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Cover Page Footnote

Charon, Rita. *Narrative Medicine: Honoring the Stories of Illness*. Oxford: Oxford UP, 2006. _____. "Close Reading, The Signature Method of Narrative Reading." *The Principles and Practice of Narrative Medicine*. Ed. Rita Charon et. al. Oxford: Oxford UP, 2017. 157-79. _____. "Clinical Contributions of Narrative Medicine." *Principles* 292-308. Herman, Nellie. "Can Creativity Be Taught?" *The Principles and Practice of Narrative Medicine*. Ed. Rita Charon et. al. Oxford: Oxford UP, 2017. 233-254. Woolf, Virginia. "A Sketch of the Past." *Moments of Being*. Ed. Jeanne Schulkind. San Diego: HBJ, 1985. 64-159. _____. *Between the Acts*. (1941) San Diego: Harcourt, 1969.

Diagnosed: Consolidating an Authentic Self within the Practice of Narrative Medicine

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“The phrase ‘narrative medicine,’ Rita Charon writes, “came to me as a unifying designation to signify a clinical practice informed by the theory of reading, writing, telling, and receiving of stories” (2006, viii). If initially conceived to be practiced by medical professionals, the field quickly grew capacious enough to include anyone concerned and engaged with the quality of the physician-patient relationship, that is the interactions which occur in the hospitals, clinics, waiting rooms and corridors of the health facilities where we all inevitably “find” ourselves, and even more broadly, dialogic relationships themselves.

As one of the few health care nonprofessionals joining the early cohorts of narrative medicine workshop participants, I brought with me a decades-long familiarity with the medical environment, having worked in development along Boston’s Longwood Avenue—Harvard Medical School, Joslin Diabetes Clinic, and Children’s Hospital. As co-editor with Suzette Henke of *Virginia Woolf and Trauma: Embodied Texts*, I also brought an empathetic understanding of the impact of trauma on Woolf’s life and work, and so on those who share her afflictions. And, I carried the hidden and varying diagnoses of my mental illness that have been attached to me since childhood.

At first reticent, as many trauma survivors are when asked to disclose something of themselves even to their physician, I struggled with our first workshop exercise, to write about our name. “Too many Daves,” I thought, recalling both Dr. Seuss’s delightful book and the effort required to integrate my disparate selves. Later I panicked when asked to choose an important story about myself to relate to another but then luckily found myself the third of a triad, and so was able to listen to the other two. A. and S. recounted deeply personal and moving stories. We three took care to hold and honor A’s story with our silence when reporting to the larger group. “You have created a sacred space,” Pat Stanley, our facilitator, noted. Together we learned how to create a safe place by joining narrative technique to the healing presence that had appeared among us.

I would encounter that space in Craig Irvine’s living room, flooded with the golden light of a setting sun at end of a June advanced workshop. We had been encouraged to bring creative work with us; ambivalently, I packed a few poems, including “Diagnosed.” I am not shy, I have published and read publicly sporadically for many years. But each time I do, I must overcome the emotional confusion, anxiety, and shame that accompanies the act of disclosure for an abuse survivor. I made the decision to read my poetry only at the last minute when in the room, responding to those around me, what Charon calls reciprocity. “The writer

of a life story,” she writes, “needs a reader [or listener] of a specific sort who will donate his or her presence to that which the writer is trying to convey” (2006, 76). My decision to *fully participate* as writer and reader had profound consequences for my future, for it allowed me to consolidate what had been the disparate interests of my life: spiritual, professional, academic and creative.

What could I do with this new awareness and skill of Narrative Medicine? My question was answered when Morgne Cramer, a trusted friend and Associate Professor of English, invited me to meet with her class at the University of Connecticut Stamford Center for Women’s, Gender and Sexuality Studies. Reading from my poetry and drawing lessons from the life of Virginia Woolf, I explored with her students the process of “(Re)creating Oneself,” linking the themes of creativity, self-censorship, and the impact of trauma on a writer’s development from young adulthood to maturity.

