AFFECT, LITERATURE AND THE MEDICAL ENCOUNTER

LEONARD BLOOM

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Department of English
Faculty of Arts
University of Ottawa

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Abstract

Although medicine has great technical achievements to its credit, its "evidence-based" paradigm has lacked in its failure to recognize the importance of the relationship between patients and physicians in the amelioration of the illness experience. Affect theory, especially as described by Massumi, Stern, Sointu, Damasio and Frank, employs the concepts of "the virtual", embodiment, and vitality in examining the dynamics, and enhanced potential for healing, of the clinical consultation. Seen through the lens of affect theory, novelists and poets such as Munro, Wallace Stevens, Dylan Thomas, Tolstoy, Carver, Faulkner and McCullers, amongst others, in the relationships they portray, in their lyrical interrogation of unusual experience, in their examination of the relationship between emotion and reason, and in their exploration of the difficulties of expressing embodied experience in words, create the possibility for a refocused doctor-patient encounter.

1. Medical Education, Narrative Medicine and Affect Theory

> Our fathers knew less of disease but more of men, and if we do not take care, our successors are liable to know much more about disease but very little about human beings.
>
> Francis Peabody (1922) quoted in *Physicianship and the Rebirth of Medical Education* (51)

Since the early nineteenth century, when medicine began to be based on clinicopathologic correlation (Boudreau et al. 51), as opposed to the scholastic tradition, the medical paradigm has been conceived as "evidence-based", an approach which defines a lexicon of diseases, determined by their pathophysiology, and prescribes a series of interventions whose efficacy is demonstrated in rigorous clinical trials. Medical education emphasizes the symptoms and signs of disease and the powers of technology to provide solutions. Disease, influenced by the Cartesian dualism of mind and body, is defined as an intra-corporeal lesion (Sointu 315) rather than as an illness of the total person. It is ultimately the pathophysiological diagnosis that provides the "true" explanation of disease (Sointu 316): "The power of the biomedical discourse is embodied in the affective clout that biomedical diagnosis and treatment possess in a society where science and scientific thinking hold enduring sway and where the scientific method is conceptualized as a primary means of accessing truth and reality" (Sointu 317).

By contrast, health can be defined in existential terms as an equilibrium which exists both inside the individual and in their relationship to their environment. For example, a developmental delay, resulting from an impoverished environment, would not normally meet the definition of disease, but from the point of view of internal and external homeostasis, it

does qualify as illness (Boudreau 11). Patients visit doctors with symptoms and sensations of great personal import which are often not well-defined by the patients themselves and, not fitting an easily recognized pathophysiological pattern, are under-appreciated by physicians. Often situations of family or personal stress manifest in individual patients who present to physicians with physical symptoms which are incorrectly investigated and treated in the search for textbook-described disease. In fact, the identification with the illness of friends, the fear of family diseases, the pressures of work and marriage, the limitations of aging, are often the underlying, unspoken, reasons for a consultation with a physician. Rather than searching for a solution in the lexicon of diseases, a more helpful approach is the imaginative recognition of the true nature of the problem and the creation of a relationship with one's patient that communicates this recognition. This calls for a different approach to the medical consultation in which attention is paid not only to pathophysiology but also to psychosocial problems which lie outside of the disease model and importantly, the focus of my argument, to the creation of a therapeutic environment in which patients—and physicians—*feel* comfortable.

This thesis presents the argument that the therapeutic relationship, the actual moment of encounter between physician and patient, is enhanced by a recognition of affect in the encounter. It places emphasis on an aspect of clinical medicine, the feeling of the visit, that the biomedical paradigm ignores as being outside of its purview. Although the consultation is largely conducted in words, affect extends beyond words into the realms of embodiment, emotion and feeling. (Not discussed is the essential role played by the physical examination, the direct contact of bodies, in the patient-physician relationship.)

I want to distinguish my exploration of the role of affect theory in clinical medicine from that of Narrative Medicine, which, from its introduction in the 1970s (Bleakley and

Neilson 24), has gained immensely in its reach. While Narrative Medicine focuses on a patient's story as it extends through time, certainly crucial to diagnosis, affect theorizes the space of the encounter as physician and patient sit opposite one another. This is a space bounded by an agenda not yet determined, a space of potentiality limited only by imagination. Here literature can work its magic, reclaiming from the participants' memories those unrecognized and unexpressed feelings, ideas and sounds that might not otherwise have been seen as having any role in a doctor's office. Whereas the telling of their complete story adds depth and richness to a patient's "chief complaint", it assumes that a story has a beginning, middle and end. By contrast, affect is open-ended, always becoming, expressing and rejecting the inexpressible. Affect occurs in relationship, having the potential to be healing in itself.

Narrative Medicine has developed as a reaction to the limitations of a strictly biological clinical model which fails to account for the individuality of patients in the understanding of illness. Amongst many others, both theorists and writers, such as Johanna Shapiro, Naomi Remen, Vincent Lam, Shane Neilson, Eric Cassell and Arthur Frank, Dr. Rita Charon has had international influence in the development of narrative medicine. At Columbia University, as both a medical internist and a PhD in English Literature, her doctorate's studying the work of Henry James, she and her team have developed narrative medicine which, through storytelling, applies the categories of textual close reading to the medical encounter. (Charon applies the skills of attention, representation and affiliation and the literary principles of intersubjectivity, relationality, personhood and embodiment, action toward justice and creativity to the clinical encounter) (Charon xi). In order to understand the complexities of a patient's illness one inquires not only about the symptoms and clinical signs of their disease, which have a biological uniformity for all patients, but also about the circumstances surrounding the reasons

for the patient's visit. What is the patient's occupation and what losses will illness cause them to suffer, who is depending upon them, what will the loss of social status due to ill health mean, what are their feelings about eternity? In her characterization of narrative, as opposed to the lyrical, emphasizing the time course of narrative, Belling writes, "Narrative extrapolates the self into event and change, morally weighted plots of cause and effect, reward and punishment" (2). Rita Charon famously opens her medical interviews with a request to hear her patient's story: "Tell me what I need to know to take care of you".

Enquiring about the reasons for the visit, the physician pays attention to the characters in the history, the time frame, the narrator and his/her point of view, what is in the spatial frame and what outside of it, what diction is used, what is not said, what is hidden in the language in its enthusiasm or lack of such. Narrative medicine is taught through close reading of pieces of literature, with or without an overtly medical content, and then writing a brief response to a prompt, "in the shadow of the text". Ann Michaels, in *The Winter Vault*, provides a beautiful example, both narrative and lyrical, of the applicability of a novel without an overt medical content to the practise of narrative medicine. In the building of the St. Lawrence Seaway homes and graves are being flooded; the young engineer Avery offers Georgiana Foyle the opportunity of having her husband's grave moved to a new location. Georgiana's astonished, tearful questions in response to the proposal: "Can you remove what was consecrated? Can you remove that exact empty place in the earth I was to lie next to him for eternity? It's the loneliness of eternity I'm talking about" (47), parallels the anguished response of elderly patients when we suggest they leave their homes of many years for a retirement home because they are having difficulty managing their self-care. We understand the importance of the phrase "the book reads the reader", as each person will respond to the text,

often lyrical in nature, according to his/her own experience. In fact, in brief writing exercises done after reading the text, the responses, developing only at that moment in the writing of them, are often surprising to the writers themselves. This exercise sensitizes clinicians and students to the multiplicity of perspectives, of both patients and physicians, the co-created nature of truth, the role of uncertainty and, most importantly the importance of imagination and potential in understanding the relationship between their health and the stories that patients tell (themselves) and that physicians hear. Physicians learn that their own points of view affect what occurs in their encounter with patients.

The dynamic of the clinical consultation itself, happening in real time, is described by turning to theories of affect. Although there are multiple conceptions of affect, they all have in common the notion of a space in which emotion, and new ideas for living, can arise. Affect, according to Massumi, following Spinoza, is the capacity of a body to affect and be affected. Our freedom consists in choosing from the numerous ways that we can affect or be affected: "And you have to remember that the way we live it is always entirely embodied, and that is never entirely personal—its never all contained in our emotions and conscious thoughts" (Massumi xxxv). Literature, not necessarily medical in content, seen through the lens of affect theory, can be employed often as a means of providing new perspectives to practising physicians and medical students but also as an offering to patients when a short story or poem resonates with the patient's situation. An example of this situation recently occurred: A patient in her eighties, a visual artist, had undergone multiple life-threatening illnesses. She reported that she was less worried about any of these than about her progressive visual loss from macular degeneration. Together we read Lisel Mueller's poem, "Monet Refuses the Operation":

Doctor, you say there are no haloes
around the streetlights in Paris
and what I see is an aberration
caused by old age, an affliction.
I tell you it has taken me all my life
to arrive at the vision of gas lamps as angels,
to soften and blur and finally banish
the edges you regret I don't see,
to learn that the line I called the horizon
does not exist and sky and water,
so long apart, are the same state of being.
…
… Doctor,
if only you could see
how heaven pulls earth into its arms
and how infinitely the heart expands
to claim this world, blue vapor without end.

The usual medical response might have been to minimize the macular degeneration in relation to the other life-threating diagnoses attached to this patient or to offer reassurances that medicine could minimize this problem. Our reading the poem, which was not a close reading, united us not so much on the level of reason but rather through feeling. We did not solve the macular degeneration but rather we generated an alternative way of connecting in our relationship that

was hopeful, that opened a glimpse of heaven rather than hell. Perhaps the fact that my patient was from southeast Asia made her more open to a conception of the unity of life expressed in the poem. The lyricism of this poem, my patient's recognition that her plight had been heard and understood, provided a moment of connection between us, not in a narrative, but rather a timeless, sense.

Affect theory, in its study of relationship, is complimentary to narrative medicine in explicating the clinical encounter; feeling and reason, space and time, are interwoven. As discussed below, there are generally speaking two schools of affect theory; the one, as expressed by Brian Massumi, understands affect as arising prior to conscious thought while the other, propounded by Ruth Leys in a rebuttal to Massumi, understands affect as determined by sociopolitical influences. If this were not so, she claims, there would be no free will as decisions would be made prior to consciousness. Massumi's theoretical framework is useful as a model for the medical encounter because, as discussed below, it creates the notion of a consultation that is filled with potential, with freedom, in which there is no predetermined agenda, where there is possibility for the new.) Affect is filled with content but is also characterized by the energy occurring in relationship. As such it is linked to Stern's notion of vitality, which describes the movement and energy of all human actions.

Massumi traces his understanding of affect to Spinoza, Simondon, Whitehead, Deluze, Guatarri and William James. Massumi is especially interested in Spinoza's idea of relationship expressed by Spinoza in his *Ethics* (446-491) in which he argues that when one body affects another it in turn is affected. Applied to the medical encounter, this describes a situation very different from that envisioned by the medical paradigm in which the physician, rather than being in relationship, stands outside of the encounter like a detective gathering and observing

signs of disease. The modulation of the affect, the intrinsic tone, of the encounter, inspired by the multifaceted perspectives of literature, makes possible the creation of a more therapeutic relationship, an encounter which encompasses not only a recitation of symptoms but is a relationship of feeling. It is this emphasis on the feeling of the consultation, the mutual recognition of patient and physician, the potential for the unexpected, beyond simply the sharing of information, that is the focus of my thesis.

The inductive reasoning of evidence-based medicine is the sine-qua-non of present-day medical encounters. Students and physicians, having been educated according to the medical paradigm, and its attendant discourse, attempt to shape every patient complaint into a recognized diagnosis, often at the risk of reimagining the patient's symptoms so that they "fit". If symptoms cannot be organized into a known pattern of disease, if laboratory and imaging studies are unrevealing, the patient's illness is discounted as psychological or not real, a perception that generates stigma for patients and dissatisfaction for physicians. Evidence-based medicine, although it has resulted in outstanding advances in the understanding and treatment of disease, falls short when it comes to treating chronic diseases or when a patient's symptoms, perhaps the result of fears and conflicts, fall outside of known description. Michel Foucault, in describing the change in the practise of medicine at the end of the eighteenth century, describes how the question, "What is the matter with you?", is replaced by another question, "Where does it hurt?" (xxi). The proud, newly found empiricism of medicine, "the care with which it silently lets things surface to the observing gaze without disturbing them with discourse" (xxi) changes the very nature of discourse about illness. The "hidden curriculum" covertly announces that imaging and laboratory results tell the real story while patients' stories, "the

discourse", are of interest, and provoke empathy, but are of secondary importance to actual diagnosis and cure.

Evidence-based medicine is thus limited on two levels: There is a narrowness of vision on both the cognitive and emotional planes. Not only must symptoms fit recognizable patterns but also the influence of emotion is minimized. That is, not only is there a cognitive bias as to what constitutes disease, there is also a discounting of the role of feeling, both in the patients' experiences of illness and in the physicians' experiences of joy, achievement, guilt, failure, sorrow and loss. Emotions that do arise are likely to be suppressed because they may be too uncomfortable for both physician and patient (Frank 58).

The paradigmatic medical history utilizes the structure of narrative—a beginning, a middle and an end. Medicine is based on the tautology that there must be an answer, even if it is not yet known. Stories engendered by illness, often with no clear resolution, especially in the case of chronic illness or relationship issues or lack of suitable housing, often do not neatly fit this narrative pattern, undermining expectations of both physician and patient, thereby troubling the physician-patient relationship. The encounter often ends in an impasse, both parties feeling misunderstood. A different way of relating to patients is required, informed by the mutual recognition that there might not be definitive solutions to the binds in which they find themselves. The affect of the medical consultation might therefore be transformed, no longer occurring in an encounter which is a communication of information but rather defining a relationship in which a therapeutic space is created in which patients feel that they are heard and respected. Physicians exposed to literature and lyrical poetry which portray unusual experiences and intense feelings might be open to conceptualizing patients' experiences in a more nuanced way.

In *The Wounded Storyteller*, Arthur Frank categorizes patients' experiences of illness. The understanding of these archetypal experiences suggests to physicians hearing these histories appropriate responses. Individual responses to illness, he argues, fit one of three narrative subtypes—Restitutive, Chaos and Quest—without wanting to "subsume the particularity of individual experience" (Frank 76) in the subtype. Individuals and institutions have preferred narratives; those not preferred are likely not to be spoken or heard. For example, in Raymond Carver's poem, "What the Doctor Said", which we later discuss, the physician, overwhelmed by the fatal diagnosis he is offering Carver, calls upon the unthinkable solution—religion—and thus betrays medicine: "Reflection on one's own narrative preferences and discomforts is a moral problem, since in both listening to others and telling our own stories, we become who we are" (Frank 77).

The preferred narrative of medicine is the restitutive, "medicine's single-minded telos of cure" (Frank 83). As physicians we cope with the anxiety engendered by contingency, avoiding confrontation with what we conceive as inevitably poor outcomes by, in the case of serious illness, almost always finding another test or medication to prescribe as a way of avoiding confronting what we understand as having failed our patient. It is expected of physicians, by patients and by themselves, that they will "do something". Frank describes the restitutive narrative as "monadic" in focusing on an individual *body* having a disease, rather than on the experience of the *self* that is, "*dissociated* from the body" (84). That is, the trajectory of the restitutive narrative arises not from the individual's experience of illness but rather from the medical management of that disease. The personal experience of illness, the resultant changes in socialization, in sexuality, in occupation, in relationships with others and with oneself, are not part of this story. Rather the focus is on how consistently the patient is

following the treatment regimen. The challenge for the physician is, while appropriately treating disease, to somehow broaden the conception of the illness, invoking potential, to envision a hopeful perspective that reintegrates an individual with whom they were before dwelling on "the night side of life, a more onerous citizenship" (Sontag 3).

Chaos "narratives", on the contrary, are not narratives; they cannot be told in their immediacy, but only from a distance: Those living in chaos lack perspective on their suffering, being in the midst of it, and therefore cannot create a narrative. As such it is not through narrative, but through affect, that such a story is told. Speaking of testimony recounted by Holocaust survivors, Frank writes: "The story traces the edges of a wound that can only be told around. Words suggest its rawness, but that wound is so much of the body, its insults, agonies, and losses, that words necessarily fail" (98).

Frank discusses the syntactic structure of the chaos narrative which is an "and then and then and then" (99) list of problems which overwhelms both the physician and patient with a sense of helplessness: "The personal and cultural dislike for such stories—a dislike that takes the form of simply being unable to hear the story—becomes self-evident" (Frank 100). One needs to find a new, non-narrative, way to forge a relationship: "If chaos stories are told on the edges of a wound, they are also told on the edges of speech" (Frank 101). The key to such relationships, always true but especially so within chaos narratives, is to listen rather than speak. The body itself, its manifestations, its positions and its touch, are a source of meaning. The excellent physician recognizes the meaning of being present for her patient: "Ultimately chaos is told in the silences that speech cannot penetrate or illuminate" (Frank 101).

