Empathy in Mental Illness

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Using literature and the arts to develop empathy in medical students

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25.1 The problematic role of empathy in medicine

Medicine has had a mixed history where empathy is concerned. Although there is a tradition stretching from Hippocrates through to the current epoch of sympathy and compassion as defining qualities of medical professionalism, modern medicine has been dominated by a reductive, rationalist approach to clinical practice (Halpern, 2003). The modernist framing of professionalism engendered by this perspective presumes that impersonality, neutrality and detachment are needed to achieve objective medical care that does not favour one patient over another. In this view, the metaphor of medicine as science predominates, and the rationalist attributes of the successful scientist are transferred wholesale to the physician. Less often stated but also influential to this line of thinking is the assumption that allowing oneself feeling for patients can be emotionally overwhelming and leads to exhaustion and burn-out.

In terms of empathy, these conceptualizations have led either to its downgrading, culminating in the call for a 'de-empathization' of medicine in order to enable physicians to make sound, scientifically based medical decisions (Landau, 1993), or for a restricted definition of empathy as essentially a cognitive process based on the achievement of a purely logical understanding of the other. As an outgrowth of this position, medical school curricula now routinely attempt to teach empathy to students as a set of cognitive and behavioural skills (Winefield & Chur-Hansen, 2000). Although this interpretation and resultant method of instruction have produced certain positive pedagogic outcomes, concerns have also been expressed about whether this approach is sufficient to bring into being truly empathic physicians (Henry-Tillman *et al.*, 2002).

Such uneasiness calls into question the proper definition of empathy. Our English term empathy is derived from the German *Einfuhlung*, a word coined by

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Theodor Lipps in his discussion of aesthetic experience, which means something like 'feeling one's way into the subjective experience of another'. Martin Buber, the great twentieth century philosopher, provided the striking image of empathy as 'a bold swinging ... into the life of the other'. However, these descriptions of 'sympathetic merging' grow out of aesthetic and philosophical, rather than clinical, traditions.

From a clinical perspective, the argument has been made that while empathy should be more than rational analysis, cold intelligence and aloof observation, it should not imply losing oneself in the other. Halpern introduces the term 'clinical empathy' (Halpern, 1993) to describe the special sort of empathy needed by physicians that derives from a detailed *experiential* as well as cognitive understanding of what the patient is feeling. Clinical empathy is neither detachment nor immersion, but rather requires an ongoing double movement of emotional resonance and compassionate curiosity about the meaning of the clinical situation to the patient. It may best be defined as the capacity to participate deeply in the patient's experience, while not losing sight of the fact that this imaginative projection is not, in fact, one's own experience but that of another. Accordingly, physicians should have the capacity to be affected by, but also to be able to contain, the patient's distress. In other words, the clinician must possess the 'negative capability' not to be overwhelmed by the patient's plight while simultaneously being moved by his or her suffering (Coulehan, 1995).

This expansive revisioning of empathy suggests more broadly conceived potential outcomes than those used in studies determining the empirical efficacy of training in behavioural empathic techniques. The expression of clinical empathy by physicians is assumed to engender trust in patients, thereby making it easier for them to tell their stories fully and honestly. Similarly, clinical empathy is conceived to be key to successful medical intervention and treatment, because it is only when patients feel deeply understood that they are willing to engage with the doctor's recommendations. Empathic connection is even viewed as potentially healing for patients, emotionally if not physically, because it helps them imagine possibilities for themselves that are more bearable than their current predicament. Finally, empathic connection gives the patients the sense that they are not alone, that someone understands them, recognizes them (Berger, 1967), and is not afraid to accompany them on the difficult journey of illness that lies ahead (Broyard, 1992).

Regardless of the debate regarding the definition, nature and parameters of empathy, most professional bodies in medicine, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, have identified empathy as a component of professionalism and specify that medical education must include curriculum whose goal is the development of empathy in learners (Larson & Yao, 2005). A survey of 533 medical residents

ranked empathy as among the top three attributes associated with professionalism (Brownell & Cote, 2001). However, although empirical research has linked learner empathy not only to patient satisfaction (Smith *et al.*, 1995) but to clinical competence (Hojat *et al.*, 2002), other evidence suggests that various humanistic traits, including empathy, either stagnate (Branch, 2000) or actually decline over the course of undergraduate medical education (Newton *et al.*, 2000). As has been poignantly observed, 'medical students start out with empathy and love . . . they learn detachment and equanimity . . .' (Spiro, 1993).

25.2 Theorizing a humanities-based approach to train empathy

If empathy is as much art as science (Misch, 2002), then perhaps it may be developed through the study of humanities and arts (Charon, 2000), as well as through more skill-based, analytic procedures. The humanities and arts engage the emotions as well as the intellect, thereby creating the potential to achieve deep experiential understanding of and insight into the human condition (Charon, 2001). From a theoretical perspective, the potential value of the humanities as a curricular option in medical education arises out of a post-modernist conceptualization of medicine itself.