Within the book and poster-lined walls of the Center, Professor Cramer has created a safe environment for her students to study and discuss the texts of violence inflicted upon women—incest, harassment, physical and sexual assault. Sitting among them on the soft bright blue chairs that filled the room, I felt as comfortable as I had in the narrative medicine workshops. Charon, concluding her chapter on autobiographical writing, “Telling a Life,” recounts the story of a gastroenterologist who elicits from a patient the story of her rape. It falls to us, she suggests, as we listen to the stories of others—and I would add, to our own—to respect the value of their telling it, and to trust that what is said means something” (2006, 81). Reading my poems and answering questions about them allowed for the meaning of others to emerge from the silencing that so often surrounded the topic of trauma outside environments like that of the Center.

Some of the questions I was asked were about the specifics of my childhood, my hospitalizations, and my recovery. Almost without exception the questions were prompted not by curiosity but a desire to learn about my history and apply it to their class reading and discussion. In responding to their questions and occasionally and transparently choosing not to reveal a detail I knew would be painful to me as well as them, I was able to model options and boundaries that they too could employ in relating their own experience to others, reinforcing the lesson that they can control the specifics of their narrative and remain true to it. At the same time I came to see that while the level of my self-disclosure varied from year to year depending on my feeling of safety, my voice too remained authentic.

I was careful to pair poems of my youth and my maturity. Reading poems written in my early twenties allowed the class to hear my emerging voice as I struggled to articulate my experience; reading poems written decades later permitted them to hear how I had changed, as I returned to the same events with a deeper understanding and acceptance. This pairing, I think, facilitated their imaginative entry and identification into what it was like for me as an adolescent and young adult like most of them, while the texts themselves facilitated and diffused their strong emotional reactions to sharing about violence and abuse.

Perhaps the most important question is the one I start each class with: why have I, an unknown and relatively unpublished poet who never graduated college, been asked to join them? (Of course, my co-edited Woolf anthology lends a modicum of credibility in an academic environment.) The answer to my question, which I am embodying in the class, allows me to speak about abuse, shame, and self-silencing. In talking about my struggles to write and publish, I can point out the similarities I share with them as women, immigrants, first generation, and gender-fluid college students—an “Outsider Society,” as Woolf described us in *Three Guineas*.

I am almost certain that among the posters hung around us was the iconic one of Virginia Woolf in her youth. Few students, even if they had yet to read “Virginia,” so often familiarly referred to by her first name, could be unaware of the traumatic events of her life—the death of her mother and other family members, her sexual abuse, and subsequent mental illness. In discussing Woolf’s memoir, “A Sketch of the Past,” Charon chooses to emphasize the mystical aspect of her practice of reading and writing, “making possible travel beyond the bounds of mortality” (2017, 168). Woolf herself draws attention to the “shock-receiving capacity” that she felt made her a writer: “I hazard the explanation that a shock is at once followed by the desire to explain it.” It is the shock of life, benign or violent, that originates her attempt to put it in writing. Putting the shock in words makes it whole: “this wholeness means that it has lost its power to hurt me . . . perhaps because by doing so I take away the pain” (72). The mystical and the painful co-mingle in her text, seeking consolidation, if not resolution. Written close to the end of her life, Woolf’s memoir, which addresses her sexual abuse, reaches across time to speak to the young recovering from their own.

Woolf was given many diagnoses and labels in her life: mad being the most common, neurasthenia, the more medically polite; and posthumously: manic-depression, post-traumatic stress disorder. I too garnered diagnoses, depending on which edition of the DSM was current: pre-schizophrenia, psychosis, agitated depression, post-traumatic stress disorder like Woolf, along with ruder ones. I named them in one of the poems I read at the workshop:

DIAGNOSED

Something in me wanted it, I thought.
Something in me liked getting hit.
Masochism my doctors called it.
I was eight. No one believed me then.
No one would stop it from happening
again. Not my mother or my father
or the family priest who walked up
the front hall steps as ominous
as God himself. I was trapped.

The rest is as blank as a bedsheet
pinned to the living room wall.
How I tottered and grinned,
waving from some lost vacation
as guilty as sin. Diagnosed.
Bad. Wrong. Liar. Thief.
Psychotic. How the labels stuck.
Something in me learned to like
what I was told I was. Victim.
Something in me sought my punishment.