The quest narrative, the third of Frank's narrative types, is, in fact, a true patient narrative, having a beginning, middle and an end, in which illness is recognized as a journey, the meaning of

which “emerges recursively: the journey is taken in order to find out what sort of journey one has been taking” (117). The person who is diagnosed with a disease, undergoes its treatment and outcome, is indeed transformed, emerging as a witness, whose story requires a listener. But this story, containing elements that surpass understanding, that cannot be analyzed and appear magical, requires an affective approach, a listener who attends carefully and accepts non-judgmentally that which cannot be rationally explained. In this sense the quest narrative, although it is a setting out, a journey and a return, still contains elements that can only be understood in an emotional way. Arthur Frank points out, referencing Jean-Francois Lyotard, that the post-modern truth of testimony consists not of the “‘grand narratives’—the narratives of church, state, science, and medicine that held earlier societies and lives together” (139). Rather, the testimony of survivors is “composed of bits and pieces of a memory that has been overwhelmed by occurrences that have not settled into understanding or remembrance, acts that cannot be constructed as knowledge nor assimilated into full cognition, events in excess of our frames of reference” (Frank 138).

In fact, testimony is embodied; the expression of the quest is not only what the person says, but, by virtue of their survival, the very person themselves. Frank argues that the “communicative body’s” offering testimony necessitates a dyadic relationship which is “an excess of communion over any verbal account” (144). Quoting, Jodi Halpern, Frank defines empathic care as “attuned … through preverbal resonance” (144). The relationship between physician and patient is precisely that of being there for the other: “The only mode for receiving testimony … is *being with*” (Frank 144). Literature, although by necessity symbolic and discursive, in its lyrical emphasis on feelings rather than narrative closure, in its portrayal of the unexpected motivations of its characters, can open the minds and hearts of physicians, to the embodied experience of patients’ illnesses.

The failure to engage with patients in their entirety, on both the cognitive and emotional levels, ignoring psychological, cultural, economic, spiritual and unspeakable fantasies, is both detrimental to patients seeking homeostasis and diminishes the satisfaction of physicians in their own practises. In fact, in the face of increasingly technological solutions to illness, it seems to matter little who the physician is as he/she is largely an instrument ordering and directing technologies, a "man behind the curtain". As a result, "[t]he subjectivity of the physician is muted, and the agency of the physician qua person is diminished" (Boudreau 53).

I recently met in the emergency room with two patients, a husband and wife, both with cognitive decline. The wife had called the paramedics from her retirement home, worried about her husband, yet she had been registered as the patient. Both were in the same cubicle. It was night-time. The resident called me unsure what to do as the wife was insisting hospitalization of her husband was required. We decided that night was not a good time to engage with this problem and so we provided both with beds. In the morning we did not discuss facts, but rather assured the wife that our concern was her well-being and that she and her husband would be safest back home. What seemed most appropriate in this situation was attention to the affect of the situation, the creation of a non-threatening therapeutic space. Medicalizing the encounter with an appeal to reason would have been fruitless; rather, our approach was one of relationship, of enquiring about their lives, of recognizing the impact of their confusion and insecurity. They readily agreed to the discharge from the emergency.

In *Looking for Spinoza,* Antonio Damasio constructs a neurological model integrating brain and mind based on Baruch Spinoza's concept of *conatus*, the tendency of any organism to strive for self-preservation. This striving, this desire, is expressed in the organism's affects. In Spinoza's terms, the principle affects are joy, the transition of the organism towards greater

perfection, and sadness, the transition of the organism towards lesser perfection (Spinoza 501). Emotional well-being, hope realized, promote the perfection of the organism, whereas poor health and depression lead to its decline. Excellent physicians, aided by imagination and feeling, conceptualize their relationships with patients in such broad, rather than in narrower, bio-medical, terms.

Affect theory offers a description of, and focus on, the actual experience of the medical encounter, the events that occur, and emotions expressed, in those moments when physician and patient sit opposite one another. What is the actual dynamic of that moment, what creates a situation for patients in which they *feel* secure? What is the maximum potential of that special moment? Belling writes that "…to describe and analyse an object or experience requires us to pause the momentum of plot and focus down, observe closely and question deeply" (2). This is more a lyrical, rather than narrative, deployment of literature in its focus on the feeling of the moment. Affect points to the role that emotion, feeling and relationship play in medical experience. Although by necessity expressed for the most part discursively, affect encompasses the potential of the medical encounter, the embodied relationship, the very connectedness of the participants and all the voices that are therein "virtually" present. Affect pays attention to bodily sensation and gesture, to emotion and the resultant creation of a safe, therapeutic space, in which patients know that they have been heard and physicians know that the patients know that they have been heard. It is important to emphasize the therapeutic value of the creation of this secure space in which patients feel understood and respected. Narrative medicine honours people's stories and experiences. Affect is a way of hearing these stories, of speaking with people, incorporating *the virtual* and *vitality.*

2. Theories of Affect

The definitions of affect theory are multiple. As Seigworth and Pedwell write, in their introduction to *The Affect Theory Reader 2*, "capturing the contemporary state of affect theory [is] not unlike entering a 'fugue' state" (4). Lauren Berlant writes, "there is no monoaffective imaginary" (Berlant 4). In their introduction to *The Affect Theory Reader*, "An Inventory of Shimmers", Seigworth and Gregg describe affect as arising in relationship "in the midst of *in-between-ness*" (1). Bodies have the capacity to act and be acted upon; affect occurs in the degrees of energy for change that are generated, the intensities and resonances that occur in the space and time of that relationship: "Affect, at its most anthropomorphic, is the name we give to those forces—visceral forces beneath, alongside or generally *other than* conscious knowing, vital forces insisting beyond emotion—that can serve to drive us toward movement, toward thought and extension [of the body]" (Seigworth and Gregg 1).

In his role as cultural critic, Brian Massumi situates affect theory as a critical response to theories of social change, based on analyses of populations in their positionings on a grid, which fail to capture, in their generality, the role in social change of individual experience, individual bodies and their movements. This grid has been "conceived as an oppositional framework of culturally constructed significations: male versus female, black versus white, gay versus straight, and so on" (Massumi 2). Affect, in contrast to this "extrinsic" description, is "brought back down to earth in order to be able to integrate into the account the local cultural differences and the practices of resistance they may harbour" (Massumi 2). It is precisely this orientation of affect, its

opposition to the homogenizing principles of the medical paradigm, which makes it generative as a theory to examine the individual process of the medical consultation.

Analyses of singular experience have been seen, because qualitative and local, as unscientific and trivial compared to more generalizable theories of social change: "The slightness of ongoing qualitative change pale[s] in comparison to the grandness of periodic 'rupture'" (Massumi 1). Even when individual ideas of resistance are taken into account, it is only the discursive that is seen as significant but not individual sensation: "[Signifying gestures] make and unmake sense as they might, they don't *sense*" (Massumi 2). Sensation is considered unscientific, being based on unmediated experience. From an affective perspective, bodies and minds lack concreteness, lack boundaries, in the sense that they are in constant flux: "This is an abstractness pertaining to the transitional immediacy of a real relation—that of a body to its own *indeterminacy* (its openness to an elsewhere and otherwise than it is, in any here and now)" (Massumi 5).

Brian Massumi's approach to affect theory, his focus on individual experience and relationship, influenced by Spinoza and Deleuze (Massumi xxxiii), as well as the critical response to it, inform this thesis. Damasio's theory of the structure of the mind, his understanding of the relationship between emotion and reason, and Stern's *Forms of Vitality,* are consistent with Massumi's theories and help describe my understanding of the medical consultation. Affect theory describes the clinical encounter. Literature plays the role, through its portrayal of unusual perceptions, unlikely relationships and intense emotions of identifying and potentiating affect in the medical encounter; at the same time affect theory, in its emphasis on relationship and feeling, is a useful lens through which to analyze literature.

Spinoza writes that when a body affects another, it in turn is affected. As a result there is a change in capacity of bodies. Rather than conceive of bodies as concrete entities, they are seen as centres of energy, interacting, in flux, with the possibilities of changing one another: "For Spinoza the body is one with its transitions. There is no *the* body. There is a continuous body*ing"* (Massumi xxxiii). Each transition of the body is accompanied by a variation in capacity for change; the degree of capacity is bodily intensity (Massumi xxxiii). This idea illustrates the transformation of quantity into quality; i.e. the greater the intensity of relationship, the more likely that qualitative change will occur. This transition leaves its mark as a trace, a memory, which will always be virtually present and, as such, will always return in future relationships (Massumi xxxiv). As well as all past subjective experiences and desires, "[the] past that the body carries forward in serial fashion includes levels, such as genetic inheritance and phylogenesis, that we think of as physical and biological. There is a reactivation of the past in passage toward a changed future, cutting across dimensions of time, between past and future, and between pasts of different orders" (Massumi xxxiv).

Affect and emotion are not the same thing: "Because affect concerns the movements of the body, it can't be reduced to emotion. It is not subjective in the sense of belonging to a subject to which the body belongs" (Massumi xxxv). Emotion, the subjective form of the affective event, is experienced as belonging to an individual subject separate from the event (Massumi xxxv): "It is the sociolinguistic fixing of the quality of an experience that is from that point onward defined as personal" (Massumi xxxv). Affect, on the other hand, is autonomous in that it always signifies more than is captured in any relationship; it is the more of experience, a remainder that guarantees the possibility of the new: "Affect is autonomous to the degree to which it escapes confinement in the particular body whose vitality, or potential

for interaction, it is" (Massumi 38). In a relationship in which the goal is profound change, participants become open to the virtual, a realm of hovering, co-created possibility: "The autonomy of affect is its participation in the virtual: potential remaindered by the past, left in reserve for the future. Its autonomy is its openness. Its openness is to the escape hatch of its own futurity" (Massumi xxxvi).

Clare Hemmings provides a perspective on the development of affect theory. Affect refers to a state of being, a situation, rather than to its manifestation in an individual as an emotion (Hemmings 551). Affect sets the tone of a relationship, the paradigm which is more than rational as it also involves feeling. The psychologist Silvan Tomkins, in 1963, "was the first to suggest that [affects] have a singularity that creates its own circuitry. Affects may be autotelic (love being its own reward), or insatiable (where jealousy or desire for revenge may last minutes or a lifetime). Tomkins work suggests that affects have a complex, self-referential life that gives depth to human existence through our relations with others and with ourselves" (Hemmings 552). Tomkins considers the contagious nature of a smile or yawn which reverberates in the space between participants, increasing the original intensity (Hemmings 552). Because of its essential role in relationship, affect is central to the alliance of the medical encounter: "Affect can thus be said to place the individual in a *circuit* of feeling and response, rather than opposition to others" (Hemmings 552). This relationship contains the memories and traces of past experiences, which Tomkins calls *affect theories* (Hemming 552) and Brian Massumi calls the *virtual*. Affect is individual, but occurring in relationship, and *embodied*, involving not only discourse but bodily emotions such as shame, fear, hope, and joy. By contrast, the medical paradigm, the biomedical model, which understands illness in terms of defined diseases, pays little attention to this complexity of relationship, the actual experience of

illness. In reaction, over the past twenty years, narrative medicine has offered an alternative view of clinical medicine which encourages a practise that addresses the effect of illness on the totality of patients' lives; affect encompasses the roles that emotion, feeling and relationship play as the experience of illness is recounted, and lived, as patient and physician face one another.

The primary point of contention between the so-called affect and non-affect theorists is the extent to which affect arises pre-cognitively, and is thus autonomous, independent of cognition, ideology and free-will, a position adopted by Brian Massumi, and the extent to which affect is socially and consciously determined. The notion that affect arises pre-cognitively is appealing to my notion of the medical encounter: It implies that the relationship between patient and physician holds immense possibilities for the discovery of what has been heretofore unrealized and unexpressed. The view that affects occur primarily, independent of intention and meaning, known as the Basic Emotions paradigm, derives from the work of the psychologists Paul Ekman and Silvan Tomkins (Uhlmann 163) and has greatly influenced the work of Brian Massumi and Deleuze and Guatarri.

Massumi and Deleuze and Guattari attribute their theoretical understandings of affect to Spinoza's metaphysics which is anchored by the notion of *substance* which is eternal and is conceived as God or Nature. The *attributes* are modifications of substance—there are an infinite number of attributes but we are only able to know two, distinguished qualitatively from substance—thinking which is an attribute of mind and extension, an attribute of the body. Mind and body are intimately linked: Activity in one realm always occurs simultaneously in the other, mind and body cannot exist one without the other. It is this concept that allowed Spinoza to integrate mind and body, a separation which Descartes' metaphysics was unable to

resolve. Arising from the attributes, dependent for their existence on them, distinguished quantitatively from them, are the *modes* or *affects*. All existing objects are modes, specific in themselves, which partake of substance but which, unlike substance, are mutable. Spinoza defines affect as both equivalent to the mode and also to the modification of the mode. Since the modes are the modifiable essences of individual subjects/objects, this definition of affect, encompassing both the body and the transformation of it, implies precisely Spinoza's idea of the relation between bodies; i.e. change and fluidity are inherent in bodies and that in affecting a body, the affecting body is itself changed.

In understanding the concept of *intensity*, Uhlmann, turning to Deleuze's understanding of Duns Scotus, a Scholastic philosopher, relates intensity to the variation in mode (Uhlmann 166). While a mode is an essence, variations in these essences, such as changes in colour, shape, energy are its various quantitative intensities, making up the composition of an individual body. Spinoza's primary three affects are Joy, Sadness and Desire. Therefore each mode, varying in intensity, depending on its interaction, will become more or less joyful or sad; that is more or less able to affect and be affected. In fact, in Uhlmann's interpretation of Deleuze's reading of Spinoza, affects are, rather than fixed states, transitions of one state to another: "This is why Deluze and Guatarri famously state that 'Affects are becoming'(*A Thousand Plateaus,* 256)" (Uhlmann 167). Intensity is both the variation in mode and the energy between modes by which they are able to affect one another.

Moira Gatens disagrees with Massumi's interpretation of Spinoza. Gatens argues that Spinoza's philosophy is a "dual aspect monism" (25) in which mind and extension (of the body) are always linked. It is therefore a misinterpretation of Spinoza to argue for an autonomic, embodied affect separate from conscious thought. It seems to me naïve, however,

to argue that all of the mind's activity must be conscious; although mind and body are always reflected in one another, the activity of mind will often come to consciousness later. As we will see, Damasio's model of the neurological system, which defines even basic homeostatic mechanisms as emotions, provides a synthesis of both the body's *unconscious* emotions and those emotions that, with consciousness, are experienced as feelings. In intimate discussions it certainly feels that there are strong feelings that are neither conscious nor expressed.

Theorists such as Lauren Berlant support Gatens' position in that Berlant understands affect as a set of beliefs that we have come to unconsciously internalize as fact. In *Cruel Optimism*, capitalism is understood as such a paradigm, a dimly conscious set of relationships, that, in the background, invisibly, shapes our aspirations, desires and core beliefs, i.e. our affect, "cruelly", because our internalized beliefs about our lifestyles compose a paradox that is impossible to resolve: The goal of capitalism is to accumulate as much money as possible in order to enjoy life, but if one spends to indulge in material pleasures then he/she no longer has the accumulated wealth, nor has the spending necessarily resulted in the expected happiness. The promises of capitalism, of which we are only vaguely aware, are illusory and self-defeating. The closer we get to our goals the more they recede, as does happiness. Late-stage capitalism, although its premises are internalized as affects, is still subject to interrogation and consciousness. From a of view similar too Berlant's, Ruth Leys, in her often-quoted critical review of affect theorists, "The Turn to Affect", identifies her concern that affect theorists such as Massumi and Damasio, who argue that affect and emotion are largely unconscious and autonomic, minimize the role of cognition, interrogation, and therefore free-will, in political life. She worries that this biological determinism robs us of choice, shifting attention away from ideology and, as well, from *meaning* in fictional and artistic representation:

> For the theorists in question, affects are 'inhuman,' 'pre-subjective,' 'visceral' forces and intensities that influence our thinking and judgments but are separate from these. Whatever else might be meant by the terms *affect* and *emotion* …the affects must be noncognitive, corporeal processes or states. For such theorists, affect is, as Massumi asserts, 'irreducibly bodily and autonomic'. (Leys 437)

Similarly, Clare Hemmings, while acknowledging the impact of affect in individual lives, is critical of the argument that affect lies outside of social meaning. Rather, as an explication of social values, "affect might in fact be valuable precisely to the extent that it is not autonomous" (Hemmings 565).

Eeva Sointu, examining the role of affect in the medical encounter, reconciling these opposing positions, actually describes the intertwining of affect and discourse in medicine, arguing that while affect is largely pre-cognitive, affects such as stigma and shame are socially determined:

> discourse is seen to constitute 'the *conscious*, the *planned* and the *deliberate'* other to affect that is conceptualized 'as the *automatic*, the *involuntary* and the *non-representational (*Wetherell, 2012:52). Affect promises something novel because it 'seems to index a realm beyond talk, words and texts, beyond epistemic regimes, and beyond conscious representation and cognition' (Wetherell, 2012:19). (Sointu 313)

Focused on the neurobiology of affect, Antonio Damasio, like Massumi, argues that affect is generated pre-cognitively. As previously mentioned, his model incorporates Spinoza's idea of *conatus*, the striving of a body to continue in its own becoming. Damasio presents a model of the neurological system which unifies bodily emotion, sensation, movement, thought and feeling in multiple neuro-anatomical maps. These anatomical pathways have been identified by

clinical experiences in which parts of the brain, either as a result of disease or in the treatment thereof, are electrically stimulated. He conceives of emotion as part of a biological system of homeostasis that occurs autonomically and prior to conscious awareness. In this system even basic regulatory mechanisms of the body such as control of temperature, blood pressure, glucose levels, etc. constitute emotions. *Feelings* ultimately arise from bodily states, coalesced as emotions, combined with a corresponding conscious mental image of those perceptions of the body (Damasio 87).

