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AFTERWORD: MIND, IMAGINATION, AFFECT

Felicity Callard

THE EIGHT ESSAYS in ‘Mind, Imagination, Affect’ address topoi, phenomena and historical junctures as varied as the prostrate form of an individual being put to death in the US via the necropolitical ritual of lethal injection; the prostrate form of Virginia Woolf that allows her to fashion, while prone with illness and ‘as a “deserter”’ of the ‘army of the upright’,¹ a new relationship with words; the affective piety of Margery Kempe’s copious tears; the dense relationalities that narratives about autistic individuals, their family members and animal assistants unfurl; and Antoine Artaud’s autoscopic, aesthetically realised fantasies in which bodies are eviscerated and suspended mid-air. The differences in these essays’ rhetorical styles, modes of argumentation and ontological commitments are startling – not least because all essays are authored or co-authored by a writer within the humanities (and, more specifically, with at least some affiliation to the disciplines of English literature or philosophy or art history). (This should drive home to us, once again, that we should not allow today’s intense investment in *interdisciplinarity*, both within the medical humanities and beyond it, to render us impervious to the profound differences in objects of study, accounts of human experience and modes of interpretation produced through *intra-disciplinary* – or *intra-humanities* – heterogeneity.) We move from the almost plangent tones of Corinne Saunders’s concluding comments, in which she argues that by incorporating medieval worlds into a ‘long cultural perspective’, we, through ‘reading the past, [. . .] more richly read ourselves’;² to David Herman’s energetic call for us to consider how a narratology beyond the human might assist with the construction of ‘new, more sustainable individual and collective stories grounded in an expanded sense of the self’s relationality, its situation within wider webs of creatural life’;³ to Martyn Evans’s insistence on our attending to the wonder provoked by our acknowledgement of ourselves as ‘embodied, experiencing beings’;⁴ to Lisa Guenther’s biting question: ‘Is there a meaningful distinction between a botched execution and a proper one? Or must we admit that there is no good way to execute a person?’⁵

Each essay has, then, its own affective tone. This tone is central to how each carves out its terrain of operations – as well as its objects of study – as being pertinent to the concerns of the medical humanities. Tone is also central to the means through which each chapter calls on, and out to, the imagination of its implied reader; and to how it

elaborates the looping relationships between the worlds that belong to the protagonists on which it focuses, the narrator's own point of observation and address, and the emotional and cognitive proclivities of its imagined reader. If each is united in its desire to address us as interlocutors within the capacious space of the critical medical humanities, then those calls have very different rhythmicities, tonal ranges, modes of construing affective transfer, and conceptions of the political. If each of these essays is gathered under the three complex abstractions of mind, imagination and affect, then each presses those abstractions into service as much through the rhetorical turns of its argument as through that argument's explicit focus on one or more of those three terms. What these essays show, collectively, then, is how broad are the animating logics that braid the threads of the medical and the humanities together, as well as how diverse are the reactions against – or, at times, commitments to – a humanism that might buttress, if not guarantee, the claims made in relation to the figure of the human that lies at those essays' heart. In this afterword, I schematically address two domains – the illness narrative and the body – in which those diverse animating logics (and in particular those that push against a tidy humanism) play out.

Deforming the 'Illness Narrative'

If one were to accept the risk of invidiousness and pull out one of the most central preoccupations of the interdisciplinary field of medical humanities, then the illness narrative would surely be the selection that many would make. Rita Charon, in *Narrative Medicine*, one of the founding texts of that field, describes how '[d]octors, nurses, and social workers', keen to complement a 'scientifically competent medicine' with the resources through which to 'help a patient . . . find meaning in illness and dying', ended up 'turning for help . . . to people who know about narratives, which can be defined as stories with a teller, a listener, a time course, a plot and a point'.⁶ Much of the writing that has addressed 'illness narratives' within the medical humanities has operated, as Peter Garratt, David Herman, Edward Juler and Laura Salisbury variously and cogently demonstrate, with conventional (broadly humanist) models of the language of illness and of the self from whom such language might issue. Analyses of what are too commonly taken as exemplars of an 'illness narrative' too assiduously winnow down who might be understood as a 'narrator' – as well as what might be traced as a plot, assessed as meaningful, be understood as an outcome, and be interpreted, to use Charon's formulation, as a story's 'point'.

