Ars Medica
A Journal of Medicine, The Arts, and Humanities

Volume 16
Issue 2
2022

Pumpkin, Penguin, and Pepper: Encounters Between a Mentally Ill Medical Student, a Psychiatry Patient, and a Psychiatrist

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Shame is an especially sticky emotion. Its grasp feels tenacious and unforgiving, and you're often unable to peel it off without losing a piece of yourself—a bit like bubble gum in your hair. Feminist theorist Sara Ahmed argues that emotions, like shame, are not just produced from within us, but rather from outside us: How and what we feel are shaped by social, cultural, and even political forces (*Emotions*). As such, emotions circulate amongst us all, but stick to some people more than others due to structures like racism, ableism, heteronormativity, and more. Understanding emotions in this way helps make sense of my own experience with shame as I navigate medical school with mental illness. I previously studied literature and critical theory, so I'm not surprised that I turned to thinkers like Ahmed to unpack how shame stuck to me during medical school. But I was surprised by how this shame finally began to peel off through working with a patient named Kate, a 30-year-old woman with OCD.[1]

Shame first adhered itself to me a year before I met Kate. I was with my first-year clinical skills group discussing how to recognize and empathetically elicit psychiatric symptoms and conditions that patients may not feel comfortable disclosing to clinicians. Often, such patients avoid disclosure because of prior negative encounters, internalized stigma, and shame. I know those feelings and experiences all too well. Our group's discussion centred around one particular mental illness, and it happened to be one I live with. Medical students are repeatedly taught that one of a physician's most critical responsibilities is empathizing with patients. Along this vein, my well-intentioned classmates asked our tutor probing questions to understand the minds of patients with this—my—mental illness. "Why would someone ever act like that?" one asked. I whispered the answer to myself: "Because I just can't help it." I felt like an impostor, trapped in the gap between my classmates seeking to understand this illness through our tutor's clinical insight and already knowing it through my own lived experience. Flushing with shame, I wondered: am I really so odd that my bright classmates can't understand this crazy mind of mine while having no problem understanding the complex physiology of acute kidney injury? Even as I write this essay years later, that shame keeps me from disclosing what specific mental illness I live with.

My classmates' approach to empathy stems from how medical trainees are socialized to approach everything unknown: to pick it apart, understand it, and ultimately master it in order to

become a valued medical expert. But empathy is not necessarily about understanding the patient's experience. Yes, it can sometimes help us empathize, but fixating on understanding risks getting in the way of what else empathy is crucially about: acknowledging the differences between your experiences so you can compassionately and justly care for another's particular situation (Jamison, 2014).

I left class that day dressed in shame, performing as a visibly healthy medical student to disguise my identity as an invisibly ill patient. Feminist theorist Eve Sedgwick understands shame as performative: one is flooded by the negative feelings and judgements of a real or imagined audience towards oneself, internalizes this, and then responds outwardly through actions like averting the eyes, flushing, and/or turning inwards (2003). This helps me understand empathy also as a performance, but with a key difference: both shame and empathy begin by internalizing the feelings of another, but then empathy projects that back out by striving to connect with others, whereas shame pulls one away. As more medical school lectures and discussions implied that illness was something experienced by patients, but not physicians-to-be, I internalized that irreconcilability by further wrapping myself tightly in shame, feeling ever more alone in my experience. This shame didn't begin to unravel until I started shadowing psychiatry in my second year.

Months into the pandemic, I was invited by my psychiatry mentor, Dr. D, to participate in narrative therapy as an "outsider witness" with a patient

named Kate. An outsider witness is a third party who listens, acknowledges, and reflects upon stories the patient shares in therapy (Payne, 2006). One of the first things Kate shared is that she has a cat named Pumpkin whom she cares for deeply. I suspected we would get along well, as I also have a beloved cat named Pepper, and Dr. D has a cat named Penguin. This connection with our cats is a surprisingly instructive, albeit quirky, reflection of one of our strongest points of connection: the way Kate cares deeply for her cat, a mysterious creature she can never fully understand, reflects how she is teaching me to care for others without expecting or needing to fully understand their experience.