This post-modernist view contrasts with the still-dominant modernist medical paradigm, whose most widely endorsed metaphor depicts the body as a machine, disease as a malfunction, the doctor as an emotionally detached expert and the patient as a passive object; and the goal of intervention as a return of the patient to normalcy (Morris, 1998). The only desirable, indeed acceptable, modernist medical narrative is the restitution story (Frank, 1995), in which an individual suffers temporary breakdown due to disease, is diagnosed and treated by an authoritative but distant physician, and ultimately is restored to perfect, pre-disease status. What the restitution story omits are all the 'left-over aspects' of the ill person's experience, i.e. those elements that cannot be transformed or fixed by medical intervention. 'Re/covering' in this sense often 'erases' significant portions of the experience of the survivor (Wagner, 2000). The modernist position does not leave room for understanding the complex relations patients have with their illnesses; it does not allow for the reality that, once ill, people are inevitably changed by their experience, in ways both good and bad.

The post-modern interpretation of medicine, found more often in the writings of social scientists, humanists and 'boundary-crossing' physicians (Aull & Lewis, 2004) than in the actual practice of clinicians or the actual education of medical students, stresses the unity of mind and body: the limits and fallibility of the physician, as well as physician expertise; patient self-knowledge and testimony; and the need to replace detachment in the doctor-patient relationship with a

certain emotional closeness (Morris, 1998). The pedagogical usefulness of literature and art that address themes and content broadly related to patients' experiences of illness and/or the doctor–patient relationship lies in their capacity to develop in learners the attitude of empathy implied in the post-modern perspective. Literature and the arts can help students see that there may be other dimensions to illness that are 'not allowed in' to the official modernist discourse. They provide additional ways in which individuals suffering from illness, as well as their families and friends, can contribute to the production of knowledge about their own conditions by raising their subjective, particularistic voices and authoring their own accounts that tell other, more ambiguous, stories than those of restitution.

25.3 A theoretical model

We have little empirical evidence, or indeed evidence of any kind (see below), to guide our understanding of the process by which literature and art might stimulate empathy in medical students. However, based on long-term observation of and interaction with learners, it is possible to theorize the following five-step model (see Figure 25.1). When medical students are exposed to literature and the arts (**step 1**), for example in a literature and medicine seminar, they achieve a psychological **zone of safety (step 2)** (Stein, 1996). One dimension of this zone of safety is that, while they are studying literature, learners have ***no direct clinical responsibilities***. The intense pressure of patient-care duties, especially for neophyte learners, not surprisingly produces stress and anxiety, emotions antithetical to the cultivation of empathy. Students are so consumed by managing their own problematic feelings that they have few emotional resources left over from which to evoke empathy for patients. Further, since in a sense patients are the cause of these negative emotions, it becomes easy for students to blame them, even unconsciously, for the confusion and misery they often experience on the wards, rather than empathize with their condition.

Reading, or viewing art, removes the direct-action component of clinical care, giving students the opportunity to reflect on, *and empathize with*, the situations or emotions portrayed in a given story, poem, or painting. In this respect, literature and art produce catharsis because they allow learners to confront horror and suffering without being contaminated by it. Learners can pay closer attention to the complexities and nuances of a fictional character's experience than they can to those of a real patient, without worry that doing so might distract them from medical issues critical to that patient's recovery. Learners also experience a sense of **emotional safety** because a protective barrier, the text or picture, has been interposed between them and the patient. Learners no longer have to be concerned

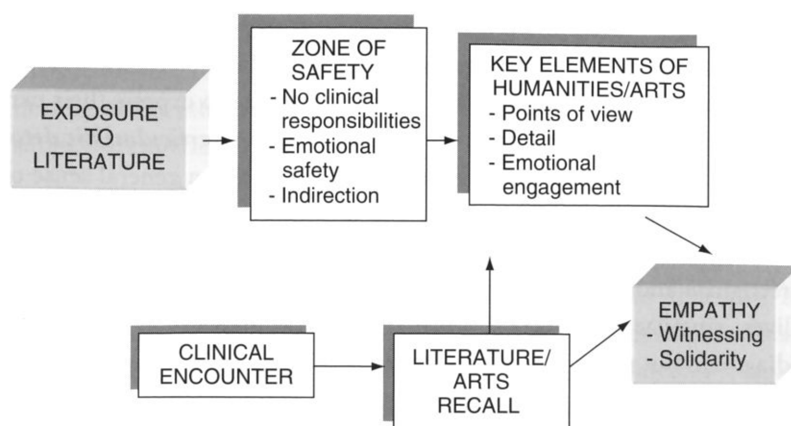

Figure 25.1. A theoretical model illustrating how literature works to create empathy in learners

that either their physical or emotional well-being is threatened by the suffering of the patient. They are free to feel and to reflect, to risk 'entering into' the world of the patient (Shapiro & Rucker, 2004).

A second component of the zone of safety is its favouring ***indirection*** as a means of bringing learners to a response of empathy rather than self-protection. Given the potential intensity of affect surrounding patient care, it becomes difficult to adequately deal with learner issues in this domain in a meaningful way. Direct probing and confrontation of prejudices, negative stereotypes, frustration, and even outright hostility in the learner generally result in denial and politically correct assertions. Literature and the arts offer the advantage of allowing learners to probe deeply into a problematic situation without, at least initially, having to reflect on themselves, and on personal attitudes and behaviours that may feel embarrassing or shameful. By focusing the discussion on an imagined creation, students feel safe in offering commentary about what 'the physician' or 'the patient' may be feeling without risk of negative personal consequences involving the intersubjective region between doctors and patients (Apprey & Stein, 1993). Interestingly, while such discussions start in the third person, they regularly move to the first person, as learners begin to feel secure enough to feel their way into their own patients' experiences, including their patients' perceptions of illness and of the medical system.