One of Damasio's essential points is that emotions arise in response to broadly defined Emotionally Competent Stimuli. Damasio's conception of emotions, consistent with the goal of *conatus*, is very inclusive. Even unicellular organisms, e.g. the paramecium, contain rudimentary "emotions"—the ability to detect situations that stimulate avoidance or approach. On a human level Damasio identifies three levels of emotion:

(1) Background emotions such as energy, enthusiasm, malaise, excitement, edginess, tranquility. These emotions are experienced by an observer not in words but in embodiment: "You assess the contour of movement in the limbs and the entire body" (Damasio 43). Daniel Stern expresses these forms of movement as the vitality of the encounter (Stern 4-5). Because affect is attached to the body, it cannot be reduced to emotion (Zournazi 1). The recent debate between Biden and Trump (Presidential Debate, CNN, 27 June, 2024) is an excellent example of how the message communicated depends on vitality as well as content. Although the content of Trump's debate lacked factual verification, the vitality, the liveliness of his affect was much more compelling than President Biden's. Similarly, in a medical encounter, as in politics, much is communicated

not through the discursive aspect, but through the experienced affect, "the vibe" of the encounter.

(2) Primary emotions such as fear, anger, disgust, surprise, sadness, happiness.

(3) Social emotions such as sympathy, embarrassment, shame, guilt, pride, jealousy, envy, gratitude, admiration, indignation, contempt.

The Emotionally Competent Stimuli, which induce emotions, can occur outside of the body or can arise from within. These can be concrete stimuli, such as witnessing trauma in war, or, in keeping with Massumi's ideas of the virtual, can be the recall of past events. When we process a stimulus, an object, an event, we process its relationship not only to other things but also to past experiences, as occurs in PTSD. The potential of a medical consultation lies in recognizing the relationship of present complaints to historical concerns: "Man is affected with the same affect of Joy or Sadness from the image of a past or future thing as from the image of a present thing" (Spinoza 504). Unconscious thoughts can trigger emotions which in turn produce feelings.

A beautiful sunset, viewed by the body's optical apparatus, can inspire, but so can the memory of such. Even sexual desire is hugely modified by memory. In Damasio's view, all experience is mediated by an already existing neural pathway, the contents of which the individual might or might not be aware. Some Emotionally Competent Stimuli are unconsciously detected by the amygdala and are acted upon unconsciously, bypassing conscious awareness. Consciousness interacts with emotion, but much of emotion is a pre-existing pathway with a stereotypical response: "The apparatus of emotions naturally evaluates, and the apparatus of the conscious mind thinkingly evaluates. In effect, one of the key purposes of our educational development is to interpose a nonautomatic evaluative step between causative objects and emotional responses" (Damasio 54).

Emotions, and the activities that underlie them, precede feelings. Primary and social emotions are public manifestations while feelings are private: “Emotions play out in the theatre of the body. Feelings play out in the theatre of the mind” (Damasio 28). While Damasio separates emotion from feeling, he explains in a footnote, that Spinoza’s term “affect” includes both emotion and feeling and that Spinoza specifies which he means in context. The role of cognition is to modify the emotions which have pushed themselves into awareness. Because emotion can be autonomic, the affective relationship between patient and physician may involve feelings, the roots of which are not necessarily fully conscious nor expressed in words. Massumi describes emotion as being “a very partial expression of affect” (Zournazi 2). Because it “only draws on a limited selection of memories and only activates certain reflexes or tendencies” (Zournazi 2), rather than all the potential possibilities for thought and action, emotion is a limited manifestation of affect. “Affect as a whole, then, is the virtual co-presence of potentials” (Zournazi 2).

In further elucidating feeling, Damasio writes that “*a feeling is the perception of a certain state of the body along with the perception of a certain mode of thinking and of thoughts with certain themes”* (86 original italics). One can substitute “thought” or “perception” for idea (Damasio 85). Feelings arise not only from emotions-proper, but from any set of homeostatic reactions with consequent representation in the mind. These reactions have characteristic mental manifestations; e.g. sadness has low image production while happiness has rapid image production. Indeed, one can conceptualize the “purpose” of feelings as being the sentinel of the inner state of the organism; as such it seems crucial to address them (Damasio 140): “Some variation of pleasure or pain is a consistent content of the perception we call feeling” (Damasio 85).

Thoughts are perceptions, in a sense in the same way as our eye perceives external objects which then, via the retina, impress upon our visual cortices. In the case of feelings, however, the

brain's perception (thought) is of an emotion, internally generated by an ECS. There is then an interaction, a back and forth, between the emotion and the feeling around it. This is consistent with Massumi's idea of affect as an impingement on the body (of an ECS) with the subsequent idea of the incorporation of the context of the impingement and then a final perspective on the incorporation of that impingement. (This unconscious generation of affect and its subsequent modification by reason is illustrated later on in Alice Munro's "Dimensions".) We experience experiencing, "our experience redoubles itself" (Zournazi 2). Both Damasio and Massumi are influenced by Spinoza who understands emotion as ultimately subject to Reason. But feelings are not simply collections of thoughts with a common theme; e.g. happiness or sadness. There are extensive complex maps, representing emotions and more, in the brain, charting every bodily state and function; it is ultimately the perception of the totality of those maps that constitutes feelings (Damasio 87). Furthermore, feelings are embodied, "feelings are functionally distinctive because their essence consists of the thoughts that represent the body involved in a reactive process" (Damasio 86). Frank argues that there are no words to express what the body wants—the body always wants more, "it is in excess of any language that testimony can speak" (Frank 140).

Damasio conducted an experiment to prove his argument that when we have an overall sensation, be it of well-being or a sensation of discord, feeling is ultimately the conscious awareness of the sum total of unconscious processes. The experiment assessed the relationship of feelings to neural mappings. Forty participants were asked to think of intensely emotional episodes from their lives, involving happiness, sadness, fear or anger. They were to attempt to experience the events with the greatest detail possible. As the experiment began, the participants began to re-enact the emotion, signaling with a hand movement the moment they began to feel the emotion. PET (positron emission tomography) scanning, which indicates

metabolically active areas of the brain, indicated that areas of the brain—the cingulate cortex, two somatosensory cortices, the hypothalamus and the tegmentum—receiving input from various parts of the body, underwent a significant activation or deactivation when the participants experienced emotions: "In the same way that one can sense that our bodies are differently conformed during the feeling of joy or sadness, we were able to show that the brain maps corresponding to those body states were different as well" (Damasio 100). In other words, feelings, which are conscious sensations of the mind and body, are the end product of diffuse, largely unconscious, mental activity, receiving input from multiple areas of the body and mind, as illustrated by the PET scanning. Looking further into the areas of the cerebral cortices involved with thought processes, the condition of sadness resulted in marked decreased activity in the prefrontal cortices, while happiness resulted in a marked increase. "These findings accord well with the fact that the fluency of ideation is reduced in sadness and increased in happiness" (Damasio 101).

An impediment occurs in medicine when thought and feeling are not in accord. The challenge occurs when bodies feel unwell yet thought is struggling to offer a hopeful perspective. Clinical relationships are thus fraught. We wish to offer hope in a situation that appears dire; as a result we make promises that we are likely unable to fulfill. Our emotions, not fully conscious, determine the affect of the encounter. This creates the possibility for new understanding but also for misunderstanding. *Beware of Pity*, by Stefan Zweig, offers an example of how the novelistic portrayal of a relationship between friends can illuminate medical relationships. Hofmiller, the protagonist in *Beware of Pity*, befriends Edith, who has an undefined disease which confines her to a wheelchair. The relationship is initially one of friendship but is misinterpreted by Edith as romance, a feeling which she feels will result in her cure. Hofmiller's feelings are more akin to

guilt and pity. Just as a physician might act in a situation where the outcome appears grim, Hofmiller, whose whole being has been consumed by the conflict between feeling and ideals, makes promises that he cannot keep. Speaking with Kekesfalva, Edith's father, whose life is invested in seeing his daughter healed, Hofmiller speaks of an experimental cure, the outcome of which is uncertain at best. Sitting beside the elderly, discouraged man, on a park bench at night in the midst of a raging wind, Hofmiller speaks of the potential cure, offering hope which has an immediate embodied effect: "Immediately I could feel a rustling and stirring at my side in the dark, and the body that but now had seemed lifeless and inert edged closer, as though to get warmth from mine. I ought really to have said nothing further at this stage, but my pity urged me further than I had any right to go" (136). Our emotions, not fully emerged into consciousness, determine our actions, even as we struggle to become more aware.

Massumi references two oft-discussed studies as being evidence that affect has determinants which operate on a level below conscious awareness: It is this unconscious nature of affect that provides an opening, the possibility of newness's emerging. This is "the autonomy of affect". The first study is the "snowman" experiment, involving a short 1980 film produced for German TV, in which a man builds a snowman on his roof garden which starts to melt in the sun. He then takes it to the cool of the mountains where he bids it good-bye. This film was shown to nine-year-old children in three formats—images but no words, a second version with a "factual" voice-over explaining the film's events, and a third version similar to the second but with some added "emotional" observations. The scenes rated saddest were simultaneously rated, on a pleasant-unpleasant scale, as most pleasant. The version with no words was rated the most pleasant (saddest), the "factual" version the least pleasant (happiest) and least remembered. The emotional version was most remembered. Physiologically, the "factual" version elicited the greatest level of

arousal in that it deepened respirations and increased heart rate, but the wordless version caused the greatest increase in skin conductivity, a measure, by virtue of increased sweating, of increased autonomic reaction (Massumi 25-27). In Damasio's experiment concerning the generation of feeling, mentioned above, it was noted that increases in skin conductance, which were also monitored, always registered before the subjects moved their hands to indicate the beginning of their (conscious) feeling of emotion: "…the experiment offered still more evidence that emotional states come first and feelings after" (Damasio 101).

Massumi, and the original German investigators, recognized the complexity of the results and the difficulty in drawing definite conclusions. For example, it is difficult to explain the discordance between the different measures of autonomic arousal—heart rate and respirations versus skin conductivity. However, he does posit, from the above, that there are two systems of image reception: One is the system of overt content, of signification, the other the system of "intensity", of autonomic response (Massumi 27). There is "a reflux of consciousness into the autonomic depths, coterminous with a rise of the autonomic into consciousness" (Massumi 27). Language and intensity function differently: "Matter-of-factness dampens intensity" (Massumi 27).

The other study which Massumi discusses in "The Autonomy of Affect" involves "the missing half second". In an experiment conducted by Benjamin Libet, between the 1970s and 1990s, the brains of healthy subjects were monitored via EEG. Participants were to flex a finger at the moment of their choosing and note the precise time of this decision on a clock with a revolving dot. The flex came 0.2 seconds after making the decision but the EEG actually recorded brain activity 0.3 seconds *before the decision.* Thus there was a half-second lapse between the beginning of the brain activity and the actual initiation of movement. When asked

to comment on the implications of this experiment for free will, Libet somewhat provocatively responded, "We may exert free will not by initiating intentions but by vetoing, acceding or otherwise responding to them after they arise" (Massumi 31). In other words, argues Massumi, the half-second is not empty but is overfull:

> …in excess of the actually performed action and of its ascribed meaning. Will and consciousness are *subtractive*. They are *limitative, derived functions* that reduce a complexity too rich to be functionally expressed. It should be noted in particular that during the mysterious half second what we think of as "free," "higher" functions, such as volition, are apparently being performed by autonomic, bodily reactions occurring in the brain but outside consciousness, and between brain and finger but prior to action and expression. (Massumi 31-2)

These two experimental observations point to the importance of cerebral activity that, while not conscious, affects our emotions and actions. The snowman study points to the importance of *intensity* (which can be conceived, in Spinoza's terms, as a variation in mode/affect), a non-discursive force which, like *vitality*, plays an important role in the movement, the energy, the dynamism, of relationship. This is important in the clinical relationship where "the rules of the game" are largely formulated around information and factuality, where what is occurring on a less-conscious level is unspoken and unacknowledged, and emotions have little opportunity to be realized or expressed. On the contrary it is passion, intensity and the expression of interest that might determine therapeutic outcome. Leys, as mentioned above, argues that Massumi's ideas minimize the role of consciousness and free will: "In short, he takes Libet's experiment to prove that the material processes of the body-brain generate our thoughts and that conscious thought or intention arrives too late to do anything other than supervise the results" (Leys 454).

In a similar objection to Massumi's conception of "the autonomy of affect", Gatens objects to what she understands as Massumi's explanation of the importance of the missing half-second: "If I follow the thrust of the argument correctly then the gap is not only that non-place of the virtual and the autonomic but through a perplexing verbal slippage it is also posited as the crack through which autonomy, or freedom, emerges in the world" (Gatens 26). Gatens continues, this is a negative conception of freedom, "a freedom *from* power, and freedom *from* ideology" (Gatens 27) because affect is posited "as an *atopos* that is free *from* signification, representation, and meaning" (Gatens 26-27). While Leys offers many objections to Massumi's interpretation of Libet's experiment, she readily acknowledges that "many bodily (and mental) processes take place subliminally, below the threshold of awareness" (Leys 456). However, she argues, because emotional responses are pre-formed and stereotyped, our ability to choose a rational, thoughtful course of action would be limited. In other words, she argues that the new affect theorists assert the corporeal/material over reason (Leys 464). In response, by making a clear distinction between emotion and affect this limitation might disappear. Spinoza, as mentioned, sometimes uses *affect* to mean emotion and at other times defines affect as feeling; i.e. emotion plus reason (Damasio 300). While emotions often arise unbidden, our assessment of these emotions, and our reactions to them, involve reason. Damasio would argue that while many emotions fly under the radar of consciousness, in a unified neurological system in matters of ideology the conscious mind is still the ultimate mediator.

The importance of the recognition of affect in the medical encounter is as a counterbalance to the paradigm which understands healing's being based on an epistemology that excludes any knowledge or experience not based on pure reason. Affect provides the space for feelings, fragments of memory, secret hopes and fears, idiosyncratic conceptions of one's

body, to emerge in the safety of relationship. The broadening of imagination engendered by literature, which promotes an openness to the varied experiences of others and a recognition of the intricacy of feelings which often escape words, make possible in the medical setting the emergence in relationship of the unexpected, the inconceivable and the barely recognized.

Massumi's view of experience, corresponding to the experience of Damasio's "emotionally competent stimuli", is complex: Every experience is different, first of all from the point of view of the setting in which it occurs: "The body doesn't just absorb pulses or discrete stimulations; it infolds *contexts*, it infolds volitions and cognitions that are nothing if not situated" (Massumi 32). Furthermore, past experience, traces of which remain in the individual, constitute *the virtual* and, in contact with present experience, make possible the admitting of the new. "How could this be so? Only if the *trace* of past actions, *including a trace of their contexts,* were conserved in the brain and in the flesh, but out of mind and out of body understood as qualifiable interiorities" (Massumi 32). That is, these past experiences are conserved not with defined characteristics, but *incipiently.* Vitality, the quality of dynamism or liveliness that surrounds events, traces of which are also conserved in memory, can be evoked by present instances of vitality: "The fading of a church bell can evoke a time when someone slowly left the room or disappeared from the relationship" (Stern 128). It is this notion of the virtual that is so powerful in the therapeutic encounter where what is ostensibly the reason for the visit is the tip of the iceberg, while the potential is up for offer.

For Massumi, following Spinoza, affect is the ability of one body to affect another-and in turn be affected. Every relationship contains virtually the "more" of the relationship, the surplus, the potential that hovers, that invokes what is (more than) possible. The communication of this surplus "more than" creates *agency* which is conceptualized not as the

effort of one individual but rather as the ability for change in the relationship resulting from the overflowing potential which is more than can be contained in the relationship (Bencherki 6). Affect is relationship; it is captured not only in language, but just as much in emotion, vitality and embodiment: “The body is not mute, but it is inarticulate; it does not use speech, yet begets it” (Frank 27).

3. Affect in the Medical Encounter

Spinoza says that no one knows what the body is potentially capable of (Ethics, 495). Affect is present in the clinic when one body influences another and is reciprocally influenced. Illness suffuses the body through pain, fear of outcome, loss of bodily function and loss of identity. Illness dwells in the body in the lived experiences of shame, anxiety and embarrassment (Sointu 321). While the anguish of loss is an understandable response to illness, there is insufficient room to acknowledge this suffering within the medical model (Sointu 314). In fact, the medical encounter is filled with largely disregarded emotion on the part of both patients and physicians. The professional experience of illness is too distant from "the immediacy of embodied suffering" (Frank 25): "Hearing the desire in the story takes me back to the need for a different level of attention to stories" (Frank 22).

The story of the illness becomes the experience of the illness: "The truth of stories is not only what 'was experienced', but equally what becomes experience in the telling and its reception" (Frank 22). In this dialogic encounter, the unfolding of affect creates the conditions for the emotional and "not-yet-defined" aspects of the physician-patient relationship that go beyond the discursive, the biomedical. The medical consultation involves a patient and physician: Both have their agendas which are not clearly defined but, in the creation of meaning, vacillate between "unfolding" and "emerging" processes (Stern 125). That is, the goals of the encounter are "hazy and inexact to begin with—more like tendencies" (Stern 125). The success of the relationship, the emergence of what could be key to the patient, is enclosed in the *vitality* of the encounter, expressed in the body's movement in time, gesticulations, facial expression, head nods and intensity or hesitancy of speech, "'soft assembled' on the spot" (Stern 122-6), as much as it depends on the discursive content.