In one appointment, Kate described feeling "stuck" in the feelings, actions, and habits of both her mind and body due to mental illness. Although she was describing her own experience of mental illness, I was struck by how well her metaphor described mine. In response, I disclosed some of my own experience, inspired by Dr. D's prior role modelling of the same. Navigating disclosure is especially tricky amidst the power dynamics of a clinical encounter. This shared feeling of "stuckness" could tempt me to want to further understand our experiences as the same, thereby risking appropriating Kate's experiences for myself. However, I was surprised to find myself more curious about what made Kate's "stuckness" different from mine, humbly hoping to help her better understand herself. Here, I circle back to Sayantani DasGupta's call for "narrative humility" in medicine—a concept I first encountered as an

early undergraduate student, curious about how my learning in literature courses mattered beyond the classroom (2008).

Through our shared curiosity and care for each other's suffering and successes, Kate and I have helped each other in ways neither of us predicted. Kate has reduced time spent on rituals and, for the first time, spent time genuinely believing in her own worth. Similarly, I have spent less time dwelling in the shame of my mental illness and more time recognizing the value it brings to my role as a medical student. Through my new encounters with Kate and my renewed encounters with my humanities background, I am relating to my own mental illness in new, affirmative ways. I have also started to consider new ways to relate with patients beyond empathy-as-understanding.

One way I have begun to re-imagine empathy is through the concept of surprise. In her seminal essay "Paranoid Reading and Reparative Reading, Or You're so Paranoid You Probably think this Essay is about You," Sedgwick argues that paranoid inquiry has problematically become the *only* accepted way of approaching a text or even the world, when it is really only one of many approaches, including reparative inquiry (2003). Paranoid reading is to analyze with deep suspicion—a sense that something bad or nefarious is always going on beneath the surface, so it never catches you by surprise. In medicine, such paranoid anticipation is necessary for timely diagnosis, treatment, and prevention. But when paranoid inquiry is the only way one approaches patients, it

transforms them into objects who only have the potential for problems to be managed. To read reparatively, however, is to surrender to the possibility that one may be surprised by what is encountered and that those surprises can even be good.

Ahmed might call reparative reading a generous encounter between two elements—a reparative reader and a text, for example, or even a doctor and a patient (2000). Surprise is also foundational to this generous encounter: it is not a meeting of elements that already or indeed ever can know each other, but depends upon the surprising nature of acknowledging that "we may not be able to read the bodies of others" (*Strange Encounters* 8). This point crucially reminds me that my humanities education has not taught me to read the bodies of patients, but rather to recognize that I may not, cannot, and even sometimes should not.

In this way, I re-imagine empathy as generosity in allowing oneself to be surprised by all one does not understand about a patient's experience. It is this kind of surprise that may get one closer to fostering a reparative (read: healing) relationship with patients.

I want to walk into the 1000th room with a patient with mental illness and still be surprised—to not fully know what mental illness is for that person, despite my wealth of medical knowledge, clinical-communication skills training, personal experience, and all the literary representations of mental illness I have read. Months into working together, I am still surprised by Kate's experiences, her reflections on those experiences, and her trust

in sharing it all with me. After a decade working together, Kate and her psychiatrist also still find themselves surprised.

Most surprising of all to me is how shame's sticky grip is finally loosening as I begin to experience how my training in the humanities and my own illness experience are genuinely assets in caring for patients—not just in theory, but in practice. And I owe that largely to Kate, Dr. D, and, of course, Pumpkin, Penguin, and Pepper.

Note

1. Patient details have been changed for confidentiality, including cat names, but the true coincidence of all three cats' names beginning with the letter "P" has been preserved.

References

Ahmed, S. (2014). Shame before others. *The cultural politics of emotion*. (2nd ed.), (pp.101–121). Edinburgh University Press.

Ahmed, S. (2000). *Strange encounters: Embodied others in post-coloniality*. Routledge.

DasGupta, S. (2008). Narrative humility. Lancet, 371(9617), 980–981. doi:10.1016/S0140-6736(08)60440-7

Jamison, L. (2014). The empathy exams. *The empathy exams*. Graywolf Press. n.p.

Sedgwick, E.K. (2003). *Touching feeling: Affect, pedagogy, performativity*. Duke University Press.

Payne, M. (2006). Telling and re-telling. *Narrative therapy: An introduction for counsellors* (2nd ed.), (pp.126–139). SAGE Publications Ltd.

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