Once a zone of safety has been created through the removal of clinical responsibility and the use of indirection, three **key elements** characteristic of both literature and the arts emerge which tend to trigger empathy in learners (**step 3**). First is their unique ability to bring to life ***differing points of view*** (Charon, 2001), especially those that are either silenced or ignored by a medical hierarchy that privileges physician voices of authority and expertise, often at the expense of

patients, family members and other lower status medical personnel. Personal narrative, poetry and art provide opportunities for such disenfranchised and unwilling participants in the health care discourse to express their perspectives.

Secondly, literature and art are unusually rich in ***particularistic detail*** (Downie, 2002). The reader or viewer does not simply obtain a general sense of character, plot and situation. Rather, he or she is completely immersed in the alternative reality created by the story or painting. This attention to detail helps learners recognize and respect what otherwise are easily dismissed particulars of patients' lives, singular facets of existence that are deemed irrelevant to the differential diagnosis but nevertheless are filled with idiosyncratic meaning. Finally, literature and art aim to evoke ***emotional*** as well as intellectual ***engagement***, creating characters and images that are loved, hated, pitied, or admired, and situations and symbols that evoke pathos, tragedy, or humour. Students studying literature and the arts have an opening to concentrate on deepening their understanding, emotionally and cognitively, of the experiences of others. They can become more versatile in recognizing, understanding and working with difficult emotions of anger, resentment, frustration, fear, hopelessness, despair and disgust in others (and themselves) in more skillful, conscious and compassionate ways.

Even if empathy can be successfully elicited in the context of a literature/arts-based teaching session, we must further ask how or whether it generalizes to an actual clinical encounter **(step 4)**. Anecdotal evidence suggests that it does (Charon *et al.*, 1996). We hypothesize that affective and cognitive **recall** of these teaching sessions **(step 5)** is a partial explanatory mechanism for how this transference might occur. Students who have participated in literature and medicine or visual-arts seminars describe a process in which contact with particular patients associationally triggers recollections of poems or art representing a similar dilemma or difficulty. The students are then able to conjure up both the insights and the empathy that were evoked by the particular poem or painting, and bring them fruitfully into the clinical present.

Two specific dimensions of empathy promoted by this pedagogical use of literature are ***witnessing*** and ***solidarity***. *Witnessing* is a term that grew out of the Holocaust literature, when questions arose as to whether it was possible to record or listen to accounts of the unimaginable suffering that occurred in Nazi concentration camps with any sort of moral integrity. In the context of this article, 'witnessing' refers to the necessity of receiving with the utmost respect, compassion, lack of negative judgement and empathy the 'testimony' of patients, accepting their stories not as means to an end (in the case of medicine, the end of making an appropriate differential diagnosis), but as ends in themselves. *Solidarity* with the patient implies the ability, through an act of empathic imagination, to see a person initially perceived to be wholly 'other' as simultaneously sharing

similarities and commonalities with the self and also possessing certain critical irreducible differences. Attitudes of witnessing and solidarity encourage a repositioning of the student in the direction of respect and empathy for the patient's subjective experience and lived reality.

25.4 Translational applications

The observational, hermeneutic and interpretive skills that can be achieved through study of the humanities and arts have important implications for patient care. The translational applications most obviously related to empathy are: the close observational skills from which inferences about the patient's mood and state of mind are derived; the capacity to identify and appreciate multiple coexisting, and often conflicting, perspectives and points of view; the ability to imagine the patient's encounter with illness within the context of his or her lived life; and a familiarity with the emotional, psychological and symbolic worlds uniquely accessed by illness and modified by both individual experience and culture. In an appeal for practising a more narrative-based medicine, Charon observes that 'physicians sometimes lack the capacities to recognize the plights of their patients, to extend empathy toward those who suffer, and to join honestly and courageously with patients in their illness' (2001; p. 1897). She asserts that it is only through narrative competence that physicians will be able to understand the meaning and significance of their patients' stories.

In literature-based sessions, learners are often asked to respond to a story from the points of view of the various characters. This strategy helps break down the tendency to intellectualize or assume an omniscient expert perspective regarding a particular clinical dilemma, the perspective they are trained to adopt as part of their medical education. To illustrate this point, in the story 'Fathering' by Indian-American writer Bharati Mukherjee (1990), learners are likely to quickly jump to diagnostic labelling (the child in the story, an Amerasian little girl named Eng, appears to be suffering from post-traumatic stress disorder). The diagnosis per se is probably not wrong, but it does highlight the medical expert's emphasis on identifying pathology and then treating it, conveniently by-passing any need for empathy in the process. This view sees patients 'from the outside in', at a safe professional distance. When learners employ not the third-person voice ('Eng needs psychiatric help') but the first person ('I saw my grandma get shot by Yankee soldiers'), they discover more understanding, insight and empathy for the character's troubles. As they become immersed in the details of her horrific past, as they begin to imagine experientially what it might be like to live through such events, Eng becomes not just a diagnosis, but a whole person, a survivor worthy of respect and caring as well as assistance (Shapiro, 2003).

