When bodies speak and words act

- *poetry, psychosomatic illness and the lost art of medicine*

Sandy Goldbeck-Wood

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Contents

Foreword

This PhD thesis comprises a monograph based on the lived experience of practising clinical medicine, writing poetry, and editing medical journals. It also draws on a body of peer reviewed writing, teaching, and presentation I have undertaken over a 20 year period in the areas of biopsychosocial medicine and psychoanalytic understandings of creativity.

While this thesis contains largely new, unpublished work, it also draws on editorials, commentaries, book chapters, and poetry which have previously been published.[1-16] An abridged version of Chapter 5 has recently been published as a contribution to a new textbook of Psychosexual Medicine,[17] and thanks are due to its editors for significant presentational improvement. The case reports contained in this chapter have either been published in the journal of the Institute of Psychosexual Medicine[18-20] or presented at Institute of Psychosexual Medicine conferences. All have been anonymised in respect of both names and significant recognisable details to protect patient confidentiality, but in such a way as to retain a true sense of the encounters. Many of Chapter 5´s underlying ideas – those addressing psychosomatic illness´s epistemological challenge to biomedicine - have appeared in different forms in textbooks of psychiatry and psychosomatic obstetrics and gynaecology.[21 22]

Chapter 4 builds on an unpublished master´s thesis on rawness in visual art,[23] in which I presented among other things a self-analytic account of making a painting, just as here, I present a similar account of making a poem (Chapter 3, When words act, p XX). Both draw inspiration from the method adopted by psychoanalyst Marion Milner in her self-reflective book on drawing, *On Not Being Able To Paint*.[24] Some of Chapter 3 and 4´s ideas relating to the relationships between poetry and therapy and poetry and sex have been presented at meetings, including the International Hippocrates Forum, and the The Nordic Network for Narrativity and Medicine. Eight of the nine poems have been published in poetry journals or prize anthologies.[25-32]

This project has had a long gestation. It has been carried out alongside a complex working life across national, organisational, and epistemic boundaries. It was interrupted in 2012 by a move from the UK to Norway. The project itself was moved from the creative writing department at the University of East Anglia to the medical department of the University of Tromsø. Navigating different jurisdictions, homes, universities, disciplines, employers, data systems, computer passwords, and mechanisms for booking leave has posed challenges, but also kept me close to the subject matter.

I have neither sought nor received financial funding. However, many individual people have supported this project generously with their time, space, hospitality, and thought. I owe many debts which I can never hope to repay to friends and helpers who have shared my excitement at the material, urged me on, and supported me practically. Not all can be named here, but some must have special thanks.

Foremost thanks for academic mentoring go to both George Szirtes, one of the UK´s great poets, and former lecturer in poetry at the University of East Anglia, who supervised this project in its early stages as a creative writing doctorate, and to Tore Sørlie, Professor of Psychiatry at the University of Tromsø, who fostered it through to completion as an interdiscplinary medical thesis. Without George´s poetic brilliance, wit, warmth and truthfulness I doubt that my account of poetry, such as it is, could ever have taken shape. Enlivening conversations in Wymondham about the point and nitty-gritty of poetry, as well as the example of George´s own poems, have been among the project´s great pleasures and inspirations.

Likewise, without Tore´s generosity, academic breadth of vision and psychoanalytic patience, I cannot imagine how this project would ever have come to completion. Having agreed to foster this foundling project *pro bono*, Tore has offered precisely the unearned hospitality, forbearance, containment and reflection which were needed for it to come together. I am grateful for many enjoyable conversations at Aasgård Hospital in Tromsø, and on the phone from Cambridge, about all that is worst and best in medicine.

Others have made key contributions to the thinking, rewriting, and editing. Nick Ingham has been present in conversations about this work from its inception to its completion. He is familiar with both the work, the life which has given rise to it, and much of the earlier work upon which it is built. He has read countless drafts with a good friend´s generosity, an experienced psychotherapist´s understanding of the material, and a Yorkshireman´s intolerance for cant.

Many interdisciplinary researchers have inspired and informed this work, and are acknowledged in references. However, I am especially grateful to Anna Luise Kirkengen, who, as well as being an international groundbreaker in medical epistemological reform, has also supported me personally in pursuing this work, as a colleague and friend. Thank you, Anna Luise, for a rich conversation which began on the steps of Norway´s Royal Palace in 2011 and has continued to encourage me and sharpen my thinking ever since, in London, Oslo Cambridge, and Tromsø.

Very special thanks are due to Ganesh and especially Larissa Acharya for generously offering me a home-from-home during supervision visits to Tromsø during the autumn and winter of 2017-18. It was a great pleasure to share food and walks, pick berries, shovel snow, and paint eggs, and a privilege to share the company of their family and friends.

During this same period, David Horwell, retired consultant gynaecologist and former acting Editor in Chief of the Journal of Family Planning and Reproductive Healthcare, kindly deputised for me as Editor in Chief of the *Journal of Family Planning and Reproductive Health Care*, at the most awkward possible moment, on the cusp of its transition to becoming *BMJ Sexual and Reproductive Health*. Only David could have handled this feat without detriment to the journal, and I am grateful that he was generous enough to agree to this tall order. Thanks also to Janie Foote, the journal´s managing editor for skillfully minimising the impact of my temporary absence on authors, peer reviewers, and the journal´s editorial board, and the Faculty of Sexual

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To my research buddy Hilde Tørnquist, psychiatrist and researcher, I say a hearty *takk for laget* – for solidarity, insistence, the inspiration which your own work represents, and many good conversations in Bodø and Cambridge, including the one at Wittgenstein´s grave. Warm thanks too to Rose Cameron, friend, fellow therapist and researcher, and expert in capturing in words things which are hard to capture in words, for conversation, encouragement, and role-modelling the completion of an unusual PhD. Thanks to Kjellaug Hatlen Lunde, artist and educator, for thought provoking conversations at Kunstkvarteret, Lofoten.

As if by magic, Thor Eirik Eiriksen appeared at the moment of writing up: a philosopher versed both in the field of medically unexplained symptoms and the drill of completing a PhD in Tromsø, he offered me two long afternoons of insightful supervision at a key moment. Thanks, Thor Eirik, for your kindness and challenge, especially for pushing me to introduce this work in less defensive, more authentic terms.

Many others have also been extremely generous. Sharon Davies, letters editor of *The BMJ* and *BMJ SRH*, and friend, has with extraordinary kindness and good cheer offered essential presentational revision during the final stages as well as thoughtful feedback on the work´s content. Will Beharrell and Lindsay Fursland each made valuable comments on drafts of chapters, and Mona Kiil shared her home, her office, and her thoughts during the writing up period. Gunnar Kirkesæther accommodated me at his home in Sørvågen, Lofoten, during the final weeks of editing, tolerated my endless writing, and offered a new reader´s fresh, honest, and thoughtful feedback.

Colleagues from the Department of Obstetrics and Gynaecology of Cambridge University Hospitals have been kindly supportive of a project they had no direct stake in, as well as welcoming the clinical approach it represents into their clinical thinking: these include Mark Slack, Peter Baldwin, John Latimer, and Catherine Aiken. The

patients and poets who have taught me to listen better to embodied knowledge are too countless to name, but I am grateful to them all.

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Chapter 1: In search of lost perspectives

Poetic knowledge is born in the great silence of scientific knowledge - Aime Césaire

Keywords: medically unexplained symptoms, multimorbidity, evidence based medicine, epistemological gap

1.1 Awareness, lost and found

This is an exploration of how important things can elude or escape awareness, how their loss causes unease or dysfunction, and how they can be recovered. It draws on my practice as a psychoanalytically trained doctor and poet, and points to knowledge and skill held within both poetry and psychoanalysis which is relevant to health but has largely gone missing from mainstream medical discourse. It is about how medicine at times risks losing, but can regain, its humanity.

Loss or lack of understanding affects all individuals, groups, and communities at times. Editing awareness is necessary to allow action and progress in daily life. Specific things elude awareness in specific settings for specific reasons, often because at a given moment they seem irrelevant to or in conflict with conscious utilitarian priorities, and sometimes because acknowledging them is compromising or costly. Sometimes, though, the material which is missing proves so important that the individual, group, or project becomes frozen or paralysed for the want of them – blocked from progress, and unable to achieve its goals, to thrive.[33]

An example is found in those physical illnesses which are intractable to the biomedical model. Both multimorbidity[34] and so-called medically unexplained symptoms,[35] pose major challenges to health care in being highly prevalent, and expensive:[36] [37] Estimates suggest that medically unexplained symptoms (MUS) may account for up to 45% of all general practice consultations.[38] The annual cost to the health service

attributed to MUS in adults of working age in England be £2.89 billion in 2008/2009 (11% of total NHS spend), while sickness absence and decreased quality of life for people with MUS was estimated to be costing the UK economy over £14 billion per annum.[39 40] and notoriously poorly addressed within the empirical model which is medicine´s primary epistemological tool. Both have steadfastly resisted explanation and resolution within a model which treats body and mind as separate objects wholly encompassable by objective measurement and population-based generalisation.[41]

The extent to which these academic deficits have been acknowledged within medical literature and culture is limited – perhaps precisely because the biomedical model is in some areas so powerfully explanatory. The more powerful a model is, the more it becomes established in thinking as though it were fact or truth, the more a community comes to ”believe in” and depend upon it, in ways which are more religious than rational.[42 43] Likewise, the greater the power and prestige conferred on its leading proponents and institutions, the deeper go their unconscious competing interests, and the stronger the structural disincentives to considering alternatives. But whenever strong, useful theories become dogmatised – that is, protected against challenge by disconfirming data – they usurp and silence the ongoing process of honest enquiry, and risk causing harm, as might a good surgical instrument used wrongly.[44 45] Conscientious re-examination of established theories and models in the light of sustainedly disconfirming data is therefore as much the condition of science and scholarship as it is of personal development, and it is to this we must have the humility to return whenever theory fails to describe experience.

I will illustrate and discuss in two sections, spread across chapters 3, 4, and 5, a creative, material-responsive approach to dealing with different kinds of disturbing or awkward material, or experience. I will show how a practice of paying close, open minded heed to inconveniently uncategorisable phenomena which seem to be seeking attention, can lead to better understanding of our own ontological limitations or “boundary conditions”,[46] and to opportunities for development. Rather than clinging to familiar models come what may, and projecting “difficulty”, “inexplicability”, or “fault” on to the illness, patient, or subject matter, we can instead

take the opportunity to expand our own explanatory potential – learn to deal more effectively and humanely with complexity, heterogeneity, and individuality or uniqueness in everyday practice.

In the following chapters, I will use lived experience from first creative and then clinical practice to illustrate how meeting disruptions or challenges with open-minded, intersubjective investigation – a kind we might for the sake of argument call poetic – can result in remedy. I will exemplify how an open, undogmatic, and rigorous return to the raw data of underlying phenomena can permit valuable lost understanding to be recovered, allowing connections to be made within and between individuals which help restore natural development or self-regulation and promote wellbeing. I will show, for example, how an individual distressed by a psychophysical or relational block can use a therapeutic conversation to make sense of perplexing experience, recovering liveliness and a sense of agency; and also how a poet can capture stimulating, lonely experience in shareable words which increase wellbeing in both poet and reader, in a kind of psychological win-win.

The point of this will be to show how creative curiosity can – across different disciplinary settings - replace denial or aversion as a way of meeting challenge and complexity, and increase insight and resilience. Put another way, this is an interdisciplinary exploration of the proper role of creativity and human intersubjectivity in health and illness.

The remainder of this introduction will address in three parts why and how this study has arisen. First I will identify an epistemological gap or problem in medicine which has troubled me, because it seems to me, when unacknowledged, to harm patients and clinicians and to breach the first Hippocratic injunction, *primum non nocere – first do no harm.* Secondly, I will by way of context point to some research traditions already working to address this problem, along with some specific methodologies which my own method resembles in certain ways. Finally, by way of introduction to my own material, I will chart my own epistemological journey into, within, and beyond biomedicine.

In Chapter 2, *A poetic method for capturing complexity*, I will outline in more detail the material-responsive method through which this thesis has arisen – one which mirrors the poetic and psychoanaytic practices which form my subject matter, echoes other qualitative and creative methodologies, and answers calls for methodological development.

In Chapters 3, 4, and 5, the backbone of this thesis, I will dive into my core creative and therapeutic material, examining first in some detail the poet-poem-reader relationship (Chapters 3 and 4) and then the patient-illness-doctor relationship (Chapter 5), characterising the mechanisms whereby stimulating or troublesome experience which has proved hard to encompass in thought and language can be made approachable via tightly framed, creative, subjective-and-objective exploration in the presence of another person. Psychoanalytic accounts of both creativity and therapy explain how these processes actually happen, and how they achieve their effects. By demonstrating the intrapsychic "workings" of these two processes in a fine grained way, I hope to show how the transformation from "difficult" raw material to satisfactory finished product is not magical or supernatural, nor irrelevant or alien to the practice of healthcare. Rather, its achievements can be conceived in terms of ordinary human observational capacities and learnable skills, analogous to those required for good science or scholarship.

Finally, I will discuss directly an awareness which grew during this study – namely, that many of the characteristics and skills called for here are moral rather than technical. I will explore how these activities invite reconsideration of the ethical aspects of medical work more generally – how they demand and sharpen a particular subset of virtues relevant to healthcare which, though present in clinical practice, are not routinely taught, assessed, or discussed in health discourse. These characteristics, discussed in the final chapter, 6, include humility, open-minded listening, scrupulous attention to phenomena, the patience to tolerate uncertainty or apparent disorder until genuine order emerges, a capacity for playfulness, and an unquantifiable but essential moral driving force which we might call devotion or love-of-neighbour.

I will conclude by suggesting what this means for medical epistemology and practice in the post-evidence based medicine era. At present, awareness of the essential role of relationship and creativity in healthcare is largely unintegrated in the policy which guides practice – the academic "mind" of medicine. The tension of this missing awareness is borne daily by practitioners and patients. Both groups may feel its strain, dimly and uncomfortably, in the clinical encounter: ordinary practitioners strive at personal cost to retain "ordinary humanity" under increasing technical, operational pressure, while the humanitarian, non-technical aspects of their practice are not formally recognised in the metrics which determine efficacy and funding. Let us look more closely at the nature of this missing awareness.

1.2 Medicine´s epistemological gap

There is a growing consensus that in burgeoning as a natural science, medicine has to a significant extent lost its way as a humanitarian discipline.[47-49] As the volume of effective biomedical treatments which must be delivered efficiently and equitably has proliferated, other subtle, individualised kinds of knowledge arising in the patient´s individual story and elicited in the relationship between clinician and patient, become drowned out. As healthcare costs have burgeoned, the authorised accounts of health and illness have increasingly been solely those which facilitate rational allocation of resources.[50] Types of evidence considered admissible have become strictly circumscribed. Treatments which have come to be known as "evidence-based" have been those based on that subset of relevant evidence which is empirical, generalisable, quantitative, and biomedical, in other words, evidence which readily allows diagnostic and therapeutic lines to be drawn, benefits and harms to be balanced at a population level, and decisions to be made about which treatments should be funded for whom.

This has in many ways been a necessary and beneficial phase in medicine´s cultural and ethical development. Lines have needed to be drawn and difficult rationing choices made, and "evidence" based medicine has rationalised and reformed a culture

where tradition and hierarchy had previously taken precedence over truth, and theory over experience. “Evidence” based medicine arrived, in that sense, as a force for epistemological liberation, underpinned by its own moral imperative of democratising rationality – proposing the *conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients*.[51]

However, the pragmatic accounts of illness delivered by the new orthodoxy of evidence based medicine are necessary, but themselves partial – prioritising population-level operationalisability over individualised understanding. They deliver clinical efficacy in just and ethical ways only where their underlying assumptions about the causes and solutions to illness apply. In many cases these generalised assumptions do not apply, but complementary accounts capable of reflecting the individuality of the clinical encounter have not been integrated in policy and practice. Rather, these remain as a chorus of dissatisfaction at the margins of modern healthcare.[47-49]

What has resulted is a new form of epistemological imbalance – a preferencing of knowledge based on ease of measurability rather than on diagnostic and therapeutic importance. So while numerous areas of health, biomedicine, and epidemiology have delivered unquestioned benefits – the eradication of smallpox, cardiac stenting,[52] antiretroviral therapy,[53] and improvements in maternal and neonatal survival -[54 55] progress in other areas of practice and policy remain selectively blocked, because the sort of knowledge required to understand and treat them has been rendered invisible, inadmissible, or given a low status within orthodox models. Those illnesses which remain resistant to established diagnosis and treatment – or to put it more self-critically, those we as an academic community have not yet learned to understand – are apt to be neglected or denied.

But such elusive information and unorthodox illness do not go away, or cease to cause suffering and consume resources. Rather, as subtle, subjective, individualised accounts of illness are overwritten by orthodox models, patients with unorthodox problems complain about not being listened to, heard, or taken seriously,[56-60] clinicians complain about overregulation, lack of freedom, and disregard for their

ethical values, and “perform” their distress in the form of high rates of burnout, alcoholism, divorce, and drug addiction.[61-66] Researchers meanwhile repeatedly point to gaps in our guideline-based approach to many common and costly illnesses – notably, those which are complex, irrational, or biopsychosocial.[3 34 67 68]

Part of the problem is that beneath this evidence gap yawns an epistemological crevasse – a gap at the level of what sort of thing, in healthcare, is allowed to count as knowledge, and how we acquire it.[48 69] Biopsychosocial complexity is acknowledged and addressed in clinical settings, where it simply cannot be wholly ignored, but in partial, piecemeal, local, ways which lack integrated academic underpinning: As biological reductionism has grown in both somatic medicine and psychiatry, earlier attempts at integrated accounts of illness, such as those offered by a combination of psychoanalysis and biomedicine have declined.[70]

In the face of this widening gap between academic reductionism and holistic clinical need, single-organ-based specialities, increasingly tightly bound to a purely empirical approach and decreasingly equipped to handle illness in its human context, have resorted to developing new, bolt-on, ad hoc subspecialties such as liaison psychiatry, chronic pain management, and psychosexual medicine.[71-73] For the want of an academically integrated approach, each country and specialty has invented its own local solutions, addressing a slightly different subset of biopsychosocial, medically unexplained, or “functional” problems. These subspecialties tend to be staffed by clinicians with unusual, interdisciplinary skills on the margins of biomedical specialties who remain unintegrated in the academic development of those specialties. I am one of these clinicians. Lacking a firm academic base, these perspectives have been underrepresented in medicine´s academic development.

Instead of pooling strongly overlapping interests and interdisciplinary skills, these individuals and groups have often been left isolated, competing for scarce resources and struggling even to name their practice in internationally recognisable and interchangeable ways. Meanwhile, uninformed by the important, generalisable insights gained from these scattered subspecialities, academic medicine has

continued to evolve a bewildering series of overlapping syndromes and "diagnoses" in often unconvincing attempts to categorise, systematise, and take control of areas it lacks the academic tools to grasp.[74] (see table 1 in reference) At worst, a forest of overlapping, inconsistent, and contested syndromes and acronyms – *hypoactive sexual arousal disorder,* is an example,[74] reflect the shortcomings of biomedical epistemology far more clearly than they illuminate the complex human problems they seek to describe.

1.3 Epistemological remedies: interdisciplinarity, biopsychosocial disciplines, and medical humanities

None of the criticisms summarised above is inherently new. Indeed, concern for missing elements in modern healthcare has long expressed itself in the development of alternative epistemological approaches. Medical academics with understanding of for example psychoanalysis, the social sciences, and philosophy have formed interdisciplinary networks in the fields, for example, of psychosomatic medicine[75-77] and the medical humanities[78 79] to build interdisciplinary bridges, develop new methodologies, and find "alternate epistemic positions" sensitive to complex clinical problems.[80] In these fields, attention has been refocused on the body as locus of experience rather than as object; the irreducibility of lived experience is explicitly recognised as a determinant of health,[74] and meaning, or its loss, is recognised as a core element in the health and illness.[81] The biographical determinants and effects of illness are explored,[47] and we have been amply reminded that medicine is among other things a narrative discipline.[79 82-84]

While some clinical specialties, notably primary care, take more interest than others in epistemological plurality, its actual integration in mainstream policy and practice has overall been limited.[85-89] Hermeneutic (meaning based, interpretational) approaches have remained largely semi-detached, pursued as individual initiatives championed by individuals with special interests, remote from the ordinary consulting room and the ordinary clinical viewpoint.

Hence, numerous and promising individual initiatives, such as poetry or dance as part of dementia treatment,[90 91] or singing in the treatment of chest conditions,[92] are pursued and even studied, but not integrated as mainstream. Indeed, viewed from the perspective of the average clinician with a long clinic list to get through, medical humanities can appear an exotic "ghetto" – a special area in which matters regarded by the mainstream as esoteric are pursued in ways which are not troubled by and do not trouble day to day clinical endeavour. Clinicians largely lack access to a basic academic understanding of hermeneutic methods, while large swathes of relevant hermeneutic evidence relating to disease and treatment remain uncollected and overlooked.

1.4 An overview of some specific methodologies

Before outlining the personal epistemological journey which yielded my own mixed-method data, I will name specifically some other forms of interdisciplinary enquiry especially suited capturing elusive subject matter - forms to which my own work at times comes close.

In reflecting on my own method of moving back-and-forth between art and science, and seeking to discover connections between the personal and the social, cultural, and political, I find similarities with other creative-analytic practices within science and the arts. These include bricolage, artistic curation, narrative research, hermeneutic phenomenology, and autoethnography. In focusing specifically on experience which cannot be separated into mental and physical, dealing with both conscious and unconscious processes, and with embodiment, I am also informed by the self-analytic methods which psychoanalysis and art share.[23 24 93]

Bricolage, a method familiar to both cultural anthropology and psychology, describes a kind of analytic, reflexive back-and-forthing, like the passage of needle and thread.[94] It is recognized as a method whereby societies[95] or individuals[46] retrieve and recombine existing knowledge in new ways.[94] Analagous practices exist across creative and academic disciplines from mosaicing, collage, *assemblage*, and

patchwork, to the academic journal "special issue," in which dissonant and consonant voices are assembled on a theme.[96]

Originality in such work arises in recombination, reconception, and re-presentation, rather than in the generation of new raw material, much of which pre-exists the finished work in piecemeal, fragmented form. The process is one of re-framing and re-conceiving and bringing things into apposition with one another, to afford a glimpse of the formerly-invisible. It is original in hermeneutic ways, because it brings new perspective and insight, not because it produces new data.

Curation is an area of interdisciplinary practice which has attracted increasing attention in the art world – regarded both as a kind of "meta-art" in which individual works acquire new meaning in the proximity of others, generating new entities, but also a form of social scientific investigation.[97] Curators writing about the process speak of an *open stance* and the need to begin *with the art work itself;* of the inclusion of relevant work from less known artists, and of a critical distance from established convention.[97] They speak of non-didactic investigation, which is at the same time playful and serious, which can capture elusive elements, and which addresses the observer emotionally, physically and mentally at the same time – investigation which can *increase the heart rate and brain activity.*[97] It offers neither merely thought nor merely sensation, but both together, intimately enmeshed in the same work - rephrased, we might say it aims at embodied or psychosomatic communication.

Narrative research is the analysis of written or oral accounts, and medicine´s identity as an inherently narrative practice[69 82] has been richly discussed in both psychoanalysis[98] and the medical humanities.[82 99 100] While the physician´s task is to understand both patient and disease,[101 102] the criticism goes, clinical method has focused selectively on what has (somewhat blithely) been termed *the relatively simple matter of the diagnosis of disease,*[101] rather than on understanding patients. Qualitative research - described as a systematic approach to the organisation and interpretation of text,[101] one of the areas in which this imbalance can be partially rectified, remains underrepresented in the medical literature.

The clinical data I present in Chapter 5 - contemporaneously recorded accounts of encounters with my patients - are narrative in nature, working psychoanalytically, with what Holmes called *recognition of the unconscious elements of a half written personal story*[103] what Frost called the *incoherence in events and breaches in the individual's sense of identity*,[104] and what Aaslestad characterises as *the patient as text*.[105]

Likewise, data presented in the form of poetry in Chapter 3, and the discussion of epistemological morality in Chapter 6, both critique the inherent capacity of expertise to suppress rather than reveal experience, and challenge medicine´s failure to recognise its own interpretive character or the rules it uses to negotiate meaning.[69] In Chapter 5, I show how psychosomatic illness, like poetry, can usefully be read as a performative "text" which, far from being meaningless or simply "unexplained" becomes meaningful in the presence of receptive, resonant, constructive listening. The conclusion I draw is that the inexplicability is in fact a function of the inadequacy of the explanatory model, and not of the "senselessness" of human experience.

Hermeneutic phenomenology is a research method involving close, immersive, participatory observation – a method of paying close attention to phenomena as they present themselves to consciousness, sometimes described as *being with*.[106 107] It acknowledges the importance of multiple perspectives, and underlines *intersubjectivity* as the closest possible proxy for objectivity in some areas of study. Derived from the pure philosophy of Husserl and Heidegger, it was developed by Gadamer, Ricoeur, and Merleau-Ponty[106 108-111] as a philosophical approach which acknowledged the fundamental interconnection of body and mind, as distinct from other philosophical traditions in which these are regarded as separate. It amounts to a philosophical recognition that we are, irreducibly, embodied subjects – a perspective which is also consistent with psychoanalysis, which takes explicit account of the intersubjective, relational origins of human development. [112]

A resonant term which phenomenology adopted and extended from biology to describe embodied psychological and cultural phenomena is that of the *lifeworld* - the universe of shared experience and assumptions within which an organism or person lives. The lifeworld denotes what for any individual or group is considered self-evident or given. Indeed, for Husserl, who rejected the concept of objective research, the lifeworld forms the basis of *all* epistemological enquiry.[113]

Lifeworld is a term which seems helpful in explaining what I am attempting to do here, and why it might be original: it is lived interdisciplinarity of a particular kind which has given rise to my observations – and in Husserl´s terms, I might argue that my particular perspective arises precisely from the repeated crossing of lifeworlds – a kind of epistemological bricolage, or journeying back-and-forth between assumptions and "givens," thereby continually regaining both the insider and the outsider perspective on each situation. Costly in terms of time spent travelling, and readjusting, and loss of prestige within one single group or field, such a practice brings rewards in terms of overview.

Phenomenology holds that *persons should be explored* because of the unique ways they reflect the society they live in, and rather than traditional data, conscious experience is gathered, with a focus on discovery and an openness to a plurality of methods. My account could be read as an exploration of my own lifeworlds as they intersect with those of my patients – an account of what it is like being a doctor and poet – in the hope that if these data are faithfully enough reported they may contain insight into the contexts I live in.