The essays in this section radically enlarge the purview of each of those narratological domains. Jonathan Cole and Shaun Gallagher, calling on the research of psychologist David McNeill, insist that gesture is not (only) an expression or representation of meaning, or vehicle for the communication of messages, but a mode of existing in the moment of speaking.⁷ Their analysis of the distinction that their collaborator Ian – the 'patient' within this story – makes between his gestures that he construes as 'throwaways' and those that he describes as 'constructed' carries fascinating, oblique resonances with Salisbury's elaboration of modernism's deep and varied interest in the

travails of discarded and sculpted language, as well as her interest in how phenomenological and neurological research in the mid-twentieth century opened up new means through which to understand the entangled relations between language, expression, consciousness, physiology, automaticity, meaning and communication. For Salisbury, to disrupt current conceptualisations of ‘illness narratives’ in the medical humanities requires not that we move *beyond* language, but that we ‘[burrow] into the resistant matter of language via modes that came to scientific, philosophical and aesthetic visibility in modernity – modes that dig into the recesses of non-propositional formulations or sheer away from linear coherence’.⁸ One important analytic and aesthetic problematic that emerges in the course of reading the essays in this section – and one that deserves significant future consideration by medical humanities scholars – is how to understand the relationship between Salisbury’s call to stay *with* the matter of language, and Juler’s claim for the ‘non- or *pre*-verbal language of graphic alterity’, which he finds in Artaud, and which, on Juler’s account, represents ‘that which is linguistically inexpressible: the haptic, the material, the optical and, above all, the visceral’.⁹ The matter of language – and that which lies inside, beyond and before it – has been an enduring concern in the humanities, not least since structuralism and its many theoretical aftermaths. It has been, though, in many respects under-investigated in much medical humanities scholarship. Several of the essays in this section correct that, and at the same time bring knotty problems regarding relations between the linguistic, graphic and affective into view.

Before I leave illness narratives, I want to return to my juxtaposition, in the introduction, between the prostrate body of the individual-in-the-process-of-being-executed and the prostrate body of an ill Virginia Woolf. What might happen to and with the critical medical humanities if we considered *both* figures, rather than simply the latter, as kernels around which ‘illness narratives’ might form? What, in other words, if we considered Guenther’s extraordinary essay ‘On Pain of Death’ as a perverse illness narrative that deforms some of the founding assumptions of that genre as it has been imagined within orthodox medical humanities research? Guenther, after all, poses questions similar or identical to many of those asked by researchers in the medical humanities who are keen to address the phenomenological, technical and intersubjective characteristics of scenes that capture or emplace an individual in medical or quasi-medical contexts. She asks, for example, in relation to the epistemological and political stakes surrounding pain experienced during execution, ‘How does one know if another person is feeling pain?’ She raises the intractable problem – as do many concerned with the absence of the patient’s ‘voice’ in accounts of medical procedures – that the only individual who could provide robust evidence about whether pain is being felt is precisely disqualified from doing so by dint of the particular configuration in which he is captured. She demonstrates – and here she joins a large cohort of researchers preoccupied with the power that the medical domain can wield – the potency of ‘selective [appeals] to medical authority, technology, and practices’.¹⁰ She notes the absence of any ‘objective test for the presence or absence of consciousness awareness’,¹¹ and then describes how one of the attendees in this

‘quasi-medical’ scene (here, the warden) is – as in so many other medical scenes – positioned as having to ‘read’ the body of the prostrate body that lies before him. And she demonstrates how, on the state’s account, execution ‘becomes legible as yet another terminal disease’.¹²