A similar account of using visual arts to increase empathy in medical learners is reported by Stein (2003). He describes presenting the painting 'The Gleaners' by Jean Francois Millet (1857) to a group of family practice residents who initially express disdain and resentment toward their population of indigent patients, living as they do on the margins of society. In Millet's painting, humble figures gather up the remains of a wheat field, following the biblical injunction (Leviticus 19:9–10) that allows the poor the residual portion of a harvested crop. For these physicians-in-training, mostly products themselves of the Great Plains, the painting evokes many personal memories of ripe fields of plenty. As the residents begin to describe emerging associations of the scene depicted with their faith and families, their emotions soften and empathy replaces scorn.

25.5 State of the research on the humanities and empathy

Although the humanities have been held up as an exemplar for improving empathy in medical learners, few data as yet exist to support this claim. In part, this is because the humanities espouse different methodologies for demonstrating veracity than those found in the social and medical sciences. Therefore, research into this question has been lacking. Pragmatic issues, including the adequacy of measures to assess empathy, the difficulty of appropriate designs and lack of funding, have played a part as well in inhibiting such investigations. A modest research programme at my home institution studying the relationship between medical student exposure to the humanities and arts and increased empathy has produced suggestive results, although the sample sizes are small and the designs limited.

For example, in one study examining the effects of a literature and medicine course on 22 first-year medical students (Shapiro *et al.*, 2004), we found significant improvement in self-reported empathy, with a scaled treatment effect in the moderate range and statistically significant pre-to-post changes. Qualitative data from this same study indicated that student understanding of the patient's perspective became more detailed and complex after the literature-based intervention.

Another study analysed second-year students' writing samples in response to a prose-poem prompt describing the death of a patient from a heart attack (Shapiro & Lie, 2004). The analysis found that two kinds of written language used by students, i.e. expressing high positive emotion and expressing distancing emotion in ways that lacked empathy for the clinical situation, were related to 'detached' coping methods. Standardized patients rated students who used highly positive emotional language lacking in empathy as having poorer professionalism and communication skills. Students who endorsed 'accepting' (more empathic) coping were perceived as more professional.

A descriptive study at the same institution examining third-year medical students' use of writing and other creative media to reflect on problematic, challenging, or memorable patient encounters during an internal medicine clerkship showed that the large majority of these imaginative works by students expressed empathy for the patient, and frequently adopted the patient's point of view in their writing (Rucker & Shapiro, 2003). A final study exposed third-year medical students to three presentations on classical art and dance, and afterwards found that students reported increased empathy for others' predicaments (Shapiro *et al.*, 2006).

Other research shows similar small-scale, but promising results. A project presenting the drama *Wit* as a way of training empathy and compassion in medical students also concludes that such exposure can be used to promote positive attitude change (Deloney & Graham, 2003). A qualitative study of reflective writing concluded that, although emotionally challenging for participants, it was an effective way to increase learner empathy (DasGupta & Charon, 2004). By and large, however, much work remains to be done before we can definitively establish that exposure to the humanities and arts is an effective method for enhancing empathy in medical student learners.

25.6 Mental illness as an exemplar of 'otherness'

The remainder of this chapter examines how literature can be used specifically to help undergraduate students, medical students and family practice residents develop greater empathy for persons with mental illness. (I have not personally employed art in this manner, although intuitively art would seem to lend itself well to such an endeavour, e.g. Munch's *The Scream*.) Although the topic of mental illness meshes neatly with the theme of this book, it is selected as a focus for a more important reason. Mental illness is a condition that epitomizes the sense of 'otherness' that can take form in student-physicians (as well as more experienced physicians) toward patients, especially patients who are marginalized and devalued because of factors of race (non-white), gender (female or gay, bisexual, or transgender), socioeconomic status (poor), educational attainment (low), or medical condition (AIDS, alcoholism). Disturbances of the mind can come to represent all that is fearful, alien and threatening in medical practice. Instead of feeling empathy toward mental patients, students may begin to experience distancing, fearfulness and rejection.

'Otherness' is a construct studied by philosophers, psychologists and other social scientists (Lacan, 1977). It refers to the identification of someone or a group of persons as 'not-self'; in other words, falling outside the boundaries of one's identity. In terms of individual psychological needs, defining certain persons

or groups of persons as 'other' creates a sense of distance between them and the individual doing the boundary-setting, thus establishing a means of self-protection from feared 'contamination' or 'pollution' of the self's 'clean and proper body' (Kristeva, 1982). Distance becomes the mechanism to avoid contamination by the feared object. In this way, the ill other helps us define our own boundaries of normality and health (Crawford, 1994). Since otherness is a construct of exclusivity, it is also potentially a tool of social control. By maintaining attitudes of otherness toward persons who are ill (as well as toward other stigmatized, minority and disadvantaged groups), society promotes homogeneity and certain standards of belongingness. Therefore, on both the individual and the societal level, otherness can be seen as fulfilling certain reassuring and cohesive functions. But otherness designations also create in-groups and out-groups, shunning, shaming, avoidance and attack. To deny our own vulnerability, to quiet our own anxiety, we engage in distancing from, silencing and isolating the diseased or different other.