Heidegger modified Husserl´s traditional scientific approach to phenomenology further, shifting the emphasis from knowing to understanding, and to relationship as the ground of understanding. Gadamer develops still further the idea of hermeneutics as an intersubjective, dialogic *Kunst der Verständigung* or art of understanding – exactly the kind of process which characterises the overlapping dialogues between medicine, poetry and psychoanalysis contained within this study.[114]

Autoethnography is a method of research based on self-observation and reflexive investigation as part of ethnographic field work and writing.[115-117] Ellis defines it as *research, writing, story, and method that connect the autobiographical and personal to the cultural, social, and political*.[118] Unlike theory driven, positivist research, this kind of research might be described as experience in search of language, or data in search of theory, not vice versa. Rather than attempting to limit the researcher´s subjectivity, it embraces and foregrounds it. Ellis writes that autoethnography is *part auto or self and part ethno or culture* and at the same time, *something different from both of them, greater than its parts.*[117]

An autoethnography is a reflexive account of one's own experiences situated in culture. In other words, as well as a critical description of personal experience, an autoethnography is also a cultural practice. For example, Holman Jones,[119] in *(M)othering loss: Telling adoption stories, Telling Performativity*, describes her experiences with infertility and adoption in relation to cultural attitudes about these issues. In seeking to understand her own story, she also questions cultural discourse. Reflection on her own experience acts as a mirror, or source of potential information. In psychoanalytic terms, this might be presented as an individual researcher´s countertransference to cultural elements – countertransference which, while not a clean mirror, is capable of reflecting information. Marion Milner uses a similar method in *On Not Being Able To Paint* (cited in chapters 4 and 6), and I used the same method in a Psychoanalytic master´s thesis on *Rawness in Visual Art*.

I cite the above methods not to lay claim to any of them, but to acknowledge that what I have done here, while it is methodologically original to some degree, is not out on a limb or completely novel. Rather, it exists within a field of methods which are themselves variously narrative, constructive, phenomenological, hermeneutic, relational and dialogic – characteristics which are not mutually exclusive, but overlap. Autoethnography does not, for example, exclude narrative study: according to Ellis and Bochner,[120] an authoethnographer is *first and foremost a communicator and a storyteller*, depicting *people in the process of figuring out what to do, how to live and*

the meaning of their struggles. Now for an account of the struggles within which this story developed:

1.5 An epistemological journey

Before training as a doctor, as part of a bachelor´s degree in Norwegian and German literature, I studied linguistics and critical theory, learning to let go of notions of objectivity and acknowledge the inevitability of any researcher´s standpoint, critical perspective, or situated-ness. A medical degree then trained me to think empirically and quantitatively, and, given the sheer volume of learning needed to become clinically competent, invited a temporary and expedient return to pragmatic, provisional certainties about the distinction between subject and object and the primacy of the empirical viewpoint. Untroubled, for now, by notions of intersubjectivity, I learned to study the human body and psyche as an object, and to don, along with my white coat and the social privileges of being a doctor, the posture of so-called *objective observer* – clean, pristine, and interchangeable with other objective observers.

Along with a wealth of useful biomedical knowledge came a set of largely unconscious, unacknowledged, and unexamined beliefs regarding the value of objective truth over subjective perspectives and accounts – beliefs which proved less useful in clinical practice. Although wise teachers exhorted me to listen carefully to patients´ accounts, not all colleagues modelled this effectively, and the subjective account was still treated primarily as raw material in a professionally-led diagnostic and therapeutic process – an object of medical scrutiny, rather than part of the evaluative framework itself. Whether in the consulting room, the lecture room, or the medical journal, the biomedical account of illness was accorded automatic, un-negotiated primacy over alternative accounts. In a covert act of what I will later argue is *epistemic injustice*,[121] biomedicine, psychological medicine, and evidence-based medicine trumped all other perspectives, claiming the privileged right to determine which facts were relevant, and what they meant.

Thirteen years of clinical practice in hospitals and community settings, mostly in obstetrics and gynaecology and sexual health, challenged this medical school-mediated view thoroughly. The biomedical perspective became richly supplemented with a half-formed, uncomfortable awareness of other stories and meanings running parallel, or counter, to the "official" gynaecological narrative. Sexual and reproductive health was an area particularly resistant to scientific reductionism: on a daily basis, subjective accounts of, say, miscarriage, contraceptive failure, or sexual dysfunction jarred with gynaecological accounts, and threatened to disrupt their reductive clarity.

These unauthorised accounts, even where they had obvious face validity, were often difficult to shoe-horn into the succinct, objective case notes and truncated oral summaries we had learned as part of making the transition from medical student to doctor – summaries in which all but the most obviously pathophysiologically pertinent personal information was to be rigorously edited out. We learned to notice and report only what our seniors felt able to treat. We exchanged our native appreciation for patient narratives for the learned expertise in constructing a medical history. [82 122]

Hence, the fact that the abdominal pain began soon after first sex with a new partner (and may therefore signal infection, a biomedical concern) was mandatory in the medical report, but the fact it began after a child left home (which has no obvious biological meaning but may nevertheless signify relevant psychosocial distress) is traditionally inadmissible, in a context where psychosocial distress is considered beyond medical responsibility and therapeutic competence. "Alternative" narratives, ever-present in the doctor-patient encounter, were simply neutralised by being "zipped" into special, reductive words which did not so much illuminate their content or meaning as wrap them up and define them as being biomedically irrelevant.

Thus we continued to learn a new language and way of thinking – patients not following our advice were *non-compliant*, symptoms which we did not understand were *medically unexplained*, patients who failed to be reassured by our explanations were *anxious,* an apparently neutral word commonly used not so much as the starting

point for an exploration as to what they might be anxious about, but as a label to relieve the doctor of the need to engage more deeply with their troublesome thoughts. It was remarkable how, though commonplace in the gynaecological encounter, feelings and subjective views were treated as a contaminant to the therapeutic setting.

It almost seemed as though, lacking tools for thinking properly about the subjective dimension of the patient encounter, we were as aspiring medics being trained to lose interest in these areas, to scotomatise them – consign them to a kind of epistemological scotoma or blind spot, or the sort of selective inattention which follows ischaemic stroke. Hence the psychosocial determinants and consequences of gynaecological illness, though frequently as present and attention seeking as an elephant in a room, were apt to be either missing from professional discussion, or present only in crude, uninformative, vestigial terms.

Patient views were officially welcome when it came to treatment choices, but their alternative understandings of their own illness were neither solicited nor especially welcome. Interpretation was our prerogative, not theirs. Hence the woman still refusing effective contraception after a second abortion owing to an aversion to the idea of hormones or foreign bodies, the healthy primigravid woman demanding a caesarean section owing to terror of childbirth was to be not so much understood as "educated," which in the worst cases amounted to a kind of skilful, rhetorical coercion. Their accounts were to be not so much explored as politely but firmly overwritten. Although patient consent was mandatory for all so-called “invasive procedures” and intimate examinations, it was not required for the interpretive process.

This doctor-centred approach served certain purposes better than others. It sometimes speeded up consultation in the short term – an inevitable and legitimate priority under pressure. Given finite resources of time and energy, getting the patient out of the room with a reasonable plan was sometimes all the doctor seemed to have mental space or time for, and often this was “good enough.” But depending on how much the excluded material mattered diagnostically, therapeutically, or in terms of

treatment adherence, it sometimes proved retrospectively not to have been good enough after all. Shortcutting away from complex material seemed to be a busy clinician´s defence against having to deal with what was often referred to as a *can of worms*, – something conceptually messy for which she felt unskilled. But it often seemed a relatively ineffective way of achieving the kind of concordance between doctor and patient which supports treatment adherence and response, or clinical improvement.[123]

I took a break in gynaecology training because the UK Royal College of Obstetricians and Gynaecologists at that time required all trainees to gain a year´s experience outside the specialty. A post as trainee medical editor at the *British Medical Journal* (now *The BMJ*) offered a chance to acquire both further narrative skills and deeper critical appraisal skills in predominantly empirical, predominantly quantitative methods. Evaluating articles across medical specialties, I helped the journal review the around 130 new manuscripts it received each week to decide which six should be published, and how these could be improved. This entailed critically appraising what had been done and said, in ways strongly influenced by the principles of evidence based medicine. It also entailed looking carefully for what had not been done and said that maybe ought to have been, and in helping authors to rework their material into a plausible, coherent, and graspable shape which respects both the material and the reader.

In parallel with this work, clinical and academic training in psychotherapy and psychoanalytic studies exposed me to a new narrative method – one which is both a "science of self-analysis" and a tool for examining cultural phenomena. In the clinical setting, psychoanalysis restored permission to think open-endedly and symbolically, to tolerate and make therapeutic use of what is *not* yet known, to attend to emotions and actions in the consulting room, including those of the doctor, and to be open to the significant role unconscious factors can play in diagnosis and treatment. In the creative setting, a master´s thesis on rawness in visual art became a first encounter with powerful theory about the nuts and bolts of creative work, and its relationship with illness and health.

I became determined to find ways to integrate this psychoanalytic learning with clinical medical practice, and a four year psychodynamic training with the Institute of Psychosexual Medicine, followed by further training to become a trainer, offered just such an opportunity. Designed as brief psychodynamic work for use by experienced physicians seeing patients with sexual problems, the method integrates medical with psychotherapeutic and empirical with hermeneutic methods in the same consultation. [17 124] And if I initially feared that sexual problems might be a narrow field, I increasingly realised how firmly this clinical area disciplines integrated, biopsychosocial thinking: sex is, par excellence, a biopsychosocial experience.

Finally, art and literature have remained as necessary a part of wellbeing as physical exercise. Nourished by the inspiration of others´ work, I have made and exhibited art and written and published poems.[25-32] [125] In the parallel tasks of psychosomatic consultation and writing poetry, I have been struck again and again by the felt sense that these two activities are somehow one and the same – drawing on the same parts of myself, the same skills or stances – that I am, as it were, the same person, making the same moves.

The same questions and themes have presented themselves in dialogue with patients as in creative, editorial, academic, and self-reflective work. These themes include the relationship between dominant and suppressed narratives, the way the meaning embedded or "frozen" within phenomena can be unlocked given the right kind of enquiry, and the conditions needed for this to occur. Such conditions include the need to place oneself humbly at the disposition of a material, not shirking complexity and particularity, or relevant knowledge, and a commitment to a constant search for the right language.

In summary, this is an account of a professional life lived in an academic borderland. It has drawn on theory and practice in apparently unconnected areas not simply once, in a unidirectional journey towards a unitary final destination, like collecting qualifications, but traversing the same professional and academic boundaries, in

different roles, locations, and languages, over many years, until the repeated, comparative experiences have begun to weave themselves into a fabric of new insight. In the process, I have come to view the separation between these forms of knowledge as artificial and unhelpful to practice.

This receptive, containing, and digestive work – in my case, the resolution of apparently conflictual "selves," doctor and artist, each refusing to be subsumed by the other – is something I have come to experience as psychic growth. I hope that the attempt to articulate this process – a project carried out in part for my own sake - may have relevance to a wider academic community. It has certainly brought me into contact with many others – like minded interdisciplinarians – who also wrestle to balance objective and subjective perspectives, empirical and phenomenological approaches, the arts and the sciences, and to embody what Gadamer referred to as *the tense relationship between modern science and the concrete wealth of human experience.*[83]

Key messages

- Modern medicine suffers from an epistemological gap because of an overreliance on purely empirical methods
- Medically unexplained illness, psychosomatic illness, and multimorbidity challenge medicine in ways which are not adequately met by purely biomedical and empirical approaches.
- Evidence based medicine may in some cases be insufficient or even harmful if applied dogmatically and unbalanced by meaning based approaches and individual data
- New insight requires both deep understanding of, and distance from, orthodox modes of thinking
- In the post evidence based medicine era, academic medicine needs to renew its connection with hermeneutic forms of knowledge.

Chapter 2: A poetic method for capturing complexity

Jeg har levd et rotete liv - i hvert fall eit omskiftelig liv. Språket har vært som eit hus - som ein heim.
I have lived a complicated life – at any rate, a varied life. Language has been like a house – like a home. -
Jon Fosse

Keywords: embodied experience, lived interdisciplinarity, epistemophilia, poetic method, borderland research

2.1 Nose to the wind and travelling light: gathering experience across borders

Johann Turi of Kautokeino lived a various life as a reindeer herder, wolf hunter, and trapper across the boundaries of Sweden and Finland. In this first ever written account of Sami life, *Muitalus sámiid birra*,[126] he began thus:

I am a Sami who has done all sorts of Sami work and I know all about Sami conditions. I have come to understand that the Swedish government wants to help us as much as it can, but they don´t get things right because no Sami can explain to them exactly how things are. And this is the reason: when a Sami becomes closed up in a room, then he does not understand much of anything, because he cannot put his nose to the wind... But when a Sami is on the high mountains, then he has quite a clear mind. And if there were a meeting place on some high mountain, then a Sami could make his own affairs quite plain.

This modest beginning is a powerful methodological manifesto. Without criticising mainstream ways of living and thinking, Turi pins down both the minority (Sami) problem of languaging embodied experience[127] and the (Swedish) limit to knowledge not born of lived experience.[128] The Swedish government, despite good intentions, gets things wrong. The Sami fails to represent his experience adequately, for the want of the right conditions. There are certain thoughts proper to nomadic, transnational experience, Turi implies, which can only be thought by a nomadic, transnational person, and only in certain places. The task of communicating these effectively to a

non-Sami interlocutor (however well intentioned) is a feat of translation; and the commitment to that effort is a mark of that Sami´s investment in the relationship with that Swede.

We can read Turi´s introduction more broadly as a statement about the psychosomatic conditions a particular person needs to first gather and then describe her or his own experience – namely, sufficient sensory proximity to that lifeworld – a place automatically distant from other people´s – but also the ability to act as participant-observer, outsider-insider, in one's own lifeworld.[108] There is of course often a political context which constrains such attempts at communication – in this case, Sami oppression by Scandinavian settlers.[129] However, social and political injustices in themselves are not my primary concern here. Rather, my focus is on the epistemological impoverishment which results for the mainstream, and in this case the mainstream academic discipline of medicine, whenever it loses the data and perspectives of non-mainstream individuals or groups.

If we set aside the political history of Sami-Scandinavian relations, Turi´s dilemma is more broadly a particularly poignant example of the universal human problem of what body psychotherapists call embodied-relating[130]– the problem of relating across the boundary of one´s own skin, or lived experience and someone else´s. Turi has been likened to an ethnographer,[131] and we might call his account an autoethnography – an account connecting autobiographical reflection with wider cultural analysis.[118]

Stumbling across Turi´s account while struggling with my own account of a life lived across disciplinary boundaries, I read his *nose in the wind*, his *meeting place on a high mountain,* as both geographically literal and a metaphor capable of capturing my own, material-driven, improvisatory methods. In terms which are both simple and condensed, both specific and open to wider resonance – in poetic terms, one might argue – Turi had metaphorised for me the problem of lived interdisciplinarity, and was offering me a way into *making my own affairs plain*.

2.2 Materials: an intertextual conversation with a single author

What I present in the following chapters is a synthesis of original texts written from the different positions of poet, clinician, and self-analytic observer in both roles. They and the themes they introduce are discussed "polyphonically," drawing together elements from different discourses of biomedicine, psychoanalysis, art, literary criticism and moral philosophy into a synthesis. The texts share common themes relating to health and the creative processing of experience. They address the pressing question of irreducible humanity in medicine, and the relationship of this with medicine´s core scientific and humanitarian aims of investigating and treating illness.

First (Chapter 3), I offer examples and analysis of poetry as a product and process which can challenge, and nourish. I present its potential as a critical tool, and as a vehicle for communicating about human experience which has the potential to be psychologically useful for poet and reader. I use a subset of eight published poems of my own which critique the insufficiency of biomedical language as a vehicle for describing human illness. They themselves form a kind of critique of medicine in poetic form – but I also use them as examples of what, more widely, poetry can do and how it can work: each poem is followed by an account of why and how it emerged from the poet´s identity and practice as a doctor, or in one case, as a patient. Each is discussed in a spirit of traditional "practical criticism" – that is, as to what it might do for a reader, and how, in technical terms.

At the end of chapter 3, I turn to the process of writing poetry, offering a second piece of raw data - a contemporaneous, self-analytic account of the process of writing, in the tradition of Marion Milner, and others. This is a method I have previously used in relation to making a piece of visual art, in a master´s thesis on rawness in visual art. In presenting this, I add to illustrations of how a poem might *work* psychologically, and what might prompt it, an exploration of how it might come into being. All in all, this chapter discusses not only a poem´s conception or aetiology, and its final characteristics and effects, but also its embryogenesis.

These examples are followed (Chapter 4) by an integrating, psychological account of the point of poetry – that is, of its communicative-restorative value for poet, reader, and culture at large. Grounded in perspectives from the British object relations school of psychoanalytic theory – with a particular debt to Bion, Winnicott, Milner, and Ehrenzweig – this account builds on the psychoanalytic master´s thesis I wrote on visual art in 2004. Here, I develop and explore for poetry, as I previously did for visual art[23] how art arises in response to need or rawness, how its creation demands a skilled and sensitive balance of conscious and unconscious achievements if the product – in this case a poem – is to work for a recipient, and how this is an inherently therapeutic activity.

Chapter 5 introduces a different and analogical form of rawness and therapeutic redress – namely, medically unexplained bodily distress, or psychosomatic illness, and its psychodynamic treatment. The model used is that established in the 1970s in the psychoanalytic tradition of the UK Institute of Psychosexual Medicine (IPM), in which I am a practitioner and trainer. Three traditional psychosexual case reports (Chapter 5), explore psychosomatic symptoms presented to a doctor as a form of incomplete communication about distressing experience – physical expressions of hidden story, perplexing both patient and clinician, and in need of being "heard." I will show how the IPM method approaches these "symptoms" or phenomena with creative curiosity, as a kind of unexpressed communication – like an artistic raw material - rather than as a pathology or "thing," to be removed. I will demonstrate and discuss how, paradoxically, this focus on understanding rather than fixing symptoms becomes therapeutic, and how this kind of approach can be effective where biomedical approaches have not been. In doing so I hope to illustrate why such understanding-focussed attitudes and skills belong at the heart of medical practice.

The final chapter, 6, gives space to some epistemological and ethical reflections which emerge from the previous discussion. Here, some moral claims about the kind of stance which both medical and artistic work demands of the practitioner, claim which have been pressing in on the arguments of Chapters 1-5, are brought to the fore.

"Poet-like skills and characteristics" are set alongside "therapist-like skills and characteristics," as elements which do not merely enhance the practice of medicine, as some kind of optional extra, but are at times needed to deliver any kind of clinical efficacy at all, in many situations where diagnosis and therapy remain stuck. I place this insight alongside evidence based medicine, and conclude by making a moral case that if we are to pursue efficacy and avoid harm, these poet-like, therapist-like characteristics cannot continue to be viewed as icing on the cake of practice at best, subjective contamination at worst – rather, they must be recognised and integrated as a key ingredient, among others.

2.3 Methods – outer: capturing interdisciplinary lived experience in text

Method is a term meaning a way of proceeding, and I outlined in the last chapter my epistemological journey across disciplinary boundaries towards a position of what could be called "lived interdisciplinarity." The following material could be seen as a set of representative objects or narrative souvenirs from my journey – a kind of diary, written from different positions. They are of course individual, personal pieces of text, but the kind of insights they contain would I suggest be recognisable to anyone who were to follow my journey from the humanities to biomedicine and then onward into a combination of medicine, the humanities via psychoanalysis. I suggest that another traveller of the same road might also recognize the the picture I paint of a clinical world more complex than biomedical language can acknowledge, and recognize the kind of remedy to be found in hermeneutic practices such as art and psychoanalysis.

What I present are samples of the kind of thing it is possible to first sense and then articulate when one has not been subsumed within a single disciplinary framework. Two areas of work regarded as separate have seemed to me to contain some common psychological principles, and this is my attempt to clarify or "precipitate out," those principles. In addressing the question of how elusive material important to health and wellbeing is recovered, I have used a method familiar to both artists and psychoanalysts: creative, interpersonal merging with a material, accompanied or

closely followed by analytic separating. It is a method which involves the use of the self as a relational-analytic tool. The material presented here has been gathered through creative merging with and analytic separation from the two fields of poetry and therapeutic practice. And the claim I make for it is like the claim a poet might make for a poem – that *this* is what resulted from a creative struggle with a material elusive to other methods, on the one hand; and on the other, that this was the analytic-improvisatory method whereby these particular insights could be made articulate.

This open, reflexive, living-working-thinking journey has necessarily proceeded free of prior commitment to one or another specific methodology or epistemological tradition. Instead, interdisciplinary ”turns” have been repeated over time, until interdisciplinarity has become an immersive lived experience or ”way of life” – not simply a cross sectional moment of purely intellectual comparison.

So what of rigour? Although free of preconceived methods, in the sense of a recipe to be followed, this work has nevertheless, like a poem or a therapeutic encounter, been disciplined by the method of close, undogmatic attention and radical openness to experience and phenomena over time. What psychoanalysis might call *merging with*, and what anthropology might term *immersion in* different lifeworlds, in order to live in and not purely to study them – allows a quality of engagement not possible from a standpoint which is purely superficial, eclectic, or preconditioned by prior commitment to a single, fixed world view or epistemological approach. These data did not arise from a dualistic intention to “know about” or “observe” poetry, or health, rather from the experience of “being with” or “in” them. Analysis then followed experience, as a matter of intellectual need. And echoing Turi, I contend that we must find spaces in medical academic discourse for unique, experience-based analysis alongside other forms of knowledge.

2.4 Methods – inner: mental tension drives epistemophilia

If the above is an account of how I have proceeded outwardly, the following paragraphs are an attempt to acknowledge or allude to internal processes which gave rise to this work. I stated in Chapter 1 that this work was stimulated by the discomfort of cognitive dissonance - a form of discomfort which is in fact developmentally optimistic, and a useful starting point for research. Addressing the question of the ontogenesis of health research, Atkins and Murphy identify three stages of the reflective process, beginning with *a sense of inner discomfort* or *unfinished business*.[132] Meanwhile, in a Kleinian, psychoanalytic view of psychic development, it is anxiety which forms the stimulus for all thought – the ground of all reflexivity.[133] Arising from the absence of *the breast* – a term meaning both the infant´s psychosomatic union with his mother, and all later moments of effortless merging with external sources of nourishment, anxiety is in Kleinian language the rocket-fuel which motivates us to formulate thoughts and stretch towards understanding. Where mother´s care stops – given sufficient inner resources - our own, mental self-care begins, by means of the *epistemophilic instinct*[134]

Naturally, we continue to be plagued throughout life by further departures from "breast-like experiences" – that is, environments[133] where things are generally familiar and cosy, and where unexamined connectedness can be taken for granted. But if sufficiently resourced, we use these separations to grow, emotionally and intellectually, learning to explore the world more personally and directly, in all its wonder and strangeness.

A life lived outside the safe confines of a single discipline has offered me ample epistemophilic potential. Separate internal relationships with the clashing, partial accounts of health and illness which biomedicine and psychoanalysis offer, have at times felt like an invitation to "split" into separate selves with separate allegiances, like a child with warring parents. I have found myself searching, instead, for some neutral ground of epistemological independence from which to integrate and contextualise these partial accounts. I have been driven to think my own thoughts.

2.5 Reflexivity and the restoration of thinking

Reflexivity is an attitude or practice in which researcher subjectivity is declared, used and discussed, rather than avoided or denied. Although widely accepted and practised in qualitative research, it is seldom examined. The means by which reflexivity achieves its scientific aims is seldom discussed.[135] Kleinian psychoanalytic theory is helpful here, and Doyle, a researcher versed in both social scientific and psychoanalytic understandings, cites Bion in explaining the role of reflexivity as *sustaining curiosity and thoughtfulness even when feelings of discomfort or bewilderment threaten to overwhelm.*[136-138] This scientific, or in psychoanalytic language, *epistemophilic* position is the opposite of one where *only that which is comfortable, tolerable, and immediately manageable can be known, and that which unsettles cannot be considered.* What seems to flow from this is a vision of all research as an act of *reflective relating* – neither mechanical observation, on the one hand, in which one claims to be an uninvolved outsider, nor introspective self-revelation, on the other,[139] in which objectivity takes second place to feeling; neither wholly subjective nor wholly objective, always intersubjective, requiring *a capacity genuinely to take things in, and to use them to develop a truer picture of the self-in-the-world.*[140]

So reflexivity represents a different form of rigour, entailing the explicit acknowledgment and use of an involved human self in the co-production of knowledge. It involves a willingness on an individual researcher´s part to take in troublesome raw material, tolerate being stretched by it, and work with it, until it can be properly integrated with prior knowledge, rather than simply excluded or ignored. Both social scientists and psychoanalysts recognize these elements. Atkins and Murphy characterise reflexive research as a three stage process, whereby uncomfortable feelings and thoughts lead via critical analysis to the development of a new perspective,[116] chiming with Bion and Klein´s accounts of individual mental development.[133 141 142] But another striking parallel is that with a key psychoanalytic account of *creative* process – Anton Ehrenzweig´s three stage psychological process of making art.

Ehrenzweig´s three stage model of the process of making art, which I describe in more detail in Chapter 4.[143-145] begins with an initial *projection,* which is worked through via

an unconsciously led, *manic-oceanic* process, to be resolved in consciously led process of *reintrojection.*[143-145] This psychoanalytic account of creativity offers a key, in my opinion, to understanding the connections between personal development and wider academic or epistemological development. It offers us a tool for tracking the connection between personal growth and cultural and academic growth, by clarifying, I suggest, how all three are irreducibly creative, intersubjective processes – neither mechanistic and reducible to depersonalised or abstracted technical procedures, nor wholly individual, solipsistic, and narcissistic.[138] Together, these interlinking theoretical accounts from social science, the psychoanalysis of personal development, and the psychoanalysis of creativity, explain the central role which the disciplines of relationship and creativity play in the acquisition of knowledge.