But, of course, the entire force of Guenther’s analysis is centred on her *refusal* to confer on this scene the gravitas of the medical, for there is no patient, no disease, no defensible medical practice, no commitment to understanding whether pain is being experienced by the one being intervened upon. There is, instead, the deliberate putting to death of an individual by the state. Guenther’s essay could be said to stage a kind of illness narrative precisely so as to challenge – and expose – the ferocious and obdurate violence meted out *under the cover of* a quasi-medical scene. In her account, the narrative that the state might tell – one that is committed to conveying its ‘civilised methods of execution appropriate for use by a Western democratic nation’¹³ – is upturned. Guenther’s own, complex narrative, which draws specific attention to how the ‘twenty-first-century American death house’¹⁴ attempts to install practices of care, and illusions of the clinic at its heart, exposes the state as simultaneously Ubu the King – whose ‘obscene form of sovereignty’¹⁵ operates at a distance – and Ubu the Pen-pusher (in the garb of the ‘imbecilic’ functionary, who prods and fiddles with a prostrate form in a room decked out in ersatz medical style).¹⁶ To consider Guenther’s essay as sitting, however uncomfortably, within the genre of the ‘illness narrative’ allows us to discern how significant her narratological and political achievements are in her rupturing of the common ways in which the medical humanities have imagined a story’s teller, listener, time course, plot and point.

Figuring the Body

In a section titled ‘Mind, Imagination, Affect’, the frequency with which the body is foregrounded is notable. Scholars of affect and emotion might well interrupt me at this point: How could the body *not* appear, given that emotion is, after all, grounded in and through the body? But what is striking in these essays is how the body does not simply appear as a guarantor for an ‘embodied emotion’, but rather as a topos worthy of consideration in its own right. We see this, for example, in Saunders’s insistence that the fluid, pre-Cartesian imbrication of body and mind poses challenges for researchers in many disciplines today who are struggling to address complex, multi-sensory phenomena (such as voice-hearing and visions); in Evans’s turn to the body in the course of his search for ‘a view of patients that does justice to their personhood and their objecthood alike’;¹⁷ and in Garratt’s attention – as he pursues Victorian models of mental fatigue, and the labour of reading – to scientists’ and clinicians’ interest in the physical basis of aesthetic experience.¹⁸

This turn to bodily matters is often concurrent with the author’s problematisation of where the evidence of experience lies (and what the political and aesthetic consequences of such a problematisation might be). We see this particularly in relation to the fugitive phenomena of voice-hearing (Saunders), pain (Guenther), visceral

sensations (Juler), gestures (Cole and Gallagher), depressive sadness (Garratt), and the particular texture of human and animal affective relationalities (Herman). In using the phrase ‘the evidence of experience’ (a phrase made famous by the feminist historian Joan Scott),¹⁹ I am thinking of how these authors often raise to visibility difficulties in accounting for the source and phenomenological density of these phenomena, as well as in adjudicating the person (or entity) who is deemed best placed to describe and analyse them. Juler, for example, describes the ‘autoscopic undercurrents’ of Artaud’s depictions of the body, noting how they ‘echo[ed] the pathological case-studies of psychophysiology’ whereby individuals claimed to observe their body, and their bodily organs, from the inside.²⁰ But what might be lost if we too readily read Artaud’s aesthetic interventions through the lens of psychophysiological expertise? Herman turns in part to individual narratives of the positive effects of animal assistants for people who are autistic to challenge orthodox clinical models of evidence that are grounded in scientific studies reliant on particular models of treatment outcomes. Herman considers, in this respect, how the ‘use of the term “anecdote”’ – which is commonly used to vitiate the potency of a story – ‘[itself might] lead to the trivialisation and neglect of narratives that deserve closer scrutiny’.²¹ And Guenther, as we have already seen, points to the unassailable fact that the individual who could offer robust evidence concerning the phenomenological effects (physically felt, mentally endured) of the quasi-medical intervention forced upon him is structurally disqualified from doing so. These essays, as a whole, then, displace in various ways the figure of the singular subject construed as a locus for authentic, legible and/or discursively audible communications.