Mental illness adds an additional layer of potential alienation between student-physician and patient because of the stigma still attached to mental health problems. Historically, mental illness was associated with moral deficiency or punishment from God. Its sufferers were therefore automatically placed in a despised and loathsome category, to be avoided at all costs. Even today, mental illness can create disgust and fear, because many people, including well-educated medical students, still see it as somehow shameful, a personal failing, despite scientific explanations involving neurotransmitters, synapses and brain chemicals. [As has been pointed out, such biological explanations both console and humiliate, because they place responsibility for very personal behaviours and experiences outside of the control of the individual (Lewis, 2003).] Although mental illness is not viewed as 'contagious', it does appear as somewhat contaminating (Shildrick, 2000). The construct of otherness insulates the non-mentally ill from the fragility and vulnerability that the possibility of 'incurring' mental illness might otherwise engender.

Contemporary biopsychiatry defines mental health and illness based on assumptions of Cartesian logic. Certain modes of thinking and feeling are designated as normal, while the various categories of mental aberration compiled in DSM-IV are considered deviant and abnormal. It has been observed that binarism is never value-free, but implies superior-inferior relationships (Grosz, 1989), so that this original bifurcated analysis of mental wellness and illness leads to other even more disturbing dualisms: good/bad; desirable/undesirable; pure/contaminated; doctor/patient; self/other, all of which become inextricably associated with mental illness. Biopsychiatry also minimizes the contributions of factors such as social injustice, lack of resources and systematic denigration to the development and exacerbation of mental illness, thereby locating the cause of mental illness

exclusively in the individual rather than the society, while privileging the domination of the interests of powerful pharmaceutical companies in defining treatment (Lewis, 2003). In the biopsychiatric discourse, suffering itself has become deviant (Epstein, 1995), so that it no longer holds a legitimate place in the human experience. Instead, suffering is translated as 'depression', thereby becoming a medicalized, dysfunctional, *and treatable* (therefore curable) phenomenon that serves to separate 'normal' people from 'abnormal' people. All of these factors work together to confirm perceptions of otherness about individuals with mental illness, and reduce attitudes of empathy.

25.7 Mental illness as a curricular challenge

Encouraging medical learners to develop empathy, and its components of witnessing and solidarity, toward psychiatric patients does not imply a romanticized view of mental illness. It does not suggest that there are no differences between people with mental illness and people without these diagnoses, or that mentally ill people do not experience real misery and anguish, although it does insinuate that the inherent suffering brought about by mental illness is often compounded by societal attitudes and behaviour. Nor do attitudes of empathy imply that persons with mental illness should not be treated with the whole range of treatment options produced by biotechnology. However, such attitudes do recognize that the only non-threatening story about mental illness from society's point of view is one which either relegates mentally ill persons to the category of irreducible 'otherness' or places them within the context of a restitution plot, so that they are returned to normalcy as fully functioning members of society. Empathy, especially in the form of witnessing and solidarity, enables students to enter into the grey area between these two extremes that so many psychiatric patients inhabit.

The medical humanities courses I teach (usually in collaboration with a physician partner) are either university or medical school electives, designed for undergraduate freshmen, or first- and second-year medical students. At this point in their education, students have little or no exposure to patients with mental illness. Their beliefs, attitudes and expectations are generally formed through a combination of popular media, previous academic study, and occasionally personal experience. The topic of mental illness is also addressed in a family medicine residency monthly seminar. In this case, all participants have already graduated from medical school, and by the end of their first (of three) years of training are licensed physicians. Consequently, they have considerably more experience than medical students with patients suffering from psychiatric disorders, and require a somewhat more clinically oriented approach.

These literature and medicine electives are broad-ranging in terms of subject matter, and cover a spectrum of issues of concern to student- and resident-physicians such as difficult patients, breaking bad news, death and dying, and the doctor–patient relationship. Of 12–15 sessions, generally only 1 or 2 focus on mental health issues. Within a given module examining psychiatric disorders, I include readings on various diagnoses, e.g. schizophrenia, major depressive disorder, bipolar disorder, anxiety disorders and personality disorders. These are all conditions that are frequently seen in low-income primary care clinics, so are relevant to learners' present or future clinical encounters. Sessions are held as small groups (between 10 and 15 learners), generally occur monthly, and last anywhere from 45 min to 1½ hours. Readings are sometimes assigned outside class, but more commonly are read on-site. Discussion ensues, and follows these guidelines:

1. Basic orientation questions, such as who is telling the story?; what is the setting?; what is happening; when is the action taking place?; what is the tone of the selection?
2. Summary and justification of the points of view expressed in the selection's 'message', themes, or main points.
3. Eliciting differing opinions and points of view about the selection.
4. Expression of personal feelings about the characters, events, and situations portrayed.
5. Take-home messages for clinical practice.

25.8 Literature relevant to specific psychiatric diagnoses

I now offer some examples of how specific literary selections about mental illness make certain points or raise certain issues that may enhance empathy in learners. The power of literature is that it provides equal validity to the voice of the physician, the voice of the patient, the voice of the family member, and anyone else who chooses to express their viewpoint. The accounts of mental illness examined below are usually attempts by an author to create a more experientially authentic image of persons with mental illness, rather than keeping hidden those aspects that do not fit a restitution plot or are viewed as socially unacceptable.