The refusal of the "absolute truth" of the medical paradigm becomes possible when "specific emotions are no longer seen as the property of either patient or physician but instead as the dynamic contents of a shared repertoire" (Weilenmann et al. in Lewis and Shapiro 278). In this relationship, affect is shared, "arising situationally to become the common currency of those who feel [it]" (Brennan, Teresa 2004 3 in Lewis and Shapiro 278). Even decline and death, from a virtual point of view, can be incorporated in the relationship, as people who both die, of patient and physician: "[T]he stories we tell about our own lives incorporate the realities of incoherence, incompleteness, and death" (Lewis and Shapiro 273). The physician too has a body so does not stand outside of the encounter: "Physicians…can become collaborators and co-creators, working with patients (and with the patients in themselves) to accept and even embrace the uncertain, open-ended transformations that disease mobilizes" (Lewis and Shapiro 275). A healing consultation is not necessarily defined by a pre-determined outcome but by the capture of the "possibility inherent in every moment" (Lewis and Shapiro 280). While the affect surrounding illness can be described, "[i]llness, health and healing all involve more than discursive meaning marking forms of affliction; paying attention to the discursive production of illness, while enormously important, cannot alone capture what it *feels like* to suffer from ill health" (Sointu 324-5).

The clinical encounter might be suffused not only with shared suffering but also with shared hope. Hope, in its becoming, is "less-than-rational and more-than-rational". It is less-than-rational in its envisaging a state "*not-yet-become"*, but is more-than-rational in that it imagines an intensely longed-for "*becoming*" (Anderson 733). It marks a discontinuity with the problematic present which does not exclude the present but rather arises from it (Anderson 745). Hope is not only a longed-for outcome, but is also constituted of a set of bodily feelings and a specific type of relationship with others (Anderson 741). As Anderson, referencing

Marcel, writes, “There is, therefore, an intuitive understanding that hope matters because it discloses the creation of potentiality or possibility and thus involves a postulate that reality overflows all possible reckonings” (Anderson 733-4). Referencing Spinoza’s idea that no one knows a body’s capabilities, Anderson asks what capacities does hope enable (734). This is consistent with Massumi’s ideas of the virtual which incorporate the vaguely realized into the possible present. Despite his/her present illness, a patient benefits from the partnership of relationship: “The taking place of hope enacts the future as open to difference but also reminds us that the here and now is uncentered, dispersed, plural and partial” (Anderson 733-4). This affective interpretation of the concept of hope, one affect modifying another in a movement of disjuncture, has its origin in Anderson’s interpretation of Spinoza’s *Ethics.* Spinoza recognizes the two-sided character of hope when he classifies it as an emotion that has aspects of both joy and sadness; i.e. as an emotion that both increases life force and diminishes it:

> XII. Hope is an inconstant Joy, born of the idea of a future or past thing whose outcome we to some extent doubt.
>
> Xlll. Fear is an inconstant Sadness, born of the idea of a future or past thing we to some extent doubt.
>
> Exp.: From these definitions it follows that there is neither Hope without Fear, nor Fear without Hope. For he who is suspended in Hope and doubts a things outcome is supposed to imagine something that excludes the existence of the future thing. And so to that extent he is saddened and consequently, while he is suspended in Hope, he fears that the thing he imagines will happen.
>
> Conversely, he who is in Fear, i.e. who doubts the outcome of a thing he hates, also imagines something that excludes the existence of that thing. And so he rejoices, and

hence, to that extent has Hope that the thing will not take place (Spinoza 534).

The complex intermingling of fear and hope described by Spinoza captures the intense emotions of illness with an uncertain outcome, our feeling at one moment that the horrible cannot possibly be happening and our feeling at the next that it is. Hope can be difficult to find when the relationship is filled with illness, exploitation and despair: "Suffering resides on the underside of agency, mastery, wholeness, joy, and comfort" (Anderson 740). The response to this suffering is precisely to "open up a new line of flight…from suffering" (Anderson 740). We can view the task of physicians, in applying Anderson's quoting of Connolly, to be, "acceptance of an obligation to respond to suffering [that] does not simply happen, instead it grows out of a protean care for the world that precedes it" (Anderson 740).

Healing involves not only the cure of biological illness but also the receding of shame (Sointu 324). The emotions that arise when expectations, on the part of both patient and physician, are disappointed, include shame, fear, loathing and disgust. Because the acknowledgement of these emotions is taboo in the clinical encounter, there is the potential for other emotions/reactions to be paradoxically expressed. More productively, to the benefit of both, finding an opening for the difficult feelings being experienced by both patient and physician, "shifts affect from a place within an individual to the space *between* individuals" (Lewis and Shapiro 276).

Affect always includes relationship. Some writers, such as Gilbert Simondon (Massumi 36), have extended the concept of affect to even include relationships between inorganic matter, in keeping with the notion of affect as dialogic, the ability in relationship to affect the other. Massumi's notion of affect is founded on lived, individual experience, the interactions of beings-in-becoming who, in their relating, create an environment. These are not

"pre-formed" individuals who relate with one another but rather are "beings-in-becoming", "dividuals" who become "individuals" through relationship. Because Massumi eschews the statistical description of the collective experiences of large groups as failing to capture experience at the local level, his theoretical writings take a position midway between the inductive reasoning of science and the extreme relativism of "truth" of post-modernism. On one hand, as an ontology, affect accounts for the reality of personal experience's being more than constructed. On the other hand, Massumi rejects the empiricism of science which has difficulty accounting for anomaly. Arthur Frank, quoting William James, says that there are no over-arching truths but the truth of each individual's experience. (Frank 17). Massumi and Arthur Frank both agree with William James's view of empiricism as applying not to discrete facts but rather that the "facts" only occur as the result of the relationship, or context (Massumi xxvii).

Massumi's ideas of affect include ideas about the fluidity of experience, expressed by the phrase "concrete is as concrete doesn't" (Massumi 1-23). Individuals are centers of energy rather than fixed beings. Truly essential in our relationships is the energy, the vitality, the potential, the real but ethereal presence, of the virtual. That which lacks movement lacks life; the concrete, the fixed, rather than being "truth" is actually only one moment in our becoming; as such, a medical interview can be co-created by its participants, unfolding in its happening, delving into sensations, revealing of truths that go beyond the presenting problem understood as a fixed entity.

Affect is influenced by the assumptions carried into relationship; but it is also the openness of the encounter, the virtual, which recognizes the possibility and potential of every encounter. There are multiple levels on which meaning and action might occur: "mind and

body, but also volition and cognition…expectation and suspense…past and future, action and reaction, happiness and sadness, quiescence and arousal, passivity and activity, and so on" (Massumi 35). The encounter is both immanent and transcendent: Potential hovers if the participants are open to its possibility. New truths are revealed. And an emotional connection is possible that exceeds what was expected. What is at stake is the new. As Massumi writes:

> The Kantian imperative to understand the conditions of possible experience as if from outside and above transposes into an invitation to recapitulate, to repeat and complexify, at ground level, the real conditions of emergence, not of the categorical, but of the unclassifiable, the unassimilable, the never-yet felt, the felt for less than half a second, again for the first time-the new (36).

Truth does not exist in deductive pre-determined categories but rather arises anew, each time, revealed in relationship. Affect is the sensed but unspoken potential of the therapeutic relationship. It is captured, whether in speech or perception or sensation, in the "real time" of the relationship. Beyond this capture in the here and now there is always a remainder—the remainder

of the virtual—which is not spoken, is not manifested in our recognized space and time, but continues to exist as potential for another moment and another outcome. Perhaps the encounter's issue is not which blood pressure medication to choose but rather how to lower stress by speaking to a supervisor—or perhaps even the need to change career or re-evaluate one's life. The conversation can go in multiple ways; the direction chosen depends upon the imagination of the participants, the influence of the virtual and the creativity brought to the encounter.

The openness of the encounter depends upon a non-judgmental attitude. Bodies have both corporeal and incorporeal dimensions. Patients' experiences are filled with symptoms and sensations that lack a definite explanation. Sensations are "doubled by the feeling of having a feeling" (Massumi14). This is always a situation difficult to define as the patient's concern is vague, an experience of a body part, not a pain, that seems "abnormal" and thus has meaning in both the corporeal and incorporeal dimensions. Such is the case with the discomfort Ivan Ilych felt, supposedly the result of a bruise: "…this uncomfortable feeling kept increasing, and became not exactly a pain, but a continual sense of weight in his side and irritable temper" (Tolstoy 110). The sensation resonates with itself; the more one is conscious of it, the more one feels it. Massumi, using the example of an echo which resonates in the space between reflecting walls, describes this "complicating immediacy of self-relation [as] intensity" (Massumi 15). The therapeutic task is not always to assign discursive meaning to the undefined sensation but rather to acknowledge it non-judgmentally, as the not-yet-named but valid.

In our everyday lives, in all our relationships, including with ourselves, affect has always escaped. We are aware of it, in a negative sense, in sudden moments of trauma, when it occurs as shock. On the other hand, in moments of happiness, we also recognize the escape of affect, i.e. our recognition of it as "the *perception of one's own vitality,* one's sense of aliveness, of changeability (often signified as 'freedom')" (Massumi 39).

As a model of affect, Massumi turns to the previously mentioned philosopher of science, Gilbert Simondon, who proposed a theoretical model which has applicability on both the inorganic and human planes. He describes a level of emergence in which germs of forms are present "along with unformed elements such as tropisms (attractors), distributions of potential energy (gradients defining metastabilities) and non-localized relations (resonation)"

(Massumi 36). There are no "individuals" on this constantly transitioning plane but "pre-individuals". This is a "continuous but highly differentiated *field* that is 'out of phase' with formed entities (that is, has a different topology and causal order from the 'individuals' which arise from it and whose forms return to it)" (Massumi 37). The germinal forms contained in the emergent field do not have definite boundaries but rather are bundles of energy, forming and reforming, as they interact with the other elements in this field. Shapes form and dissolve as regions change and energies shift. Shape is defined as a center of energy: "'Implicit' form, partaking of Massumi's notion of the virtual, is a "bundling of potential functions, an infolding or contraction of potential interactions" (Massumi 37). These potentials, playing out in real time, are thus unfolded, actualized and expressed, where they are now defined and thus limited.

> Emergence, once again, is a two-sided coin: one side in the virtual (the autonomy of relation), the other in the actual (functional limitation). What is being termed affect…is precisely this two-sidedness, the simultaneous participation of the virtual in the actual and the actual in the virtual, as one arises from and returns to the other. Affect is this two-sidedness *as seen from the side of the actual thing,* as couched in its perceptions and cognitions. (Massumi 37-8)

Deleuze and Guattari formulate an analogous model, similar to the dimension of emergence and the plane of the actualized: They name planes of consistency/composition and of organization. The plane of consistency "involves fluid identity, driven by the affects, and the imagination. This concerns processes of becoming or passages from one state to another" (Uhlmann 167). The plane of organization is a "determined [state], existing on the plane of organisation, in which we are identified as subjects or selves" (Uhlmann 167).

Bergson, as discussed by John Protevi, describes a similar binary model of consciousness. Analogous to Massumi's field of emergence and the actualized, and Deleuze and Guattari's planes of composition and organization, Bergson proposes two levels of consciousness: The level of sympathetic intuition and the level of intelligence and thought. Sympathetic intuition [lying] "beyond utilitarian reification" (Protevi 78), allows us to "access our inner life, which is marked by 'duration' (temporal interpenetration) and 'qualitative multiplicity'" (Protevi 76), while "quantitative multiplicity, on the level of thought, consists of the numerical distinction of juxtaposed objects" (Protevi 76) which marks our day-to-day interactions. It is only this quantitative multiplicity that can be expressed in language.

All of the universe can be understood, in parallel with consciousness, as alternating between duration and quantity (Protevi 72); as quantity increases in frequency it becomes durational, a change in quality, (reminiscent of Spinoza's definition of increasing intensity's being a change in mode and Stern's notion of increased vitality's being fundamental to meaning). In Protevi's interpretation of Bergson, as with Massumi's formulation and that of Deleuze and Guattari, there exists a level of reality "wider than we perceive" (Protevi 78). Hence, quoting Bergson, "we can learn to grasp our sensation 'as if this sensation itself were pregnant with details suspected yet unperceived'" (Protevi 78).

These dimensions of emergence, planes of consistency and the concept of sympathetic intuition may be thought of as containing forms engaged in implicit relationships that are in flux, containing all the possibilities for relationship that an individual has, awaiting only to be unfolded "in three-dimensional space" and linear time" (Massumi 37) in interaction. This unfolding in expression, in the actualized, is now subject to perception and reflection. Expressed in terms of the relationship around illness, the field of emergence is called upon for

new narratives about the body; illness is the pre-condition for the story. While the modern, biomedical experience of illness is the medical narrative, the post-modern version, arising from the field of emergence, is the reclamation by the patient of their own voice (Frank, 7). This conceptualization of affect, incorporating the virtual, envisions a clinical encounter as an event filled with potential, a quest with multiple pathways, with outcomes that are not initially anticipated. In the beginning all is potential: "There are no predictable outcomes within the restless flux of becoming" (Marsden, 189).

Eva Sointu characterizes medical consultations as the intertwining of discursive societal values with non-representational affects. She recognizes that identity in, and produced by, the medical encounter is saturated with affect; the source of that affect seems often to be on an instinctual level but also is intertwined with societal discourses of stigma. Affect, on the autonomic level, she writes, has been conceptualized as describing a range of experiences, "ranging from the 'basic emotions' such as joy anger and fear to more ineffable and fleeting affective experiences of, for example, apprehension, pity, disappointment, shame, excitement or hope…[Affect] permeates lives and bodies, yet also eludes conscious reflection as well as more traditional means of interpreting social life" (312).

Sointu defines affect, quoting Burkitt, as "a feeling or emotion that *takes us* or *moves us* in ways that we cannot help or prevent" (Sointu 315). As does Sointu, Sara Ahmed describes the intertwining of the pre-cognitive and situational in the creation of affect; she references Teresa Brennan's notion that when one enters a room one feels the "atmosphere". At the same time, the feeling that one carries within oneself, upon entering the room, modulates, and changes, the relationships that one has in the situation ("Happy Objects" 36).

As mentioned earlier, Damasio's neurological maps describe how stored, emotionally competent stimuli, residing in "fields of emergence", as traces of previous experience, can be triggered by a random external occurrence. A new threat of illness can trigger these previously embodied experiences, whose presence in the body is not consciously recognized. While this presence is in keeping with Massumi's concept of the virtual (which must allow admittance of the new), and Damasio's ideas of the previously-established neurological pathways, the resultant affect, although autonomous, "is shaped in relation to complex individual, social and cultural meaning" (Burkitt, 2014 in Sointu, 323). As Ahmed says, "feelings rehearse associations that are already in place" ("Collective Feelings" 39).

Sointu explicates the complexity of the affect engendered by the medical encounter in which affect is inevitably wrapped in the biomedical discourse, shaping "the illness experience, the therapeutic encounter, and the reproduction of inequality" (314). While ideally every patient has equal stature in the medical consultation, "the doctor-patient relationship is an affect-laden encounter where the entwining of affect with social assumptions carries important, yet poorly understood, repercussions for treatment decisions and for the furthering of health inequalities" (Sointu 312). The biases of biomedical medicine are instrumental in shaping the affect of the clinical experience: "Both the biomedical manner of locating disease within the physiological body (Nettleton,2006; Armstrong, 2011) and social meaning associated with disease are meaningful for the generation of affect in affliction" (Sointu 316).

Sointu, quoting Cromby, notes that "feelings amount to the raw stuff from which experience is primordially constituted, so much so that the very fabric of our being is thoroughly imbued with their texture, valence and affordances" (Sointu 315). The biomedical paradigm, with its predetermined rules of relationship, generates affect which results in

inequalities in medical care in various ways. Often unrecognized are the unconscious beliefs imbued in physicians by their values, training and social class. (This illustrates the importance of who, culturally and socially, is accepted into faculties of medicine.) Symptoms are validated if they can be explained by the medical model based on pathophysiology; if they cannot this failure, and the attendant emotion of shame, is understood as the patient's, not medicine's. To name is to legitimize, even if the naming does not result in definitive treatment: "As such, lack of diagnosis ties not only with diminished access to treatments but also with self-doubt and uncertainty" (Sointu 317). The medical paradigm has a bias, in formulating "acceptable" diagnoses. When the patient's history lacks coherence we diagnose the patient as being a "poor historian" rather than attempting to imaginatively look for an underlying unifying theme (Coulehan and Block xv). On the other hand, diagnoses themselves can be stigmatizing and generative of affect: They might evoke the fear of contagion, as was the case with COVID or AIDS in previous days. They might evoke blame of, or self-recrimination by, the patient who previously smoked cigarettes, diagnosed with lung cancer. Both the generation and effects of stigma illustrate the double nature of affect, a feeling generated in relationship that is the result of both the pre-conscious workings of mind and of discourse: "…feelings like shame and guilt can dwell in the body in a manner that bypasses conscious thought (Probyn 2004a). Yet social meaning can feature prominently in the constitution of affect; stigma involves socially situated meaning that can generate ineffable negative affect reverberating through bodies" (Sointu 318). A disfiguring disease, generating disgust, has the potential to spread from the disease to our perception of the suffering patient, "especially when she is not able to fully recover-and thus distance herself-from the disease" (Lewis and Shapiro 276). Disgust, in the medical context,

functions, on the part of the physician, to minimize "any disturbing likeness [of the physician] to the unsavory patient" (Lewis and Shapiro 276).