2.6 Psychoanalysis as an integrative analytic frame

The capacity of psychoanalysis to address intersubjective phenomena gives it particular potential in addressing both art and health care. It has proved invaluable in interdisciplinary areas of study, especially those where unconscious influences in the research field need to be taken into account. Despite its unfamiliarity to many academics, and its own relatively weak tradition of ontological questioning,[146] psychoanalysis´s capacity for bringing unconscious elements into consciousness represents a unique contribution to research.[136]

Although not a single approach, psychoanalysis offers, collectively, one of the most comprehensive, dynamic theories of human nature and development.[147] Integrating two complementary evidence cultures – empirical or neopositivistic, on the one hand, and hermeneutic or interpretational, on the other – it has formed an epistemic bridge between the humanities and the social sciences, and between therapeutic and cultural phenomena.[147]

Psychoanalysis can, admittedly, be a difficult field of discourse, rich in apparently mutually contradictory dialects, and elaborate terminologies. At times is has been heedless of the duty to make itself understood, and in places, it has taken its metaphors too literally, betraying its own historical grounding in clinical phenomena,

and appearing hermetic and self-referential.[148] Very much would be lost, however, if the worst examples were misunderstood as representative of the field as a whole. The psychoanalytic commentators I introduce are writers whose accounts of the relationship between creativity and health I have found both legible and essential – writers such as Bion, Winnicott, Milner and Ehrenzweig whose theory is firmly grounded in practice. Without these writers´ insights I could not have thought clearly about my subject matter.

2.7 Poetic methodology – fostering, containing, synthesising

In the introductory chapter, I describe my method as *poetic,* an adjective derived from the Greek verb *poiein – to make* or *create.* I might therefore equally call it a creative, constructive or artistic methodology. While Chapter 4 discusses poetry´s origins and methods in detail, I will summarise what I mean by a poetic method, briefly, as follows: a need, or a niggle, is felt by a poet or researcher in response to an experience or material. This drive is both emotional and epistemological in nature, calling on feeling and thought. The poet or researcher approaches the material in an open, receptive manner, listening and searching not only for its obvious or well-articulated elements, but also those which are elusive, unimagined or surprisingly absent. The sense impressions coming from the material are held, provisionally, within the person of the researcher/poet, alongside the feelings and thoughts they elicit, and this mix is subjected to a condensing, constructive, or integrating process which also draws on past knowledge and acquired skill. Although hosted within, and also shaped by, the researcher/poet´s inner world, and the extent and limits of their prior knowledge and skill, this process also obeys the external, non-negotiable constraints of the material. The researcher or poet is required to place him/herself "at the disposal" of the material, in an attitude of listening. By "palpating" for or "feeling out" connections, the researcher/poet uses a balance of conscious and unconscious process, a balance of thought and feeling, to create a new piece of understanding capable of being grasped and used by an external recipient – a piece of work which if it is to reach another person, must be embodied in a form which can be taken in or swallowed, and

for this, it must bear the hallmarks of *aesthetic coherence*.[149] Let us look at these three stages – fostering, containing and integrating - in more detail:

Fostering raw material – the intersubjective origins of new knowledge

For a poem to arise, a poet must first be "captured" by a material, and agree to "foster" it or give it "house room," - time, energy, love, and other resources - in its immature state. We might think of this in terms of Winnicott´s *primary maternal preoccupation*,[150] a state of devotion characteristic of *ordinary good mothering,* without which, in *good enough* measure, no human can emerge into independent existence. *There´s no such thing as a baby,* Winnicott proposes playfully, meaning that viable, independent consciousness is not congenital but acquired ex-utero, intersubjectively, through the grace of a *maturational environment*.[151]

Winnicott´s point – that new human life and thought arises intersubjectively – is worth pausing to take in, in a discussion of methodology because of its scientific implications: Although our intersubjective ontogenesis is uncontroversial in physical terms – who would dream of denying that a baby´s body develops within a mother´s body? And although, increasingly, the role of intersubjective influences in health and pathogenesis are also well described, whether we consider inherited disease, the fetal (somatic) origins of adult (somatic) disease,[152] or the pathogenic effects of chronic psychosocial stress, [153] [154] when it comes to thinking – to data gathering and analysis, our intersubjective ontogenesis is largely overlooked or denied in health discourse. Somehow, whether by familiarity or convenience, human health research continues to adhere in large measure to false, hard dichotomies between subject and object, leaving it selectively blind to interconnectedness, even where interconnectedness is where the grounds of health, illness, and treatment are to be found.

The contemporary American philosopher Hustvedt picks up on this unhelpful oversight, accusing Western philosophical and scientific traditions of clinging to dualism, *despite the fact that the very definition of mind is subject to heated, if not tortured, debates.*[155] She challenges the simplistic notion that knowledge is acquired

when *a man sits alone in a room and thinks,*[155] apparently untroubled by reflexive questions as to how his own history, experience, and relationships are shaping his thoughts. Instead she invites us to consider the question: *What significance, if any, does the fact that mammals gestate inside another body have for the mind?*[155]

What I attempt to offer here, therefore, is not more data of the same kind - a further instance of objectively acquired data in one pre-existing field - but a proposal about how we can access data inaccessible or overlooked by common methods. The claim I make for my method is therefore not of objectivity in any one area, but that of reflective intersubjectivity across a number of different relationships and subject areas, generating comparative information which would not have been accessible by any other means.

Containing and processing chaos: the creative conditions of academic development

For a poem to emerge into a useable form, chaotic raw material has to be held on to and processed, in ways which are both adaptive and assertive. Bion describes a mother as the container for an infant´s mental development – an individual volunteering herself as a chamber in which immature experience can be held, digested and made bearable and nourishing. In Bion´s model, the infant´s his mind can merge with the mother´s, creating an *intersubjective* environment which can hold and process his incomprehensible experience until it can be made meaningful.[156]

In this model, a space is configured which did not exist before, except virtually or potentially. It emerges via one person´s elastic response to a stretching material. This process is central to therapeutic and artistic methods, and to my research method, here. The willingness to foster and merge temporarily with, a material, balanced by a capacity for synthesis or condensation (and I suggest that the two are connected, because psychologically one cannot afford the risk of entertaining a tension which one is not confident of "surviving") allows a "pop-up", psychological space to be created in which a set of connections or contradictions can be held and explored while something new may emerge.[157] This creative, synthetic act requires a capacity to

balance thought and feeling, conscious and unconscious elements, and this balance, is, I suggest, "read" by a recipient as being adequately present or absent, the product therefore as satisfying or disappointing.[143] Such intuitively informed methods, honed by training and practice, are recognisable in many artists´ descriptions of their creative process, as well as in psychoanalytic accounts of both therapeutic and artistic practice.[24 144]

In summary, I present this poetic, or "receptive-containing-constructive" approach as a material-responsive tool for capturing important cultural, psychological, or interpersonal material which might be lost in a purely conscious, or theoretically driven approach. I propose it as a method which is particularly suitable for studying unexplained embodied distress, or other material which is difficult to access, grasp, or speak, or bear. In doing so, I join forces with other qualitative researchers working at the methodological edgelands of the field of health.

2.8 Other borderland exploration and research

Like a disturbing wind blowing across traditional boundaries and certainties, there has been a burgeoning in both the arts and sciences of interdisciplinary projects, including what has been called borderland research and exploration. An exhibition of craft objects recently presented to the art going public of Tromsø, for example, made by people whose lives are conducted across national boundaries,[158] was accompanied by an *interdisciplinary aesthetic monograph*, inviting the reader to consider *what we take with us when moving from one place to another* – what is essential and what expendable.[159] Voices from medical humanities departments in the UK, meanwhile, are advocating *edgeland* research in health and social care – creative methodologies which relax rigid frameworks around the presentation of results and the interpretation of findings *to allow room for the unexpected to happen.*[160]

Meanwhile, the unbalanced positivism of clinical guidelines and medical journals and the institutionalised discrimination against research which does not *ape the reputed*

certainty of the methods of natural sciences[49] [160] is under criticism. In an open disagreement between leading international researchers and a leading medical journal over the deprioritisation of qualitative research, 76 senior researchers from 11 countries challenged editors publically to develop a more *proactive, scholarly, and pluralist approach to research.*[161] In an attempt to escape interpretive subjectivity, critics argue, medicine threatens *to expunge its primary subject – the living, experiencing patient*.[162] Its one-sided commitment to quantitative enquiry *rules out essential elements of clinical interaction and judgment – topics that involve, communication, opinions, and experiences.*[101]

There are calls to develop and extend the *quantitative biomedical methods which rule out essential elements of clinical interaction*, to include *communication, opinions, and experiences*.[101] Rather than viewing methodology as a standardised recipe to be followed ritually, "alternative epistemic positions" are being called for,[160] – those which can restore an idea of research as a form of discovery which retains *a sense of the unknown*, evolving continually *through ongoing experimentation, reflexivity and theoretical development*,[160] perpetually *on the way* because context, subject matter, and researcher are also always changing.

As part of this wider methodological debate, there are also specific advocates for arts based research. Shidmehr has advocated the re-integration of poetry in research. She criticises its excision from science following Plato,[80] with the divisive exclusion of the possibility of knowledge taking lyric form, or of poetry as carrying conceptual content. Shidmehr almost seems to be pointing to a kind of "epistemological cleansing" (my reinterpretation) of poetry from knowledge, a development rich in unacknowledged violence.[163] Poetry´s intersubjective potential – that blurring of boundaries between self and other which Plato considered scientific "cheating" – is the precise location of its potential to capture and voice difficult, elusive material, according to Shidmehr.[80] In difficult or marginalised areas of knowledge, she argues, poetry may offer a different kind of epistemic opportunity, a different kind of honesty, to that offered by the positivist[164] Aristotelian-Cartesian-Kantian approach. The hard distinction

between art and science, argues Shidmehr, is both false and romanticised, and poetry is needed as "*a chorus of inquiry .. at the margins of academic research.*"

My intention here is not to take sides in an argument between the relative values of poetic and scientific forms of knowledge, but to propose the use of poetry-enriched science where poetry-depleted science fails to address its human subject matter adequately. I am aiming at at a three dimensional view of a complex subject, which has adequate richness, breadth and depth to make that subject real for a reader. The method I have used does not claim fixed objectivity but unique, experience based insight gathered and analysed with rigour and reflexivity. In contrast with the biomedical research tradition, which has been accused of a refusal to accept that results of its own research are *also* outcomes of interpretation,[69 100] it starts from an acknowledgment that objects can only be known through their representations.[165]

How could one possibly establish the validity of a creative study? Does an aesthetically grounded study, or a work of art, have the capacity to "tell the truth" or "lie," or Is it merely a matter of taste? Szirtes, a figure whose credentials as a leading commentator on poetry are uncontested, gives an uncompromising account of poetic rigour as a test which be failed as surely as a scientific hypothesis can be refuted. This is discussed in chapter 4.[166] Ehrenzweig´s account of goodness (or its absence) in art establishes a psychological definition of what we might call "aesthetic rigour." Koppe more directly addresses the relationship between aesthetics and research using the notion of *aesthetic coherence*,[167] a term denoting *resonance in an audience* or *the fit of the parts to the whole.* For an inherently intersubjective subject matter such as mine, this approach helpfully avoids the limitations which dualistic notions of research in terms of subject and object would impose. It takes account of art as an inherently intersubjective practice, and also of research as a practice in which intersubjectivity is necessarily present, whether acknowledged or ignored.[116 167]

Arguably, we could rephrase Szirtes´ poetic truthfulness and Koppe´s aesthetic coherence in the psychoanalytic language of countertransference. The critical reader´s reflexive analysis of their reading experience can be seen as a kind of as

academic countertransference analysis – the analysis of what you feel and think in the face of another person´s self-representation. What do you make of her? What, of her self-representation, strikes you as convincing, and what as anomalous? Where do you find yourself sympathetic, pleased, grateful or somehow "in harmony" with the text, and where confused, irritated, bored, or affronted? [20] The self-reflexive "reading" of a person, a piece of art or music, a poem, or an academic paper formalises the intuitive knowledge embodied in *experience*. And while a reading cannot reduce a poem to mere technicalities, it can tell us something about its qualities – its external validity.

Finlay suggests that the quality of research craftsmanship should result in *knowledge claims that are so convincing that they carry the validation with them, like a strong piece of art*.[168] This means avoiding reflexivity´s pitfalls – degeneration into infinitely regressive, apparently purposeless "legitimised emoting". Finlay argues that reflection on oneself (in action and relationship) should not be an end in itself, but carried out to gain new insight. Its dangers are mitigated, she argues, by *a sincere focus on the participants or texts involved*.[137] Research is not therapy,[138] and the proof of the pudding is in the eating.

All methods illuminate certain aspects of a problem and obscure others. In addition to strengths, my individual, creative method has numerous obvious and unavoidable limitations. Unlike highly fixed, multiply repeatable, abstractable methods such as the cohort study or randomised trial, my method cannot generate the kind of value which results from discrete, categoric pieces of knowledge such as the establishing of optimum blood sugar levels to reduce mortality in diabetes. The power of such knowledge is in the intensity and clarity of the signal, and its wide generalisability in very specific, albeit narrow, ways. The utilitarian benefits of such knowledge are unarguable, and if we did not have a wealth of such specific biomedical knowledge, a thesis like mine might appear redundant or irrelevant to healthcare´s most pressing needs.

However, much data relevant to health is neither graspable by these means nor generalisable, except in terms of principles and processes, attitudes and approaches.

Here, highly individualised or embodied methods can be more inclusive of relevant perspectives, and less prone to the kind of the kind of bias which can arise from lack of triangulation, perspective, or "binocularity." Methods which offer more extensive, associative insight, taking account of material which is elusive to other methods, because it is dynamic, hidden in symbolic representations, or unconscious, are needed.

Like a poem, a poetic study cannot possible be a fully defended intellectual assault, so much as an exploratory overture. Inherently intersubjective, appealing to both the conscious and unconscious mind of the reader, it cannot claim to have succeeded until and unless one or more willing readers find it to have resonated meaningfully and fruitfully provoked thought or contributed to debate.

According to Doyle, "coming out" through reflexive analysis is ultimately a political act. Done well, she argues, it has the potential to *enliven, teach, and spur readers toward a more radical consciousness.*[136] If research is an attempt to capture an image, we must accept that while some subjects can be "posed" or composed, others must be chased after, camera in hand, generating results which may not be crystal clear, nor easily repeatable, but may nevertheless offer insight unavailable by other means and capable of revising understanding significantly. It is this that I have attempted.

Key messages

- This study´s methodology entails *fostering*, *containing* and *synthesizing* complex material, and can be called poetic
- It makes use of reflexivity, which balances proximity to and distance from one´s lifeworld
- It gives an account of interdisciplinary lived experience, which affords a view not visible from within a single disciplinary framework
- Poetry, psychosomatic medical consultation, and conducting reflexive research are all characterised by creative interpersonal merging followed by analytic separating.
- Such methods can be useful for exploring complex or elusive material unamenable to other methods

Chapter 3 – When words act

" .. although poets are most needed when freedom, vitamin C, communications, laws, and hypertension therapy are also most needed .. a poem is not one of the last but of the first things of man."
Miroslav Holub

Keywords: poetry as a semiotic form, embodiment, holistic communication

What follows is a series of poems in which aspects of the world of illness and health are reimagined. They are offered as examples of what poetry can achieve more widely – of poetry as a specially compressed way of dramatising and investigating the world in the light of subjective experience, one which can bridge the gap between outer and inner worlds for both poet and reader, and connect one person´s emotionally charged experience of living, and another´s. I will argue that it this emotional gap-bridging between fact and feeling, and between one person and another, which we value poetry for, if we do.

And it seems that collectively, we do value poetry – that even people who do not otherwise feel the need for it in their everyday lives turn to it, along with religion, at moments of overwhelmingly strong experience. It is among the special gestural responses we reach for in the face of experiences like falling in love, birth, death, natural beauty, the massacre of teenagers at a summer camp, or the death of a president or a princess. Whether poetry produced by any given person solely on such an occasional basis is "any good" – whether it does anything for anyone else – is secondary to the evidence that in reaching out for it, *we know what poetry is good for.*[169] We seem to understand it as a useful place to put experience whose intensity is almost too much to contain. Poetry is, it seems, for expressing in words things which cannot be expressed in words.

Indeed, in poetry, words are explicitly stretched beyond their normal uses and formed into gestures. In this, poetry´s achievements resemble those of non-verbal art forms such as painting and music, more than those of plain prose. A table at the end of this chapter suggests some ways in which poetry and prose differ. Kristeva observed that

unlike prose, which uses language in primarily semantic ways, or at least has straightforward semantic meaning as an alibi, poetry is inherently semiotic or performative.[170] It addresses the whole person, mentally, emotionally, and physically, rather than offering a thesis or thought which can be grasped purely mentally. The poet, therefore, is a kind of word-artist who ruthlessly repurposes ordinary language as an art material, supersaturating apparently innocent or mundane words with encoded personal meaning. In doing so (s)he draws attention to the materiality and contingency of words themselves – the slipperiness of the very medium upon which we depend to express raw experience. In this way, ordinary or surface meaning in a poem is no more nor less than the "armature" around which the poem´s actual potency is built.

This repurposing of words amounts to a form of serious play, I suggest. Through word games, the poet carves out a kind of "pop-up," intersubjective, reflective space in which emotionally charged experience can be encoded and passed on, like charge passing along a wire between separate electrodes of a battery, or a specially-compressed file being passed from one person´s computer to another´s. What began as deeply personal investigation turns out, if the poem is any good, to touch on the universal-in-the-particular, and thereby to touch another person, or many others, and thereby to achieve what we might, extending Koppe´s notion of aesthetic validity or *Stimmigkeit,* call *aesthetic generalisability*, or *external aesthetic validity*.[171]

A working poem is brought into being, I will argue in chapter 4, by a mixture of intuition and craft, a mixture of unconscious and conscious intention. Poetry, of its nature, makes conscious use of unconsciously-active elements. Hence words are selected for the alternative meanings and associations they also carry, which tease the reader by pressing in at the margins of the primary meaning. They are worked into a shape which gives a physical experience on the lips, throat, or ear, or a rhythmical experience in the body: musical, liturgical devices such as rhythm, repetition, alliteration, assonance, and percussion make a physical, not purely mental, mark. In this capacity to address the body and the mind in one and the same gesture lies

emotional power. To feel ourselves addressed “whole,” in this way – mind and body, conscious and unconscious – is disarming.

In this way, poetry holds a seductive potential which the poet must deploy judiciously, if there is to be pleasure rather than simply dutiful endurance, or aversion, for the reader. At best, a poem offers the poet an opportunity to have his or her own deepest experience validated in another´s reception, while for the reader, it is a way of having his or her own experience validated through another person´s skilful re-presentation. Though poet and reader mostly never meet and may be separated by centuries, a poem is at best the comforting trace of an intimate human presence in a lonely grown-up world.

In the discussion of poetry which follows later in this chapter, I will sidestep attempts to define poetry *as distinct from* other artistic or verbal forms, such as prose, visual art, film, or other forms of expression which might at times also be referred to as “poetic”. I will not engage directly with the many, often evasive definitions or anti-definitions of poetry which have been offered, such as Dylan Thomas´s that “poetry is what makes my toenails twinkle”. Rather I will focus on what poetry does, how it does it, and how and why it is made. These I will address primarily as psychological questions.

A tentative definition of poetry as a psychological achievement will follow my observations, rather than precede them – and not because I think poetry is in need of psychological definition, but because I think understanding what it achieves psychologically is useful for health. I will end by suggesting that we can think of poetry as a condensed, highly crafted, holistic communication device in which we can exchange and retrieve valuable, sensitive, elusive material in someone else´s presence. A kind of embodied-relational “app”, which combines pleasure with multi-level communication to achieve personal development.

I present these poems – selected because they deal with the body, and have satisfied external poetic peer review[1], because in being their writer, I have access to the poet´s, as well as a reader´s, perspective. I can at least to some extent speak about why (psychologically), and how (technically), each arose. Each of the first eight poems is presented in its own right, and then discussed from a reader´s and a poet´s perspective, in parallel. In the case of poem 9, *Bone talk*, I present contemporaneously collected data on how (both psychologically and technically) the poem emerged. In doing this, I hope to "track" how a poem can originate, emerge and function, looking, as it were, into the mechanism whereby one person´s experience or concern can be encoded such that another person can "feel" it. It is a way of trying to image a moment of creative intimacy between two people who may never meet – one which, while apparently valueless in utilitarian terms, is nevertheless highly prized. It is no coincidence, in terms of the development of my thesis, that this highly prized, intimate, interpersonal practice is at the same time an epistemic critique of medicine misunderstood as a dehumanised natural science.

[1] The 8 poems presented have all been peer reviewed by poets and commended and/or published in poetry magazines or prize anthologies. A sound file of each being read aloud is supplied electronically.

Bitter Treatment

It was the area between
the midlines of the two
temporal lobes, and back
for eight to nine centimetres –
the hippocampus, the parahippocampal
gyrus, the entorhinal and pararhinal
corteces, the amygdala –

the patient was awake
on the table the whole time
as Dr Scoville inserted a silver straw
and sucked out nearly the entire
greyish-pink mass including
his memory, like finest *maté amargo*
through a bombilla.

3.1 A found poem

This little two-stanza poem, almost but not quite a sonnet, summarises the therapeutic events surrounding a famous case history often referred to as "the man without memory".[172] Beginning in what later turns out to be the operating theatre, but could as well be the anatomy dissecting room, the poem parachutes itself directly into the language of specialist neuroanatomical detail. It makes poetic capital of the unfamiliarity of neuroanatomical terms, filling stanza 1 with a smoke-screen of special, resonant, repetitive, "brain-words" – words which place the reader on the outside of a professional sanctuary, peeping in.

Like a child, the reader, including the ordinary doctor, is lulled by specialist words whose meanings are elusive – *hippocampus, parahippocampal gyrus, pararhinal corteces, amygdala* – words which used like this, might as well be liturgy pronounced by a priest – *… in nomine Patris et Filii et Spiritus Sancti …* inviting the simple assent of *Amen.* Its complacent incantation invites not so much adult understanding as awe, alienation, and that dreamlike suspension of rational thinking which fairytales, or songs, also invite.

A-my-g-da-la ´s dactylic judder breaks this rhythmic intoxication. It strikes the ear, physically. Disrupting the dreamy child-parent, priest-parishioner collusion, it brings stanza 1´s professional mumbo-jumbo to a physical standstill, and propels the reader into the shock of stanza 2. It shakes the reader awake, like a train traveller arriving at the station of disembarkation.

Leaving stanza 1, the reader is met with a new and startling view, as the poem pans back to reveal a wider context. The language flips from the academic and hieratic and to the clinical and everyday. If stanza 1 presents a disembodied brain, stanza 2 confronts us with *the patient* – a real person who is not only *awake* – as the reader now perhaps also is – but on an operating table. The patient is the nameless, passive object in the hands of a named doctor, *Dr Scoville*, who is in the middle of carrying out an intricate and grotesque procedure with a beautiful instrument. He is removing from

the patient *a greyish pink mass*, which turns out to have contained the patient´s capacity for forming *memory*.

Memory is the punchline towards which the poem has been building. Abruptly, this word withdraws emotional permission for stanza 1´s purely objectified view of this brain, forcing instead an identification with the experience of the person to whom it belongs, the man whose capacity for memory formation it holds. If stanza 1´s impenetrability has lulled us into cosy, scientifically clean, emotional irresponsibility, stanza 2 is an emotional awakening as vertiginous and rude as a fall from a high place. We thought we were in the inner sanctum of high neuroscience, but suddenly find ourselves witnessing a terrible injury occurring in real time, inflicted in medicine´s name.

The poem could have ended here, but did not. Having met its traumatic climax, it moves right on, like the biblical Pharisee passing by the wounded man on the other side. A conventional little couplet comparing the events of the poem with the ceremonial drinking of maté tea hints at medicine´s potential for sadism – its potential to cause trauma by refusing empathy with suffering – to insist on objectivity, remaining untouched, refusing emotional engagement. This is an accusatory poem with a smoking gun, and a culprit - not the flesh-and-blood Dr Scoville, hapless amanuensis of a higher force, but the impersonal force of objectifying medical academia itself.

3.2 Or opportunistic revenge

Why was this poem written? Superficially, I remember simply hearing the case discussed on the radio and thinking it a ready-made poem, ripe with its own irony, awaiting poetic capture like a view asking to be photographed. Less invented than discovered, I remember its arriving almost fully formed, like a found object in need only of a little cleaning up, framing, and displaying. But on minimal reflection, this account of the poem´s ontogenesis in which the poet figures as sovereign, "material-selecting" subject, seems like a half-truth which denies the play of the "poem-finder´s"

hidden concerns and interests. Closer examination reveals how this material matched my own unconscious rebellion against aspects of medicine, rebellion which existed in at least three areas:

First, there was a straightforward, Freudian, ego-conflict between work and play of the kind we all know – years of feeling squeezed between the infantile id´s desire for play and gratification, and the demanding, parental superego´s injunction to work. [173] [174] While work was engaging, I still almost constantly craved more rest, time with my family, and creative freedom to pick blackberries or read novels. At times I felt like a slave of my own ambitions and intentions. The childish id, consigned to a back seat, harboured a somewhat dark, rebellious view of medicine.

Secondly, there was an emotional-energetic conflict within the work itself: The empathy with which I aspired to balance technical competence was frequently overstretched – at times, I ran out of patience with my patients – I feared that if I did not "tune out" from being fully present I might burn out. While colleagues seemed to feel similarly, stoicism was a badge of office and we did not complain much or feel anything could be done about this. Denial helped us through the day, but did not dispose of the discomfort. So even if being a good doctor were my only desire in life – which it was not – I was still in conflict – between being the doctor I wanted to be and the one I felt I could be under the circumstances. My idealised professional self contemplated *Dr Scoville* with horror, thinking *there but for the grace of God go I.*

But, thirdly, in addition to infantile rebellion and human weakness, there was also the constant, internal jarring between what I was encouraged to notice and attend to at work – a reductionist repackaging of human experience in closed, pre-existing diagnostic categories, with only brief, marginal scope for meaning or subjective experience – and what I actually noticed, which included feelings, medically unwanted bits of story, and interpersonal interactions. I lived with a vague sense of complicity in a kind of half-truth or injustice – the roots of the epistemological conflict I named in the opening of this thesis – but which I struggled to articulate.

In other words, I did not approach the *man with no memory* innocently. Rather, burdened by these three mundane conflicts, but also in possession of a secret weapon or "get out of jail" card in the form of a growing capacity to play poetically with words, I seized upon the material with a view to having a serious game and squaring-up some psychological and moral imbalances. Consciously I may merely have been hoping to amuse myself and a reader, but cursory self-analysis reveals my deeper project: here, like manna from heaven, was a material which matched my concerns well enough that the two could meet: from out of this real-world story I could fashion a small repository outside of myself capable of carrying some of burdensome conflicts I was tired of carrying. And if rather than simply "dumping" these in the material, I could also fuse and craft the two to the point where they might become something new and interest a reader, I might momentarily re-establish a sense of feeling "real" in a working world where I sometimes felt unreal – re-establish, in the face of anxiety or disruption, a sense of what Winnicott calls *continuity of being*.[175]

Freud describes this process whereby the artist *possesses the mysterious ability to mold his particular material until it expresses the ideas of his phantasy faithfully; and … to attach to this reflection of his phantasy-life so strong a stream of pleasure that for a time, at least, the repressions are outbalanced and dispelled by it. When he can do this he opens out to others the way back to the comfort and consolation of their own unconscious sources of pleasure.*[176] Like the infant who reaches for the security blanket which is mother´s permanent representative within his grasp - Winnicott´s transitional object, which is both *me and not-me* - the poet reaches for a poem as a *me and not-me* space, an external material capable of absorbing her intractable disquiet. That way, the disquiet can be contained, quite literally, physically and firmly, in the poem´s tight, condensed structure. So beneath the cover-story about a found poem, the ontogenesis of this might more completely be summarised as "rewarding material meets disturbed artist."