In a way that a psychiatric textbook cannot, literature raises the question of what is sanity and what is insanity. *Aberrants* (Biggs, 1992) explores the notion of the social construction of insanity. In this poem, the narrator has a chance encounter with the husband of a friend, who explains why he recently had his wife committed to a mental institution. She was doing 'crazy' things, the husband complains, such as walking at night, talking to the stars, listening to Bach, running naked and generally recognizing the craziness of the world. The husband seems glad to be rid of this troublesome spouse. The narrator's final thought, by contrast, is that,

according to these criteria, she too is not far from insanity. This is an interesting poem because, in the minds of students, there is usually a clear dividing line between people who are 'crazy' and people who are not. Because the sympathies and point of view of the reader are filtered through the eyes of the friend of the committed woman, the poem invites us to reconsider how madness is defined, by whom, and for what ends.

In another poem, *The Invisible Woman* (Morgan, 1994), we see madness from an insider's perspective. An insane woman, locked up in an asylum, is convinced she is invisible. Because her doctor tries to tell her she *isn't* invisible, the patient concludes *he* himself must be quite mad. To comfort the doctor, she momentarily assumes visibility, body and voice, out of pity that the doctor is not strong enough to confront his own derangement. This poem, too, probes the relationship between psychological normalcy and abnormality. In addition, it challenges the view of mental patient as passive object acted upon by the patronizingly benevolent physician. Here, we hear only the patient's voice, judgements and assessments. What is most remarkable about the poem is the way the narrator responds with compassion and caring to her psychiatrist's perceived insanity. Her act of generosity provokes perceptive exchanges among students about mutuality in the doctor–patient relationship.

The Walking Woman (Grant, 1990) also hints at the aspect of social control present in defining mental illness. Elaine lives her own life, singing, cursing, communing with UFOs, lost in a glamorous fantasy existence, parading up and down the street. She is that homeless person so well-recognized, yet so little known, by most of the students. The merchants of the area circulate a petition to lock her away, but at the writing of the poem she remains crazy and free. This poem serves as a trigger for students to share stories of personal experiences with persons who are homeless, both negative and positive. The poem is also a useful stimulus for considering how the plight of the homeless can be glamorized as a carefree existence freed from the constraints and norms of society, ignoring the real suffering, psychological and physical, that most homeless persons endure.

In *Differences* (Shepherd, 1990), the narrator is a schizophrenic man who is hospitalized, treated and 'normalized', but feels he has lost some part of himself in the process. The man insists he is happy following 'his way', but family, doctor and psychiatrists force him into treatment which leaves him 'less crazy' but 'so much alone'. This perspective adds to a more nuanced interpretation of the nature of madness. Painful and distressing as mental illness is, it is also intimately wrapped up with personal identity, and shedding its signs and symptoms is often no easy matter. The poem is also useful in provoking discussion of 'forced treatment' for mentally ill individuals, and whether this violates their rights, or serves as a critical protection for society.

In Amy Bloom's moving *Silver Water* (Bloom, 2000), the story opens with the narrator describing her sister's amazing voice, a voice so beautiful it is like water poured from a silver pitcher. It is a beautiful, extraordinary image, and as a first introduction binds the reader emotionally to sister Rose who, we discover as we read on, is also psychotically violent, unpredictable and generally out of control. Although some first-person accounts of mental illness fault family for their difficulties, in this story the parents are concerned, loving and caring, good people who try to do the best for their daughter. *Silver Water* is also useful in its portrayal of both bad and good family therapists. The examples in the story motivate engaged discussions about how health professional behaviour can ameliorate or exacerbate the torments of patient and family. Eventually, Rose commits suicide and her sister, although aware of what is happening, does not try to save her. Remarkably, the mother is able to find within herself an understanding for the anguished choices of both of her daughters, to whom she refers as 'warrior queens'. The grim conclusion is not the happily-ever-after ending that medical students often expect medicine can provide through stories of restitution. Instead, it leads them to reflect on the limitations of medical care, and to confront the possibility that medical intervention cannot always stave off suffering and tragedy. Students also struggle to understand the feelings and consequent decisions of sisters and mother. There is strong disagreement about whether these are moral acts, but the eloquence of the perspectives represented enables students to approach the family with respect and empathy.

William Styrone's *Darkness Visible* (1990) is a compelling evocation of the experience of depression. Although it is possible to extract from this account the requisite symptoms necessary to make a DSM-IV diagnosis, more importantly it provides a window into the lived nature of the author's suffering. Especially in the era of selective serotonin re-uptake inhibitors (SSRIs), physician learners tend to regard depression as a rather prosaic disease, easily managed by psychopharmacologic intervention. They often overlook the intense and constant psychic pain it causes, as well as the variable individual response to medication. Styrone's ability to describe his sense of dread, of no exit, of being among the walking wounded, and of experiencing without surcease the 'despair beyond despair' helps learners gain experiential knowledge of the devastating effects of major depressive disorder.