Sointu describes the embodied nature of affect: "gut wrenching anxiety…cheeks burning with shame…embodied intuition [that] can…be judged more correct and true than assessments arrived at through conscious reasoning" (Sointu 318). Self-respect and validation of symptoms are inevitably tied to one's adherence to the prescribed biomedical discourse; shame, on the part of both physician and patient, might saturate the relationship in which the patient fails to heal. Importantly, not only patients, but physicians also, depend on this coherence of view to find satisfaction in the relationship.

In "Speaking with *Frankenstein*", Jayne Lewis and Johanna Shapiro describe the entwining of affect with cultural standards of beauty. It is ideally the "connexional" (Matthews et al.) experience which drives the affiliation of doctor and patient, the affective connections of loneliness, longing for love, suffering, vulnerability, consciousness of mortality (Lewis and Shapiro 275). However, despite these deep yearnings, it is often the aesthetic ideals of the society, shared by both physician and patient, that "gobble up our desires" (Lewis and Shapiro 275). Disease will often disfigure or rob us of function, revealing, in Susan Sontag's phrase, our dwelling in "the kingdom of the sick" (qtd. in Frank 9). The challenge in the clinical relationship is finding a way to incorporate these stigmatizing disruptions into a newly conceptualized life: "…to the extent that aesthetic priorities of form and function are not objective but born of the social medium of language, they belong to both physicians *and* their patients" (Lewis and Shapiro 275). As an unexpected story is forced upon patients, and their physicians, it is incumbent upon both to search those "dimensions of emergence" for alternatives which incorporate unthought of possibilities.

There are specific responses to illness that are expected and valorized such as "displays of self-responsibility, emotional coping and acceptance, even the embracing of adversity" (Sointu 319). We value patients who cope "stoically" with pain and with the threats of poor medical outcomes. In North America, neoliberal values, dealing with emotions that arise in the face of illness, prize "making the most of a difficult situation, following doctor's orders and smiling in the face of hardship" (Sointu 319). As such, the affect generated in the medical encounter arises partially from shared cultural assumptions which, in turn, generate shame, gratitude, admiration and embarrassment. There are assumptions concerning the differences, and extent, of displays of emotionality amongst men and women and between different socio-economic groups. Those patients from an economic class similar to the physician's, those who have more years of schooling, have linguistic facility and those who are seen to take responsibility for their health are more likely to have a relationship with a physician acting as an advocate: "Introspectiveness and reflexivity that characterize middle-class emotional cultures are, for example, normalized today" (Sointu 319). We value patients who are well-informed (but not *too* well-informed) about, and take responsibility for, their illness. Different cultures, fearing catastrophic outcomes, consistently tend to focus symptoms, sometimes metaphorically, on specific anatomic regions, a specificity which physicians must understand but often fail to do so, with resulting incorrect diagnoses and dissatisfaction on the part of patients. Cultural alignment, while generating a relationship of mutual self-worth, of potentially better outcomes for such lucky patients, and increased satisfaction in practice for their physicians, nevertheless has the potential to create unequal access to health resources, and poorer outcomes, for those less-aligned.

The potential in a medical relationship lies in the discovery of a patient's principal concern, which is not necessarily the same as the supposed presenting problem. What is often required is understanding why this problem is a concern, an understanding not obvious without knowing the patient's entire situation. Affect's affordance of the unexpected, the virtual, the unsaid but present, the importance of feeling and the position of the body in space, creates the potential for this profounder, deeper, more nuanced understanding of a patient's problem. By examining socio-economic, as well as pre-cognitive and autonomic, factors, Sointu shines a spotlight on the complexity of the emerged in generating affect. Reflecting on this complexity, literature, speculative, passionate, generative of sensations, penetrates relationships, creating a knowledge much different than that offered by the medical textbook. Contrary to the medical model which views individuals as discrete, isolated beings, affect can be conceptualized, as in Simondon's field of emergence, as the relationship occurring between beings who are centres of energy, with undefined boundaries, who are vital, in motion, who are becoming. As such, a therapeutic space is created in which the now realized potential transforms both participants.

It is the movement of affect that "create[s] the transpersonal sense of *life"* (Anderson 736). Emotion, according to Massumi, as opposed to affect, is the distinctly personal "capture" of affect in a specific context. It is subjective, fixed in language and is henceforward personal. "Emotions are formed through the *qualification* of affect into 'semantically and semiotically formed progressions, into narrativizable action-reaction circuits, into function and meaning. It is intensity owned and recognized'" (Massumi quoted in Anderson 737). Anderson points out, however, that Massumi's conceptualizing emotion as a capture or blockage should not limit an understanding of the role that emotions play in social interactions: "Emotions, as qualifications that fold into a set of more extensive relations, can instead be described as artful types of

corporeal intelligence-in-action enacted from within a subtle choreography of rhetorical-responsive joint action" (Anderson 737). That is, although emotion is more personal than affect it obviously exerts an enormous influence in response to, and in modification of, the prevailing affect. Emotion is largely ignored in medical education and, in fact, is discouraged in the behaviour of physicians: It is seen as inimical to the objective nature of the enterprise. There is little acknowledgement given to the effect on students of experiences such as cardiac arrests and unexpected deaths of patients. In addition to the ever-pressing time constraints, the biomedical paradigm, focused on reason, discredits the validity of emotion.

Danielle Ofri, in *What Doctors Feel*, describes how a junior pediatric resident, Eva, attending at the delivery, to teenagers who did not want to be pregnant, of a child with an immediately lethal congenital malformation, is instructed to quickly remove the baby from the delivery suite to wait with the baby, and record the moment, that he/she dies (101-2). She can find no place to take the newborn and finally discovers a closet. She is overcome with grief, recognizing the tragedy of a human who will never be loved. Subsequently Eva has under her care a beautiful four-year-old boy, the victim of a near-drowning after his mother left him alone for just a moment, who will never regain consciousness. While the child is in the Intensive Care Unit, his mother continually tries to engage Eva, hoping to find an outlet for her grief and guilt. Eva's response, a result of the previous trauma of unspoken grief, is to "feel absolutely nothing for that boy and his family during the entire two weeks [she] care[s] for him" (Ofri 104). After temporarily leaving her pediatric residency, Eva, one day, attends a movie, a comedy, in which a child "languidly [drifts] down into deep water" (104): "A shudder of emotion hit Eva with bodily force. In seconds, she was sobbing uncontrollably, her body trembling in the plush velvet seat. In a rush it all came back—the blonde, blue-eyed boy who

had drowned, the mother's piercing wails of anguish after the code, the inert body kept alive on a ventilator" (106).

In less intense moments, in the day-to-day activities of the clinic, there are continual interactions and transformations of affect, emotion and feeling, though affect in its potential will always exceed emotion and feeling which are limited by the fact of actualization (Anderson 737). Affect, belonging to no one, can be understood as "pure gift" in that the virtual in relationships, the not consciously expressed possibility, the connectedness occurring freely and without design in the space between one participant and the other, always exceeds, offers more, than is expressed in emotion and feeling:

> The double escape and ingression of affect (or eruption and disruption) take place, as outlined by Massumi, according to an implicit model of a pure gift: an anonymous, impersonal donation of potential that animates *because* of the expression and qualification of affect (in feelings or emotion) never coincide with the totality of affect and therefore neither the recipient nor the donor are aware of giving or receiving (Anderson 739).

Furthermore, crucially important and often not realized, and not taught in "Interviewing Skills" courses, the affect of a therapeutic encounter depends not only on its expressed content but on the energy of that expression, the "vitality" of the encounter, its "vibe", the creation of a healing space in which patients *feel* that they are safe, respected and have been heard. Daniel Stern says, "we naturally experience people in terms of their vitality" (Stern 3). Vitality is the dynamic aspect of experience, encompassing movement, time, force, space and intention/directionality (Stern 4). In fact, all of life is movement. We do not experience these aspects of vitality as individual components but in their entirety, as a gestalt: "We live

impressions of vitality like we breathe air" (Stern 3). While the vitality of the participants in an interview is essential to shared meanings, we fail to recognize the vitality of interactions because the vitality form is absorbed into the content and it is on the content that we focus. Although expressed in movement, vitality is a mental creation, the result of the mind's integration of the totality of events in an interaction. Einstein described "the dynamic" as "the changing happenings of the universe". This same dynamic, as vitality, describes the "body-language" of personal encounters:

> the force, speed, and flow of a gesture; the timing and stress of a spoken phrase or even a word; the way one breaks into a smile or the time course of decomposing the smile; the manner of shifting position in a chair; the time course of lifting the eyebrows when interested and the duration of their lift; the shift and flight of a gaze; and the rush or tumble of thoughts. (Stern 6)

Affect, as experienced through vitality, can be understood as continuous or discontinuous (eruption and disruption as referenced above). At moments of experiential rupture, such as in a chaos narrative (Frank), we perceive affect in its discontinuity; that is our relationships suddenly transform and we see patients in an entirely new way. In *The Story of the Lost Child,* by Elena Ferrante, at the moment an earthquake strikes, Lila, observing through a café window her rejected lover Marcello in his automobile with his family, panics: "She exclaimed: Oh Madonna, an expression I had never heard her use. What's wrong, I asked. Gasping for breath, she cried out that the car's boundaries were dissolving, the boundaries of Marcello, too, at the wheel were dissolving, the thing and the person were gushing out of themselves; mixing liquid metal and flesh" (Ferrante 175).

This rupture of a relationship's usual affect serves, by the contrast, to highlight the individual's quotidian being, their day-to-day vitality. By contrast to the terror evinced by the earthquake, the narrator writes of Lila's usual energy, her usual way of being: "But to my great amazement I wasn't as frightened as Lila. In those seconds of the earthquake she had suddenly stripped off the woman she had been until a moment before—the one who was able to precisely calibrate thoughts, words, gestures, tactics, strategies—as if in that situation she considered her a useless suit of armour" (173).

In the clinic, our connection with patients depends on our relationships, the mutual recognition of each other's vitality. It is to this that we largely relate. When we are tired, irritable or unengaged we are less therapeutic. Patients have hidden strengths, only recognized, with the help of imagination, in moments of rupture, during medical crises. Imagination allows the ingression of the array of human strengths. Elizabeth, an elderly patient, always very talkative and seemingly tangential, transformed in my eyes when she unfortunately developed breast cancer, to which she reacted with quiet optimism. What I had perceived as talkativeness I now viewed as resilience, transforming the affect of our relationship. Not only was this rupture of affect, this changed perception of vitality, recognized by myself, but the recognition was communicated to my patient, who in turn appreciated that her strength had been acknowledged. This dynamic is not only therapeutic for patients but importantly meaningful for physicians.

4. Affect and Language: "The Idea of Order at Key West", Colour and "Too Blue"

Characterization of affect, the totality of relationship, appears limited by the necessity of its expression in language. Affect is the dynamic experience of the bodies and minds of participants collectively infolding within relationship. Because experience is embodied, language feels inadequate to express affect; it seems that language should be accompanied by choirs and theatre in order to give affect full expression. In the clinic we struggle to find the words that express the enormity of patients' experiences. Nevertheless, experience informs language; linguistic expression in turn "in-forms" experience. Massumi resolves this apparent contradiction of expressing embodied experience in words:

> There is no antinomy between affect and language. There is accompaniment and becoming, always involving the full spectrum of the graded continuum of experience. The nonverbal grades on the continuum of experience are not in opposition to the verbal registers, any more than infrared is opposed to red. They companion them (as any infrared camera will show). The infra-linguistic registers of experience accompany linguistic expression (Massumi lviii).

In the clinical consultation the array of issues we bring to an encounter is first and foremost, ironically for a science whose main concern is the body, predominantly recounted in language. And yet, patients, especially those with chronic illnesses, find that their experiences are not easily expressed. As Arthur Frank writes, "...actually hearing traces of the body in the story is not easy: Observing what stories say *about* the body is a familiar sort of listening; describing stories as told *through* the body requires another level of attention" (Frank 2). "Functional" illness is a term which describes disorders that cause distress but, having no observable

pathophysiology, are minimized, considered to exist "all in the mind". Irritable Bowel Syndrome, the symptoms of which are bloating, alternating constipation and diarrhea, and a general sense of abdominal discomfort, is such a disorder. Because there are no observable derangements in laboratory and pathology specimens it is conceived of as stress-related, the etiology sometimes explained by the notion that the mind is best thought of as embodied, located not only in the brain but in the gut. When distressing symptoms fail to have objective pathological signs, when the physical examination is normal as are the laboratory and imaging studies, the patient's experience of illness struggles to find validation within the discursive medical paradigm. To say an illness is "all in the mind" is essentially to discount the illness. In Arthur Frank's terms, we have difficulty making sense of those illnesses which, defying description, are told *through* the body.

Wallace Steven's poem, "The Idea of Order at Key West", can be viewed as a relationship between the ocean and the artificer, an attempt to capture undifferentiated nature in words. The experience and its interpreter are analogous to the undifferentiated symptoms of a patient's experience and the physician's attempt at characterizing undifferentiated experience in a medically sanctioned format. The participants, patient and physician, ocean and artist, have agency, are in relationship with each other. The "maker of the song", recognizing the need to find a melody that encompasses the vastness, the tragedies that lie at its depths and the impossibility of ever fully knowing the ocean, "[t]he ever-hooded, tragic-gestured sea", struggles to find discrete words to overcome the complexity of the boundless seashore:

…the dark voice of the sea

That rose, or even coloured by many waves;

If it was only the outer voice of sky

And cloud, of the sunken coral water-walled,
However clear, it would have been deep air,
The heaving speech of air, a summer sound
Repeated in a summer without end
And sound alone.

In her encounter with the sea, the maker, in her attempt to somehow express the sublime, is transformed, as is the ocean. Language, can never fully capture the vitality, the force, the liveliness, the movement and energy, of "[t]he grinding water and the gasping wind". The excellent physician, in relationship with his/her patient, struggles to limit, yet preserve, the multi-sensorial complexity of the patient's experience to both fit, and yet undermine, the medical paradigm. Unlike the artificer, the physician ideally preserves his/her patient's not fully realized voice, avoiding premature closure of a story that does not yet have an end. In relationship there is always a remainder which necessitates the need to meet over and over.

It was her voice that made
The sky acutest at its vanishing.
She measured to the hour its solitude.
She was the single artificer of the world
In which she sang. And when she sang, the sea,
Whatever self it had, became the self
That was her song, for she was the maker.

While words are always inadequate to fully capture experience, conversely they might beemotion-laden so that their meaning is actually over full; not objective but containing within themselves traces of past experience. Referring to the essay, "Too Blue: Colour-Patch for an

Expanded Empiricism" (Massumi, 227-78), we learn that colour is composed of three dimensions: brightness, saturation and hue. But our experience of colour involves more, an excess—a surplus, that depends on context. A particular colour can be defined in a general way, but, in fact, there are no general events, only specific situations. As Massumi says, the general conditions of colour are necessary for it to occur, but these necessities are always accompanied by contingency, an inevitable part of any experience. Although words for colour appear to have objectivity, they in fact contain emotion.

> ……..Why
> Do I happen to like red bush,
> Gray grass and green-gray sky?
>
> What else remains? But red,
> Gray, green, why those of all?
> That is not what I said:
>
> Not those of all. But those.
> One likes what one happens to like ("Table Talk" Stevens).

Wallace Stevens's explanation for preference of colour is simply arbitrariness, "happens to like". Analyzed from an affective point of view, one needs to consider the context of colour and the traces of past experience in determining feelings towards it. In our above discussion we examined the difficulty of expressing affect in words. We now look at how affect cannot be separated from language. In "Too Blue", Massumi outlines how affect penetrates language, especially within relationships, so that seemingly objective meaning is made indeterminate by

affect—emotion and individual meaning are embedded in so-called "neutral" language. He recounts David Katz's experiment, *The World of Colour,*1911, in which subjects were asked to remember the blue of a friend's eyes and then match this memory to a colour swatch in the laboratory. Massumi continues: "The procedure is repeated with the black of the subject's hat, the red of his own lips, the brown of the bricks of the house he lived in" (228). The purpose of the experiment was to test the subject's ability to accurately pick a swatch matching the remembered colour. The word "blue", from the point of view of the experimenter, is assumed to have an objective and transparent meaning to both the experimenter and subject. However, there was most often a mismatch, with the memory of the remembered object's colour's being more intense than it actually was: "They 'almost always' selected a colour that was 'too bright to match a bright object,' 'too dark to match a dark object,' and 'too saturated to match an object which is known to have a distinct hue'" (229). Massumi points out that researcher and subject do not have the same relationship to "blue". For the subject, "blue", the blue of a friend's eyes, is saturated with affect and memory, while for the researcher "blue" is simply an objective, transparent designation, perfectly matched to objects in the real world. Because the experimenter makes the rules, "linguistically, architecturally, and on any number of other interlocking levels" (231), the context is pre-determined, such that the subject's experience of increased intensity of colour is understood within the experiment as a mismatch, as an error of memory. On the other hand, from the subject's point of view, the subjectivity of experience vacillates between two poles: On one hand the subject is told that he is wrong, that their memory has failed to appropriately match colour. On the other hand, the truth of one's experience of the intensity of colour persists. The emotion embedded in the memory of the friend's blue eyes existed prior to the experiment; its excess intensity only became evident

because of the limited parameters of the experiment. Furthermore, the heightened perception will now exist forever, named and intensified, whenever looking the friend in the eye.