Anosmia

Never mind the niceties
of pettitgrain and musk,
topnote and basenote,
or survival´s sniffing for
unlikely smoke in a home,
or gas in a trench –

Search the old brain´s
crevices for the mislaid
mother-milky rag of memory –
the absolute pleasure of
rose otto, rising

like a charmed snake,
bacon sirening breakfast,
stockfish souring the wind
with the stench of money,
and the comfort and joy
of beeswax and cinnamon –

Ah, bin your dead metaphors
like used tissues! Stop up your
mockery of scented words
and weep honestly
for lost honeysuckle,
leaf mould, and bitter orange,
clinging to a lover´s skin.

3.3 A writing exercise: the deliberate practice of empathy

This four stanza poem arose in response to an invitation to submit a poem for an anthology on the theme of loss of sense of smell. It is a piece of free-association – a quest for the most poignant examples of this particular sensory loss. Hinshelwood characterises psychotherapeutic endeavour as *a journey towards the point of maximum pain*,[177] and this exercise might be seen as its poetic equivalent – the laborious bringing to awareness of a buried feeling. What in therapy is the moment of release is in poetry, the moment of emotional reward. The relevance of Hinshelwood´s epithet becomes clearer if we generalise it as *a journey towards the point of maximum sensation*: the point of a poem , or of therapy, is that we get to feel something at the same time as we "see" it. So a poem which attempts to demonstrate or propose something without succeeding in kindling an emotional response is impotent, purposeless, and prosaic.

3.4 A seduction

In a sense, a functioning poem is a form of seduction. I have elsewhere[178] compared poetry with other consensual erotic experiences, such as the merging or reverie experienced by lovers, or infant-mother couples – in both states, the (ego-) boundaries between two people are transiently blurred, in a shared state of regression. A successful poem, I argued, involves just this kind of pleasurable collusion – literally, "playing together," in which the sense of being separate is temporarily replaced by a sense of connection. Beneath the surface-meaning of the poem, beyond the reader´s conscious awareness, using special forms of touch, the poet negotiates the opening up of an intersubjective space, in which preverbal feelings, or yearnings, are shared.

This touch is neither random nor innocent, but involves the harnessing of unconscious or "natural" impulses within technique. For example, it means knowing how to use

ordinary language in special, physically and emotionally charged ways, such as double-meaning, pleasurable sound patterns, unconscious associations, and a tacit invitation to enjoy "private" understandings. It involves the conscious use of unconscious communication. And because poetry has no functionalist alibi – either this bid to establish intersubjectivity (merging) succeeds, or the poem fails wholly: if bad prose invites disapproval, bad poetry invites disgust. Highlighting the balance of freedom and stringency which seduction requires, contemporary American poet Michel Ryan says in a poem about sex: *I want my touching intelligent, like a beautiful song.*[179] His words apply equally to poetry´s freedoms and demands. He quotes fellow American poet Wallace Stevens: *You can do what you want, but everything matters*.[180]

Questing for maximum sensation – what really matters emotionally about smell – *Anosmia´*s first stanza dismisses with a lordly hand-wave the trivial, the improbable, or purely historic. The perfume industry´s shallow marketing patter is dispatched along with the unlikely event of smoke signalling fire, or gas as a weapon of war: ours is no longer Wilfred Owen´s first world war environment of gas in trenches.

Instead the poem dives deeper, in stanza 2 into the ineluctable physicality of mundane need and pleasure. We enter the territory of *the old brain* or reptilian brain, deep beneath the cerebral neocortex, where brain stem, cerebellum, and limbic system process reflex and repetition, trauma, and nurture. Here, we are down in the primitive part of our selves which connect us anatomically with animals and our own infantile origins – line 3´s *mother-milky rag* is Winnicott´s intimate transitional object itself, rich with the scent of mother-and-self mixed, without which the child is lost in the world.[181] The precious essential oil of *rose otto*, in its *absolute* or most concentrated form, conjures sheer olfactory loveliness. Stanza 3 expands into the wider significances and emotional associations of smells: bacon means breakfast to an English person; to a North Norwegian, the sour smell of stockfish on an onshore wind is money.

But the final stanza cuts off the indulgence of its own olfactory reverie. Like the bitter turn of a tragic protagonist on stage, the poet invites herself to renounce these re-

imagined smells as mere conceits. Pursuing Hinshelwood´s point of maximum pain, the final stanza urges depressive confrontation with grief – *Bin your dead metaphors!* Clipped sarcasm consigns the nostalgic references of the previous stanzas to the waste bin like so many crumpled, tear-soaked tissues.

Achilles

Tendinosis:
a disruption

to the smooth running
of collagen in its sheath
causing irritation,
and pain

of separation

from night walks
across a darkened field
hunting the barn owl

and from locomotion's
calming continuo, balm

against the world
and its unpurged
toxins: so give me your
remedies! Eccentric
exercises, insoles, pills –

or surgery – anoint me
in ambrosia, burn away
my mortal parts on a pyre
or throw me headlong
back into the Styx:

only give me back
the smooth running rhythm
of my self!

3.5 A cri de coeur

If *Anosmia* was an exercise in empathic imagination, *Achilles* is a personal *cri de coeur,* born of the physical frustration of a prolonged bout of Achilles tendinosis. Walking, a simple, accessible form of goodness, bringing relaxation, exercise, stress reduction, and connection with the natural world, was suddenly gone, leaving frustration verging at times on despair. I quite literally "did not know what to do with myself." So *Achilles* arose around an experience of psycho-physical distress, like a crystal grows around an impurity or a pearl around a piece of grit, as a kind of self-protective secretion. It takes the form of an elaborate howl of pain from patient to doctor.

Ten-di-no-sis, the first word, occupies a whole line of its own. When reading it aloud, I sometimes linger over it, spitting out its four technical syllables with a dissatisfied patient´s scorn at a medical label which has not helped. The double entendre of *disruption* in line two conflates technical disruption and wider disruption to a life, dramatised on the page by a mid-sentence stanza break. This creates a kind of stumbling or rupturing of subject and object of the sentence, an effect repeated elsewhere, such as in the single line stanza 3: the whole poem limps along, as it were – its own smooth-running disrupted.

Until the end of stanza 2, the language could easily come verbatim from a medical textbook. But stanza 3´s single line is a fulcrum which tilts the reader from literal to metaphorical meanings, from purely physical to physico-emotional pain, and from the doctor´s objectifying, biological perspective to the patient´s compound, subjective lived experience. The poem began with a doctor observing her own body at arm´s length, presenting her own pathophysiology in a reductive professional language in which she, as it happens, has a stake. But the word *pain*, a transitional word belonging to both professional and personal discourse, recreates the lost connection with subjective experience.

As the dry, pathophysiological account ends, the poem begins to come to life, emotionally. The language becomes, if you like, more poetic, more capable of transmitting feeling. Stanza 4 has moved on from the theoretical discussion of pathology to something more palpable – the meaning of an illness in a person, expressed in terms of goodness lost and mourned: contact with nature, contact with the self-comforting rhythmicity of my own body, *night walks through a darkened field hunting the barn owl* and *locomotion´s calming continuo.* The poem´s staccato stumbling gives way to a passage suddenly extensive and fluent with enthusiasm, rich in sensual words for the lost pleasure I want to make the reader *feel*. The poem has escaped its own confines, as the poet has momentarily escaped hers.

And this imposition of feelings onto a receptive witness, an essential element of the poem´s function for both poet and reader, is a form of projective identification: just as a patient finds ways to make the therapist feel their feelings before they can reorder things for themselves, using the processes known as projective identification[182] and working through,[183] the poet strives to place the *felt sense* of lost barn owls and calming rhythmicity directly *into* a reader, borrowing their emotional space, or the possibility of it – spinning the straw of lonely distress into the gold of empathy and appreciation gained.

But if there are parallels between the patient´s gain from the doctor and the poet´s from the reader, the direction of responsibility, and movement between conscious and unconscious communication, are opposite: A patient presents unconscious material raw, owing the doctor nothing but minimal engagement in the therapeutic encounter. Though the creative-therapeutic work is mutual, the job of helping find insight and clarity is the doctor´s. The poet´s responsibility is opposite: her reader owes her nothing – on the contrary, it is the poet´s job to make the reader´s experience worthwhile. So while the patient´s projections are, by definition, presented prior to creative working through, the poet must earn her reader´s empathy by working through her own projections.

The direction of travel between conscious and unconscious communication is also opposite. Whereas the patient presents emotionally charged unconscious raw material for therapeutic "decoding" – a process which reduces the emotional charge and promotes conscious understanding – the poet has the reverse job, of *en*coding raw material which is both felt and understood, via the creative work, in order to touch the reader emotionally as well as mentally. To fail in encoding the emotional charge, when writing a poem, is to be merely prosaic.

What Winnicott´s baby or the patient carries out more or less unconsciously, the poet learns as a trick: the trick of making people feel. It might call upon instinctive abilities, to an extent, but it is at least in part a craft, learned like surgery, spoon-carving, or psychotherapy – in this case, the craft of verbal seduction. Like a seduction, the stakes are high. However open the reader potentially is to the medium and the subject matter, the poet has to get it right. If the poem fails for the reader – meaning for most or all readers – it is at best an embarrassment and at worst a humiliation. A poem which fails to reach its reader is as embarrassing as an unwanted sexual advance.

Suddenly tired of reflection on pain, just wanting a cure, the poet exclaims, in the middle of stanza 6, *Give me your remedies!* I´ll try anything, no matter how strange, she seems to be saying – the implication of "strangeness" also encompassing in just six words the entire medical management of Achilles tendinosis. Brushed over with casual disrespect, *eccentric exercises, insoles, pills,* and *surgery* are shrunk to fit the line, given equal status with wildly implausible mythological remedies. The disrespect is compounded by the dismissive, generic vernacular *pills* in place of specifically selected medicines, and the ironic subversion of the technical use of the word *eccentric.*[2] With barely a backward glance, the poet steps from modern medicine into the language of classical mythology of the original Achilles, with his equally ineffective Styx-dipping, as though nothing therapeutic had been achieved in three thousand years.

[2] Meaning, in Norwegian, *"ekssentrisk"* as in "*ekssentrisk trening/belastning"* but also *sær*.

The poem is self-ironic in its mock grandiosity, but it jabs at medicine´s grandiosity, too – medicine, with its insulting habit of naming what it cannot fix, and then talking as though its own impotent discourse were primary – as though it were disruption to collagen which mattered rather than the loss of barn owls. But the irony cuts both ways: it is, after all, to the doctor this poem addresses itself in its despair.

Mess

Pause a moment
among yesterday's ruffled
and distracted papers
and the smell of tikka
masala from the tins
on the pool table,

spread spongiform bread
with marge disturbed
by a hundred hurried knives
into a livid landscape
of crumb-strewn hills,
spoon coffee powder

into a mug from the jumble
in the sink beneath
that reminder that
doctors are responsible
for their own washing up,
draw breath between

the asthma and the
repeat enzymes, collapse
if you must into the arms
of the plastic chair by the TV
rehearsing the day´s news,
but do not sleep!

– because sleep will be
cut from under you,
like underwear from
the critically injured. No –
keep vigil with the
once-white clogs

worn out running
the night corridors:
watch them jostle before your
eyes, and mutter
in the Sisyphean language
of sickness – dream

if you like, of fresh air –
but you´ll likely find
the windows are sealed,

and even the milk
in the fridge
has run out.

3.6 Masochistic nostalgia

Mess is a dystopian reverie from the perspective of a junior doctor on night duty. Some of the imagery of a medical on-call will be internationally recognisable, but this is a poem about location as much as roles, responsibilities, and experiences – the grungy doctor´s mess of the British National Health Service, replete with the ironic, alienating pseudo-comforts of plastic armchairs, poor coffee, cheap margarine, blaring television, a pool table catering for only a subset of the population, take away food in foil tins, missing milk, and patronising reminders about washing up.

Doctors´ messes I have known, across the country, have fused into a kind of universal character. With a kind of metonomy – the poetic device whereby a part represents the whole – the run down, neglected, depressing doctors´ *mess* – the conventional name for a doctors´ common room for rest and recreation – stands for the run-down, neglected doctor, and the run-down, neglected health service – "distracted", like newspapers, both in the superficial sense, and in the deeper sense of "pulled apart." The word "mess" escapes from its conventional meaning into its wider meaning of chaos.

In the poem, a junior doctor depersonalised with tiredness addresses herself in simple, short injunctions – like memorised steps of emergency treatment – or like kicking a weary mule. *Pause, spread, spoon, draw breath, collapse … dream*, even, but *do not sleep!*

No-one cares for the carers, the poem seems to accuse. Doctors are responsible for…. the line break makes its reader wait, creates a moment to imagine the many things doctors on call might be responsible for – checking blood tests, delivering emergency treatment, relieving pain – but also, when everything else is done, *their own washing up.* The doctor feels mocked in her comfortless responsibility. In the language of a poem, she mocks back.

The line between doctor and patient becomes blurred, as the doctor is invited to

collapse if you must …. to *draw breath between the asthma and the enzymes*, almost as though the breathlessness were her own, not that of the asthmatic patient. *Sleep will be cut from under you*, the poem warns, making her into an accident victim, and at the same time bringing echoes of enforced sleep deprivation. Like the once white clogs her hallucinating brain sees jostle and mutter, the doctor´s once-white idealism and verve are becoming worn out from running the corridors of the hospital.

Fresh air is just a daydream, and milk – that final, maternal symbol of comfort and nourishment, that minimal, sine qua non of a British cup of coffee – has run out. The windows are sealed. The doctor is a prisoner.

If the vision is dystopian, it is nevertheless laced with masochistic nostalgia and dark humour, such as are common in the retelling of tales of struggle. Doctors, soldiers, and fishermen on the high seas might at times present themselves as victims, but at other times romanticise themselves as heroes – bloody but unbowed. The belief in the capacity to master adversity which would break others can be a working defence against being overwhelmed. It can also be a dangerous invitation to hubris – a misplaced belief in one´s own superiority: The "heroic" doctor, having denied, or as she believes, triumphed over, her own frailty is ill equipped to empathise with the frailty of others.

Inappropriate ADH

WHO International Classification of Diseases 10: Syndrome of inappropriate secretion of antidiuretic hormone (SIADH). A condition found in patients diagnosed with small cell carcinoma of the lung characterised by excessive release of antidiuretic hormone, hyponatremia and fluid overload.

– I'll say! Toxic little
nodule, insinuating itself
into prime position, right
where the breath comes in,
smug as a gatecrasher
at a party, peddling poison
as if the very stuff
of honest self-regulation.

Small cell, it calls itself,
but don't fall for
the false modesty:
you just watch it wring from him
his last molecule of salt,
trash all proper fluid
balance, blitz his brain with
fits, hallucinations, coma –
you just watch it dilute him
to death.

3.7 Interruption and insult

This short dramatic monologue about rude interruptions is in the voice of a gossip, discussing a tumour with theatrical contempt, as though it were a rude intruder at a party. It begins abruptly by interrupting a pre-existing medical conversation which has been established in the title, singling out the technical word *inappropriate* for deliberate misunderstanding and sarcastic counter-attack. Itself a rude interruption, the poem´s first two words herald a haranguing monologue which takes over the whole of the rest of the poem. Medicine and its definitions are never allowed back in in their own words, though the biology of death by small cell carcinoma is rendered in everyday speech.

Instead, medicine is (unfairly) ridiculed, its technical jargon mocked, deliberately misunderstood as an example of how *inappropriate* can be used in polite conversation as a pompous, judgmental cover for visceral dislike. With dark sarcasm the gossip both reasserts the word´s everyday use, and mocks a word which appears to characterise a deadly tumour in cool, unemotional language as merely “misplaced”. The tumour is anthropomorphised as *toxic little nodule,* echoing vernacular expressions of disgust such as “nasty little madam” or “namby-pamby little so-and-so.” Small cell, an innocent sounding name for a disaster, is reframed as *false modesty*.

This poem is just a word game, but with a dark underbelly: in playing with dual meanings of words, dual dialects within a single language, and dual perspectives on illness, it is not offering “fair comment” or reflective insight – rather, it is a dramatised verbal assault by what we might see as the despairing id on the maddeningly unemotional superego: it acts out rage and disgust at the insult of illness, compounded by the insult of language which is both impotence and smug. As though words, definitions, and finely turned phrases helped. It is a game – in words – about the uselessness of words in the face of death, the final rude interrupter.

Big Game

I inspect. Quiet at last on the table
I find a uniformly distended abdomen
consistent with pregnancy,
as we were taught to say.

Large for gestational age, large even
for forty weeks, or twins – despite
the scan, despite her age, it's hard to credit
the diagnosis cannot after all be that.

I palpate. Find your characteristics
beneath her taut white skin: smooth,
discrete, mobile, *dull to percussion*;
fluctulant as we were taught to say,
and somehow satisfying, as we were not.

We scrub. Gather in blue paper gowns, a fluttering
of gloved curiosity and masked excitement:
priests in the sanctuary to bless the sacrament;
carrion-fowl, at the kill.

Someone incises, breast to pubis.
Skin gapes, fat splays, the tough sheath is divided,
the fine membrane ripped, to deliver *you*:
forty centimetres or more of cystic ovary, firm
as a nut, warm and heavy as a baby,
dusky, now, on your twisted pedicle,
starved of blood by your own greed.

It's almost a shame. Your surface
Is like polished marble, traced
with the finest venules; for all your hubris,
your curves lie delicate and smooth in my hands.

Great bean, extraordinary bean,
grown inside the pod of her by the indulgences
of strange mother nature – sleek form
in the image of Hepworth or Moore,
did you not deserve a plinth
in a gallery, so the public could marvel
at your curves and tracery?

But only the pathologist will see you:

lift you from your plastic bucket,
cut you up and judge you
on criteria of legitimate interest: contents;
thickness; histogenesis; differentiation:
benign, or malignant.

3.8 The surgeon disrobes

This poem is a side-stepping of the surgeon´s "proper" role – a kind of divesting of a purely professional viewpoint, like the moment at the end of a surgical procedure where gloves and gowns are removed and thrown into waste bins and linen skips, and normal clothes are put back on. But this switch occurs, transgressively, in the middle of a surgical procedure. In a moment´s reverie, with her hands inside the patient´s abdomen cradling a cyst, a surgeon allows herself to step aside from her habitual, morally preconditioned view of pathology as *the bad thing*, which she must hunt and kill like big game, and to look with artistically dispassionate eyes. She pauses to indulge in a moment´s aesthetic appreciation for this product of nature, this "creature," about to be killed – like the Inuit hunter´s momentary pause to revere his prey.

A benign ovarian cyst the size of a rugby ball, initially reminiscent of twin pregnancy, turns out on closer artistic inspection to have a strange, smooth, patterned beauty, like a living sculpture. This neutral, aesthetic observation is transgressive because it is the doctor´s. What right does a doctor have to an aesthetic view of pathology? Has she abandoned her struggle on the patient´s behalf, like a renegade soldier who has deserted his post? A sudden ethical vacuum opens up, in which tissue is contemplated merely as tissue, with aesthetic qualities which can be admired, regardless of the personal meaning to the patient or doctor. An unauthorised viewpoint has been admitted to the operating theatre.

The shift is reflected in the change of language, which begins with the short sentences and beautiful, liturgical economy of medical procedure and note-taking – *I inspect . . . I palpate . . . We scrub . . . Someone incises.* Dutiful reference to what *we were taught to say* begins to give way to acknowledgment of what *we were not.* Mention of the normally taboo creeps in – conventionally unacknowledged excitement. The thrill of the chase – a thrill I suggest many surgeons will recognise, but which is not readily acknowledged. These amoral, understandable human emotional responses, normally contained firmly within professional codes, are now, in the poet´s imagination, peeping out transgressively from behind the masks and gowns of operating room

procedure. By stanza 5, the doctor has set aside the therapeutic context and begun to address the pathology as *you* – the cyst anthropomorphised as though it were a newborn baby – and the whole poem breaks out into the language of untrammeled imagination, like a prisoner escaped.

It is a reflection on what a doctor is allowed to notice: about the balance and opposition between artistic and scientific, aesthetic and therapeutic perspectives. It is about both the sadism and the love contained in both scientific and artistic gaze - both unempathic, observational ways of knowing. It is a reverie I felt permitted in relation to a benign tumour, which I saw as an unthreatening interruption to a life which could resume unaffected, but one which I could not have allowed had the cyst been malignant. It was an awareness relevant to the medicine and art which could perhaps only arise in the very particular three dimensional psychological space offered by a pathology which was at one and the same time unarguably aesthetic, unarguably pathological, and unarguably benign. It was a safe perspective on sadism without actually feeling like a perpetrator of a crime. It walks a fine line. Poetry might be seen as a tool for walking fine lines.

Slip

It was just a mistake.
GTG for GAG – a typo,
both looked like nonsense
to me.

I *meant* GAG –
was being so careful to match
t with a and c
with g, I don't know
how it happened.

How was I to know
it would end in
t*he substituton of valine*
for glutamate at the sixth position?

And now look:
The blood is clotting,
sickling inside her. God.

I had no idea
it was a coding region –
one slip, and …

My God! – look at her now –
doubled and twisted, crying
for her baby,
dead inside.

3.9 God´s amanuensis slips up

Slip was written late one night, while revising for a difficult exam with a low pass rate. It seemed a Sisyphean task, rich in the kind of anxiety that might invite poetry. Fascinated by the material, but overwhelmed at the level of detail required to pass the exam, I was losing concentration on the genetic pathology of sickle cell disease. The writing of this poem offered momentary escape into a dream-like identification with an imaginary, diligent, but tired and fallible transcriber of DNA. I created for myself a psychological third space in which I could re-engage with my study material on my own terms. Eluding the super-ego´s demand for unbroken concentration, the id stole some rest and play – a compromise in that I played *close to* my work, rather than *far away* from it, though far enough to re-establish a sense of freedom and agency.

If this is a poem which arose between the pressure of two needs – to work and to play – it is also one which makes explicit use of both the material I am in flight from, and my emotional resistance to it. It re-works the objective material under the auspices of feelings. Had I not been mentally close to the genetic pathology of sickle cell disease, I would not have had the conscious, cognitive material for this poem at my fingertips. Had I not been in a state of almost hallucinatory tiredness, and fear of failure, I might not have had access to its emotional context.

The poem is a hand-wringing lament in the voice of God´s genetic editor – an imaginary translator and proof reader whose job it had been to ensure correct DNA transcription and translation. On this occasion, she made a tiny, terrible single-character error with disastrous consequences – sickle cell disease, placental abruption, fetal death, and all manner of maternal agony. Like a system out of control, the brief poem accelerates rapidly, to its abrupt conclusion – the moment where the fragilities of all parties concerned – dead baby, agonised mother and hapless translator – meet in tragedy.

Another poem playing with medicine´s technical language, contrasting *coding regions* and *glutamate at the sixth position* with the everyday language of a woman, *doubled and twisted, crying for her baby, dead inside,* this is more confession than challenge. A fallible human confesses fatal failure to the genetic creator. Her rationalising explanatory narration, the poem´s surface meaning, is no more than an anxious elaboration of the mortal truth – a performance of fragility. It attempts to capture the fragility of editor, mother, baby and biology – humans trapped in their own and each other´s inadequacies, and the dreadful play of chance. It is, in a wider sense, about the fragility of things.[184]

The fragility which becomes the poem´s endpoint was, I suggest, the poet´s starting point – in this case physical and mental exhaustion and fear of failure. The poet seizes the opportunity to transform and metabolise these by working them into a form emotionally recognisable to others. Or put another way, uses her own exhausted anxiety, which is no more nor less than the trace of her sentient humanity under pressure – as the engine to drive a poem. It is through first merging with, and then wrestling with, the subject matter that this is achieved. It involves entering a kind of *intersubjective, interpersonal* relationship with an inert but promising material.[185] The poet lends the subject matter her empathy and emotional liveliness, while "borrowing" its fixed externality, its enduring realness, as a container. This parallel giving and taking. Through this merging of *me*, and *not me*,[181] and then wrestling with the material in a kind of loving fight, a new, third object and a new set of emotional circumstances arises: a dry subject matter has been enlivened; an overwrought doctor has discharged a burdensome emotion and found a new way to "inhabit" her work. A brief psychological intervention has resulted in short term relief (restoration of pleasure), the production of something later deemed useful or pleasurable by others, and the kind of everyday growth which comes from practising a skill.

Sex education for boys

If new life is to occur
you must first find strength,
speed and determination
to penetrate the *pellucid zone*,
proteoglycan protector
of her haploid,
double-X contents,
that thick, soft shell which,
though see-through, is tougher
than you might think.

Only if you prick that
jellied bubble
can you hope to fuse
your DNA with hers
seal the membrane
to other comers, and imprint
her cytoplasm with your genes
for posterity.

It will cost you.
All those sharp enzymes
poised in your arrow-head,
all the mitochondrial reserves
of energy stored tight in your
endoplasmic reticulum, all
your glycolytic strategies.

And whether it'll happen
and whether it's worth all that
in any case depends entirely
on who you are, and who she is
and how much you want it.

3.10 Serious teasing

This poem is a tease, and a romp, in and with the language of reproductive biology. Using fertilisation as a metaphor for sexual relating between a man and a woman, it addresses itself in the half-mocking voice of an older woman offering advice to a young man.

Reducing the serious biological business of reproduction to a mere metaphor for erotic and relational connection, this poem lectures *boys* from an adult woman´s perspective, on the emotional conditions of female sexual accessibility or *new life*. Like the fairlytale hero, he must overcome obstacles and prove his worth, in the form not only of desire and prowess (*strength, speed and determination)*, and the ability to overcome resistance (the *proteoglycan protector . . . that thick soft shell which though see-through is tougher than you might think*), but also the unreserved commitment of energetic resources (*all the mitochondrial reserves*) and creative cleverness (*glycolytic strategies*). The tone is flirtatiously tough – the language that of hard-headed bargaining. It is both serious and playful, warning and inviting, and laced with innuendo (*prick that jellied bubble* and *other comers).*

Part of the tease is the use of boyish, action-movie language of reproductive biology, and it is in part a tease of that language itself. Biological Latin´s *zona pellucida,* the egg´s protective layer which the first and fastest sperm must penetrate, is ironically anglicised to *pellucid zone* – more *Star Wars* than IVF laboratory. Like a heroic tale it lays out the near-impossible obstacles the romantic hero must surmount in order to win the girl.