Sylvia Plath's account of her own descent into madness – *Under the Bell Jar* (1971), although somewhat dated, is also useful in depicting the lived experience of depression. Her small book offers yet another portrayal of patient and psychiatrist, the latter presented in a highly unfavourable light precisely because he seems such a perfect individual, with the requisite good looks, education, wife and children. Plath plumbs the inevitable gap that exists between doctor and patient and suggests that, when it is too large, and not bridged by empathy, a healing

relationship cannot be constructed. Plath's vivid description of the psychiatrist often leads to a discussion of vulnerability and mutuality versus authority and unilaterality in the doctor–patient relationship.

An Unquiet Mind by Kay Jamison (1995), a leading researcher on bipolar disorder as well as someone who herself suffers from this disease, courageously describes her cycling of manic and depressive episodes, which for many years she keeps hidden in fear and shame. Her brutally honest recounting of spending sprees, hallucinations, and her own physical violence, as well as her descriptions of the beauty and excitement of the early phases of a manic episode make the experience of bipolar disorder accessible to learners on a human level. Particularly valuable is Jamison's history of her own non-compliance with medication as both a denial of her illness and a fear that she was consigning herself to a bland, robotic existence. In a profound insight, Jamison acknowledges that despite her suffering, her disease has taught her to feel more deeply, experience events more intensely, appreciate life more and find the courage to explore 'new corners of her mind and heart'. Students are struck by the complexity of the relationship between the disease and the person *with* the disease. Instead of seeing mental illness only as bad, or something to 'be gotten rid of', they begin to appreciate how integral it is in shaping a person's life, and how controlling such illness produces many consequences, some desirable and some surprisingly problematic.

The poem *Therapy* by physician-poet John Wright (1998) strikes a wise, balanced and hopeful note regarding the complex process of treating depression. Written in the voice of a physician, the poem directly addresses his patient as 'you'. Doctor and patient seem to be discussing the patient's symptomatic improvement from a major depression. While the physician credits only pharmacology for the patient's recovery, the patient perceives healing to be a more complex process. In contrast with the logico-scientific, reductive model of his doctor, the patient gives 'half the credit' to the hope of rebirth and renewal symbolized by the pear tree blossoming outside the physician's window; and to the human warmth of the physician himself. Reading this poem reminds students that, although medication is often necessary, healing powers exist within the therapeutic relationship itself.

Anxiety Wins a Round by Marge Piercy (2000) describes generalized anxiety disorder. The narrator tells of a fear that is so grinding, oppressive like a stone, throbbing like a toothache, that it produces the sense of being completely overwhelmed and swept away, as in a flood. She also talks openly about the dissolution of self, and how the old familiar anchors cannot reassure her. In vivid imagery, it is as though she is 'impaled' by this experience of anxiety – lost, overwhelmed, reduced to a rat in a maze. The range and depth of metaphors, the uncompromising detail offered by the poem make it impossible for learners to avoid or intellectualize the pain of pervasive anxiety. Despite the patient's well-documented

misery, the poem is essentially optimistic. The title suggests that dealing with anxiety is an ongoing process, and the narrator is hopeful she can overcome her demons and regroup in the morning. These words enable students to see treatment of mental illness as an ongoing process, one which requires commitment and perseverance from both patient and physician.

Another poem, *Agoraphobia* by Susan Hahn (1994), describes the psychiatric condition of fear of open spaces and crowds. In this first-person rendering, the narrator reveals an encroaching isolation, so that her encounters with the outside world become increasingly reduced to the realm of memory. Her world steadily shrinks until the only safe place is the bed and TV, a classic agoraphobic outcome. The narrator anchors herself in this small realm by listening to news of disasters, which confirms her sense that venturing out is unacceptably dangerous. Although pleasurable events are tempting, she can now experience them only in her mind. The chronology of the narrator's illness enables learners to 'walk with' her as her agoraphobia progresses and begins to dominate her life. Yet it also becomes apparent to the learners that, from the patient's perspective, her responses are logical and sensible. Again, seeing the world through the eyes of the patient evokes compassion and additional insight into what reassurances this patient might need in order to accept treatment.

Arthur Kleinman's classic work, *The Illness Narratives* (1988), contains perceptive sketches of hypochondriasis and panic disorder, as well as other psychosomatic ailments. Arnie Springer is convinced, despite all evidence to the contrary, that he has cancer. Although medicine can reassure him, it cannot unequivocally guarantee that he will never develop cancer, so Arnie remains perpetually terrified. A systems analyst, he has lost his ability to deal with the uncertainty and inherent disorder of the world. Kleinman also describes Wolf Segal, who regularly presents in emergency rooms, convinced he is having a heart attack, with accompanying symptoms of chest pain, numbness in his hands, shortness of breath, rapid breathing and palpitations, as well as the sensation that he is going to die. In fact, there is nothing wrong with his heart; Wolf is experiencing a typical panic attack. Hypochondriasis and panic disorder can easily be dismissed by medical students as 'non-illnesses'. Kleinman's brilliance lies in the way he reveals these patients not as cases, but as *stories*, involving readers in their narratives, and forcing them to see through the eyes of these patients.