A similar situation arises in a clinical interview in which the physician's relationship with her patient is seen as a fact-gathering exercise and the different stances—paradigms and agendas—of clinician and patient are not taken into account. The context has been determined by the medical paradigm, the rules are set. The physician interrogates the patient with the assumption that they are presenting a set of objective symptoms, to be subsequently confirmed in an objective physical exam, that will match the diagnostic "swatch" in UpToDate, the most popular summary of evidence-based medicine. From the patient's point of view, the symptoms are suffused with unmentioned contexts, with anxieties concerning the potential for diseases that they have witnessed in friends and family or read about on-line. The neutrality of language is assumed and not questioned. The concerns brought to the clinic contain more elements than are found in any medical compendium. The relationship is not an equal one—the physician is perceived as the expert, as embodying objective truth; the patient is hesitant to offer their fears as the reason for seeking the consultation. Not only are patients embarrassed to expose their vulnerabilities but want the assurance that the facts, as presented, do not indicate serious disease. Thus, the patient has a hidden agenda in not exposing their secret fears because they do not want those fears to somehow confound the physician's "objective assessment" of the situation. That is, they are hoping that the possibility about which they are worrying is so remote that it doesn't even cross the physician's mind. If they mention their secret concerns, those concerns somehow take on a reality. In terms of the *virtual,* as was the case with the remembered blue, the symptoms have an excess of meaning for the patient beyond the "objective". Those fears, meanings and possibilities form an integral part of the consultation;

in their virtuality they are more than real. However, because the prevailing medical model does not recognize the affect brought to the encounter, the "affective exaggeration" (Massumi 238) must be contained. To the extent that symptoms fit the medical model of disease, they have "been functionalized", the individual, less-defined concerns "relegated to the tawdry status of a private 'emotion'. The subjective share is conventionally considered arbitrary: fluff to be discarded" (Massumi 238). The excellent clinician ideally should always be searching for the virtual in the relationship, the unexpressed concerns. When the physician attempts to describe in medicalized terms the import of which can only be understood emotionally, the patient's underlying fears are not allayed.

If the affect in the office is determined by the medical paradigm, a patient's fears will not be expressed. A therapeutic consultation allows for the expression and validation of feelings that might otherwise be thought of as having little importance:

> …it becomes all the clearer that the "affect" in play in [the blue eyes experiment] was not so much the personal "familiarity and fondness" already felt by the experimentee for the owner of the eyes of blue. These were already operating emotions, personalized contents. The affect was more accurately the openness of the context to an anomalous expression of these emotions. (247)

5. "Dimensions": The Relationship of Emotion and Reason

Alice Munro's short story "Dimensions", in which a major trauma is progressively incorporated, can be analyzed through the lens of affect. Although Doree endures the murder of her children, her eventual coming to terms with this horror can be understood by applying the affect theorists' models of emotion and reason. Emotionally competent stimuli, whether arising externally or virtually (from previous experience), find ultimate expression in consciousness. In the snowman experiment previously discussed, Massumi illustrates the role of *intensity.* The melting of the snowman, and its survival moving from the hot roof to the cool mountain, presumably arouses traces of previous emotional experiences virtually stored in the children's memories and recalled, while watching the brief film, in somewhat changed *mode,* i.e. with increased intensity. The conflation of sadness and pleasantness is understood when considering Spinoza's definition of Joy as a passion which promotes "greater perfection" rather than happiness. "By Joy-that *passion by which the mind passes to a greater perfection. The affect of Joy which is related to the Mind and Body at once* I call *Pleasure or Cheerfulness* and that of *Sadness, Pain or Melancholy"* (Spinoza 500-501). In the realm of the incipient, "sadness is happy (happy because the press to action and expression is life)" (Massumi 33). Massumi argues that for Spinoza there is no body but rather continuous bodying. The body is in flux, always becoming. Every transition of the body is accompanied by a change in affect—that is a change in the ability to affect another body and be affected. This change in affect is accompanied by a corresponding change in vitality. Stern explains, "I shall continue to use the term 'affect attunement'. This is meant to be the same as matching of vitality forms" (43). The degree to which the capacity of a body can change is intensity: "The Spinozist problematic of affect offers a way of weaving together concepts of movement…and intensity" (xxxiii).

From the perspective of Spinoza's *Ethics*, growth equals Joy, even when the stimulus is painful. Furthermore, there is an absolute relationship between the activity of the mind and the body. All of the mind's activity parallels the body's activity and the modifications of, the impingements upon, that body. In a relationship, when a body is impinged upon, an affection occurs and then is doubled twice. The affection is initially infolded by the body (i.e. the effect of the impingement is infolded, apart from the context; the impingement on the body is experienced as external to itself). The *idea* of this impingement then doubles the original impingement, now taking into account the context of the event, causing a trace in the mind's field of emergence. This doubling is then doubled again in consciousness, in reflection (Massumi 34). There is thus an incorporation of the impingement of a body on a body, i.e. of a relationship, on a progressively more conscious, reflective level. In agreement with Massumi's interpretation of Spinoza, Damasio, discussing Spinoza's identity of mind and body, remarks that in certain instances Spinoza will privilege one over the other. He quotes Proposition 2 in Part II of *The Ethics:* "The human mind perceives not only the modifications of the body, but also the ideas of such modifications." Damasio interprets this to mean that once the mind forms an idea of a certain object, it then forms an idea of an idea and an idea of an idea of an idea and so on (Damasio 214-5). This incorporeal, or virtual, level, is less concrete than Spinoza's attribute of extension, which involves modification of the body, but rather refers to the ultimate incorporation of ideas in consciousness.

Affect develops in context. Anderson, influenced by Spinoza, in his discussion of the role of hope, also explicates the becoming of affect in a developing/changing relationship. Affect emerges from the relationship between bodies in context(s). There is a continual back-and-forth between bodies and their context (s); thus affect is not a response to a situation but,

rather, emerges from the situation it is in the process of creating. Just as occurs in the creation of fear and excitement in a crowd or, as Ahmed discusses, in the interaction between an individual's mood and the tone of a social gathering ("Happy Objects" 37), there is a recursive relationship in which the created emotions feed-back into the affect from which they emerged.

The body has a background state, the background emotions as described above by Damasio, which can perhaps be characterized as the usual vitality, in Stern's terms, of the organism. Against this background are movements of affect which occur when the body is disturbed by primary and social emotions. These emotions impinge upon the body as "proprioceptive and visceral shifts in the background habits and postures… Examples include the blush of a body shamed, the heat of a body angered, the restless visceral tension of a body bored" (Anderson 736). These subsequently come to consciousness as images of the change of a body state. In a final movement of consciousness, the mind incorporates this image of a change of state and passes a sort of judgment on it as a feeling.

"Dimensions", by Alice Munro, can be understood as the doubling and redoubling of an impingement on a body. This short story demonstrates how problematic relationships leave their remarkable traces which re-emerge in more complex understandings of oneself and one's relationships, ultimately leading to change in one's life. This short story is germane both in showing how affect theory provides a lens for literary analysis and as an example of how literature can change the affect of a clinical encounter.

"Dimensions" opens analeptically with Doree making the five-hour bus trip to London to visit her imprisoned husband, in jail because he has murdered their three children for no obvious reason other than a marital dispute. His actions in some sense might have been anticipated because of the petulant, unyielding, autocratic nature of his personality. Applying

the schema derived from Massumi's interpretation of Spinoza, the initial impingement on Doree's body occurs when, returning home after a night spent at her girlfriend's house because of her frustration with Lloyd's behaviour, she steps past her husband Lloyd, sitting outside on their steps, and finds their three children suffocated and strangled:

> Doree had run out of the house and was stumbling around the yard, holding her arms tight across her stomach as if she had been sliced open and was trying to keep herself together. … For some time Doree kept stuffing whatever she could grab into her mouth. After the dirt and grass it was sheets or towels or her own clothing. As if she were trying to stifle not just the howls that rose up but the scene in her head. (Munro 16)

The immense horror of the crime is a direct insult to Doree's body; its immensity is experienced autonomically, corporeally, immediately; although introspection is not yet in the loop, Spinoza's parallel tracks of mind and body are evidenced in Doree's response to this initial impingement. Over the ensuing months the *idea* of the affect doubles the original impingement, Doree now reflecting upon the context. A "trace" of the horrible trauma is registered in the mind's field of emergence, the mind's unconscious, generative site of experience, not fully incorporated, yet leaving its emotional reverberation. With the passage of time, there is potential for a partial incorporation of the experience, coming to some understanding, getting on with life; there are incipient possibilities, waiting for fuller expression. And so, gradually, Doree's relationship with the world, her affect, has changed:

> Her hair had been long and wavy and brown then, natural in curl and colour, as he liked it, and her face bashful and soft-a reflection less of the way she was than of the way he wanted to see her.

> Since then she had cut her hair short and bleached and spiked it, and she had lost a lot of weight. And she went by her second name now: Fleur. Also, the job they found for her [chambermaid at the Blue Spruce Inn] was in a town a good distance away from where she used to live (2).

At odds with common-sense, Doree decides to visit Lloyd, the murderer of her children, in prison. Her motives are complex, not fully understood by her, nor by us. In "Munro fashion" we are left to speculate about the unimaginable. After the murders Lloyd explains his motive had been wanting to spare the children "'the misery of knowing their mother had walked out on them,' he said. That was burned into Doree's brain, and maybe when she decided to try to see him it had been with the idea of making him take it back" (17). Is it possible that Doree, seemingly a victim, also feels some guilt?

When she does see him in the prison, Lloyd "is so strange and wasted. Not a person worth blaming for anything. Not a person. He was like a character in a dream" (18). In fact, there are hints of tenderness on both their parts, joined, ironically, by having both suffered the loss of their children.

Doree's original shock, the original impingement, has morphed into something else, an attempt to get on with her life, an attempt to incorporate this tragedy to an extent that she can continue to live. Then Lloyd sends her a letter saying: "I have seen the children. I have seen and talked to them. … they do exist and it must be that there is another Dimension or maybe innumerable Dimensions, but what I know is that I have got across to whatever one they are in. … They are fine. Really happy and smart. They don't seem to have a memory of anything bad" (25).

From Doree's perspective the children are now virtually alive. Affect has been transformed, in its various manifestations, in Lloyd and Doree's relationship, as the trauma's impact has unfolded. First there was pure impingement, a visceral response to murder, then as an incorporation of those murders in the day-to-day survival of the parents, somehow able to carry on with their lives. Now there is a new context—the potential for closure evinced by Lloyd's letter, for the conversion of Sadness into "Joy", not in the sense of happiness but in the sense of a more fully realized consciousness, a greater perfection of the bodies in Spinoza's sense. As Doree pursues her work as a chambermaid:

> From time to time, when she was in the middle of spraying a bathroom mirror or tightening a sheet, a feeling came over her. For almost two years she had not taken any notice of the things that generally made people happy, such as nice weather or flowers in bloom or the smell of a bakery. She still did not have that spontaneous sense of happiness, exactly, but she had a reminder of what it was like. (27)

On Doree's last visit to the hospital, sitting in the front seat of the bus, she is the witness as a truck, crossing the road in front of them, catapults into a ditch. The young driver suffers a respiratory arrest and Doree, remembering instructions ironically given to her by Lloyd, the instrument of her shattering and now the potential source of her reassembly, resuscitates the victim, with mouth-to-mouth resuscitation. As "Dimensions" concludes, Doree, awaiting the ambulance, after the successful resuscitation, indicates to the bus driver to carry on with his route to the prison without her—somewhat shockingly she no longer needs to visit Lloyd in prison.

In Massumi's terms, the impingement on Doree's body, initially pure physical agony, over time has been incorporated at a progressively more "joyful" level; the insult to her body

precipitated by the murder of her children, in the fulfillment of what Arthur Frank would call a quest narrative, has come full circle in her providing another young person with life. Even in the horrific murder of her children, although obviously impossible to ever completely incorporate, there is some potential for mitigation. In Doree's depending on Lloyd's instructions in her saving of life, the initial impingement has been incorporated as "the idea of an idea", as a reality on both the level of mind and the level of extension (of the body).

In my professional experience, a mother had lost her son to suicide: He and his wife, although not getting along, were still, for financial reasons, living together. Alcohol was involved and he took his own life at home; his body was discovered by his children. For two years, as my patient incorporated this tragedy, it was never mentioned; eventually she told me that she was still friends with her daughter-in-law—in order to continue to see her grandchildren. Because her revelation resonated with the themes in "Dimensions" I suggested she read this story, hoping it might offer "the idea of an idea", an aid towards closure. When I saw her again she told me she had read not only that story but all of *Too Much Happiness* in which it appears. She also unexpectedly said she that she had decreased her smoking and drinking.

Why did "Dimensions" affect her in this way? One might say that the impingement of Doree's loss of her children mirrored the death of her own son. Both she and Doree, contrary to "common-sense", maintained a relationship with the person instrumental in/connected to the loss; in Doree's case because her husband suffered the same loss as she, and perhaps because of a sense of her own responsibility in the tragedy; in my patient's case because of the dual loss of her son, and all that is involved in that, and the threatened loss of grandchildren. Because of Alice Munro's ability to express the potential of relationships that, at first glance, seem highly

unlikely, “Dimensions” offered the possibility of hope, by reimagining the primary emotions of shock and sadness in a new context. The impingement was thus incorporated with a more expansive understanding that promoted my patient’s going-on. In our medical relationships there is the potential for healing, even in those situations that involve serious loss. Is there, in our relationships, an unexpected potential for “the more-than or less-than rational” (Anderson 734) of hope?

Damasio expresses similarly the notion of context, of the specificity of situation, when he defines affect as the new relationship that develops when we come to fully understand how the actions of one body affect another:

> I have suggested that the most basic kind of self is an idea, a second-order idea. Why second order? Because it is based on two first-order ideas—one being the idea of the object that we are perceiving; the other the idea of our body as it is modified by the perception of the object. The second-order idea of self is the idea of the relationship between the two other ideas—object perceived *and* body modified by perception.” (Damasio 215)

“Dimensions” provided insight to my patient to understand how her body, in Spinoza’s terms, had been modified by the death of her son; it then made possible the incorporation of this modification as a higher order idea.

6. *The Sound and the Fury* and *The Member of the Wedding*: Lyrical Literature and Affect in the Medical Encounter

In engaging with a work of fiction, we "speak" with it (Lewis and Shapiro 268). By the phrase "the book reads the reader" we understand the individual history that each reader brings to this work will shape its meaning. In a similar manner, our relationships with patients are determined not only by the "objective" facts of a biomedical paradigm but in the unfolding of a conversation. The clinical moment, the direction of the conversation, the affect, is determined not only by the medical exigencies but by the realities of the participants.

Jayne Lewis and Johanna Shapiro, English professor and physician respectively, in their article "Speaking with *Frankenstein"*, interrogate the novel *Frankenstein* as a model of *speaking with* a patient specifically in fraught situations, where, in a difficult relationship, "things don't work out". In this article, which examines the relationship between Dr. Frankenstein and his creation as somewhat analogous to problematic relationships between physicians and patients, they acknowledge that Rita Charon's principles of narrative medicine—"intersubjectivity, relationality, personhood and embodiment, action toward justice, and creativity"—promote an "empathic, nuanced and transformative" appreciation of the patient's situation (Lewis and Shapiro 268). In pursuit of its role in understanding relationships, including those that are conflicted and do not allow for the usual co-operative conceptualization, literature is not always to present a harmonious picture but rather to interrogate all experience, to examine the hidden, the unspoken, "the night-side of life" (Sontag 3). Furthermore, those "works that break the modern novel's mimetic contact with reality and instead ground themselves in fantasy, speculation, and non-resemblance to a seemingly recognizable world" (Lewis and Shapiro 268) are perhaps most effective in imaginatively questioning the experience of patients. The light of imagination extends the possibilities for the

often opaque reasons for patients' visits: "Because they stimulate readerly … incomprehension, such texts provide an opportunity to rehearse a range of probable and improbable responses to lived experience" (Lewis and Shapiro 282). In their call to "shift our attention from the 'narrative' aspect of 'narrative fiction' to its 'fictive' dimension" (269), these texts point to the affective dimension of our relationship to them and, by analogy, to patients. The close reading of texts that distance the reader from what *is* to *what could be* "incorporate distance and disappointment as well as recognition and rehabilitation, unresolved fear as well as pragmatic hope" (269).