The poem´s dramatic fulcrum is the short line: *It will cost you.* In the language of street bargaining, it warns against emotionally immature approaches – against the fantasy of pleasure without relational responsibility. Part wise counsel, it is also part threat.

3.11 Witnessing the emergence of a poem: self-analytic raw material

Having presented eight published poems in terms of their effects and origins, I now offer a ninth, unpublished poem, *Bone Talk,* with a discussion of the writing process. I make no claims for this flawed poem other than that, immediately after writing it, I also happened, for my own interest, to have written a contemporaneous account of the writing process, using the kind of blow-by-blow, self-analytic approach used by Marion Milner in *On Not Being Able To Paint*.[24] This is a method I also followed in a master´s thesis on visual art.[23] The account, which follows the poem in full below, can broadly be summarised as describing 1. a libidinal bid for escape from work into creative pleasure, followed by 2. a prolonged phase of concentrated, dream-like, constructive work-play, concluded by 3. conscious refinement of the product with a reader in mind. It is a process which can readily be read in terms of Ehrenzweig´s three stage process of making a piece of art,[143] [144] which I will discuss in the next chapter.

Bone Talk

Others have antlers
or beaks, we have bones
for support and structure,
strong, fragile things on which
we can depend.

That tissues wrench
and undermine them, each tendon
tugging its own way, each nerve
and vessel straining only
for its own safe passage
through the matrix,

you sense in the forbearance
of groove and prominence,
eminence and tubercle; to each canal
its proper sinus, each condyle
its epicondyle. Feel

for the marrow's quiet ebb
and flow, the circulation
of clasts and blasts, and pause

to bless the dry bones of the dead,
the soft bones of the unborn,
the shackled bones of children
in a cellar. Take care

of each epiphysis and diaphysis,
growth-plate and shaft,
head, and neck: lest some day

you shatter

into bloody fragments,
twisted as a green stick,
or dry as a biscuit.

Self-reflective contemporaneously written notes on the process of writing a poem: Bone Talk

Bone Talk began as a response to the language of bones, its associations, and its material qualities. Revising for an exam, I came upon a text full of bone words – *condyle, epicondyle, groove, prominence, eminence, tubercle* – lovely, strange things which I wanted to capture. The desire seemed primitive and lively, like a child's desire to play - or, as adults might see it, "mess" – with grown-up materials properly intended for other purposes. One of my children was once found, aged one, having escaped the cot, blithely "painting" in nappy cream on the wall. This image of innocent transgression captures for me the spirit of creativity: nappy cream, or words, can be borrowed or stolen as a vehicle for original exploration of the world, and oneself.

My "poet-self" – a somewhat childlike character – had borrowed or stolen these words from my "professional self". The poet wanted them for something beyond their medical face value – for their power to conjure a dream-like, anatomical landscape, to tell stories, and also for the sheer pleasure of their physical properties – the soothing, liturgical way they trip off the tongue and strike the ear. Rather than allowing them to remain confined in their conventional semantic boxes, static subjects defining fixed objects, the poet saw them as objects in themselves, to be explored and enjoyed – taken out of the anatomy room and showed off to friends, bathed in one´s own emotional responses as beautiful, fascinating, recontextualised things. In showing both findings and feelings, both material and self, the poet is looking for company – inviting a reader to play with her, with these words.

Structurally, *Bone Talk* began like other poems as a "bag of bits." There were far more desirable words than could be accommodated in the poem – space is always too small, just as life is always too short – so the poet has to start somewhere, commit to a process of condensation, and accept that some words will fall away, including some good ones. This capacity to accept loss of desirable elements, to *mourn and relinquish* them and accept limitation, in Klein´s terms, is part of the learned skill both of writing a poem and of becoming an adult – a skill never acquired once and for all, but learned and relearned through practice and courage, in the face of a persistent unrealistic, childish desire to include everything, have everything, lose nothing.

At this stage, the poem wasn't laid out in sentences, but existed as groupings of words and phrases, fragments scattered on the page or in the electronic document in the kind of loose arrangement which is my habit when beginning a poem: 6 or 7 stanzas of 3 to 6 lines each. Each

fragment was a complex of raw material loosely rendered or elaborated by early personal responses. Individual words, newly arrived into my internal world, laden with imaginative potential and promising double meanings, are, by the time they reach the page, wrapped in traces of my own thoughts or feelings. Like digestion, or immunological processing – the rendering and presentation of newly invading material in combination with "self-representative" proteins, so as to enable future intrusions to be met processed with minimum dysregulation – these words are "rendered" for personal use.

This composite material is still much too raw for inclusion in the final product, but I now have my work laid out: the work of making the poem will require (as a process) and become (as a product) the integration of these two, inner and outer reality, in a manner presentable to a third party – a reader. I must "format" the biologically real subject matter of bones and the physically real medium of words via the filter of my responses, so as to imbue them, but not overload them, with a trace of my human presence or liveliness. The aim is to enhance, but not overload, the subject matter with personal responses. Having been disturbed and excited by the material, my inner world must go to work to reassert itself; a negotiation must be brokered between inner and outer experience which leaves room for the authority of both; in other words, a working intersubjective space must be carved out of the slippery and resistant material of words.

The idea that bones are breakable suggests itself, as a matter of biological fact, early on in the process, hence the idea of fragility crept in to even the earliest drafts. Rapidly, fragility took over as a theme, re-emerging in the final stanza´s violent imagery, and offering an architectural "arc" for the poem´s development. "Twisted as a green stick", and "dry as a biscuit," images referring to types of fracture – seek to ground a poem which is otherwise threatening to be too dreamy and loose.

As the poem develops, I dive down into a kind of enquiry into the subject matter. It is as though I were asking myself, or as though my conscious mind were asking my unconscious mind – which is full of images and associations and a different kind of knowledge about how things connect – what it "is" about bones that might be worth saying. What is the *point* about bones? What is it that bones might metaphorise? My answering of this question inevitably takes on the mark of my own preoccupations.

In a way, the word game or exploration with which the writing began is morphing into a self-analytic enquiry into my own original interest in the words, much as a therapist might enquire more deeply into a patient's surface response to a question. *What's this about, really*? I seem to

be asking the poem, and although it ostensibly relates to what *bones* are "about," the answers come, willy nilly, in terms of what they represent for *me*, and therefore about *what I am about*. Instinctively, inevitably, as all of us do with all materials at all times, I project my imaginative, psychological world into the material in hand. The poem, therefore, comes to reflect me as much as it is a reflection on bones. It becomes what Winnicott called a transitional space – bearing the unmistakable hallmarks of both me and not-me.

The particular preoccupation I find has been stimulated by the bone words and their associations, and which I find myself projecting into the material is a kind of meta-psychological interest in the self, and the integrity of the self. The self´s fragility and strength. How do those relate to each other? Where does the boundary lie? When and where do you need to pay attention lest something dreadful happen? The bones are still present in their own right, but are also beginning to become a vehicle for something else. They hover in the poem as both literal and metaphoric, taking on an imaginative multidimensionality.

So here I am, in the middle of the poem, wrestling with words, just as the tissues wrestle with bone matrix, undermining, tugging, and straining to find my own safe passage through the medium of the poem, seeking to bring awareness to bear on this material. It is an act of penetration, or imposition, but in order to work, it must also be a collaboration: the words must remain true to the bones, and accessible to a reader, not simply overloaded with personal material.

As I write the second and third stanza, these hidden preoccupations begin to emerge. My conscious mind is busy with bony landmarks and their anatomical and functional importance, as doctors, or medical students know them; which tendon or muscle attaches where and what this means functionally. But while my conscious mind is thus occupied, and therefore in some sense "out of the way" - as T.S. Eliot suggests the conscious mind needs to be for a poem to emerge - other, associative thoughts and images are bubbling up like dreams in the "back room" of my mind: my unconscious mind is engaged in a kind of reverie or meditation on *containing-structures-which-when-stressed-are-strong-but-not-unbreakable.* An imaginative abstraction is taking place, without fully letting go of the bones-as-metaphor: a discourse about forces, containment, and breaking points is taking shape within the armature of the bone-ideas. I am scanning my awareness for other instances of these things, in a way which feels more intuitive than idea-driven: more emotional than mental. The conscious mind, trained with difficulty into a degree of humility, for these purposes, seems to be enquiring respectfully of the unconscious: *what does this remind us of?* As these deeper concerns emerge, I can feel a space opening up

inside myself and inside the poem´s structure – a resonance chamber between literal and metaphorical meanings.

As my work with the poem develops, the worked and re-worked conscious, subject matter of the bones and the muscles, itself becomes a temporary container, or chrysalis, within which something softer and darker and less consciously formed begins to emerge. I know from experience that this emergence is important in bringing life to the poem. I also know that I cannot control this in a fully conscious way.

Some poets talk about this process in terms of "listening" to the poem and its images. Even that almost sounds too much like an active project that the conscious mind can drive. It feels to me more like a divining or dowsing process, less like an active, questing stance and much more of an open, expansive, soft, receptive stance: something more like an antenna tuning into different frequencies, or a mid-cycle endometrium preparing to receive an embryo.

From out of this “deeper divining,” the idea pops into my conscious mind of “the marrow's quiet ebb and flow, the circulation of class and blasts” – language borrowed from craniosacral osteopathy, in which it is customary to palpating the craniosacral rhythm – a practice I was once invited to try. In terms of the writing, this seems to be an expansion and blurring away from Western medicine, and into less conscious, more instinctive parts of myself.

The poem, or rather my writing process, then takes a series of sudden and probably ill-judged turns from an Old Testament reference to Ezekiel's Valley of dry bones to a sudden, shocking reference to the shackled bones of children found in an orphanage cellar at Haut de la Garenne. A doubtful and loose stanza ends with an injunction, apparently to the reader, presumably in fact to myself, to take care. I appear, suddenly, to be trying to get at something – somewhat clumsily.

Each time unconscious process has interrupted the conscious mind's play, the resulting countercurrent has begun to open things up, and the poem has become more three dimensional and lively. This requires a kind of acquired or learned humility on the part of the conscious mind; a willingness to set aside its up-front shaping-and-structuring ambitions for just long enough for something new to emerge. It involves a willingness to tolerate the relinquishing of control, and the surrender to uncertainty, a psychological risk, precisely because each permitted incursion of unconscious material brings, along with liveliness or depth, the risk of greater chaos, of of spoiling what is already there. In addition, every new uconscious incursion entails more

integrative work, to integrating the structure of the work. In this case, it seems, the new material, like the Ezekiel reference, seems to go too far, breaks the structure of the poem, and spoils the work already done. Creativity is not a recipe for success but for liveliness.

The conscious mind, present throughout the process though not always in control, acts in the final stages as the elected ambassador to the outside world, with special responsibility for taking care of the reader´s experience. The conscious mind is the poem´s first reader and editor – the more critical, the better – and is on the lookout for bad notes, lazy or self-imitative habits which do not serve the poem. In this case, for example, the critic vetoed a sentimental use of the word “cherish," separated out the penultimate line for emphasis, debated about whether it should be “you” or “they” who shattered. It required revision of a habitual use of an injunction – “listen!” as a device for changing the emotional energy of a line, because it did not fit and was more of a self-important flourish which got in the poem’s way. *Work a little harder to be faithful to the poem,* the editor urged. *Stop trying to impress*. As I work on this individual poem, or any individual poem, I am also challenging myself to develop as a poet.

The whole process reminds me of learning, while training in psychosexual medicine, to set aside interventions which served my need to "feel useful" more than the actual needs of the situation. A tendency to say too much, for example, to take up too much space in the conversation, to try and "take over" thinking on behalf of the patient, or to adopt so empathic a role that I deny my patient the space to feel the anxiety or space in which they might - usefully and properly - discover something new for themselves.

What is the point of a self-analytic exercise such as this? Clearly, understanding where a poem came from and why is not its point. It is not necessary to understand the poet´s writing experience in order to appreciate a poem´s weaknesses or merits – once written, a poem, like any art or other piece of writing, must stand or fall free of an umbilical connection to its author, and biographical or psychological background detail is arguably irrelevant to a poem´s value or reception.

The point, I suggest, is that these kinds of reflexive data offer the only kind of longitudinal imaging we have – data gathered in real time, albeit retrospectively recorded - of the interior aspects of creative process. This account attempts to show the real-time building of a poem-material-reader relationship within the person of the poet, in ways which are otherwise invisible and unmeasurable – to show what actually happens when a physical material connects with a thought and a feeling and the three become embodied in something new.

It is all very well examining the effects on a reader of the "facture" of a finished poem, – as I did in the first eight poems – of the physical effect of legato or staccato, alliteration or assonance; vowels ringing with onomatopoeia; pulses like a heartbeat or breath; how a phrase conjures sensory memory and the emotion which clings to that; where a word suddenly fizzes with double meaning, or smacks you in the face after a line break because it is not what you were led to expect. But none of this tells us anything directly about why valuable time was spent creating an apparently purposeless product, and how, privately, the poet negotiated with the material, to persuade or coerce it into the service of feeling-in-need-of-expression. If practical criticism offers a cross sectional view, which addresses the question "what has been done," self-analytic accounts of creative work add longitudinal data answering the questions "why" and "how" of creative processes. They address the question of how, as it were, spirit, becomes embodied in matter. It is a little like fetoscopy.

Such private, psychological data are normally hidden from view in the privacy of the poet or artist´s head or work space, possibly buried somewhere unconscious. Painters have been filmed painting – Karel Appel, for example, whose almost violent engagement with the canvas explains something of the liveliness and spontaneity we feel when viewing his work. [186] But it is of limited value to see only the externally visible objective aspects of what is in part an

internal, subjectively driven process. For deeper insight we rely on contemporaneous first hand accounts, in the tradition of Paul Valery[187] or Marion Milner.[24] And although introspection is prone to recall and self-observation bias, and must be weighed as to its plausibility, internal consistency, and conformity with known external patterns, and aesthetic validity,[171] self-analytic accounts have been important in developing understanding of the process and point of art.

Key Messages

- Reflexive accounts can give essential insight into otherwise hidden creative processes
- Poetry, like other creative activity, demands a mixture of craft and intuition, conscious and unconscious intention
- Poetry is semiotic, embodying and *showing* what is hard to *tell*, semantically
- Poetry makes a reader *feel* something, rather than merely *thinking* something
- It insists on physical elements such as alliteration, assonance and rhythm, where in prose these are optional
- Poetry is seductive - uses pleasure to invite surrender to an intimate, intersubjective encounter
- It makes use of dual meanings, allusion, and unconscious association
- Poetry is capable of being truthful or untruthful, and bad or good

Chapter 4 – Poetic process and purpose

Poetry ... is the revelation of a feeling that the poet believes to be interior and personal which the reader recognizes as his own.
Salvatore Quasimodo

Keywords: rawness, benign regression, conscious-unconscious balance, integration, voicing the inexpressible

4.1 This obscure impulse: where do poems come from?

If we look at what artists and poets have to say about how their work arises, many speak of a raw impulse, need, or burden – Gottfried Benn refers to a *dumpfer, schöpferischer Keim* (nagging, creative seed),[188] T.S. Eliot to *some rude, unknown psychic material*,[189] Szirtes to *a smell*,[169] and Newton, a psychoanalytic commentator on painting, to *the primitivist impulse*.[190] In the last chapter, I outlined the role of such impulses in initiating my own poems – for example, a desire to escape from work into play, to rebel against professional constraint, or to rail against the loss of walking.

Whether artists and poets are particularly vulnerable people who feel such burdens especially keenly, or whether, having learned a knack for turning psychic burdens into cultural capital, they come to view intense feeling as valuable raw material, is debatable. Psychoanalysis has always understood art as a special response to the vicissitudes of experience, but Freud took an arch view of it as a kind of infantile "messing around" – a chaotic, if rich, *primary process* which represents an escape from real life. He viewed works of art in largely reductionist ways which ignored the value people found in them, as mere encoded symptoms of the artist's psychopathology.[191]

Kleinian commentators such as Stokes[192] and Segal[193] [194] presented a more optimistic, developmental view of art´s psychological purposes and achievements as a means of processing anxiety or conflict in embodied form, while object relations analysts, with their emphasis on intersubjectivity as the very condition of psychological development, saw art as an intersubjective phenomenon, involving at least two people from its inception right the way

through to its reception. Winnicott in particular identified it as a form of play, vital to the growth of the individual and culture at large. (Indeed, *play,* in Winnicott´s terms, is an absolute precondition for growth, its absence a developmental emergency which must be addressed before other meaningful work is possible.[195]

But it was Anton Ehrenzweig, an artist-analyst whose psychoanalytic theory arose from his own painterly practice, who developed the first coherent psychoanalytic theory of the creative *process,* and its relationship to the quality and success of the artistic product.[143 145] Rejecting Freud´s idea of primary process, which had offered no help in understanding either how art is made or why anyone beyond the artist would care for it, Ehrenzweig did two important things. First he identified the balance of conscious and unconscious elements required to make a work of art good, creating a distinction between articulate and inarticulate form elements.[143 144] Secondly, he identified three distinct phases in the creative process which the artist must undergo if the product is to succeed.

In a three stage model from the 1950s, Ehrenzweig, describes this initial impulse as projection – the exporting of primitive parts of the self into the art material in a bid for psychosomatic merging, the boundaries between self and the outside world temporarily suspended.[144] It is a gesture psychologically analogous to the infant´s cry, smile, or outstretched arms – an appeal to the environment for the kind of receptive, containing, interpreting response that will support development.

Unless you become like little children, you will not enter the kingdom of art, Ehrenzweig seems to be saying. In his model, an art material performs a service for an artist like that a mother offers her infant, or a therapist her patient: a benign, tolerant matrix or frame yields and accommodates, but is also separate, substantial, and makes counter-demands, promoting maturation even as it supports and challenges.[185] The artist's inner world merges with the materials, in what Winnicott characterises as a transitional, "me and non-me" space. The infant has permission to merge and muddle elements of himself and elements of the outside world, unchallenged.[181]

For the purposes of a thesis on poetry´s contribution to health, two things are worth reinforcing about this kind of developmental, transitional space. One is the unconditional accommodation or adaptation required initially, and the other is the resistance that must also be offered, if development is to take place. In the mother-infant reverie, inner and outer elements, or self and other, must be allowed to fuse, symbolically. They must not be forcibly, prematurely separated or reduced into separate elements – "analysed," if you will. The mother who makes demands on her infant which he cannot yet meet violates his integrity. Something similar applies to other forms of creative merging later in life. To the child playing imaginatively with a hobby horse, Winnicott emphasises, the hobby horse *is,* temporarily, in a kind of necessary suspension of disbelief, *a horse*, and to assert that it is merely a stick of wood is a violation of the creative reverie.[195] Likewise if a therapeutic relationship is to develop, a therapist must accommodate a patient´s raw "bits and pieces" of thought feeling and action, without insisting on conventional order or common sense. In all three examples, a basic need is met by means of someone else´s grace, rather than via right or reason, but in each case this grace is the absolute precondition for something vital to occur.

So yielding is essential at the outset, and the matrix – the mother, the art material, or the therapist - must be accommodating and welcoming enough to receive the primitive gestures as well as strong enough and malleable enough to "hold" or "contain" them without breaking or retaliating or punishing them. But an inbuilt propensity to offer resistance by "being oneself" is equally essential, because in this, the matrix also functions as a true representative of the outside world. An art material, mother or therapist which/who simply reflected fantasy in a completely passive, compliant way, would be too insubstantial to be useful as a representative of the outside world. A creative medium is initially receptive, but also imposes the rigour of its own inalienable characteristics and limitations.[185 190 196 197]

The analogy between infancy, therapy, and art, only goes so far before we need to draw a distinction in terms of whose mind is fulfilling which function. In this, the artist differs by playing two roles at the same time – one part of the self, as it were, parenting, or helping, the other. Unlike the infant or patient who relies on the external agency of the mother or therapist´s mind to help metabolise unintegrated elements of lived experience, the artist plays both roles in parallel. Having used her external medium or matrix as a repository for her

primitive projections, she then turns to her own more sophisticated psychological capacities to process them. She brings to the material both her primitive projections (her sensitivity to provocation by the outside world´s impingements and demands) and her quasi-maternal, quasi-therapeutic capacity for working through (her material skills and artistic experience). Of course, she is only able even to begin do this for herself with practice, after many, many "doses" of goodness received from creative "foster-parents -" other artists whose examples have inspired and nourished her.

In trying to grasp this process whereby raw experience is welcomed, contained and turned into growth, Bion´s developmental model of the psyche is helpful. If raw experience is not to "stick in our craw," as it were, like a collection of hard, indigestible, and distressing objects which Bion called these *beta fragments* – help must be available to transform them into something digestible and nourishing – in Bion´s language, *alpha particles*. In Bion´s model, the mother or therapist acts as both a receptive psychological "container" plus a mind which can help digest indigestible experience, or, in Bion´s language, perform *alpha functioning*.[198] Given such a space and such a mind, distressing products of indigestible lived experience can be taken out of the embodied self, where they lodge as a foreign bodies or intrusions, and "re-embodied" in shared experience via verbal or visual language, making them bearable and tractable. *A trouble shared is a trouble halved*, as the saying has it. This can be seen of as a kind of "means of grace" – something unearned in any transactional sense, but needed by all of us, at different moments, and received as a gift. And poetry´s gift, when it works, is to speak to and for us about our own deepest, most raw experience; the poet expresses, "in verse – using all his resource, of words, with their history, their connotation, their music – this obscure impulse".[189]

4.1 Wrestling with the angel: joining things up

Eliot asserted that poetry is necessarily *difficult,* a comment Szirtes has interpreted not as an aim, but a condition of poetry.[169] Life is irreducibly complex, Szirtes suggests, and the point of Eliot´s assertion would be that the poet must "make a whole of out fragments and shards." (Szirtes ibid) In other words, if projection – the spewing of a bunch of words onto a page, or

the haphazard attack on a canvas with paint – is a necessary beginning to art, it is not a sufficient end. In order to meet the aesthetic requirements which can satisfy a recipient, and therefore the artist´s own need to be heard, there must be a successful struggle with a material, and facing this requires of the artist a certain stance or disposition of the self.

Elements of this stance are common to any craft, such as surgery, cooking or plumbing – knowledge and experience combined with diligence and close attention to external phenomena – the concentrated giving of one´s trained mental and physical self to a task in hand. But in common with other less utilitarian pursuits, poetry, like psychotherapy, play, or prayer, also requires attention to internal phenomena, a particular kind of open-minded listening, and submission to a process whose outcome (like life itself) is not consciously controllable. It demands psychological risk-taking, and acceptance that success cannot be guaranteed up-front. Hence these activities require, in addition to skill and concentration, a particular humility: a willingness to commit time and energy to engaging with what one can never hope fully to grasp. This state has variously been described by poets and artists as struggling with the octopus[169] or angel.[189]

Returning to Ehrenzweig´s theory, we find an explanation for how it comes about that this octopus-wrestling yields good art, and how it is power-sharing between the conscious and unconscious mind which is the guarantor of that goodness. In Ehrenzweig´s second, *manic-oceanic* stage of the creative process, the work initiated by primitive projection proceeds under the auspices of the unconscious mind. Using *unconscious scanning*, a formulation markedly different from and far more deliberate than Freud´s (chaotic) primary process, the artist is actively but unconsciously *integrating* the work's *substructure*. As the work develops, *articulate form elements* – those obviously articulated structures and shapes which are created by the conscious mind and will present themselves to the recipient´s conscious awareness – are, crucially, balanced with *inarticulate form elements.* The latter emerge from the artist´s *depth mind,* and are essential to aesthetic depth and integrity, addressing the observer unconsciously at the same time as the articulate form elements address him or her consciously. In painting, inarticulate form might reside in textural elements such as brushstrokes, impasto and apparently random marks or drips; in musical performance, in glissandi, vocal breaks, and other unscripted physical phenomena. In poetry, it is so-called

poetic devices, such as alliteration, assonance, rhythm, repetition, onomatopoeia, and double entendre which carry the poem´s emotional weight, addressing the listener physically and emotionally, unmediated by cognition.

This piece of theory represented an important development in understanding creativity. Via Ehrenzweig´s acknowledgment of the essential role of regression and unconscious structuring in art, psychoanalysis had for the first time delivered an account of the value and processes at work in art, in terms which artists and art lovers recognised.[190 197] I suggest it also provides the basis for understanding the risk which creativity entails, and allows us to explain why creativity is therefore resisted, within individuals and organisations. Ehrenzweig´s contribution is to clarify that creativity *requires* regression – a compromising state associated with infancy and other forms of powerlessness, generally felt to be incompatible with power in the adult world. Even artists contemplate it with ambivalence: Stokes describes the anxiety which attends the aggressive act of defacing a virgin canvas, in the full knowledge that once made, the infraction will have to be made good.[192 194] My own ninth poem from the previous chapter, *Bone Talk,* bearing the embarrassing hallmarks of not-quite-succeeding, exemplifies the risk of loss of face. Because the necessary *manic-oceanic* phase of creativity is outside conscious control, it is by definition unamenable to systematisation and instrumentalisation, hence it is not possible to guarantee outcomes – even if this is how you earn your living. No wonder we resist creativity: Failure can have existential consequences.

Because creativity occurs beyond the protection of guarantees and existing security structures, it carries existential risk. Hence, if it begins in sensitivity and vulnerability, it is completed in resilience. This balance is important to understand, because it determines how far – up to what precise point of intersection between desire for freedom and need for safety – we are willing and able to go, as individuals and groups, in developing ourselves creatively. The questions we all face are: *How much predictability, equilibrium, comfort, and protection will we sacrifice for the sake of liveliness and renewal?* And, on the other hand, *How much constraint will we accept for the sake of safety?* At one end of the spectrum lies alarming, Nietzschean abandonment to creative chaos; at the other, the stifling predictability Bollas has

called “normotic illness.” Life can be seen as an excercise in navigating our own sweet path between the two.[199]

In a master´s thesis on rawness in visual art,[23] I proposed the notion of an individual sweet spot between chaos and normosis as a tool for thinking about the psychological relationship between the so-called inherent value of a work of art, and the stylistic preference of the observer. Different observers prefer a different visual balance between “finish” and “rawness” in painting, or in poetry, between what is said explicitly and what is only implied, felt or left open. But if preference varies between individuals and groups, how can there be such a thing as goodness in art? What do these taste differences actually reflect? Why is one person´s “accomplished, fine art” another person´s “chocolate-box cliché”, while one person´s “brave representation of difficult material” is another person´s “horrible mess”? And how is it that so much art which later becomes canonised[200] begin its life by being resisted and reviled?

