores or disallows."

The chapter by Jeffrey Berman provides a ready transition into our final section, "Acts of Reading." Like Kimberly Myers, Berman in "The Teaching Cure" addresses what takes place in the classroom, and he picks up where Jean Mason leaves off by doing so initially through a close reading of May Sarton's 1961 novel, *The Small Room*. As emerges from his masterful exposition, *The*

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Small Room is "one of the most moving academic novels about how a teacher's empathy makes a difference in her students' lives," and it explores profoundly the dynamics of transference and countertransference in teacher-student relationships, though Berman shares Fred Griffin's inclination to eschew potentially arcane terminology in bringing his psychoanalytic sensibility to bear on Sarton's text.

From a detailed examination of *The Small Room*, the plot of which hinges on whether a student who has been caught plagiarizing at an all-female college should be expelled or given psychological counseling (at a time when the latter option was not routinely available on campuses), Berman proceeds to reflect more generally on the personal element in teaching, concurring with Sarton that teachers show their true greatness by being "humble and respectful" toward students. In a series of landmark books, Berman (1994; 1999; 2001; 2005) has advocated a pedagogy of "risky writing," the success of which depends on the teacher's capacity to create "a safe and empathic classroom." Through connecting their academic work with what is going on in their lives, students reach "not simply intellectual understanding but emotional understanding as well"; and in licensing his fellow teachers to pose the unanswerable question of "how to live," Berman eloquently vindicates his conviction that "literature and psychoanalysis are two of the best ways to learn more about ourselves and others and to preserve these provisional truths for those who come after us."

The next two chapters, both by thoughtful and literate psychiatrists, raise theoretical questions about reading prompted by the convergence of psychoanalysis and narrative medicine. Neil Scheurich's "Reading, Listening, and Other Beleaguered Practices in General Psychiatry" is written from the standpoint of someone concerned that the "core values" shared by both literature and psychotherapy have become endangered both in his own professional domain and in contemporary culture generally. Ironically, as Scheurich points out, even as medicine as a whole has seen a modest broadening of its vision beyond the technical, psychiatry, now largely divorced from psychoanalysis, "seems increasingly reduced to a biological understanding of human experience." As Scheurich argues, reading and psychotherapy, as well as the use of literature in psychiatric training, "all share common justifications stemming from the virtues of narrative form," and thus what is ultimately at stake in narrative medicine is the classic problem of how to defend literature against the charges of irrelevance or even dangerousness that go back to Plato.

Scheurich enlists many prominent thinkers who have responded to the attacks on both literature and psychotherapy, but his chapter is at bottom a personal plea in favor of the values of *autonomy*, *complexity*, *curiosity*, and *patience* shared by proponents of "serious reading and listening," notwithstanding the differences between these endeavors. While renouncing the

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"fantasy" that there is some "ultimate justification" that "will magically open the eyes of the indifferent," Scheurich retains the hope that literature can be used in the education of future psychiatrists "not merely to gain a clinical 'pearl' or two," but rather to induce them "to *care* about literature and the values it embodies, and to see that these same values also underlie the mixed status of psychiatry as both liberal art and science."

In "Uncertain Truths: Resistance and Defiance in Narrative," Schuyler W. Henderson offers a commentary on Michel Houellebecq's *Atomized* and John Kennedy Toole's *A Confederacy of Dunces*. He does so in the context of a searching interrogation of how behavior that most mental health professionals would classify as "resistance" can from the standpoint of the counternarratives told by those deemed to be "sick" or "mad" be affirmatively described as "defiance." To label something as "resistance," as Henderson notes, is to "put the power of knowledge squarely in the hands of another," rather than in the hands of the patient himself or herself. Whereas resistance explains the phenomena in question almost completely in terms of personal psychology, moreover, "defiance is a consciously articulated ideological position" that insists, with Houellebecq in his novel, that the very "privileging of the individual, along with his or her experience and narrative," is itself "historically derived and socially sanctioned," and hence must be subjected to a transpersonal critique. According to Houellebecq, the same period of modernity that gave birth to the ideals of "personal freedom" and "human dignity" has been "characterized by decline and destruction"; and thus, in Henderson's extrapolation, "psychology and therapy, rather than offering a solution, are themselves seen as part of the problem."

Despite his sympathy for "the deepened understanding of illness and the ill person" afforded by "the resistant/defiant text," Henderson is not an advocate of "anti-psychiatry." Although he recognizes that people with schizophrenia in the United States "not only do not do better . . . compared to other countries, but are worse off than they were thirty years ago," this indictment of the inflated claims of the pharmaceutical industry is counterpoised by Henderson's reminder that the celebration of defiance in *A Confederacy of Dunces* must be weighed against "the resounding caveat of Toole's suicide." The unwritten books by this author dead by his own hand at the age of thirty-two are no cause for celebration. In the end, Henderson leaves us with a measured plea for a "complex negotiation" or "dialogue where the narrative can be read with and against the counternarrative," as "any notion of 'progress' requires such dialogue," while he remains vigilant to the ever-present "risk that during this dialogue an appropriation of the counternarrative can occur." The most that can be said is that "resistance is an obstacle to insight, while defiance is an obstacle to abuse," and the desirability of being able to tolerate the uncertainty generated by these antithetical perspectives is one of the enduring lessons still to be learned from reading Freud.