In a similar vein, Jill Marsden argues that narrative structures themselves, and literary criticism's employing these structures, mitigate against the expression of feelings that "do not make logical sense". This parallels precisely the bias of the biomedical model which strictly defines those conceptions of disease that are accepted as valid. The role that literature can play, in the clinical encounter, is the representation of the "truth" of unspeakable experience. Conceiving of ourselves as boundless centres of energy, rather than already-determined subject-objects, we are continually in the process of becoming. The Platonic and Kantian ideals of fixed categories of truth privilege a set of ethical values which necessarily understand the individual as a defined moral being who must live according to an idealized set of eternal values (Marsden 187). Marsden, referencing Nietzsche, argues that, in fact, it is only for historical-cultural reasons, living in a Judeo-Christian-Muslim environment, with fixed moral codes, that our values have the status of eternal truths. As opposed to the idea of truths, and reminiscent of Spinoza's ideas of conatus, Marsden, quoting Nietzsche, writes, "'It is improbable that our 'knowledge' should extend further than is strictly necessary for the preservation of life'(sec 494)" (Marsden 187). An exploration of the forces that buffet people, often unconscious and often the cause of

visits to a physician, are at the heart of literature: "For Nietzsche, art is the license to create something illegible and enigmatic: something that challenges the culturally established habits of thought. Indeed, the impersonal matter that selfhood must repress or deny in order to function as a self returns with seismic force in the experience of art" (Marsden 187).

The "southern gothic" novels, *The Sound and the Fury* and *The Member of the Wedding*, concerned with intense emotional turmoil and strikingly unusual experience, lyrically rend our assumed boundaries of time and space, revealing the unexpected which, without imagination, would not be considered likely to have occurred. Not only in their content, but in their structures, these two novels highlight the ineffable nature of experience: "Both Faulkner and McCullers evade what Massumi describes as the 'socio-linguistic fixing' of the quality of an experience as personal (1995,88), resisting the politics of naming associated with textual truth" (Marsden, 194). Rather than narrative, a boundless world is created in which we wander without specific direction.

Quentin Compson, in June 2, 1910, the second chapter of *The Sound and the Fury*, inhabits a liminal geographic and psychological space, in Spinoza's terms, of "Sadness", devoid of hope. He is overwhelmed by "the impersonal matter" of living that he is no longer able to incorporate. Quentin's chapter, written from his point of view, often as an inner monologue, describes the last day of Quentin's life, marked by his obsession with the arbitrariness, yet relentlessness, of time. The progress of the day is filled with seemingly random travelling marked by the inexorable progress of the sun which ironically makes of his body's shadow a sundial. The peripatetic feeling of Quentin's travels creates of Cambridge a virtual space. The repeated chiming of bells, marking every quarter hour, and the shapeshifting of Quentin's shadow, mark the inescapability of time: "I went to the dresser and took up the watch, with the

face still down. I tapped the crystal on the corner of the dresser and caught the fragments of glass in my hand and put them into the ashtray and twisted the hands off and put them in the tray. The watch ticked on" (Faulkner 80). Quentin's final internal dialogue with his father will take place in the virtual space of Quentin's mind and the imaginary time between the first and final chimes of the three-quarters of the hour. Time and geography become "like wide water" (Stevens, "Sunday Morning"), an expanse in which there are no boundaries other than Quentin's perceptions. Past and present join: Quentin's preoccupation with his sister Caddy's virginity, conflated in his mind with Gerald Bland's treatment of women and his own fight with Caddie's lover Dalton Ames, results in a physical fight with Gerald, over his chauvinism, of which Quentin is completely unaware, experiencing the fight as being the one he had with Ames, much as would occur in a dream: "Did you ever have a sister" (92)? Time is indeterminate as the scene oscillates between present and past. The geography is a symbolic geography marked by the river, ominous yet restful, which we know, as he carries the two "tailor's geese", weights with which he will drown himself, is his ultimate destination. The obsessiveness of Quentin's actions, his excessive preoccupation with his personal appearance in the moments before his suicide, perhaps referencing the ideal of the southern gentleman, demand an understanding that escapes logic. Expressed as stream of consciousness, shaped by the virtual, the insubstantial, the arbitrary nature of time, the shadowiness of thought, feeling and dusk and the fragments of personal and cultural history, Quentin's experience is a study in the complexity of suffering. The virtual is inhabited by the voices and failures of the past, Quentin's virginity, Caddie's promiscuity, his father's alcoholism and "the rape" of the post-bellum Confederacy. A physician would be hard - pressed to create the "more-than-rational" of hope. We are left with unresolvable feeling.

The remembered dialogue, just prior to his suicide, that Quentin has had with his father is intensely lyrical. The first chime of the quarter hour is "measured and tranquil, serenely peremptory, emptying the unhurried silence for the next one" (176), a paradoxical space of peacefulness in the unfolding of Quentin's suicide. The prosody, lack of conjunctions, the "enjambment" and necessity of sorting out grammatical meaning create the vitality and the movement, that also occur in "Fern Hill" and "What the Doctor Said". Our understanding is an embodied understanding, we *feel* what we are reading, it needs to be read aloud: "if people could only change one another forever that way merge like a flame swirling up for an instant then blown cleanly out along the cool eternal dark instead of lying there trying not to think of the swing until all cedars came to have that vivid dead smell of perfume that Benjy hated so" (176). The rationale for Quentin's distress and suicide is his almost incestuous relationship with Caddie as a defense against her promiscuity but also his inability to tolerate the petulance of his mother, the alcoholism of his loved and respected father and the selling of Benjy's pasture so that Quentin could attend Harvard. Perhaps, like the South, he is doomed. His solution, the idea of incest, is "to sublimate a piece of natural human folly into a horror and then exorcise it with truth" (177), an obsessive sort of reasoning that would challenge a reader to grasp this logic, so very different from any established paradigm. Quentin believes that if he had told his father that he and Caddie had committed incest it would be so, even if not true, so powerful is his relationship with his father, "and then the others wouldn't be so and then the world would roar away" (177).

Quentin Compson's chapter of the *Sound and the* Fury, an undemarcated, internal, timeless space, is best understood, contrary to Spinoza's notion which understands Joy as emotion resolved in reason, as reason overwhelmed by emotion. The reader struggles to make

reasoned sense of the unfolding of the narrative per se, the cognitive search to create an ordered story, so embroiled, so thick, is it in feeling and sensation regarding the fecundity of the south and the escape from time in "the cool eternal dark". Rather, a "lyrical" affect is demanded of our relationship to *The Sound and the Fury*. Just as the immensity and incomprehensibility of Quentin's actions are not to be understood by a usual logic, so a listener in any relationship learns to listen with an openness for what is, and is not, said.

The Member of the Wedding is similarly saturated in physicality, unbearably beautiful, a study in the literary problem, as with "The Idea of Order at Key West", of how embodied feelings can be expressed in words. It is a multisensory expression that attempts to stretch the limits of words. As such it portrays, again and again, the notions of embodiment and the virtual: "They spoke softly and their voices bloomed like flowers—if sounds can be like flowers and voices bloom" (115). F. Jasmine, like Benjy in the *Sound and the Fury* "wants to say" but can never find the words to express what she feels. Words are never sufficient to express great emotion, but emotion requires the body: "F. Jasmine jerked open the drawer of the table and fumbled inside for the butcher knife. She did not need the butcher knife, but she wanted something to grasp in her hand and wave about as she hurried around the table" (117). The trope of joining a wedding, in its very impossibility, expresses a logic based not on the rational but on feeling. When F. Jasmine recounts to their cook Berenice the uncanny experience she had in an alley, Berenice responds with her profound identification with this feeling: "'Well, this is mighty remarkable,' said Berenice. 'This is a thing been happening to me all my life. Yet just now is the first time I ever heard it put into words'"(99). Told analeptically, thereby subverting logic, Frankie, twelve years old, wants to escape her narrow world of the kitchen where she spends days playing haphazard bridge with her six-year-old cousin John Henry West and their cook

Berenice, and would rather join another improbable world—specifically as a "member" of her brother Jarvis's and his fiancée Janice's wedding. Part one begins on Friday, the day Jarvis and Janice visit from Alaska, but then abruptly, and subtly, without fanfare or warning, within the space of a sentence, the time switches to the day before the visit.

Jarvis is a soldier, stationed in Alaska, and the wedding is now to take place in the South, but in a town improbably called "Winter Hill". Frankie's fanciful, but illogical, notion of "joining" a wedding sets the novel's tone of yearning, physicality and experience that feels always out of focus. The kitchen, the scene of much of the action, "was a sad and ugly room. John Henry had covered the walls with queer, child drawings, as far up as his arm would reach. This gave the kitchen a crazy look, like that of a room in the crazy-house" (6). Like the Crazy Kitchen in Ottawa's Museum of Science and Technology, one feels a sense of vertigo imagining this kitchen. This room is absolutely saturated with nostalgia, longing, feeling beyond thought, colour and music. Through the window we hear the tuning of a piano, but the scale, like our quest for understanding, fails to be completed: "Mr. Schwarzenbaum had played a ragged little waltz; but the piano was not yet tuned to suit him, and he began to harp and insist on another note. Again he played the scale up until the seventh note, and again he stuck there and did not finish" (108).

The atmosphere in the kitchen is heavy with emotion. After Berenice recounts the loss of her one true love, Ludie Freeman, no one moves. Recalling Massumi's recounting of "the lost half-second", referencing the extent to which our brain's decision-making is pre-conscious, John Henry, overwhelmed with the intensity of Berenice's story, emotionally pre-occupied, only physically reacts well after the stimulus to do so has passed: "Nobody moved. John Henry stared at Berenice, and the fly that had been hovering above him lighted on the left rim of his glasses;

the fly walked slowly across the left lens, and over the nosepiece, and across the right lens. It was only when the fly had flown away that John Henry blinked and waved his hand" (103).

When Berenice reminisces regarding past loves, it is the vitality we experience: "In the grey of the kitchen on summer afternoons the tone of her voice was golden and quiet, and you could listen to the colour and the singing of her voice and not follow the words" (84). The characters in the kitchen with Frankie are peculiar: John Henry, half of Frankie's age, "had a little screwed white face and he wore tiny gold-rimmed glasses" (5). Berenice, their cook, "was very black and broad-shouldered and short. … There was only one thing wrong about Berenice—her left eye was bright blue glass" (5). This shabby kitchen, both refuge and prison, situated within a vision of snow in the hot south, defies ordinary logic, not quite magic realism, provoking a visceral response.

Marsden points out, in her article "Senses Without Names", that *The Member of the Wedding* opens with, "It happened that green and crazy summer when Frankie was twelve years old" (191). To what is "it" referring? The turn of phrase is epic in scope, as is the phrase "green and crazy", implying growth, and the momentous. As does the kitchen, the phrase situates the activity in a phantasmagorical space, simultaneously immanent and transcendent, where a logic other than reason rules. In its lack of reference to any specific event, "it" points to a series of events, a surplus and intensity, which are greater than any one experience but, taken all together, similar to the unexpected snowstorm in *Ballad of a Sad Cafe*, mark a transition, a transformation of identity, the unleashing of universal forces. Frankie, as a young adolescent whose mother died on the day she was born, feels herself empty, "unjoined", but we empathize with her angst and potential: "This was the summer when for a long time she had not been a member. She belonged

to no Club and was a member of nothing in the world. Frankie had become an unjoined person who hung around in doorways, and she was afraid" (3).

Frankie's transition to F. Jasmine in Part Two, (and then to Frances in Part Three), as she travels through her small town the day prior to the wedding, is ineffable, a transformation of her perception of the world. (The change in her name is consistent with ideas of becoming, the insubstantial nature of self.) She does not perceive the change as a change in her attitude but rather as a change in reality; "all was natural in a magic way" (49). The unexpected appears normal, "only the long known, the familiar, struck her with a strange surprise" (50). Referring to her experience, "The day before the wedding was not like any day that F. Jasmine had ever known. It was the Saturday she went into the town, and suddenly, after the closed blank summer, the town opened before her and in a new way she belonged" (49). Her affective relationship to her town and its inhabitants has transformed. Nothing objectively has changed, other than the visit of Jarvis and Janice, but F. Jasmine's perceptions and feelings, without regard to reason, have changed her world: "Because of the wedding, F. Jasmine felt connected with all she saw, and it was as a sudden member that on this Saturday she went around the town. She walked the streets entitled as a queen and mingled everywhere" (49). F. Jasmine feels that there are many tasks she has set for herself, somethings that need to be accomplished, but what they are escape words: "Some of these things she could name to herself, but there were other things that could not be counted on her fingers or made into a list with words" (50-51).

The Member of the Wedding is saturated with embodiment, with a richness of the tactile. F. Jasmine's perception of her father, coloured by her belief that she was not to return home after the wedding, conflates the past and the present in illustration of the virtual:

> All of a sudden it seemed to F. Jasmine that she saw her father for the first time, and she did not see him only as he was at that one minute, but pictures of the old days swirled in her mind and crossed each other. Remembrance, changing and fast, made F. Jasmine stop very still and stand with her head cocked, watching him both in the actual room and from somewhere inside her. (51-52)

As she leaves home for town on the day prior to the wedding, just as the memory of the blue of a friend's eyes is intensified by love in Massumi's recounted experiment, emotion transforms "objective reality", and in the cries of children calling, "for the first time in her life she heard a sweetness in these sounds and she was touched" (53). Of her own yard, "she felt she had not seen it for a long time" (54). In a remarkable example of the capture of affect, and the entry of the virtual, illustrating relationship's power to transform, F. Jasmine passes "an old coloured man, stiff and proud on his rattling wagon seat … But in that glance, F. Jasmine felt between his eyes and her own eyes a new unnameable connection, as though they were known to each other—and there even came an instant vision of his home field and country roads and quiet dark pine trees" (55). F. Jasmine's heightened state creates an empathy that comes from her and that connects her to others: "It was a feeling impossible to explain in words" (55).

F. Jasmine's intensified state, not psychotic but magical, is marked by out of the ordinary events. Her search for the monkey and organ-grinder, urged on by the distant sound of their music, is a questing after a wraith. In fact, F. Jasmine's state of mind cannot be captured in thought only. It is an experience marked by embodiment and the conflation of present, past and future times:

> A second fact about that day was the forgotten music that sprung suddenly into her mind—snatches of orchestra minuets, march tunes and waltzes, and the jazz horn of

> Honey Brown—so that her feet in the patent-leather shoes stepped always according to a tune. A last difference about that morning was the way her world seemed layered in three different parts, all the twelve years of the old Frankie, the present day itself, and the future ahead when the JA three of them would be together in all the many distant places. (61)

Despite F. Jasmine's "intoxication", the role of reason in guiding emotion still remains, although faintly, in the background, as she remembers Berenice, her cook and bridge-partner, and anticipates her reaction to F. Jasmine's experience: "It is far easier, it came to her as she remembered Berenice, to convince strangers of the coming to pass of dearest wants than those in your own home kitchen" (59). As F. Jasmine travels throughout the town, loving people whose name she does not even know, "a little conversation buzzed on the bottom of her mind. It was the voice of Berenice…" (63). Just as Spinoza and Damasio understand the brain as having emotions subject to higher functions, Berenice's logic frames F. Jasmine's intensity:

> The argument that afternoon was, from the beginning to the end, about the wedding. Berenice refused to follow F. Jasmine's frame of mind. From the first it was as though she tried to catch F. Jasmine by the collar, like the Law catches a no-good in the wrong, and jerk her back where she had started—back to the sad and crazy summer that now seemed to F. Jasmine like a time remembered from long ago. (78-79)

Despite F. Jasmine's euphoria after her first encounter with a soldier, flattering but lingeringly wrong, doubt creeps into her mind: F. Jasmine "finds herself, on the burning sidewalks, where passing walkers looked dark and shrunken in the angry glare" (74). In other words, reason can still temper euphoria.

Berenice's tale of caution for F. Jasmine is based on her two fraught marriages after the death of Ludie Freeman: to Jamie Beale, "the sorry old liquor-drinker", whom she married because, while sitting next to him in the pew at church, she caught site of his "mashed" thumb, which was identical to Ludie's. And to Henry Johnson whom she married because: "he had chanced to buy Ludie's coat and he was built on the same shape as Ludie. And from the back view it looked like he was Ludie's ghost or Ludie's twin" (106). McCullers' contention that human motivation is not based on reason but on feeling is confirmed by F. Jasmine's response to Berenice: "People certainy [sic] do curious things" (106).

McCullers presents a world saturated with feeling as does ee cummings in "since feeling is first", 1926:

since feeling is first
who pays any attention
to the syntax of things
will never wholly kiss you.