When introducing my poems, I am careful to establish the fictional nature of the first person “I,” a more difficult task in a lyric poem than in a novel, where the convention of an unreliable narrator is more securely established. Declaring the unreliability of the “I” in trauma narrative reinforces and challenges the nature of the traumatic event. It may also protect the story from the intrusive imposition of a definitive meaning. In so doing, it differs from medical narrative which must sift symptoms for a most plausible diagnosis, or cause, for pain. The defensive, often unconscious, silences, omissions, and gaps of a patient suffering from the impact of childhood sexual trauma make establishing a coherent medical narrative the more challenging for both patient and physician.

Thus, I remind my readers, I am *not* a masochist; in fact, I abhor and avoid violence, having suffered from its effects. It is the rhyme “hit/ it,” surrounded by an expanding multitude of half-rhymes—thought, eight, step, stuck, psychotic, and so on—that propels the poem forward in its narrative. These half rhymes create a dense web of sound that leads to and finally liberates the reader from the ultimate diagnosis, “victim.” It is, I think, one reason why a listener will hear survival in the poem’s difficult lines.

When reading “Diagnosed” aloud, I noticed another effect. When spoken, the poem’s litany of labels has the paradoxical effect of defusing the shame which would normally accrue around any one of them. No longer kept secret, each is recalled and claimed. The list is a simple one, simultaneously specific and representative, inviting the listener to insert his or her own shameful labels, and so verifying their own validity, which the impact of the abusive event may have minimized or negated. I would like to believe, particularly in the context of the Women’s Center, that the poem invites young women and men to speak for themselves, opening rather than foreclosing a healing dialog, and mitigating the defensive, often unconscious, narrative strategies that can arise.

In her concluding chapter of *The Principles and Practice of Narrative Medicine*, Rita Charon makes the claim that through its “rigorous routines,” narrative medicine “moves clinical practice towards its ideals of creativity, reflexivity, and reciprocity” (2017, 308). The same rigorous routines, as I learned in the Narrative Workshops I attended, can be applied not only in the examining rooms of the

hospitals and clinics where I worked as a development officer, but in the classrooms and other venues where I read and speak as a poet and independent scholar.

Chief among those routines is that of “close reading,” as exemplified in my discussion of “Diagnosed.” A fundamental principle of Narrative Medicine, close reading bridges “some of the relentless divides—resulting from conflicting understandings of mortality, contextualization, causality, and emotional suffering—that separate clinicians from patients,” (Charon, 2006, 126) and more broadly, I would argue, a poet from his audience and a teacher from her class. Learning how to apply what I knew of narration, form, voice, metaphor, and historical context, allowed me to speak and teach about abuse in ways that acknowledged and bridged the painful gap of silence that surrounds the acts of incest and sexual abuse. (My own literary scholarship has been devoted to the question of “how to read” Virginia Woolf’s books as texts of trauma and illness, paying attention to what she describes as the “orts, scraps, and fragments of ourselves, and what Charon points out, quoting Derrida as “some interval or gap” which must separate itself to be itself (2006, 76.) I learned too that focusing on a “text”—short story, life writing, or in my case poems—facilitates class discussion and resolution of strong emotions surrounding the validating “diagnosis” we seek, or less benignly are subjected to, depending on circumstance.

Charon also emphasizes creativity among the ideals of narrative medicine. Unlike her colleague Nellie Herman, a novelist and Creative Director of the Narrative Medicine Program, I do not conduct writing workshops. However, my awareness of the self-silencing shock and shame of trauma that befalls survivor and patient, and attending medical caregiver allows me to encourage others, if only by example, to surmount their silence and speak. Creativity necessarily implies an audience—a teller and a listener—as exemplified in the Narrative Medicine workshops. As Herman notes in her contribution to *The Principles and Practice of Narrative Medicine*, without a reader, the exercise of writing and learning is incomplete (251-52). It is this same search for audience that animates the relationships of *Between the Acts* where its characters witness the pageant created by Miss LaTrobe. “We remain seated. We are the audience,” Woolf writes in *Between the Acts* (59), bringing our unique and partial awareness to the performance of the pageant she celebrates in her last novel, as well as to the dialogic interactions of its characters.

Thus, Narrative Medicine led me to the reciprocity I first discovered in its workshops sitting face-to-face among the “participants from various professions” and later in the Stamford classroom where I explored with its students what Charon describes as our own “perspectives, imaginations, memories, and values” (2017, 299) and in doing so reclaimed an authentic voice for myself and others.