I suggest the mistake we make is in the shorthand of seeing “goodness” as a fixed property of a decontextualised work (albeit one which we can if necessary agree to disagree about), without seeing the part we play in co-constructing the experience, with our own preferences and projections. To consider quality in art more precisely, I suggest we need to see it as an embodied-relational phenomenon – a material entity which is acting more or less successfully as a relational vehicle. Goodness then becomes about the quality of communion a given work affords between a given artist and a given recipient, or range of recipients. Quality still depends crucially on the work and the artist, but is only ever realised in terms of the scope of its capacity to communicate. Fixed notions of right and wrong can be replaced with more dynamic notions of sensitivity and fit.

“Goodness” in art, I suggest, occurs when the artist´s successful struggle for self-containment and self-articulation is sufficiently palpable as a kind of “souvenir” in the work, but also sufficiently cleansed of the artist´s narcissism to serve as an account of the recipient´s (or a culture´s) own experience. The extent to which these conditions are met differs not only between individuals, but also within individuals and cultures and over time. This model explains how a work initially encountered as confronting and objectionable – *bad* – might

later come to be appreciated deeply. It highlights how the rejection or embracing of a work of art can arise, far from pure objective observation, also in either mature recognition, or in immature rejection of the unfamiliar. Some work is loved at first sight, and some, never. Some work – Bach, or Shakespeare - achieves a level of aesthetic generalisability or external validity so deep and wide that it elicits almost universal gratitude.

To achieve such intimacy with many unknown individuals is an extraordinary feat of empathy. Rogers described it as a high-wire act between the dangers of subjectivity and objectivity: too much regression, and the work´s symbolism becomes private and the work "auto-erotic" or masturbatory; too much control and the work becomes cold, mechanical and untouching.[201] The more ambitious the project, Rogers argues, the greater the need for control, the combination of deep involvement with high control offering the recipient the greatest satisfaction.[201] By contrast, wherever creativity becomes uncoupled from "external object relationships" – that is, relationships with real people – wherever a poem or an art installation disregards its real reader or an artist its real viewer, it forfeits its power and status as "art" at all.[190 202 203]

Once in the manic-oceanic stage, the poet is not so much concerned with the product as with the process of voicing the obscure impulse: "finding the right words, or anyhow, the least wrong words."[189] The poet is by now in a kind of labour or trance –"oppressed by a burden which he must bring to birth in order to obtain relief" haunted by "a demon . . . which, with words, he must exorcise."[189] In other words, he is going to all that trouble to gain "*relief from acute discomfort*" [my italics].[189] No wonder Newton referred to this surrender to primitive parts of the self as a kind of "intrapsychic revolution".[190]

Again the need for humility is clear: "The first effort of the poet should be to achieve clarity for himself," who "does not know what he has to say until he has said it".[189] This involves stretching towards something as yet unknown, confronting fear, persisting when the going is hard, and perhaps being rewarded with a sense of mastery. Szirtes captures the instinctive, material-responsive process of making a poem in an extended skating metaphor:

It sets out across the ice and begins to cut light patterns in it, following some trainable instinct about the direction and way of moving, the notion of meaning arising out of the motion of the dance as a series of improvisations on the pattern. These patterns present the poet with a number of apparently arbitrary possibilities at any one time. But that is the very nature of language: it is what language continually does. The poet's patterns, the twirls, wheels and whips of the dance, invite the chance interventions of language: you end a line with the word houses, say, and you are soon invited to consider the possibility of trousers or blouses or almost anything that carouses. [169]

Szirtes insists that the poet is not trying to dress up a pre-existing meaning, but to *write the best possible poem starting out with some as yet incoherent perception relating to an experience or set of experiences*.[169] The reward, when it goes well, is being there when something new and lively emerges.

4.3 Learning how to die: the final separation

For a poem to be completed, rather than being left an unfinished, overwritten or self-indulgent mess, there must be constraint. There must be structure, of some sort, however loose, and that must relate to what a reader might be expected to tolerate and appreciate. Not only poor quality material but also good, highly desirable material must be left out – something which requires a capacity for mourning and letting go, demanding maturity, or what Klein terms the achievement of the depressive position.[182] In this sense, a good poem mirrors a life well lived, one in which promising beginnings have been brought to fruition to an extent which is necessarily limited, while the unattainable has also been mourned and relinquished. Montaigne asserts that *to live well is to learn how to die* [204]: gradually, we accept the limited condition of our existence; gradually, if things go well, we mature into the acceptance of loss and suffering as part of love and life, relinquish an infantile[182] insistence on "splitting" experience into the parts we like (success, health, pleasure, beauty, and life itself) and those we disavow, relinquish our infantile grasp on half-truths an part-objects,[182] embracing a truer and more complete version of life. Segal, exploring the relationship between art, daydreaming, play, and creative thinking, emphasises that the successful artist,

as distinct from the failed artist or daydreamer, must have a strong hold on the psychological maturity of the depressive position – a highly developed sense of reality – a highly developed capacity to face and deal with ugliness, pain, and death.[194]

Constraint in a poem is, as in life, not artificially imposed, but inheres in the material. To differing degrees, depending on the form chosen, limitation is present in both the subject matter and what the words will allow. So while the "art materials" of language offer the poet a welcoming space for challenging subject matter, they also push back, and make demands of their own – in the same way a mother also makes gradually increasing demands on her infant by being only *good enough,* not *perfectly adaptive;* by representing, therefore, the outside world, as well as fidelity to the infant himself. Eliot is clear about the strictures which everyday language imposes on the poet, despite poetry´s special status as a musical elaboration and adaptation of everyday speech. Even free verse is not a revolt against form per se, he argues, but against *dead* form. The poet must always follow *the ordinary everyday language which we use and hear.* Its music must be *a music latent in the common speech of its time,* and the poet must "*use the speech which he finds about him*.[189]

Ehrenzweig describes this final, integrative stage of creative work as *reintrojection*. What began as projection and continued as an unconsciously guided struggle with the materials, is finally resolved and assimilated consciously. Back under the auspices of the conscious mind, *part of the work's substructure is taken back into the artist's ego on a higher level.*[144] The work is finished, or rendered fit for an audience. Szirtes calls this the *final separation of the poem from the author*[169] – the moment of umbilical severance; the final letting go.

Poetry is inherently intensive rather than extensive, and economy is essential. Part of a poem´s vitality derives from the absurd challenge it takes on of saying more than can be said in a restricted space using a restricted material. Intense subtraction, omission, and condensation are needed. "Extra" words – if only one can work out which those are – dilute and "damage" a poem, rendering it as incompetent as a dilated artery, sclerotic valve, or atonic uterus. No wonder a much cited piece of advice to aspiring writers is to *murder your darlings*[205] – sacrificing even fine words and phrases for the greater good of the whole.

Szirtes uses the metaphor of skating, and I also find the gravitational image of slalom skiing helpful: the irresistible force driving the skier down through slippery terrain forces moment-by-moment, intuitive decisions. Not everything is possible, and constraint drives commitment. Beginners are taught to *let the skis hop*, finding a single, effective, perhaps even graceful, way through and down. An effective poem mirrors the living of a life – a short, precious thing which we cannot *get right*, but must busk our way through, improvising for dear life, in the face of uncertainty.

4.4 Your organs: what poetry does for the poet

The poems in the previous chapter each took a dilemma or discomfort, dramatised it, and turned it into a form of critical-creative discourse on subjects such as the balance between objective and subjective experience, professional and personal language, honesty and lying, and humanity and brutality, in medical practice. They gave me somewhere to place and make sense of my concern. Like a patient entering therapy with an irksome puzzle, I found in poetry not a panacea or way of getting rid of my dilemmas, but a space and a language in which to meet them.

Making sense of experience – *making one´s own affairs plain*[126] – is understood to be essential to health.[81] Poets have variously described this self-reparative function as *a secret and subversive pleasure*,[169] *putting pain in a story*,[206] or *a last attempt at order when one can't stand disorder any longer*, and *not one of the last but of the first things of man*[207]. It is in this capacity to transform one´s own nagging, rude impulse into relief, to spin pain into pleasure, and difficulty into recognition, that an artist´s moral and existential value to the wider group or society lies.[169] [173] After a while, Szirtes says, *it becomes who you are. It becomes your organs. You need your organs.*[208]

4.5 Voicing the unsayable: what poetry does for the reader

I have characterised a poem as a way of voicing something elusive, and as the trace of an intimate human presence – a vehicle through which experience can be passed between individuals who may never meet. For Eliot, poetry affords the reader *some new experience, or some fresh understanding of the familiar, or the expression of something we have experienced but have no words for, which enlarges our consciousness or refines our sensibility*.[189] For me as a reader, what matters is not that the poet communicates *his* experience to me, but that he captures *my own.* Based on the blueprint of the poet´s experience, if this is made sharp and spacious enough, I rediscover my own unarticulated experience. Any ballast or baggage which ties the poem down to the poet will have been excised, setting the poem free to be used by others. At the same time, the poem will avoid vague generalisation – it will be firm, clear and palpable. Like a sail, it will be both firmly fixed to the poet´s experience, and still free to fill up with the unchannelled wind of my experience. The poet´s specific personal experience, crucial to the poem´s genesis, will have been filtered, clarified and universalised, to make it a vehicle also for my experience.

In addressing the reader simultaneously at the level of thought, feeling, and body, a poem offers the kind of rare holistic experience otherwise associated with the intimacy between mother and infant or lovers or with religious experience. It momentarily enfolds our rudeness and our sophistication, our thoughts and our feelings in a single, containing whole; for a moment, we can both be ourselves and feel close to another person or even a wider web of mutually sustaining humanity. So while poetry is no panacea, it is the unmistakeable sign of a human presence.[169]

In a world preoccupied with utilitarian outcomes, it is worth pausing to wonder at the high value we place on a supremely non-utilitarian pursuit which “merely” frames and acknowledges our experience while solving nothing. As doctors, we should ask ourselves how it is that the act of touching unflinchingly and skillfully on the most tender spots, far from weighing us down, brings relief. Szirtes, who describes poetry as a form of truth telling, argues that the *task of poetry is to tell the best truth it can about whatever it happens to be dealing with.*[169] Could it be that we experience not-being-lied-to about matters of importance as an act of love or respect or kindness? Could it be that like other gracious forms of relating, poetry

has a capacity somehow to *make well* things which cannot be *fixed*? To *heal* even though it patently cannot *cure*?

4.6 Why poets are persecuted: why poetry matters

Since poetry has the capacity to shape and influence mainstream language and thought, to define what is *ours*[189] and therefore who *we* are, to affirm or challenge identity and to speak uncomfortable truths, it is easy to understand why it may be feared. In the 1950s, the speaking of Sami languages in schools – viewed as threatening to Norwegian values - was forbidden, but joiking, a poetic or song form, remained alive as a means of affirming Sami culture. It is always futile, according to Eliot, to try taking from people their language and compelling another upon the schools, because *unless you teach that people to feel in a new language, you have not eradicated the old one, and it will reappear in poetry which is the vehicle of feeling.*[189] Poetry often insists on both a more local and a more universal sensibility than that embodied within cultural conventions and political regimes – a kind which can be rediscovered in the diverse and particular which may precisely threaten the more narrowly generalisable and mainstream. Poetry may invite or facilitate non-conformity of thought and feeling – indeed, if it did not, one might accuse it of unoriginality and purposelessness.

So poetry´s power to move, its specificity as a means of pursuing truth, is connected with its capacity to change and disturb. We have seen how poets vigorously resist definitions of poetry.[209] We have seen poetry´s propensity to cross boundaries and break taboos – the way it thrives on playing with what is supposed to be taken seriously, on questioning and interrogating authorised ways of seeing and speaking. Its capacity to play, to repurpose, to recontextualise words, for example, technical medical words; its propensity, like religion, to point to or hint at important things which cannot be seen or grasped directly.

If poetry can help people see and say things they might otherwise only have felt dimly, then it has the capacity to betray the secrets and challenge the party lines which protect group or family identity. It may at any moment name the children´s bones in the cellars of our

collective awareness – the inconvenient truths or concealed abuses. One need not ascribe a positive or negative value to poetry to realise that in the hands of an enemy, it can be a weapon.

So if poetry can be a revealer of matters we have hidden from ourselves, our response to poetry´s intervention will depend on what we have to gain or lose by the restorative process. Awareness simply forgotten in the flow of concentrating on other things may be welcomed back easily or even with pleasure, but other material we have built a personal or collective life over the top of denying – inconvenient or threatening data – may represent an existential threat, provoke terror, undermine our sense of coherence and control.

Bion speaks of the powerful and primitive "survival" responses of splitting and projection which occur in a group when unbearable unthinkable elements of experience become actively split off from consciousness, and lodged in other people.[210] Group psychodynamics takes a particular interest in how particular individuals with particular characteristics are left "carrying" particular forms of awareness on everyone´s behalf. In less threatening circumstances, the awareness in question may, for example, be the sense of a need for orderliness and time-keeping, on the one hand, or for spontaneity and creative disruptiveness, on the other. In others, it may be knowledge of abuses or deceptions. The process of analysis – noticing and naming phenomena – becomes the beginning of redistributing awareness more fairly, but can threaten vested interests in an unequitable distribution.

What has this to do with medicine? Am I arguing that all practice and teaching should be constantly guided by the poetic principles of restoring to awareness lost material, under an Ehrenzweigian banner of relinquishing conscious control in the pursuit of deeper creative integration? Am I suggesting we constantly return to first principles and take nothing at face value? Certainly not: we would surely drown in too much awareness and too little action. Suppressing opposition, limiting or focusing attention, and overcoming (rather than endlessly entertaining) obstacles are, within limits, a natural part of realising conscious intention and completing a task. Creativity itself entails cost, and as Schumpeter famously observed,

destruction. If omelettes are to be made, eggs must be broken, and this is a necessary form of brutality.[211]

What I am arguing, rather, is that there are times and places which we need to learn to recognize where things have become so stuck, where collective cultural collusion, or groupthink[210] have so insulated the mainstream from dissonant or disconfirming data, that creative disruption and release are necessary. I have argued, in good company, that this is the situation we face in modern health care, and that so-called *medically unexplained* illness offers a case in point.[49] Sometimes, it takes a maverick or whistleblower or someone with an outside view to name what is missing. Sometimes, it takes a poet to find new words: sometimes, within our own lives, or the organisations we are a part of, it is necessary to allow the smooth surface of things to be disrupted – to take the risk of benign regression and creative extension towards something unsettling but important which may lead to more integrated, more grounded understanding.

4.5 Help for the helpless: a final attempt at order

What I am arguing is simply that there is something in poetry which contains psychological help for the troubled – and that we are all to some degree troubled, as a condition of our shared humanity. Our trouble can be defined broadly to include both the particular and extreme, the universal and everyday, the painful and the pleasurable. But whether it is pain or joy we need to share, it relates to the difficulties of bearing our embodied experience alone.

This may help explain the long standing connection between poetry and medicine,[84] an area of endeavour which entails particular exposure to rawness. Suffused with a higher than average intensity of human suffering, medicine can be seen as a repository of life´s unwanted experiences – those we find hard to accept and integrate and which leave marks on the self: pain, loss, frustration, malfunction, and death. The “wounded healer” archetype, originally

applied to doctors, has also been claimed for artists – individuals whose pre-existing psychological vulnerabilities equip and predispose them to play a healing role for others.[212]

And that was how this work began – with a doctor-artist seeking to survive rawness at work while remaining alive, sentient, and humane; looking to avoid the self-brutalisation of mechanical, inhumane responses without burning out or becoming overwhelmed. Looking for ways to practise medicine as both a science and a humanity.

Key Messages

- Art, including poetry, arises in a raw impulse, a desire to resolve a conflict or to express something stimulating or provoking
- Art requires a willingness to surrender to unconscious process and a capacity to withstand the anxiety this entails
- Like science, art requires close attention to external phenomena, but in parallel, close attention to one´s own responses
- Goodness in art arises when the artist´s struggle for self articulation is sufficiently palpable as an emotional ”souvenir” in the material, but sufficiently cleansed of the artist´s narcissism to hold the observer´s experience

Chapter 5 – When bodies speak

I was much further out than you thought

And not waving but drowning

- *Stevie Smith*

Keywords: psychosomatic expression, intersubjectivity, contained space, therapeutic boundary

5.1 Psychosomatic symptoms as incomplete communication

In the chapter which follows, I will present psychosomatic symptoms as a form of partial or blocked communication – a muffled cry for help which needs creative and open minded attention in order to be understood. I will show how with the right stance and skills, psychosomatic symptoms, exemplified here by psychosexual symptoms, can be read as a hidden story in need of a listener.

First, we should acknowledge that this is an area where terminology has been difficult. *Psychosomatic* means different things to different people. Although innocent enough in its etymological origins, where it simply points to the indissoluble connection between mind and body, the word *psychosomatic* has frequently been used in confusing, stigmatising, and uninformative ways. Some commentators use it broadly and neutrally to refer to all illness where there is a significant interplay between emotional and physical distress, such as angina pectoris or severe asthma. Many use it to refer to purely symbolic, historically called *hysterical* illness, such as medically unexplained pain syndromes. But worst of all, clinicians uninterested in mind-body connections but reluctant to admit lack of understanding have used it to imply *illness which is not real* or *illness in which I am not interested*. This makes it, in turn, difficult to raise as a possibility with patients, who reasonably enough resist a diagnostic label which they fear may condemn them to therapeutic disinterest and nihilism.

This terminology-creep is particularly unfortunate given that all illness is to some extent psychosomatic. We blush with shame, and tremble with anxiety. Myocardial infarction is associated with *angor animi.* And while it is, of course, perfectly possible to deliver a distressed baby or remove a tumour without recourse to a psychosomatic model, no competent or humane clinician would delude themselves that obstructed labour and cancer are purely biomedical phenomena, free of psychological and social dimensions. The fact remains that while many illnesses can be treated successfully by a combination of biomedicine and ordinary human kindness, many others simply cannot helpfully be thought about at all without a psychosomatic model. This includes most of those we call *medically unexplained*, almost all sexual problems, and also a great deal of multimorbidity, where common psychosocial risk factors may drive a multiplicity of apparently unrelated illnesses. Rather than invent new words, I propose for the purposes of this discussion to reclaim the term psychosomatic at its face value, to mean simply illness where mind and body are interacting to produce real symptoms – illness where we cannot helpfully split the two.

Sandor Ferenczi, the Hungarian psychoanalyst often regarded as the father of psychosomatic theory, argued that *When the psychic system fails, the organism begins to think*.[213] In his account, unprocessed psychic distress manifests as real, often incapacitating physical illness, as the body is left to articulate what cannot be expressed in any other way. This focus on *symbolic* forms of bodily communication has formed a core element of psychoanalytic and psychodynamic approaches, and the cases which follow illustrate its diagnostic and therapeutic potential. But we should remember that chronic distress, as well as causing emotional and psychosomatic distress, also impacts the body in literal, biological ways. Dysfunctional or abusive relationships, chronic overwork, lack of control over one´s own destiny, loss of meaning in life, and other forms of chronic stress eventually overcome the body´s ability to cope, driving risk, disease, and death. The psychoneuroendocrinological and epigenetic mechanisms by which this occurs are increasingly well understood.[214 215] The ways in which life experience affects health, biography affects biology, is not only relevant to those of us interested in psychosomatic illness in a narrow sense but affects all of health practice and policy.[47]

We could think of psychosomatic communication as a theatrical gesture – a piece of improvised, incomplete poetry or theatre – an instance of what the philosopher Julia Kristeva called *semiotic* communication where ordinary *semantic* reporting has proved impossible[170] – a sort of non-verbal cry for help like that of Stevie Smith´s struggling, misunderstood man who was *Not Waving but Drowning.* Understanding psychosomatic symptoms as incomplete creative communication is useful, because it explains why empathic imagination is essential to treatment, and why non-creative, purely scientific or reductive approaches simply do not work.

A theatrical performance or poem gains its power by embodying something emotionally important in physical terms, and addressing an audience or reader in emotional and physical terms at the same time. These holistic forms of expression invite, or perhaps force, the observer or reader to feel and think in parallel. But unlike a successful poem or piece of theatre, which we can enjoy as a complete communication on several channels at once, a psychosomatic symptom is neither complete, nor heard. Precisely the reverse – the story has become somehow blocked, and is not making sense either to patient or other practitioners. External help is needed because the block is causing distress, and that help involves creativity. The task of psychosexual medical treatment is to help a person first complete the job of expressing, and then hearing, his or her own story.

In psychosexual medicine, this is done using the combined skills of medicine and psychodynamic therapy, in a process which requires the practitioner to think and feel at the same time. The practitioner reflects on and integrates both subjective and objective data, using two different ways of listening, based on two different theories of knowledge or epistemologies. The empirical approach of biomedicine which captures and analyses objective, external data is complemented by the hermeneutic approach of psychotherapy which captures and analyses internal and subjective data. Each approach is relevant to understanding illness and health,[81] but the two became split during the history of philosophy and developed in ignorance of each other.[216] But many areas of health, including medically unexplained symptoms, multimorbidity, and psychosexual medicine demand an integrative approach. Let us look at some examples.

5.2 Case report 1: **Woman with dark glasses**

"Can I help you?" I heard the receptionist say, as I walked towards the clinic waiting room to meet Emily and Dave, and I heard Dave reply, "Well, I certainly hope so – no one else has been able to." I feared a challenge.

Emily was not, in fact, wearing dark glasses – that bit is an elaboration, in memory, of her extreme fragility and defendedness – though she may have been walking with a stick. But she rose to her feet slowly and with some difficulty, as though arthritic or elderly; and Dave, at fifty-something ten years her senior, sprang to her aid.

The referral had been for Emily, whose long-standing difficulties in having sex were now interfering with the couple's desire to have a family. But they had made it clear on the phone that they would both like to attend. I invited them both to tell me about what had brought them. "It's me" said Emily, confessional: "I find sex painful. Impossible. The thing is, I go to the chronic pain clinic . . ."

A story unfolded which seemed much wider and more intractable than a specific sexual difficulty – a story featuring several kinds of musculoskeletal pain which made sex uncomfortable in her whole body as well as vaginal pain, pretty much everywhere, on penetration. My heart began to sink. There were several doctors and even a counsellor in the story, all of whom had failed to help – some were characterised as well-meaning but impotent, others as unkind or uninterested. I saw pitfalls everywhere, and feared walking across land mined territory only to join the company of inadequate colleagues.

Conscious that I was working with a couple, I made repeated efforts to turn the conversation to Dave, but he simply referred me back to Emily's distresses. Sadly, tenderly, he described how Emily had had to give up her work as a textile designer, and her piano-playing, at which she was very talented, he said. The three of us agreed that somehow or other Emily's passions had become stymied, right across the board.

On enquiry, Dave said he loved Emily, would love to be able to make love with her, but was reluctant to push, when it clearly caused her so much pain. Endorsing Emily's account of the many unhelpful doctors, he nevertheless praised Steve-the-physio. I leaped to enquire more about Steve – keen for a hint about how to work with Emily.

Steve-the-physio had, according to Emily, been gentle but also persistent, according to Dave. As the two of them described his work with her, I imagined someone focused, attentive, compassionate, and hard to live up to. I reflected back to Emily my impression that gentleness was extremely important to her and earned a glance of what may have been gratitude, certainly it felt like momentary contact. I felt I had scored a first point in what promised to be a tricky chess game.

What was it about gentleness? Had gentleness been lacking somewhere in Emily's life, I wondered? She began to describe her mother – a critical tyrant: measuring the milk in the bottle in the fridge lest her daughter take too much; criticising her for holding a pen the wrong way or for inadvertently dirtying the waste bin while throwing something away. "Hypersensitive," said Emily – ever since an episode of severe postnatal depression following Emily's younger sister's birth. Intolerant of vulnerability in her daughter, even when ill or in pain, she accused her, wherever it showed of "hypersensitivity". Did Emily feel angry? "Seething!" she said.

I felt relief. I wondered, aloud, whether perhaps Emily´s whole body was now seething – saying, "I'll give you hypersensitivity!" Emily´s assent encouraged me, but we still seemed a long way from our agreed subject matter – sex. My job here was to offer a brief, four-session, psychodynamic, psychosexual intervention, not long-term psychotherapy. My anxiety about the scope of the work and the timescale grew.

I became a bit more explicit and pushy – wondered aloud whether anyone had ever hurt her sexually. "No, nothing like that," she assured me. Physical examination – medically indicated given painful sex, and expected of me as an IPM trained doctor – was smoothly declined – "Perhaps another time." I was getting nowhere and starting to feel disempowered: unsure what Emily's many present physical problems and past psychological distress might have to do with the sexual difficulty; aware that while she might benefit from long term psychotherapy, we had just four sessions to focus on sex; and that, while they had come as a couple, we had despite my best efforts spoken only of Emily. I reflected this imbalance back, suggesting Emily might come on her own next time. But while Dave leaped at the idea, Emily resisted it, wanting him at her side – her protector: perhaps also her defence against working, I feared.

I was surprised when at our next meeting only Emily stood up in the waiting room, after all. She explained she had come alone to answer my question about whether anyone had hurt her sexually. To tell me something that Dave did not and must not know. She said that since we only had four meetings, she had, "better get on with it". But she then stopped. Prevaricated. Didn't

know whether she would be able to tell me; insisted it felt too difficult. I sensed both a kind of game-playing in the prevarication, but also a genuine difficulty in approaching something distressing. Feeling tantalised, I registered an impulse to try and "wrest" her story from her, by brute force, as it were. Instead, I acknowledged the difficulty in speaking, and waited.

Between sobs, a halting, sketchy story emerged of a relationship with a university teacher by whom Emily had been bullied, undermined, and "forced to do things she did not want to" – yes, sexually, she admitted, on direct questioning. Already in her early 30s at the time, though a virgin, she excoriated herself for having been "stupid" enough to allow these shadowy, unspoken, unspeakable things to happen. She became withdrawn and distant, hunched, fearful, and inarticulate; she shook and sobbed, and would or could not make eye contact. For the remainder of the meeting she seemed to regret bitterly having told me her still-sketchy story.

Just as Emily felt "stupid" for not stopping whatever abuses she had suffered, I was left after this second consultation feeling vehemently self-critical: why had I failed to make clear, crisp connections between Emily's distress and her sex life? And to make her tell me more of what actually happened with the bullying lecturer? Why had I got mired with her in this "distress of uncertain analytic significance'" and why, for goodness' sake, had I, a psychosexual doctor and gynaecologist, again failed to examine her (though to do so, given her "abused child" state – had seemed inconceivable)?