In many of the essays within this section, there is, at the same time, a potent sense of the pathological, the violent, the decaying and the dissolute as enduring, insistently, *within* the everyday experience of being human – rather than coming, unbidden, as an effractive force from the outside that disrupts an untroubled and pellucid self. We should not underestimate the significance of this for helping build new directions for a critical medical humanities. For, even as there exist many exceptions to the rule, medical humanities has, to my mind, long been hampered by a frequent assumption that certain things that characterise human experience tend to line up, unproblematically, one alongside the other. A partial list might include: the readability of the body; the clarity of the communicative acts that are given through language and gesture; the urge to health; the ennobling achievements of aesthetic engagement; the succour offered by particular forms of narrative closure. If we were to pick out two instances in which this smooth passage is upset, we might note Garratt’s insistence that nineteenth-century writers frequently regarded ‘the literary–aesthetic realm . . . in itself as injurious or corrupting to health even while art is valorised as an imaginative or spiritual resource capable of transforming lived experience’,²² or Salisbury’s delicate reading of Woolf through which she cogently avers that, for Woolf, ‘illness is both the instigator of revelation and the normal run of things; illness marks the extraordinary as a quality furling inside the very fabric of the common.’²³

Such arguments often go hand in hand with the rendering visible of the heterogeneity of that domain of thought and practice we call medicine (as well as of the life

sciences that lie in such intimate relationship with it). In many of these essays, ‘medicine’ appears in markedly different forms from those flat, inert images that many of us in the medical humanities are too wont to conjure up. For if today’s default reaction amongst some humanities scholars is to lament the ‘biomedical reductionism’ of medicine and its allies – and, indeed, we see such laments in some of these essays – what is abundantly clear is the strangeness, perversity and cobbled-togetherness of much of what passes as the ‘medical’ or ‘clinical’ in these authors’ essays. Consider how Salisbury’s exploration of aphasia narrates complex passages that lead from the work of neurologist and psychiatrist Kurt Goldstein and Gestalt psychologist Adhémar Gelb to the phenomenological explorations of Merleau-Ponty. Here, the philosopher, the life scientist and the psychologist are equally preoccupied with understanding the complex tangle of the physiological, the psychological and the existential that might help to elucidate the human being’s projection ‘towards a “world”’.²⁴ Or consider the assemblage constituted by the clinician Cole, the psychologist McNeill, the philosopher Gallagher and the patient Ian, who, together, tinker and experiment so as to produce new understandings of the semiotics, physiology and phenomenology of gesture in the unmarked as well as the ‘damaged’ body.

Why Critical?

That no easy cut might be made between the ‘medical’ and the ‘humanities’ in many of these heterogeneous essays surely opens out new questions, frameworks and orienting ontologies for those of us intrigued by the promise of critical medical humanities.²⁵ But we should note that these essays install various visions – both explicit and implicit – of what the ‘critical’ of the critical medical humanities is, and where it might take us. Some authors powerfully articulate a somewhat familiar defence of the role that humanities research might play in relation to various shibboleths that characterise the domains of medical thinking and of therapeutic exhortations. Garratt, for example, turns to models of mental pathology within Victorian literary aesthetics in order to displace John Carey’s strange endorsement of both a relativist account of aesthetic impact and a Leavisite shoring-up of where literary value and goodness lie. The efforts in the mid-nineteenth century to address how the senses and the nervous system are central to understanding the complex effects of artistic works on those who encounter them are, for Garratt, important correctives to today’s easy arguments surrounding the benefits of bibliotherapy. Here, then, engagement with the mid-nineteenth century’s ‘sometimes hidden aesthetic models’ might ‘historically enrich any current medical humanities research predicated on determining the relationship between the ends of aesthetics and particular embodied subjects’.²⁶ This sense of the humanities as ‘enriching’ is also found in Saunders’s claim that the medieval can ‘illuminate, complicate and validate’ current scientific and medical models;²⁷ and in Cole and Gallagher’s conviction that phenomenological attention to the first-person, patient perspective ‘can help us understand more’.²⁸