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Since the theme of trauma has run like a red thread through this book, it seems fitting that our final chapter should be Geoffrey Hartman's "Narrative and Beyond." Modestly acknowledging his "own limited roles of teacher, reader, and occasional interviewer of Holocaust witnesses," one of the leading literary critics of our time seeks in his "*membra disjecta*" to offer the outlines of a "poetics of narrative medicine." Like Lisa Schnell, who takes her epigraph from one of his essays, Hartman appeals to Aristotle's analysis of the cathartic effects of art—a concept linked to psychoanalysis through the "cathartic method" employed by Freud as a way station between his practice of hypnotic suggestion and of free association, and mediated by the medical interpretation of Aristotle's controversial notion put forward by Jacob Bernays (the uncle of Freud's future wife) in 1857.[3] And as for Neil Scheurich both reading and psychotherapy are not religious but "spiritual practices inasmuch as they entail attention to the moment, a slowing of onrushing time, and observation of discipline and ritual that impose some order upon chaos," so too for Hartman the great gift of literary seminars (and, I would add, of psychoanalytic sessions) is that they furnish "the time to think freely, to explore the very process of interpretation, without having to do it in a state of emergency," while the indispensable notions of "bearing witness" and "testimony" must be invoked without "carrying, necessarily, a religious overtone."

The range of reference in Hartman's essay extends from Tolstoy to television, from the poetry of Celan, Donne, and Milton to the experiments of Stanley Milgram. In no less productive dialogue with Terrence Holt and Fred Griffin, Hartman concurs with Holt's postmodern emphasis on the inevitable fracturing of subjectivity by citing Arthur Frank's *The Wounded Storyteller* on the "variety of illness narratives that exist," and in particular on the irreconcilability of the perspectives of physician and patient, which enforces the conclusion that "the claim of a 'sovereign consciousness' may have to be given up." And yet, Hartman also lends credence to Griffin's humanistic definition of the "fortunate physician" when he observes that the physician who displays "narrative competence" will be one who, "despite the constraint of time, cultivates an empathy that ideally seeks to being forth the patient's own understanding, even self-discovery." Indeed, "what seems of paramount importance" to Hartman in the mysterious process of healing is "the element of trust."

Hartman closes his sinuous meditation by drawing attention to an Israeli study of Holocaust survivors, who were found to be "chronic patients in mental hospitals" in disproportionate numbers compared to the general population. Strikingly, their experiences of persecution were often not noted on their medical charts, and the possible traumatic etiology of their psychopathology was thus disregarded. In response, a group of psychiatrists undertook what Hartman describes as "a story cure, or more precisely, a testimony cure," by soliciting from these elderly individuals a videotaped auto-

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biography that could then be studied by other people as well as viewed by the patients themselves.

Hartman insists that this experiment has an intrinsic value above and beyond any demonstrable practical effects, yet the results have been promising even when measured by "recognized scientific parameters." According to the authors of the study, "it has been suggested that the testimonial method alleviates many chronic symptoms by transforming the painful trauma story into a cathartic experience and document which could be useful to other people." Hartman observes that this remark "points clearly to the potential of narrative medicine," but, somewhat surprisingly in my opinion, he nowhere mentions the psychoanalytic underpinnings of the entire project undertaken by Rita Charon and her colleagues.

In particular, when Hartman goes on to urge that "more could be done in the medical humanities with different aspects of literature, not only its narrative component," and that the physician who practices narrative medicine should strive to be "sensitive also to non-narrative, apparently inconsequential or lyrical moments, surprises in the narrator's mood and mode," one might have expected him to note that this type of "listening with the third ear" is precisely the province of the psychoanalyst. To continue with Hartman's own lyrical words: "One learns to respect fragments of speech, abrupt figurations, shifts, jump-cuts, mixed genres. It also means . . . to respect what does not fit. For there may be more than one story struggle to emerge, as in a multiple birth."

As the truths of the unconscious are no less powerful for going unrecognized, or being uttered only obliquely, so in coupling "narrative" (medicine) with "beyond" Geoffrey Hartman uncannily invokes psychoanalysis without mentioning its name. In "Material and Metaphor: Narrative Treatment for the Embodied Self," Rita Charon brings this volume full circle by performing the analytic function of making the unconscious conscious. Looking back at her opening presentation in light of the experience of the conference itself and the other papers gathered here, Charon in her afterword again takes up the interplay between body and language in medical practice, where the physician not only may but must touch his or her patients, and in analytic therapy, where physical contact is prohibited. She aligns this contrast with that between the pivotal role of transference in psychoanalysis, in which "the analyst operates on the metaphorical and not the material level," and the way that the medical doctor "enters the lives of patients guilelessly, open-faced, as himself or herself." Despite this "disidentity," Charon has come to see with increasing clarity how the ordinary doctor, like the analyst, "is confronted by materiality saturated with metaphor" on a daily basis, and must draw on all the resources of both heart and mind "to divine, imagine, follow allusions to what the matter is." Although practitioners of both mental and physical healing have much to gain from this new interdisciplinary conjunction between

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psychoanalysis and narrative medicine, the ultimate beneficiaries promise to be the patients themselves—that is, each one of us—who have the right to expect not only "diagnostic accuracy and appropriate medical management," but also, and above all, "recognition and company on their journeys of illness."

NOTES

1. My comments here concerning Ferenczi and Groddeck draw on the more extended discussions in my *Reading Psychoanalysis* (2002).

2. Charon cites Freud's statement in *The Ego and the Id* that "the ego is first and foremost a bodily ego," and her remarks on this topic could be profitably supplemented by Didier Anzieu's (1985) psychoanalytic work on the "skin ego."

3. I have translated salient portions of Bernays's *Fundamentals of Aristotle's Lost Essay on the "Effect of Tragedy"* in the Fall 2004 issue of *American Imago*, guest-edited by Nicholas Rand, *The Growth of the Unconscious, 1750–1900*.

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