To my great surprise, Emily seemed somehow different at our third meeting. Neither the defensive, brittle woman-child hiding behind Dave nor the broken, lonely, abused child of our last meeting, she seemed more adult and composed; said she felt better, and thought she would "come through this". She seemed in touch with her creative, reflective self, had come with dreams suggesting healing, and about challenging her abuser. She took charge of the consultation, and seemed in touch with space, strength, and self-compassion.

From this situation, we were able to wonder how Emily could still have been so defenceless in her 30s. The tyrannical mother re-entered the conversation: and young Emily, smacked for holding the mop the wrong way while cleaning the floor. Emily, buying her own food and keeping it on her window ledge, to avoid criticism; Emily, terrified to remove a sweltering wool coat on a long, hot bus ride on a summer school trip, lest her mother, who had expressly forbidden its removal, find out and punish her. Criticising her father's impotent attempts to mediate, she wept: "I was only little – I just didn't know how to stop it". Still "only little" therefore, when it came to resisting further, sexual bullying from a man in authority whom she should have been

able to trust. Twice bullied where most she would have needed gentleness, Emily was now locked inside a woman´s body "seething" with a little girl´s anger and pain.

Our final meeting yielded the long-postponed examination. It proved something of an anticlimax – little more than an epilogue. I had expected clamped legs, and shrinking up the examination couch – but Emily tolerated examination with no more than a slight wince. We agreed that it wasn't as bad as either of us had expected. "Tolerable discomfort" was the phrase we agreed upon, and it seemed also to describe where Emily was left with her abusive history.

Summing up the work done, Emily said she had known from the beginning that she needed to face this story. She had revisited it, privately, numerous times since our first meeting, and found each facing slightly less painful than the last. She was singing and playing her piano again, interested in a more equal relationship with Dave, less child-like, more challenging. What about sex, I wondered? She pulled a face, as though this question were an intrusion too many: "we're having much more closeness and non-genital sexual contact." And penetration? I probed, gently – because this had been her presenting complaint – well . . . she could imagine it. A shy smile. "Does Dave know that?" "I guess I´ll need to tell him". Emily was setting the pace of things: "In my own space, in my own time," was the message I was hearing, loud and clear, from this now more assertive, more adult woman.

I could not, at my heart-sinking first encounter, have expected Emily to make the progress she did, in just four meetings. Had I known in advance the extent of her problems, I might have wondered whether such brief work was suitable at all. Yet, modest as they were, set against a lifetime´s suffering, these four sessions felt like a significant opening up of space and reclaiming of adulthood, relative to our first meeting.

What did she think had helped? A balance of gentleness and persistence in our conversation, she thought. In the tradition of Steve-the-physio, then. Maybe also the knowledge of the strict time limitation, we both agreed – certainly she had referred to it so clearly as the work evolved that I had at one point decided against my impulse to offer her extra sessions, for fear of disrupting her obvious use of the time frame´s rigour. Indeed, although Emily and I each worked hard with the "content" of the material she brought – she to face pain formerly locked in her body, I to tolerate the anxiety of work which threatened to disempower and overwhelm me – I think "the frame" was the mysterious third element in this work. As therapeutic as any specific intervention I offered or might have offered was the firm boundary: a firmly contained space in which openness to Emily's broad, intractable, more-than-sexual problems, coupled with a

commitment to returning to the question of sex, drove the work forward. Also as an obstetrician, I imagined this frame as a kind of contracting uterus: a benignly rigorous maternal space, such as Emily had lacked. By no means cosy – uncomfortable for both parties – but containing, safe, and essential to progress.

5.3 Radical openness

Long before Emily entered the consulting room, her difficult lived experience was communicating itself through her general practitioner´s referral letter, her husband´s despair-laden opening comment, and her own pained body language. She was offering unconscious clues about her extreme vulnerability, and about her husband´s assigned role as her asexual protector. These clues were far from a full story, without her own verbal account, but could, with the use of a kind of radical, imaginative openness, be gathered as up-front, contextual evidence – factual material with emotional resonance – presenting themselves to the practitioner´s awareness in the form of vague feeling which could be noticed and stored for future reference. I read her clues as an early warning against approaching too close.

5.4 Using intersubjectivity

This broad welcoming of subtle clues, accompanied by emotional self-scrutiny, forms a way of "reading" the other person in the light of one´s own responses. In psychoanalysis this is called *countertransference* – a form of emotional imaging which, like radiological imaging, does not identify a problematic structure with 100% certainty, but is a useful guide to the right kind of further investigation. Right from the beginning of the encounter, the practitioner is capturing objective clues together with the subjective responses they produce, in a process which is neither purely objective nor purely subjective but intersubjective. She is observing and interacting, thinking and feeling at the same time. Subjective responses, such as the practitioner´s sense of Emily´s extreme fragility, are not treated as contaminants to be ignored, denied, or risen-above but as sources of potential information, in a carefully qualified, provisional, hypothesis-generating sense. Maintaining a clear sense of what

originated as fact and what as feeling, the practitioner holds the two side by side in awareness, allowing potential connections to emerge which can be offered to the patient as hypotheses. The practitioner allows feeling to illuminate fact, fact to illuminate feeling, and an inner dialogue between objective and subjective truth to emerge.

5.5 Applied sensitivity

This process may be subtle, but it is not magic: it is sensory, not extra sensory. It is based firmly on observation, but includes observations normally ignored in everyday life or ordinary medical practice. It is *sensitive*, in that like an ultrasound scan it involves tuning up reception of a particular set of real but subtle signals of a kind easily swamped by other data, if not actively sought. Emily´s subtle injunction to *stay away*, alongside the invitation to come close which is implied by seeking an appointment, was a useful beginning.

5.6 Spaciousness

The practitioner´s stance could be understood as one of "hosting" some unresolved subject matter and difficult feelings, to give the patient space to completed the creative work of integrating them. From early in the conversation, the practitioner was preparing inside herself a space for something whose identity she could not possibly yet know, but had allowed herself to sense "between the lines" of the patient´s clues. She was agreeing to encounter this unknown element with warm, open minded curiosity – tolerating the discomfort of sensing something she could not yet name. It was impossible to understand in advance the connection between this "space" and the lack of accommodation which Emily´s childhood needs had been given. Winnicott uses the word *holding*, Bion, *containing*, for these "hosting" roles, which characterise all psychologically developmental relationships, whether between practitioner and patient, parent and infant, or teacher and pupil.[133 151]

5.7 Therapeutic endurance

Insightful interpretation is often how we think of therapeutic work, and this can be the most satisfying and flattering part for the therapist. The conversation with Emily certainly offered occasional, pleasurable moments of interpretive success, such as articulating *gentleness* as a key, missing dimension in Emily´s life – moments which restored in the doctor a sense of therapeutic competence and agency, and mitigated the sense of struggle and mess which characterised other moments.

But the work also brought several prolonged phases of confusion – "not knowing what was happening", "not knowing how to move forward", "not being able to imagine a satisfactory outcome in the time available". This therapeutic persistence in the face of difficulty, or "hanging in", is to my mind one of the most challenging, important, effective, and underreported interventions in therapy. We may overlook it for various reasons: These might include perceptual bias – just as a figure in a painting strikes us more readily than the background, elegant interpretations, obvious defences and neat breakthroughs may stand out more than the texture or background – the matrix, if you will, of "mute process". There may also be narcissistic bias in what we choose to report, too – a natural if unconscious desire to look good, sound insightful, and present work in supervision or group reflection as though we knew what we were doing. But in overlooking the background "commitment to struggle" I suggest we overlook one of the greatest therapeutic gifts in a therapeutic encounter – moral solidarity and emotional role modelling.

What happens when we persevere in the chaotic-seeming passages of an encounter, allowing the patient to make us feel uncomfortable without turning away, tolerating our own uncertainty, I suggest, is that we offer is our own vulnerability, as a form of therapeutic role modelling. By not attempting to remain – or pretend to be – uniformly strong and all-knowing, the secure practitioner is willing to struggle visibly and authentically alongside the patient, offering valuable moral solidarity and creating a climate of developmental optimism. The patient is, then, not alone in floundering, and can sense that it is not she who is stupid – the practitioner is after all also puzzled – but the material which is difficult. But as the work proceeds, she can also experience that *it is OK to flounder* – that floundering can be tolerated,

survived, met with creative exploration, and curiosity, and can lead to greater self-awareness. Consider the particular place of therapeutic vulnerability in the following encounter:

5. 8 Case report 2: On women and gearboxes

"Hello Sandy, I´m Andrew." He was nice-as-pie, well-presented with a warm smile and a firm handshake. I had no idea why the receptionist had thought him angry. "How can I help? Your doctor has written that there have been some problems with sex." "No – not problems really – I´m just not interested – I´ve come because I´ll get earache otherwise!" he quipped. "Well – *she* cares; wants some attention: all I really want, to be honest, is a good armchair." They were married with two grown up kids, and a granddaughter they adore, he related; he plays bass guitar in a band and has motorbikes. Life was pretty good. So why was he here, then? The conversation felt like jousting – a bit like a lad´s game. Search me! he shrugged, then added, breezily, I´m probably wasting your time . . . feel a bit of a fraud!

"But something brought you?", I challenged. "Yes, I´ve no idea really," he shrugged. I was having to work harder than usual to get this conversation going and felt "at sea". Retreating into the familiarity of a more medicalised sexual history, I elicited a flat, factual account of vasectomy, and also diabetes, meaning that now "the mechanics didn't work very well," and it was hard to "get a result." He didn´t say what counted as a "result" and for now, I didn´t ask. Yes, he had tried Viagra – but it gave him a headache and was not worth the bother. The alternative phosphodiesterase inhibitors I mentioned – retreating into biomedicine – those with fewer side effects, raised no interest either – he had no idea what the problem might be, and did not seem interested in finding out.

It sounds like you´re "out to pasture," I needled, searching for a response, wondering where his feelings were. Yes, that´s about right, he smiled, completely unruffled. I tried another tack: if someone could wave a magic wand and fix the erection problems or headache, did he think this would make a difference to his desire for sex? Was it, I wondered privately, all too painful because of the erection problems – was that why he had given up? I felt I was practically "swinging from the chandeliers" in an attempt to get a response, but all he said was: In all honesty? No.

Andrew was firmly in control of the conversation, and I was frustrated and anxious – disempowered by a pleasant man seeking treatment but denying any real problem or feelings. Observing my own discomfort, I commented that she cares and I seem to care, but not him. "Oh, right! Was that the wrong answer?" he said, blasé. Feeling patronised and a little irritated, I nonetheless battled on . . . "What constitutes, "a result"?"

There was a long pause. Then hesitantly, Andrew said: "The thing is, I´ve never been able to orgasm Debbie." His words were powerful, and vulnerable, and shifted the atmosphere in the room: suddenly he seemed uncomfortable, while I registered relief and a sense of connection – with his feelings, and with a story, which might begin to explain his presenting complaint: a story not, after all, only about erections, but about something less technical and more emotional, to do with his relationship with his wife´s pleasure. I´ve been married to Debbie 26 years, he said, I love her. We used to have a lot of sex – used to be at it like rabbits. But I can´t orgasm her. Not really. I could count the times on the fingers of one hand. She can do it herself; we got into a habit early on – I just felt in the way and let her get on with it. It was clear, he said, that she would like him involved in her orgasm, but he was not interested.

What did that feel like? I asked, more gently, feeling for a moment that we might now be on track. I think it's just how it is, he said, calmly closing things down. Yes, but what does it feel like to be in that place? I pointed to a place on my own chair, as if to indicate physically what I meant by being *in* a situation. "Well I just can´t be bothered." Dissatisfied with his slippery response, I tried a third time: "yes, but how does it *feel"* – this time he completed my sentence for me: " to be superfluous to requirements?" he said, his words hanging painfully in the space between us, as though I had wrested them out of him by force. "Nauseous," he said.

Well sometimes it had happened, he said – taking a step back: What did that feel like? I wondered. Good, he said flatly. I said I imagined it might be touching, or quite special – something good, that didn´t happened much. Oh, I´m not very emotional, he said, unmoved. Then as if catching some dissatisfaction in me, he said: " Am I saying the wrong thing again?" There seemed to be both pain and pleasure in the room, now, but it was I who seemed to be feeling them, while he remained flat. I reflected, internally, that it seemed a struggle to get "hold" of him in the conversation and felt a bit anxious. I wondered whether *he* felt anxious in relation to Debbie.

Partly as a matter of clinical routine, partly in escape from this difficult conversation, I proposed physical examination – "no problem" for Andrew, who stretched out on the couch, arms above

his head, teasing me that he hoped my hands were warm, maintaining control even while undressed. I was more than usually businesslike and brief, perhaps in response to some embarrassment of my own at the intimacy of genital examination; perhaps also reflecting this mechanically-minded man's discomfort about sexual relating. Abdominal and genital examination were unremarkable. Except that at the end, Andrew sat up abruptly and said: "I´ve really got to sort this out, haven´t I?"

I asked him where he felt his passion went – if not into sex. I´m not passionate, he said. I wondered, privately, if "not caring" is a way of expressing anger at feeling superfluous. "It's funny that I can't be bothered," he volunteered suddenly, "because I'm not like that about mechanical things . . . gearboxes, for example. I do prefer mechanical to biological systems. I´d be perfectly happy to stay with a gearbox problem till it´s fixed – with Debbie's orgasm, I can´t be bothered." He said it almost smugly, and I, maybe irritated on Debbie´s behalf, or maybe on my own, played devil´s advocate: Why? Was it that gearboxes were more interesting or important? "Of course not!" He threw back, needled.

We explored the higher stakes, lower confidence, and more uncertain outcome associated with the orgasm, compared with the gearbox. The way uncertainty combined with a sense of responsibility and wanting to get it right made the sexual exploration harder to stay with than the mechanical one – harder to know where you were. I knew the feeling – from the here and now of the doctor-patient relationship. I wondered aloud whether the key task might precisely be to stay with not knowing how to do things. Andrew shifted the conversation to manuals. Slightly boastfully, he told me he never used a manual because he doesn´t need them. And that if a thing is user-friendly, you shouldn´t need one. He was back in his element, and away from the sore spot of Debbie´s orgasm, and from contact with me.

I commented on his language: "user-friendly" . . . "getting a result" – clinical, distancing terms, I suggested. "Oh, have I said the wrong thing again?" We seemed to be handing the discomfort back and forth between us – the more I found my feet in the conversation, the more uncomfortable he became, and vice versa, until tapping on the table nervously, he said, "I´m tapping on the table." "Are you anxious?" I asked. "Yes." "Do you know why?" "Well, some of the things you´ve said . . ." "What have I said that's made you anxious?" "Well, we´ve talked about why I´m here. I suppose. That, and the gearbox conversation." "Well, I suppose maybe that's some sort of a result," I quipped, laddishly, nervously.

Almost to my surprise, he accepted my offer of a series of further appointments. In the waiting room, in front of the receptionist, in a gesture that seemed suddenly, uncharacteristically intimate, he said: "Thanks for listening".

This initial session had seemed like a long football match. Andrew had been a slick opponent, skilled at maintaining the upper hand without obvious aggression. Humour had proved a powerful defence against intimacy – at times charming, at times irritating – heading off my initiatives and hypotheses. As my best efforts failed and I feared letting this likeable man down – as he, perhaps, feared letting his wife down – my anxiety had mounted. But all of this anxiety and resistance – Andrew´s anxiety, resonating in me, as we struggled together – was the clue to the problem.

5.9 Achieving therapeutic intimacy

Each of these two individuals presented a hidden story in a kind of camouflage. Each presented a physical block to something consciously desired – having a family in the one case, marital harmony in the other. In neither case was *the relational intimacy of sex* presented directly as a lost pleasure in its own right – rather, its absence figured as a mere obstacle to something else – a “thing” brought to the doctor for removal or treatment, almost like an inconvenient foreign body. But in both, a more or less dissatisfied partner waited in the wings, unable to get close; and in each case, it was the relational context in the treatment room, the rapid establishment of a kind of therapeutic intimacy against the odds and within a time constraint, that melted the frozen “thing” – the physical block or symptom – back into palpable distress, and an audible call for help. Part of the doctor´s job was to re-experience in the doctor-patient (transference-countertransference) relationship, and tolerate, what *being kept at a distance* felt like, but not to give in, using the therapeutic role to sustain the pressure of warm curiosity and keep pushing for intimacy of real contact.

Both encounters involved the re-establishment of a free flow of feeling and thinking, around a block, where things had become two dimensional and fixed. The process in both cases required the practitioner to use her creative, spontaneous self to establish a climate of “playing with” the material. The feelings initially “in play” in the room are those of the

practitioner, accompanied by her imaginative hypotheses as to what the patient might be feeling. These hypotheses are sometimes right and sometimes wring, but collectively begin to set a tone, a terms of engagement. The practitioner´s sustained, warm, at times insistent search for meaning in the patient´s story begins to create pressure towards intimacy and insight.

5.10 Performance

In his book on mental space, Resnik characterises the therapeutic setting as a theatre, or, by analogy with ethnography, field work.[157] The patient presents a kind of performance, within which a hidden story is encoded. The work, then, becomes a kind of textual analysis of the patient´s presentation.[105] This analysis requires a particular kind of listening – to oneself and the patient at the same time: what emotion do I find in myself on hearing a man describe his intimate relationship with the woman he loves in purely technical terms? How does this information help move the conversation forward? To listen, according to Resnik is *to leave space for the other to speak and to allow oneself to introject his projections;* if you like, to *cut the patient some slack* – an intervention which I suggest psychotherapy has understood and used more effectively than clinical medicine, where it it equally relevant.

5.11 Space and containers

In understanding what took place, Bion´s word *containment* helps us, with its connotations of a physical space with firm, if flexible, boundaries, and three dimensionality. Like the psychic growth or learning of an infant, and like the creative process whereby a feeling develops into a poem, the therapeutic process requires a chamber or space into which material which cannot yet be borne or integrated can be safely placed, or projected.[133] Beginning literally in a physical room and an agreed time frame, a relational space is established between clinician and patient, and ultimately, if all goes well, a psychological space within the patient. In the process known as projective identification, the patient uses the therapy space, borrowing the therapist´s own mental and emotional space, as a temporary repository for frozen feelings,

agreeing to allow his or her therapist "feel his or her discomfort." This requires a capacity in the therapist to tolerate the patient´s introjected feelings without retaliating or collapsing for long enough that new thought can emerge. This “firm elasticity” of the therapist´s mental space allows tough material to be reviewed, rearranged, and broken down into something more digestible and useful.

5.12 The therapeutic boundary

A therapeutic space has a boundary, in terms of time place and conventions, and in brief psychodynamic work, this can feel quite tight. Time pressure can sometimes feel extreme relative to the burden of distress, especially in a publicly funded health setting where patients may have waited many months for treatment. Establishing the therapeutic alliance rapidly and efficiently is of the essence. Without the luxury of the extended development and analysis of a transference relationship, such as is possible in long term psychotherapy, a reflective space with future potential for the patient must be opened and used within a few sessions. Rather than aiming to deliver a set of doctor-centred interpretations relating to a single set of circumstances, issued like a medical prescription, the patient ideally needs to leave treatment with a strengthened sense of his or her own capacity to interpret his or her own experience. Emily appears well aware of this urgency, and her awareness seemed actually to drive the work forward.

At times, the intensity of this can feel almost surgical, as the need to move swiftly but atraumatically through layers of resistance and confusion – "to cut to the chase" – can feel urgent. But if surgical and obstetric analogies make the work sound tense and pressured, the work also contains playful elements – a kind of serious play. The ability to play has been identified as an absolute precondition for psychic growth and development in adults as well as children. So this is work which connects therapeutic and creative activities.[195]

We might think of this kind of intense, serious-playful work as a kind of poetry. Psychosomatic symptoms present a kind of disturbing but promising poetic raw material which through careful listening and reconstruction by two people in intimate dialogue can be made clear

and coherent. Practitioner and patient embark on a swift but careful journey towards the place where important knowledge lies hidden – the point of maximum sensation. Time limitation can be a tough ally, helping the hidden story to emerge.

Key Messages

- Psychosomatic symptoms can helpfully be thought of as incomplete communication
- Psychosomatic symptoms are often be semiotic, rather than semantic – a physical cry for help where distress could not be expressed in words
- Addressing psychosomatic symptoms requires attention to both objective and subjective data
- Feelings, facts and thoughts are all relevant, and considered
- The therapeutic frame and relationship constitutes a developmental space
- The doctor´s experience of the patient can be an important source of information
- Therapeutic perseverance on the part of the doctor can be as important as insightful interpretation

Chapter 6 – Epistemic justice and the lost art of medicine

Formerly, when religion was strong and science weak, men mistook magic for medicine; now, when science is strong and religion weak, men mistake medicine for magic.
Thomas Szasz

Keywords: epistemic injustice, unopposed empiricism, medically unexplained symptoms

I began this thesis by outlining a general problem of drowned out or suppressed knowledge or awareness. I gave examples of burdensome experience which can find expression in poems, or in the unprocessed, creative raw material which (I have argued) psychosomatic symptoms represent. But haunting this writing throughout has been a sense that these parallel processes of poetry and psychosomatic consultation are not only about plugging gaps, restoring balance, or even alleviating discomfort, but about restorative justice, or righting wrongs. It seems to me that embedded within the aesthetic and therapeutic dimensions of this work, there is a moral dimension.

While I am certainly no philosopher, it seems that I should at least consult some moral philosophers on the kind of philosophical arguments which might underpin the moral claims I am making. It is not purely scientific, nor morally neutral, to speak of *drowned out* knowledge, of the *tacit overwriting of subtle, individualised accounts of illness or symptoms*, or of the unacknowledged but *systematic suppression* of clinically relevant data on the grounds that they do not fit models which are currently orthodox. I have spoken about the prioritisation of *operationalisability over understanding* and introduced the notion of *unopposed empiricism* as a harmful development within healthcare. I have used terms such as *emotional irresponsibility*, and *linguistic arrogance,* and accused my profession of delegating to others things which are properly our job as doctors. In saying these things, I am suggesting injustice which causes harm and violates the first Hippocratic injunction, *primum non nocere*. These are serious allegations concerning both action and attitude, which if they are to be credible need to be placed in a moral context.

6.1 When is exclusion unjust?

In thinking about when and why exclusion might be unfair, we can helpfully use Miranda Fricker´s notion of *epistemic injustice*.[121] Fricker characterises as *epistemic injustice* the situation where a particular perspective is excluded or accorded a deflated level of credibility on the basis not of its intrinsic qualities or relevance but of its provenance. When a particular individual´s testimony is disregarded because they are for example foreign, female, or non-professional Fricker terms this *testimonial injustice.* This injustice has long applied to patients of all kinds, since patient accounts of illness have tended to be overwritten by professional accounts. And while patient partnership, or *co-poduction* in research is becoming accepted as best practice, and is now mandatory with some funders and journals,[86 88 217] this problem is far from solved: critics still accuse researchers of mere, tokenistic *virtue signalling, in an enterprise that remains skewed to serving the vested interests of professionals and industry – not patients*.[86]

Where, on the other hand, a particular subgroup lacks the shared social resources and language to represent their experience in mainstream discourse at all – examples might include trans people in a cis world, women suffering from post-natal depression in the 1960s before this was recognised as an entity, or nomadic minorities among a mainstream population of settlers - this is termed *hermeneutic injustice.* I suggest this form particularly affects patients with *medically unexplained illness* - illness which is by definition inexpressible within conventional mainstream explanatory models and hence by definition, epistemically marginalised.

From a social justice perspective, the main problem with epistemic injustice would be the wrong committed against the person whose testimony was ignored or the group whose experience cannot heard and therefore cannot be voiced. But from an epistemological point of view, the problem is the impoverishment and impotence which affects the whole body of knowledge when vital information is lost because certain relevant sources are systematically excluded. A striking example of this kind of epistemic loss occurred when the London Metropolitan Police attended the scene of the murder of black British teenager Stephen Lawrence, but failed to question the key witness Duwayne Brooks, on the spurious grounds

that Brooks, in being a young black man, was considered inherently ”unreliable.” The testimonial injustice committed against Dwayne Brookes was compounded by the hermeneutic injustice which undermined the criminal investigation, affecting confidence in the integrity of the whole criminal justice system. A public enquiry found evidence of institutional racism in the Metropolitan Police and stimulated necessary reform.

For anyone concerned with the emergence of knowledge in health care, and this must at the very least include all clinicians, researchers and editors, Fricker´s theory underscores a vital insight usually overlooked in medical discourse - that knowledge gathering is not a morally neutral activity. Whether in the consulting room, research or teaching, our information gathering is front-loaded with our prior epistemic biases. As in other areas of conflict of interest, epistemic bias is best understood not so much a crime as a fact of life, but one which is less harmful and distorting when acknowledged. This is better understood in the social sciences than in medicine. Unacknowledged epistemic bias, by contrast, risks becoming academia´s institutional racism.

I am not suggesting that medical discourse has been completely blind to contextual biases of one or another kind. It is, of course, a standard requirement that methodological terms of reference be broad enough to answer the question of interest, relevant to the field of study, and that conclusions from data gathered under limited conditions must not be overgeneralised. But what might constitute relevant limitation or inclusion is not always seen clearly. And it is rare, in medical journal publications, to see authors acknowledge explicitly the deep, prior epistemic biases which are likely to have informed study design, conduction and analysis - those arising in background and training, and the various forms of professional ”groupthink” (including evidence based medicine) which might as easily obscure vision in some areas as they sharpen it in others. Evidence based medicine arose from a desire to standardise, not to individualise, care, and its critics argue that the insistence on treating individuals according to population norms rather than personal needs is, itself, a form of bias.[218]

At worst, we risk academic hubris, or false pretence to an objectivity which is neither attainable nor desirable. We risk blocking clinicians´ access to relevant individualised or

contextualised information. A dogmatic, prior methodological commitment to numerical generalisablity withdraws permission to give proper weight to individual elements. Clinical judgment is subjugated to data which have been, as it were, epistemologically cleansed of the true complexity (acknowledgment of multifactorial causation), heterogeneity (the fact that illness varies between people), and embodiment (the fact that health and illness exist within people) of clinical practice. In the process, even the language in which to think about these is eroded.

Blanket exclusions of whole groups on the grounds of age, gender, comorbidity or language yield evidence depleted of these people´s experience, and therefore of real-world heterogeneity. The resulting simplistic overgeneralisations, at best a valuable shorthand, are at other times an obstacle to both clinical efficacy and the therapeutic relationship. In the face of illness which is complex or individual in origin, mechanistic aetiological explanations or the proliferation of questionable diagnostic labels such as *hypoactive sexual arousal disorder* neither help us make sense of patients´ problems nor guide appropriate treatment[2] This matters, because it wastes scarce resources while discriminating epistemologically against patients who seek our help.