In other essays, the desire to *intervene* in the world – ontologically as well as epistemologically – is expressed more acutely. Herman is keen to draw from the ‘potentially revolutionary, paradigm-changing energies of “history from below”’ in his call for new individual and collective stories that situate humans ‘within wider webs of creaturely life’.²⁹ Guenther argues, with exquisitely calibrated anger, that what is required – if one accepts the implications of her argument about the strange logics of the death penalty – is not a philosophical clarification of the distinctions between the humane and inhuman, or the proper and the improper, but ‘an abolition of the death penalty in all its forms, through a radical reconfiguring of meaning and power’.³⁰

These essays offer us varied accounts of the intellectual and political work that might be achieved within critical medical humanities if we tell different kinds of stories and depart from desiccated explanations of their ‘point’. They allow us to think more carefully about who, in relation to the areas of health and pathology, is granted the gravitas with which to denote, speak about and interpret a medical (or para-medical, or quasi-medical) scene. They put pressure on how the medical humanities too readily determines which kinds of mark, gesture and utterance might be endowed with meaning, and which brushed aside as meaningless. And they push us to think more keenly about whose narratives about minds, bodies, imaginations and affects come to stick, and whose are structurally or implicitly foreclosed.

Acknowledgements

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Notes

1. Virginia Woolf, *On Being Ill*, with *Notes from Sick Rooms* by Julia Stephen (Ashfield: Paris Press, 2012), quoted in Laura Salisbury, ‘Aphasic Modernism: Languages for Illness from a Confusion of Tongues’, in this volume, p. 451.
2. Corinne Saunders, ‘Voices and Visions: Mind, Body and Affect in Medieval Writing’, in this volume, p. 423.
3. David Herman, ‘Trans-Species Entanglements: Animal Assistants in Narratives about Autism’, in this volume, p. 476.
4. Martyn Evans, ‘Medical Humanities and the Place of Wonder’, in this volume, p. 349.
5. Lisa Guenther, ‘On Pain of Death: The “Grotesque Sovereignty” of the US Death Penalty’, in this volume, p. 396.
6. Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford and New York: Oxford University Press, 2006), p. 3.
7. David McNeill, *Gesture and Thought* (Chicago: University of Chicago Press, 2005), pp. 99–101; quoted in Jonathan Cole and Shaun Gallagher, ‘Narrative and Clinical Neuroscience: Can Phenomenologically Informed Approaches and Empirical Work Cross-Fertilise?’, in this volume, p. 382.
8. Salisbury, ‘Aphasic Modernism’, p. 458.

9. Edward Juler, 'Man's Dark Interior: Surrealism, Viscera and the Anatomical Imaginary', in this volume, p. 372.
10. Guenther, 'On Pain of Death', p. 397, p. 401.
11. Ibid., p. 404.
12. Ibid., p. 402.
13. Ibid., p. 397.
14. Ibid., p. 401.
15. Ibid., p. 396.
16. Ibid. Guenther is quoting from Michel Foucault, *Abnormal: Lectures at the Collège de France, 1974–1975*, trans. Graham Burchell (London: Picador, 2004).
17. Evans, 'Medical Humanities and the Place of Wonder', p. 350.
18. Peter Garratt, 'Victorian Literary Aesthetics and Mental Pathology', in this volume, p. 434.
19. Joan W. Scott, 'The Evidence of Experience', *Critical Inquiry* 17.4 (1991), pp. 773–97.
20. Juler, 'Man's Dark Interior', p. 367.
21. Herman, 'Trans-Species Entanglements', p. 468.
22. Garratt, 'Victorian Literary Aesthetics and Mental Pathology', p. 429.
23. Salisbury, 'Aphasic Modernism', p. 458.
24. Ibid., p. 455.
25. Cf. William Viney, Felicity Callard and Angela Woods, 'Critical Medical Humanities: Embracing Entanglement, Taking Risks', *Medical Humanities* 41.1 (2015), pp. 2–7.
26. Garratt, 'Victorian Literary Aesthetics and Mental Pathology', p. 440.
27. Saunders, 'Voices and Visions', p. 414.
28. Cole and Gallagher, 'Narrative and Clinical Neuroscience', p. 378.
29. Herman, 'Trans-Species Entanglements', p. 476.
30. Guenther, 'On Pain of Death', p. 405.