25.9 Limitations, possibilities and conclusions

Literature is not a panacea for helping learners to become more empathetic toward patients with mental disorders, or other illnesses. One problem with its use is that it may idealize or glamorize the illness experience in a simplistic fashion, creating

an exaggerated identification or advocacy in learners rather than clear-sighted empathy. For example, the efforts of persons with mental illness, or their supporters, to present an alternative perspective to the dominant discourse may sometimes convey the impression that mental disorder is an invention of the medical establishment. This radical conceptualization is not helpful to either students or patients. However, the awareness that there are *multiple* perspectives about how to interpret mental illness, or the illness experience overall, is revelatory for medical students. To guard against over-simplification, it is useful to expose learners to a wide range of texts.

Other potential problems are more subtle in nature. How the humanities are taught in medical schools is of critical importance in influencing their efficacy. If they are perceived as simply additional bodies of knowledge to be mastered, they will be unlikely to help learners become more empathetic. Although it is, of course, legitimate to approach the study of literature or art as a purely intellectual inquiry, this will do little if anything to help students be moved by their patients' suffering. It is not the specialized erudition of literary or aesthetic analysis that stimulates empathy in medical learners, but rather the fundamental insights and knowledge about the human condition that can be acquired through becoming fully engaged on multiple cognitive, emotional and spiritual levels with a text or painting. Humanities succeed best in promoting empathy when they offer opportunities for thoughtful reflection, rather than concentrating solely on transmitting academic information (Koppelman, 1999).

In a somewhat different way, curricular error also occurs when the humanities are 'quarantined' (Stempsey, 1999) from the core of medical education, much as psychiatric disease is quarantined from less stigmatized medical conditions. When literature and the arts are not part of the standard curriculum, they will be regarded by learners as tangential and low status. Whatever they attempt to convey to learners about the importance and value of empathy will similarly be devalued, or perceived as irrelevant to 'real' patient care. This method cannot produce humane physicians because learners will see the experience as too limited and ivory-tower (Greaves, 2001).

In an ideal world, the humanities and arts would become integrated into the overall medical school curriculum (Gorovitz, 1998), where they would be viewed as an equally legitimate, although different, method of accessing important knowledge about doctors and patients. In this utopian medical school, students learning anatomy would be just as likely to read a poem about a cadaver as to examine a bone. The patient chart would include not only the history of present illness, physical findings, a SOAP (subjective, objective, assessment and plan) note and treatment plan, but also would be enriched by a personal narrative written by the patient, and perhaps a poem by an orderly, nurse, or physician who was moved to

reflect creatively about the patient. Attending physicians would model encouraging patients to write a letter to their diabetes, sharing their frustrations and fears, while medical students would keep journals documenting their own socialization experiences into the medical profession. The corridors and walls of the hospital wards would be filled with the photography, paintings, sculptures and poems of students, physicians, patients and staff. In the hospital courtyard a volunteer medical student orchestra might serenade off-duty nurses, residents, patients and family members, while in a lecture hall across the way cancer patients, students and physicians might attend a performance of the play *Wit*, about an English professor dying of ovarian cancer (Edson, 1993). The efficacy of all of these activities to reduce stress, promote mutual compassion and increase healing would be evaluated by innovative combined quantitative and qualitative methodologies that gave credence to experiential as well as abstract knowledge (Saunders, 2001) and to particular, individual perceptions as well as statistically significant group differences. It is as an equal partner of this as yet non-existent educational system that the humanities and arts might best help medical students develop the necessary empathy to compassionately and wisely address the needs of patients with mental illness, and indeed the needs of all patients.

In summary, the role of empathy in medicine has been a longstanding but ambivalent one. The concept of clinical empathy makes a significant contribution toward defining the proper relationship between doctor and patient, including as it does a balance between emotional steadiness and tenderness. Because of the limitations of teaching empathy to medical learners strictly as a behavioural skill set, the possibilities of integrating literature and the arts as pedagogical supplements to the standard curriculum are intriguing in terms of promoting empathy.

A theoretical model of the relationship between exposure to literature and the arts and empathy posits creating a zone of practical and emotional safety through removal of clinical responsibilities. The use of indirection allows learners to attend to issues of multiple perspectives, individual particularity, and emotional engagement that literature and arts uniquely address. In subsequent clinical encounters, these experiences are vividly recalled, and incline the learner toward actual expression of greater empathy toward patients, particularly in the form of witnessing and solidarity. At this point in time, little research exists to substantiate this model, although preliminary investigations do find a relationship between study of fictional and first-person narrative literature related to illness and increases in self-reported student empathy.

Although empathy is a necessary component of all patient–physician interactions, it is acutely relevant in the case of psychological disorders, where issues of otherness and stigma are especially in evidence. Using literary examples to teach medical students about schizophrenia, depression and anxiety heightens learner

understanding on dimensions of point of view, particularistic details and emotional connection. Such an approach challenges the omnipresent restitution story as the only acceptable story about mental illness, and offers learners the opportunity to listen closely to the voice of the patient. The result is often increased empathy and understanding.

While literature and the arts have great potential in medical education, their value is by no means guaranteed. Problems that compromise the pedagogic goal of promoting empathy in learners arise when the arts present too one-sided a view of illness; when they are taught as a purely academic subject; and when they are marginalized within the curriculum. Nevertheless, literature and the arts offer great potential for helping medical learners understand how to be more empathic toward their patients.

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