6.2 What things get excluded?

If the old, the foreign and the complicated become excluded from medical knowledge gathering, how can we step back and understand more generally what kind of things are typically excluded from awareness? What phenomena and experiences do we never learn to see and name, or perhaps even learn not to name and see? What, as we focus in on personal or professional goals, seems so inconvenient, ungeneralisable, complex, nebulous, distracting, uncomfortable, or hard to grasp that it ends up beyond even our peripheral vision, as though it did not exist? The answer, I suggest, can usefully be thought of in terms of elements which cause anxiety by challenging our sense of mental control: the particular, the bewilderingly diverse, the wild and uncontrollable, the difficult-to-operationalise, the irreducibly embodied, the great or terrible - in short, material which in one or another way threatens to overwhelm our capacity to deal with it. Let us consider some poetic examples:

Adders and buttercups: the individual

In a poetic tribute written in *celebration and defence* of words lost from modern English, *Landmarks,* Robert McFarlane reveals how many relate to experience of the natural world. Among words removed from the most recent version of Oxford University Press´s classic Children´s Dictionary as *no longer relevant to a modern childhood* are: *acorn, adder, beech, bluebell, buttercup, catkin, conker, cowslip, cygnet, dandelion, fern, hazel, heather, heron, ivy, kingfisher, lark, mistletoe, nectar, newt, otter, pasture and willow.*[3] Replacing these are generalisable words such as *attachment, block-graph, blog, broadband, bullet point, celebrity, chatroom, committee, cut-and-paste, MP3 player, and voice-mail.*[219]

McFarlane reflects on the ecological impoverishment which the loss of these unique words represents. He invites us to take responsibility for which words we cultvate or abandon, because they do not only reflect but also shape our experience. To jettison words for the wild, the particular, and the irreducibly embodied, he argues, is to abandon our potential to experience these things. He offers the English dialect word *smeuse* - a word new to him denoting *the gap in the base of a hedge made by the regular passage of a small animal*. Armed with the new term, he began to *notice these signs of creaturely commute more often*. Anyone who has learned another language will recognize this phenomenon – those moments when an experience or gesture silent in one´s own language comes alive in another, and how the new word – what McFarlane calls *scalpel-sharp words that are untranslatable without remainder* - so extends experience that it becomes hard to do without. Both English and Norwegian are all indebted to German for *Schadenfreude.* Wittgenstein proposed that *the barriers of our language are the barriers of our world*[220] - that words can facilitate or limit experience; and McFarlane warns against demoralizing, abstract monocultures of language and thought – against the aesthetic and epistemic consequences of replacing *blackberry* with *BlackBerry* [219]

[3] Norweigan translations for the removed words: *eikenøtt, huggorm, bøk, blåstjerne, smørblomst, gåsunge, marianøkleblom, svaneunge, løvetann, bregne, hassel, røsslyng, hegre, eføy, isfugl, lerke, mistelstein, honningsaft, vannsalamander, oter, beitemark, selje.* The second group require no translation, in itself an interesting contrast.

Cans of worms: the complex

Conceptual complexity is another common reason for rejection. Generalisation is simpler and more efficient, and complexity interrupts this. Mentally, it can produce cognitive dissonance, a state of discomfort which if cannot be met with cognitive growth, results in denial.[221] but balancing the need for simplification and the recognition of complexity is an unavoidable challenge.

In attempting to think about the delicate relationship between abstract philosophical or scientific theory and day to day practical situations involving human beings, Toulmin is helpful. He presents a proper balance between generalisation and specificity as a condition of philosophical validity, opposing both absolutist and relativist approaches as unbalanced. Criticising both modern science and modern philosophy for an overemphasis on *universality*, Toulmin proposes that no argument can ever be universally true or applicable – rather, each contains *field-dependent* aspects, which vary from field to field, and *field-invariant* elements which do not. If relativism at times overemphasises field dependent elements to the exclusion of field-invariant ones – and Toulmin cites examples from anthropology[222] The problem with absolutism, he argues, is that it overlooks field dependent aspects of arguments. At worst, this makes absolutism not only theoretically flawed but practically useless – irrelevant, in fact, to the actual field.[223]

Kirkengen et al accuse biomedicine of just such an absolutist, collective denial of information relevant to health, in the form of oversimplistic studies of complex issues which omit key contextual elements, betraying both individual lived experience and the complexity of clinical phenomena. She is, in effect, challenging medicine´s systematic refusal to acknowledge field dependent aspects of knowledge, denying practitioners the evidence they need to meet their patients. This leads, Kirkengen argues, to a travesty of care in which the patient´s illness is made worse by the medical establishment´s systematic disinterest in its wider and deeper grounds, effects and remedies.[74 224]

Many academic clinicians from primary care have pointed us in the same direction: Evans, reminds us that *the medical gaze* is as much an active construction as it is a description,

underlining the necessary connection between *the medical body*, or *body-as-nature* – as empiricism seeks to define it - and *the lived body*, or *body-as-self* - as phenomenology attempts to understand it.[225] Ahlzén argues for the notion of *bodily empathy* as a vital, epistemological bridge between these two positions in the clinical encounter – an empathic act, on the clinician´s part, of *sharing the predicament of being a vulnerable embodied being.*[226]

Shit: the unthinkable

Sometimes, the material which needs to be considered is not merely particular, or complex, but for some reason unbearable or disgusting. Such material is often actively excluded, or repressed. Repression is the psychoanalytic term for the kind of active forgetting whereby threatening material is placed outside of consciousness – the psychological equivalent of consigning dangerous material to a nuclear bunker.[227] Examples might include impulses or insights which threaten one´s terms of living or strongly held values - thoughts of leaving a spouse, resentment against a dependent child, parent, or patient, suspicions of malpractice in a popular and powerful colleague, or experience which is unbearable, traumatic, inhumane or physically abhorrent.

Bowlby argued that we *cannot see what we cannot bear to see*[228] and professionals working with victims of torture or abuse offer horrifying examples: Sinason, a psychoanalyst with extensive experience in working with dissociative identity disorder and ritual abuse, gives a confronting example, when she acknowledges her own initial misunderstanding of a patient´s statement that *they made me eat shit*. Even as an experienced trauma therapist, she had initially excluded the possibility that this statement was true literally, rather than merely metaphorically.[229]

The desire not to know or hear certain things can be powerful, accounting for the well recognised processes of social discrediting which often surround abuse.[228] With collective denial, families, groups or organisations hide from knowledge of abuses which threaten their integrity, at the expense of the individuals affected. Such denial allows abuse to continue in

trusted organisations[230-232] or tight-knit communities[233 234] This collective denial also extends to research, where the recognition of traumatic phenomena, such as dissociative identity disorder is also resisted. For many years after the characteristics of dissociative identity disorder were clearly specified in DSM IV, the diagnosis was ignored both clinically and in medical journals.[228] Epistemic exclusion proliferates, causing harm at multiple levels.

In thinking about this type of instinctive, physical, prelinguistic rejection of unwanted material, I find Kristeva´s word *abject* helpful. Such material becomes repressed, Kristeva argues, because it reminds us of *our ignominious origins and ending* and of what we *permanently thrust aside in order to live* [235] At the same time, she suggests, the abject represents an eruption of what she calls *the Real* into our lives – a view consonant with the psychoanalytic voices I cited in chapter 4 who argue for rawness as the starting point of art (*Chapter 4, The point of poetry*).[235]

Here, I suggest, lies a vital connection: the very material rejected from everyday living because it is messy or raw, would seem to form the raw material for creative renewal. It is interesting that *the abject* is a sphere of enquiry well established in art, with exploration incorporating fur, bone, body fluids, dead animals, and images which challenge a sense of everyday propriety.[236] In a master´s thesis on rawness in visual art, I presented examples of The part-physical, part-mental, part-conscious, part-unconscious recycling and ordering of lived experience which art represents. I argued that art takes over precisely where our capacity to bear things in everyday ways approaches its limit. *The stone which the builders refused is become the head stone of the corner*[237] *the abject* has initiated a new therapeutic or creative response.

We can trace this connection between rawness and renewal, discussed in Chapter 3 *The point and process of poetry*,[188 190] into the debate around the use of artistic methods in research and treatment. Rapport, for example, argues in a more literal way than I do, for poetry as a tool for research with subject matter other methods cannot reach – those *who feel displaced, disenfranchised or isolated ... vulnerable groups ...who have been caught up with an extraordinary event beyind their control*.[160] She uses poetry as a research tool with holocaust

survivors who have had to repress vital information in order to survive[238] There are also many examples of the effective use of poetry as a therapeutic tool[239]

My own interest has not so much been in the literal use of poems in a therapeutic or research setting, as in teasing out, epistemically and psychologically, what it is that poetry epitomises that medicine (sometimes) needs: what are its active ingredients or key methods which should not be excluded from clinical understanding. I have been concerned to show how poetry´s welcoming, containing and processing of difficult or elusive material parallels psychotherapeutic practice, and how such stances and skills can add vital diagnostic and therapeutic understanding. I am most interested in how the epistemological rebalancing of health care, to re-include the kind of creative, interpersonal elements which poetry and therapy represent could help us work more effectively with prevalent illness which we currently manage badly.

6.3 What virtues can poetry and psychosexual medicine teach health professionals?

How, then, in busy lives, do we avoid such unfair exclusions, and epistemic injustices - overwriting important accounts, shirking emotional responsibilities? And how do poetry and psychoanalysis help? I suggest that in extending towards, containing, conceptualising and voicing elusive material certain psychological ”muscles” are strengthened, different to those developed and strengthened through other tasks. The habitual practice of stretching to accommodate raw material, attending to what might lie beneath the surface of things, mulling and sifting large amounts of amorphous material efficiently for what is most important, staying open to the unexpected, and attending closely to phenomena and process, rather than seeking to control an outcome, develops certain virtues. These, I suggest, are humility, hospitality, honesty, hermeneutic balance, and devotion to phenomena.

6.4 Humility

In chapters 4 (*The point and process of poetry*) and 5 (*When bodies speak*), I explained why it is impossible to be a successful poet or therapist while cultivating a preoccupation with

”looking good” or only taking on work which is somehow orderly, or whose successful outcome can be predicted. The very condition of successful creative or reparative work, I argued, is a willingness to place oneself in the service of a task, acknowledge ignorance, tolerate unpromising beginnings and entertain the possibility of an unsuccessful outcome for the sake of intimate engagement with something important. To allow the rich, supplementary *manic-oceanic*[144] process of unconscious intuition to supplement conscious overview.

Humility requires that expertise is held lightly, and not allowed to overshadow the clinician-patient relationship and the patient´s expertise about their own illness. Both Kierkegaard the philosopher and theologian, and Winnicott the paediatrician and psychoanalyst, are equally uncompromising on the technical importance of this moral stance: All true help, according to Kierkegaard, begins not with expertise but with humility and patience. The first qualification is a willingness to meet a person where he is and understand what he understands, and any attempt to assert expertise before these have been fulfilled is no more than a conceited bid for admiration. Helping, he emphasises, means *tolerating being wrong when you do not understand what the other understands*.[240] Winnicott in similar vein, admonishes would-be therapists that it does not matter what you know, as long as you know how to keep your knowledge out of the patient´s way.

But humility also applies to a willingness to take on whatever material needs to be worked with rather than only kinds which one finds pleasant. A scene in Richard Attenborough´s film *Gandhi* has the Mahatma ordering his wife to rake and cover the latrine – an ”untouchable” task she experiences as humiliating. He first beats her for resisting, then, repentant, rakes and covers the latrine himself.[241] It is a scene which neatly encapsulates how the flight from work which is perceived as dirty or unflattering is understandable, futile, morally wrong, and dies hard even among otherwise exemplary people. Such avoidance is based on a misconceived splitting up of the world, in fantasy, into people and subjects which are ”untouchable” - difficult, awkward, messy or abject – ”them” – and that which is clean, healthy, sanitised, and socially respectable.

Good art and therapy work, by contrast, are built on a prior acceptance of shared, flawed vulnerable humanity, in which no one gets to claim privileged status. One of the 20th

century´s great poets and immunologists, Miroslav Holub, calls art *fidelity to failure*.[242] Playfulness and artistic reverie are impossible if we cannot set aside prior knowledge and become, in a certain sense, *like little children*[243] - curious, undogmatic, experimental observers of phenomena, not performers of expertise.

6.5 Hospitality

Both poetry and therapy also require in addition to humility, also a particular openness or generosity. A willingness to stretch, accommodate and meet a person or a material – to make space. Buber distinguishes such radical openness - the kind of intimacy one finds between close friends, lovers, mother and infant, and religious and therapeutic encounters from common, everyday forms of relating. He calls the former *ich-du* (I-thou) relating – an authentic encounter without qualification or objectification of the other, and not based on preconceived ideas, and distinguishes it from the more everyday *ich-es* ("I-it") relating,[244] in which the other is reduced, in a kind of emotional shorthand, to an idea or representation. The *ich-es* relationship is in fact not so much a relationship with another person as with one´s own mental objects – not a true dialogue, but a monologue. While many transactions occur reasonably enough using “ich-es” encounters, some cannot meaningfully take place without genuine dialogue of the “ich-du” variety. These include art, which succeeds or fails as the palpable, intimate trace of a human presence – and many situations in health care where “ich-es” mental representations have failed to deliver a sufficient understanding of the patient´s problem and person. Agledahl´s video analysis of doctor-patient encounters offers an excellent example of doctors exhibiting politeness which masks existential neglect.[245] Such refusals to meet the other as a person where it is most needed devalue both parties in the encounter.[244]

6.6 Honesty and hermeneutic balance

Both poetry and psychotherapeutic work require a willingness to acknowledge without fear or favour whatever appears in the field of encounter, whether or not it is understood or can be named, and whatever emotional response it elicits. Both practices also require reflexivity

and alertness to practitioner perspectives and biases. Both require, as I have explained in chapters 3, 4 and 5, a balance between emotional and intellectual, objective and subjective engagement.

Marion Milner´s famous account of drawing offers advice about the need to balance subjective and objective elements in almost moral terms: she warns against the danger, on the one hand, of erring on the side of something which is too inward, private and incomprehensible - *an extreme monologue of action out of touch with thought .. a meaningless babble of lines*, or on the other hand, or producing, *a monologue of thought that would not listen to what action had to say*.[24] (p74)

Rabinow offers us a view of what such skilled, epistempological balancing means for medicine, arguing that it is *emotional and moral as well as intellectual*, or as Hunter argues, is best characterised as a *moral knowing, a narrative, practical, interpretative reasoning*.[69] But while health care in practice *shares its methods of knowing with human sciences concerned with meaning,* it wrongly claims a gold standard based on the natural sciences, failing, therefore, to *recognize its interpretative nature or the rules it uses to negotiate meaning*[69] At its most arid, Hunter accuses, *modern medicine lacks a metric for existential qualities such as inner hurt, despair, hope, grief, and .. pain, which frequently accompany, and often indeed constitute, the illnesses from which people suffer*.

When patients present symptoms which do not make immediate sense within a natural scientific model, it is not good enough, in terms either of efficacy or ethics, to adopt a narrowly biomedical perspective and dismiss these as ”meaningless scribble.” In doing so, we betray the patient´s call for help and violate a developmental gesture, rather like an unempathic adult sadistically insisting that a hobby horse is merely a piece of wood.[189 195 246] Instead, such phenomena need to be understood for what they are -”action out of balance with thought,” in Milner´s terms – incomplete communication, in need of interpretive help. Kleinman characterises the clinician as an anthropologist of sorts, who can *empathise with the lived experience of the patient's illness, and try to understand the illness as the patient understands, feels, perceives, and responds to it.”*[247]

6.7 Devotion

All work, of course, whether science, art or craft, demands mental, emotional and physical devotion. Iris Murdoch discusses this kind of devotion of the self in terms of virtue. Much moral philosophy has taken a behaviourist, or utilitarian view of virtue - a quasi-natural-scientific position, in which virtue is held to exist only in measurable actions and behaviours, without reference to the relevance of inner attitudes or the possibility of inner objects. Murdoch challenges this, arguing that the central concept of morality is not objectively measurable action, but loving attention to reality. Criticising what she sees as philosophy´s uncritical attachment to science and observability as the criterion of reality, she defends the idea of internal objects, proposing what she calls *an alternative theory of mind*. She gives the example of a person who is able to make a moral shift from initial dislike to appreciation and understanding, via a process of *getting to know.* Without ever having actually behaved badly in the first place, she nevertheless makes a change of attitude via the inner work of engagement.[248]

Murdoch´s criticism of much analytic philosophy seems to me to chime with the criticism I and others are making of what I have chosen to call *unopposed empiricism* in health care. According to Murdoch, philosophy simply does not fit into the world describable by science[248] and no more, I would argue, does clinical medicine. Unless, that is, we expand the term science beyond empiricism to include hermeneutic, creative and relational forms of enquiry. Murdoch accuses her philosophical contemporaries[248] (referring to Hampshire as an example) of *imposing upon us a particular value judgment in the guise of a theory of human nature*, resulting in *a kind of Newspeak which makes certain values non-expressible* - a form of philosophical cheating, of sleight-of-hand, Murdoch seems to be suggesting, perhaps consonant with Fricker´s later term, *hermeneutic injustice*.

The sleight of hand Murdoch is naming, I suggest, is not the direct presentation of false information, but the false presentation of unacknowledged value judgments as thought they were facts, and the false presentation of a partial view as though it were an overview. Without direct falsehood, truth is diluted out by bias or decontextualisation, undermining the

analytic neutrality which is philosophy´s aim, or claim. Likewise, a wrong is committed in Murdoch´s terms – it seems to me – if a purely biomedical or empirical account of illness is presented as a complete account of illness. The wrong is not in the scientific method per se and the (perfectly good) knowledge it generates, but in its unacknowledged incompleteness – its scientific hubris, if you will, its distortion of the scientific record via unjust exclusion of relevant data and perspectives, and the epistemological violence and impoverishment of discourse which this represents.

Murdoch offers a philosophical basis for what I illustrated using poetry in Chapter 3 (*When words act*) and clinically in chapter 5 (*When bodies speak*) – how technical medical language renders key subjective, emotional and relational aspects of epidemiology, pathogenesis, history, examination, diagnosis and treatment inexpressible, and how this constitutes an injustice and a betrayal of a healing profession´s ethics.

It is easy to understand how the overvaluing of natural science has come about if we remember how science grew as part of the enlightenment project of attempting to free the world from the ”dark ages” of religious and political dogma and abuse. There is, in modern society, a widespread consensus that since religion cannot be the basis for common language, rationality is the only common language. Rationality, after all, guards against capricious irrationality, and if the cost is that much that is personal and particular gets excluded, this often seems a price worth paying. Evidence based medicine itself arrived as a kind of academic liberation force from a preceding tradition where eminence and dogma had trumped evidence and truth. It came with its own epistemological moral imperative.

The risk, though, is that rationality, with its deliberate blindness to cultural, emotional context and metaphysical perspectives, is turned into an alternative God-concept – an unacknowledged religion of decontextualised information, placing general principles before people, risking violation of individualism and difference. Branson accuses medicine of having acted as *a kind of religious system, with its own symbols, values, institutions and rituals*”.[42]

There are no easy answers, as we struggle to balance rational reductionism with social inclusion: to draw fair and clear lines which balance protection for shared values with

permission for the particular and personal – whether that be joiking, prayer or the wearing of religious symbols at work, non-discrimination against LGBT people in public roles, or the right to parade with one´s own chosen flag on any given occasion. We constantly face the need to balance objective, observable phenomena and unconscious, elusive or emotional phenomena; to value the benefits of science while avoiding reductionist denial of all that is elusive, complex, sensitive or hard to grasp. Murdoch, an avowed atheist, nevertheless chose to describe her philosophical position on virtue as a *rival soul-picture*.[248] It is not the observable action but the individual, she argues, which is the central concept of morality, knowable *by love*. Good, she argues, is an indefinable and unmeasurable but real quality, captured in aesthetic and contemplative terms, not reducible to a set of externally observable actions.

The ethics I am alluding to in this study, it will by now be clear, are not those of external codes of reference which define acceptable professional behaviours, such as the General Medical Council´s *Good Medical Practice*[249] – essential though these are – but an ethics of personal codes and internal motivations. I am referring to an inner compass, not an outer code of conduct. Murdoch argues for morality as an area of study indissolubly enmeshed with metaphysics, not merely a tractable set of inherited commands or rules to be applied by the will. In a post-Kantian philosophy centred on the notion of will, she identifies *the metaphysical* as an important excluded element. It is tempting to see Murdoch as arguing, from her atheist position, that *"God"* cannot be reduced to guidelines.

6.8 Concluding remarks

Where are we left, after this extended reflection on unjust exclusion and its creative and moral remedies? Am I arguing that teaching children technological words or research into molecular genetics is wrong? That everything pleasant and desirable can be included in a dictionary, a medical curriculum, or a nation´s health policy, without the need for rationing and prioritisation? Certainly not.

This is not a charter – based on a handful of closely scrutinised poems and some case reports - for unexamined subjectivity, the replacement of empirical with hermeneutic methods, or an end to the benefits evidence based medicine has brought. It is not even an attack on psycho-physical dualism per se, which is useful for some kinds of clinical thinking; only against its heedless overgeneralisation to areas where it is unhelpful.[226] Rather, it is a call for us to develop our attitudes and our methods of gathering and interpreting data, to better fit the complex human field we work in. I am not advocating a move away from natural science, but away from a natural scientific monoculture which leaves patients troubled that *most doctors are not primarily interested in finding out what is the matter with them, but are concerned instead with discovering what disease is the source of their illness.*[250]

I have not spent time in this thesis defending natural scientific viewpoints or evidence based medicine, because others have done this, and in any case they need little defence. I acknowledge their essential contributions to human health with gratitude. My opposition is not to biomedicine, which I have practised for 25 years, but to its misuse in areas where it does not help. I am arguing, along with others I have cited, for a paradigm shift in medicine – a soft revolution, to modify and develop, not overthrow, the assumptions and rules for how knowledge about human health should be gained, and delimited from non-knowledge.[251] I favour Toulmin´s view of scientific development as an evolutionary process of innovation and selection, rather than, as Kuhn suggests, a fight to the death between competing and mutually exclusive paradigms.[251]

The question is how and where such evolution might occur. There has been lively discussion in the medical humanities literature about the differences between multidisciplinarity and interdisciplinarity, and much collaboration of experts from essentially different disciplines and theories of knowledge. The problem, as I see it, is that while interesting conversations take place, the underlying theories and models appear to continue on parallel train tracks relatively untroubled by each other, engaging in occasional conversations or shared initiatives. The risk is that interdisciplinarity never moves beyond a kind of flirtation.

There are many calls for reform, but far fewer serious attempts at integration of the humanities such as moral philosophy, or poetry in the academic mind of medicine. Much

valuable work is being done by humanities academics interested in medicine but without clinical experience, or by clinicians interested but inexperienced in the humanities. Currently, the humanities in medicine have not yet adequately troubled core medical thinking. The humanities, or at worst, humanity as a stance, are still apt to be viewed as a luxury, ignorable in the heat of the clinical encounter, like Duwayne Brooks´ missing testimony at the scene of Stephen Lawrence´s death.

Genuine interdisciplinarity insofar as it matters to patients, does not belong in occasional interdisciplinary seminars and conferences between experts from separate disciplines, but inside the consulting room, the medical journal, the medical school, and the doctor´s head. I suggest we need to emerge from a view of interdisciplinarity as a polite conversation between parallel but separate worlds, like two partners sleeping side by side in twin beds, and instead promote genuine intellectual interpenetration of ideas and ways of thinking *within the individual practitioner*. This means taking the risk of allowing old, familiar structures to be remodelled, and it is to this I have attempted to contribute.

I suggest we need at the highest academic and political levels to acknowledge that unopposed empiricism has become a systematic block to progress in health care, and that epistemological development is urgently needed. In an era where we understand better than ever that technical solutions cannot solve the problems of health care, the best technological and empirical advances need to be balanced by a mature commitment to context, meaning, and individuality, if we are to grow to the next level, as a profession.

I have written this analysis to make my own interdisciplinary affairs plain. It arose from creative engagement with and analytic separation from two kinds of material, and from allowing myself and my writing to be “invaded” by the moral dilemmas the material raised. Although not usually discussed in science, I suggest this kind of ”invasion” or ”merging” with a subject matter, though seldom discussed, is as much a part of scientific as of artistic research, and that research is therefore a relational process. My guess is that a researcher studying climate change, the accumulation of plastic in the ocean or the pathogenesis of pre-eclampsia also begins with a set of skills, a puzzle to solve, and an epistemological passion for a subject matter which for whatever reason attracts them emotionally as well as mentally,

though this is traditionally excluded from scientific discussion. Each requires diligent commitment of the self, via a chosen methodology, to the phenomena at hand. Each combines close observation of phenomena with the hermeneutic act of interpretation and contextualisation. At the stage of publication, a scientific narrative is required, as well as demonstrating methodological rigour, to answer the questions: *why does this matter*? *why were resources spent on this study? what does it mean for practice*? and therefore, *why should anyone read it?* Increasingly some of us now also ask: *how, if at all, did you involve patients in the design and interpretation of your study?* I suggest that the whole process of research and publication is characterised by a concern for diligence and truthfulness, but is not, contrary to common assumption, defined by objectivity, so much as self-reflective engagement. Merging and separating.

I offer this analysis to colleagues in the clinic, the medical school, and the medical journal; to others interested in health and the humanities, and to fellow poets. In presenting myself as a doctor who needs something which poetry represents in order to feel fully human, I am arguing that medicine needs something which poetry represents to remain fully humane. I am reminding myself and others that the language we habitually speak shapes and limits what we see, and that there may be other things as yet unframed in language, which we need to discover. I am arguing for academic ecology, for epistemological balance, and for self-reflection. I am encouraging persistence in questioning models which do not fit experience, and the courage to return in a spirit of wonder and scholarship to the live, raw data of phenomena, with heart and mind open.

Key Messages

- Unopposed empiricism in medicine is ineffective and unjust, because it undermines clinical relationships and academic understanding.
- Not all knowledge relevant to diagnosis and treatment is purely objective and can be apprehended purely objectively
- Hermeneutic knowledge of the kind poetry and psychotherapy deliver complements natural scientific knowledge
- Mature medical practice requires that empirical and hermeneutic elements be integrated at the level of the individual consultation.
- To be useful to patients, epistemological integration needs to occur within the mind of individual clinicians, not merely as occasional interdisciplinary conversations between experts from different disciplines
- The ethical practice of medicine depends on internal attitudes such as humility, hospitality, honesty, hermeneutic balance, open mindedness and devotion to phenomena, not only on external actions or codes of practice.

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