Similarly to Wallace Stevens in "The Idea of Order at Key West", Marsden tackles the problem of expressing affect in words. "This is the kind of experience that language tends to cover over rather than to reveal. McCuller's text abides with sensations in their process of coming to be, feelings that for the most part fail to materialize as recognizable emotions" (Marsden, 192). In a beautiful example of Stern's idea of vitality, in which meaning lies as much in presentation as content, and Massumi's idea of intensity, defined as variation in affect, McCuller's writes about the conversation in the kitchen: "It was the darkening hour when the remarks they made had a sad and beautiful sound, although there would be nothing sad or beautiful about the meanings of the words" (112). Meaning lies in the diminishing light, the fact of conversation, the prosody of

speech; the discursive twists around feeling like an electric wire around its supporting cable. As readers, critics and clinicians we search for effective modalities to understand and express Frankie's experience but the terms at our disposal fit predetermined categories for understanding the world, and as well are moral judgments: "The norms of thought that privilege representation and the assumption of a knowable world are embedded within the syntax of interpretation itself" (Marsden, 193). F. Jasmine's desire to travel, to be otherwise, to be a "member", might be understood as the turbulence of adolescence, but, in fact, the term "adolescence" being socially constructed, can hide experience rather than explain it: "[I]nvoking a concept of 'adolescence' seems to be an example of setting up what Nietzsche calls 'a word at the point at which our ignorance begins' (1968, sec. 482). As a technical term, 'adolescence' has a 'truth' value which is comforting as a social designation rather than illuminating as an experiential state" (Marsden 192). Just as the conventional view of adolescence is that of a stage of development in a teleology connecting childhood to adulthood, so narrative is understood as having a progression with a beginning, middle and an end. Quoting Hayden White from *Content of the Form* (1987), Nicole Seymour argues, "'narrativity, certainly in factual storytelling and probably in fictional storytelling as well, is intimately related to, if not a function of, the impulse to moralize reality' – to inflect it with a sense of what is 'right' and 'wrong,' 'valuable' and 'dispensable,' in the culture at hand" (298). Seymour, cognizant of the historical values of the American South during and after World War Two, in her analysis of *The Member of the Wedding* as a criticism of adolescent development, demonstrates how McCuller's recounting of F. Jasmine's experience, even as she transitions from Frankie to F. Jasmine to Frances, actually undermines the notion of adolescence as a defined stage in a developmental narrative constructed around specific notions of race and reproduction. F. Jasmine's experience should not be understood as a stage in a

narrative conception of development, but actually a queering of adolescence, which negates this pre-defined order of development. Affect is born in the relationship between the individual and the society in which they find themselves. Prevailing ideas, hidden in their influence, result in unquestioned beliefs. How does the individual find validation when their experience feels real to themselves but somehow unacceptable? Frankie/F. Jasmine/Frances's experiences occur in a world with a set of expectations that do not match hers. As a detail, but one that contributes to the affect, McCuller's evoking the pathetic fallacy in her references to winter and snow creates the discordance that F. Jasmine feels.

It is not that Frankie's experiences as a twelve- year-old, such as the dawning awareness of sexuality, are at odds with adolescence: "But she recalled the silence in the hotel room; and all at once a fit in a front room, the silence, the nasty talk behind the garage—these separate recollections fell together in the darkness of her mind, as shafting searchlights meet in the night sky upon an aeroplane so that in a flash there came in her an understanding" (155). Rather, it is not clear that Frances has resolved the intensity of her complex and transformative feelings, unique in their individuality, and that she will progress along a path with the expected narrative trajectory.

Seymour argues that *Member of the Wedding*, in the ambivalence of its ending, functions "as an antistory"; in her quoting Chatman, he says, "if the classical narrative is a network…of kernels affording avenues of choice only one of which is possible, the *antistory* may be defined as an attack on this convention which treats all choices as equally valid (56)" (310). This focus on idiosyncratic experience and feeling, no matter how quirky, indicates the role for the affective within a narrative approach to medical practice as the affective emphasizes a different aspect of the medical encounter, the immediate experience of relationship, the creation of a respectful, safe

therapeutic space, a “somatic syntax”, an emphasis which does includes narrative as the virtual, but is immediately a visceral *now*.

Frankie, like Quentin, is in a “fugue” state, but hers, in Spinoza’s terms, as it promotes the ongoingness of the body, is a state of “joy”. As also occurs in *The Sound and the Fury*, time and space merge in an omnipresence without boundaries. Reading and experiencing the possibility of such “incomprehensible” experience opens the minds of medical clinicians to not only consider broader differential diagnoses, when patients present with symptoms that do not fit a known disease pattern, but also to empathize with their patients’ experiences which do not fit the expected.

7. Vitality in "Fern Hill"

Essential in understanding a therapeutic relationship is not only what is said but how it is said, its vitality, and, perhaps even more importantly, what is not said. While clinical medicine valorizes content and information, the energy with which it is delivered actually carries meaning which is fundamental to healing. As previously mentioned, Daniel Stern, in *Forms of Vitality*, separates content from arousal, which he calls vitality. Recall, vitality is precisely the dynamic aspect of experience, the energy and charisma displayed in relationship. We often fail to recognize vitality: "…we do not pay attention to the feel of the emergence of the thought, but only to its contents" (Stern 10). Not only is vitality evidenced in large gestures but makes up the small social gestures, body movements, facial expressions that give meaning to social relations (Stern 6). Stern points to Susanne Langer who described "forms of feeling", a term referring to experiences such as fading, exulting, easiness and rushing; feelings that are not emotions nor belong to a specific action. These sensations, which Stern calls "vitality forms" because of, and to distinguish them from, the association of feeling with emotion, lie at the boundary between narrative and the physiological (Stern 37). These vitality forms change the tone, and therefore meaning, of a clinical encounter.

Vitality plays a fundamental role in characterizing the relationship of physician and patient. We often refer to the messages conveyed by "body language"; e.g. the importance of not adopting a closed body posture with arms across the chest, the need to sit, not stand, when talking to a patient, the importance of looking at your patient, rather than keyboarding, as he/she talks. Central to relationship is the absolute vibe of the encounter, the mindfulness of participants, the intensity of concentration, the noting of every word, the recognition of the importance of this encounter for the participants, the sense that there is more at stake than

meets the eye. The psychologist Carl Rogers is known to believe that the most important part of a therapeutic relationship is unconditional positive regard.

Older adults and youth experience, and are described by, different forms of vitality. "Fern Hill", by Dylan Thomas, in its structure, in its lyricism, rather than describing youth and older age, embodies vitality. Similarly to the task in "The Idea of Order at Key West", capturing the continuity of nature in discrete words, "Fern Hill" solves the problem of capturing emotion in language through the employment of linguistic vitality forms. Inspiring physicians, the lyricism of the poem might have a profound influence on the affect of encounters revolving around the problems of aging. Bringing vitality into the clinic requires an encounter that is more than a list of diagnostic questions but rather one that captures lived experience, the inexpressible, the feeling of how a problem weighs on one's life.

"Fern Hill is an example of how feeling is captured through movement. The very structure exudes vitality. Initially an embodiment of youth, it is difficult to explicate the sheer energy and joy expressed in gerunds ("lilting", "All the sun long it was running", "it was air/And playing"), in metaphor ("happy as the grass was green", "In the sun that is young once only") and in lines that convey summer, and vivacity and wonderful ephemeral youthfulness. The metaphors in the first four stanzas are dense and filled with sunlight, with clarity, with energy and with optimism:

And once below a time I lordly had the trees and leaves

Trail with daisies and barley

Down the rivers of the windfall light.

We are bathed not only in the warmth of the "sun that is young once only", but also, by means of metaphor and enjambment, in the visions of earth's first day:

So it must have been after the birth of the simple light

In the first, spinning place, the spellbound horses walking warm

Out of the whinnying green stable

On to the fields of praise.

The embodiment of emotion is not only visual but also auditory:

And green and golden I was huntsman and herdsman, the calves

Sang to my horn, the foxes on the hill barked clear and cold,

And the sabbath rang slowly

In the pebbles of the holy streams.

In the fifth stanza, with the advent of : "…that time allows/In all his tuneful turning so few and such morning songs", the vitality changes, motion is gentler, wistful: "…time would take me/Up to the swallow thronged loft by the shadow of my hand,/In the moon that is always rising". The metaphors are more sedate, the moon beams are gentle, lack the intensity of rays. We *feel* the change of energy as sadness, as the theme changes from youthfulness to older age. This change in tone is brought about by both the changed metaphors and also by the decreased intensity.

"Fern Hill", employing the imaginative stretching of language, expresses lyrically the vitality that escapes straight-forward narrative. This is a type of communication that would be considered incomprehensible as medical dialogue. Addressing a similar issue in literary criticism, in the modernism of the early twentieth century, I.A. Richards, aware of the growing influence of science, urged that emotions did not have to be attached only to "intellectually certified ideas" (Thaventhiran 86). Furthermore, while "logic had its machines, systems and symbols" (Thaventhiran 86), "vocabularies and practices of reading [had] to give sense and significance to 'uncertifiable' language" (Thaventhiran 86).

8. *The Death of Ivan Ilych*: Sincerity and Embodiment

The Death of Ivan Ilych is instructive in its teaching of affect to physicians not through its structure but rather through its content. In Tolstoy's story, affect is intimately related to an understanding of the etiology of, and response to, illness: Not only does affect find expression in the emotion connected with illness, but it actually generates disease, determines Ivan's understanding of the origin of disease and mismatches the physician's approach with what Ivan is actually seeking. In fact, Ivan's struggle with death, from an indeterminate illness, the source of which is completely unclear to physicians and which apparently began as a minor injury to "the appendix or kidney", ultimately becomes an existential struggle when he conflates his illness with the absolute failure of the "truths" that have shaped his life.

Tolstoy is critical of the medical profession, as evidenced in the physicians' approach to Natasha's illness in *War and Peace.* Their prescription is a regimen of precise treatments, (none actually useful in themselves), their efficacy supposedly depending on their being exactly followed as to dose, time, and method of administration (*War and Peace* 655-7). Arthur Frank, describing the "disciplined body" in the restitutive narrative, discusses the patient who copes with illness by precisely following a medical regimen, exactly as the physicians wished Natasha, in *War and Peace,* and Ivan Ilych, to do. Facing the uncertainty of illness, "contingencies it cannot accept", the disciplined body attempts to reassert control, in partnership with physicians, by self-regimentation (Frank 41). The patient becomes alienated from his/her own body, seeing it as an external object to be treated in an undeviating way. At the same time, the individual becomes "monadic", disconnected from others, as their whole focus is on undeviatingly following the treatment regimen. As such they also become dissociated from themselves, lacking normal desires. It is only when Ivan throws off the

prescribed medical discipline, accepting his situation, substituting relationship for isolation, that he is able to find a degree of palliation.

Ivan Ilych's illness begins when, having recently received a long sought-after promotion, he is enthusiastically involved with the decorating of his very bourgeois apartment. His mood is excellent, buoyed by his recent promotion; everything in his life is falling into place:

> He was so interested in this business that he often set to work with his own hands, moved a piece of furniture, or hung up curtains himself. One day he went up a ladder to show a workman, who did not understand, how he wanted some hangings draped, made a false step and slipped; but, like a strong and nimble person, he clung on, and only knocked his side against the corner of a frame. The bruised place ached but it soon passed off. Ivan Ilych felt all this time particularly good-humored and well. He wrote: 'I feel fifteen years younger.' (106-7)

This injury grows in importance however, intertwined with Ivan's declining fortunes. This bruise, seemingly trivial, is the beginning of his fatal condition. Is it just coincidence that Ivan subsequently becomes seriously ill, the disease centred in the very spot of the injury? Is it Ivan's uncomfortable, unconscious recognition that bourgeois society, as Lauren Berlant shows in *Cruel Optimism*, will never provide ultimate satisfaction, that the closer he gets to his goal the more it recedes? The initial unadulterated joy felt by Ivan Ilych, his new status in the best society, is replaced by a feeling that something always seems to be lacking: The house is just one room short, the new income is just five hundred roubles too little, there are disputes between husband and wife over which expenses are justifiable. Every little thing out of order in the

perfectly arranged house irritates him. At work, as a magistrate, his life must be absolutely ordered, his modus operandi excluding any relationship with vitality:

> People with petitions, inquiries in the office, the office itself, the sittings—public and preliminary. In all this the great thing necessary was to exclude everything with the sap of life in it, which always disturbs the regular course of official business, not to admit any sort of relations with people except the official relations; the motive of all intercourse had to be simply the official motive, and the intercourse itself only official. (108)

One wonders about the etiology of the illness. It's beginning is mysterious. Ivan dates its onset to the minor trauma; so often patients look for an event that seems to mark, and make sense of, the onset of an illness. But at the same time we feel that Ivan's dissatisfaction with what he has achieved, Tolstoy's disdain for the bourgeois life, is intimately linked to the illness. It painfully dawns on Ivan that his longingly sought-after goals, ultimately meaningless, lead to disease of the body. The illness might be generated by the values of Ivan's society. What he has longed for is actually the cause of his demise. Could his absolute denial of vitality in his professional life, essential in his mind to success, be the inevitable source of his disease?

Gradually Ivan begins to complain of a queer taste in his mouth "and a sort of uncomfortable feeling on the left side of the stomach" (110). This results in a progressive irritability, becoming ubiquitous, until the peacefulness of the house is completely disrupted. At his wife's urging (Praskovy Fyodorovna is now so fed up with him that she would wish him dead except that she relies on his income) Ivan visits a physician who treats him with the exact disdain that Ivan has treated defendants in the court:

> The waiting and the assumption of dignity, that professional dignity he knew so well, exactly as he assumed it himself in court, and the sounding and listening and questions

> that called for answers that were forgone conclusions and obviously superfluous, and the significant air seemed to insinuate—you only leave it all to us, and we will arrange everything, everything in *one way for every man of every sort* (my italics). (112)

Although an extreme example, the biomedical paradigm is called to mind by the uniform approach to every patient. Ivan's doctor provides multiple explanations, so provides none: "This and that proves you have such-and-such a thing wrong inside you; but if that is not confirmed by analysis of this and that, then we must assume this and that ... To Ivan Ilych there was only one question of consequence, Was his condition dangerous or not? But the doctor ignored that irrelevant inquiry" (112).

Ivan Ilych's illness, pathophysiological and moral, although of mysterious etiology, seems to have had its origin in his desire to be accepted in "good" middle-class society, from which his illness is now excluding him. He knows that anger and frustration only make his condition worse, yet he cannot help himself. He feels isolated and is blamed by his family for making their lives unhappy and this in turn redoubles the illness. He is furious in his relations with those around him because of their hypocrisy: "Ivan Ilych's great misery was due to the deception that for some reason or other every one kept up with him—that he was simply ill, and not dying, and that he only need keep quiet and follow the doctor's orders, and then some great change for the better would be the result" (127).

As terrible as is his dying, just as terrible is the refusal of his physicians, and acquaintances, to honestly acknowledge it. One cannot change the fact of dying but one can perhaps change its *potential* to isolate by incorporating a vision of the individual as part of a greater, meaningful whole. The only person who can comfort Ivan is Gerasim, his man-servant, whose genuineness acknowledges that Ivan is dying. He does everything in his power to make Ivan comfortable,

including allowing Ivan to sleep with his legs on his shoulders, a position that seems to ease the pain. Gerasim embodies the possibility of healing, if not cure: The vitality that he brings to their relationship is one of demonstrable caring. His approach is not discursive, he doesn't try to minimize or explain Ivan's suffering, but it is embodied in his willingness to support Ivan's legs for hours. It is not that he is able to change the narrative of Ivan's fatal illness, but the emotion captured in their relationship, their honest recognition of one another, ensures diminished suffering. Speaking to Gerasim's care, in a recent study on medical-legal risk, exploring the dynamics of physician-patient relationships, it is noted that "nonverbal cues may be more indicative of medico-legal risk than verbal communication" (Mostafapour et.al.), giving support to the role of embodiment.

Contrast this with Ivan Ilych's relationship with the doctor, which lacks the possibility of palliation: "Ivan Ilych feels that the doctor would like to say, 'How's the little trouble?' but he feels that he cannot talk like that, and says, 'How did you pass the night?' Ivan Ilych looks at the doctor with an expression that asks—'Is it possible you're never ashamed of lying?'''(130).

When there is no obvious cure, healing depends on reimagining the goals of care. The assumed task of the physician is to cure; the challenge is summoning, at times when this is not likely, a way to conceptualize the illness that can bring some relief. The possibilities for palliation of suffering involve reaching for *potential*, attempting to find meaning as part of a larger whole.

9. The Virtual

The "virtual" refers to all the unseen influences, of which the participants are only dimly aware, which shape a relationship. Contrary to the medical model which views individuals as discrete, fixed beings, affect conceptualizes relationship as occurring between beings, influenced by experiences not actually, but "more than", present, beings who are centres of energy, are in motion, who are always in the process of becoming. It is in this process that physician and patient can connect, such that a therapeutic space is created which reveals the previously unimagined. The medical paradigm views physicians as objective observers, outside of the encounter, detectives gathering signs and symptoms. More accurately, physicians bring their own histories, experiences and vulnerabilities to the consultation; the affect of the relationship is so determined.

In "Fortuneteller", by Laura di Quinzio, the first story from *In Our Hands*, a collection of stories written by medical students at University of Western Ontario, a young medical student transforms, in the midst of an encounter with an elderly patient, from physician to fortuneteller. Identities, shaped by the traces of memory, are not concrete but fluid. The young physician, making her rounds, as she speaks to her older female patient with "wild silver hair", suddenly transforms, uniting her own mother's past, when she had her future, both happy and tragic, told, with her own present: "Suddenly the curtain I have drawn around us has become the sides of a carnival tent. My white coat has been replaced by a patchwork skirt, and my brown hair tumbles in mounds around my shoulders. I smile, and see the contours of her hands so clearly—searching for signs of a past filled with too much drink, or promiscuity" (27).

The encounter reciprocally transforms both the young doctor, as it connects her own internalized family history, and her patient, as the patient also, in keeping with her magical appearance, has a history involving the occult:

> Amidst piles of white cloth, in the pale morning light, mischievous blue eyes look up at me inquisitively from a wizened, strangely smiling face. Wild silver hair crowns the small head, giving her an impish look. … I am captivated by her stories of long ago and far away: stories of how her mother, years ago in the British Isles, was a well-known tea-leaf reader; stories of gypsies, soothsayers, and travelling performers…(26-7)

The curtain surrounding the hospital cubicle now encloses a magical space. The patient has become both the recipient of the young doctor's foretelling and a fortuneteller, recalling both their mothers' pasts; perhaps she also has knowledge of her young physician's future. The newly-minted doctor has also become a fortuneteller in two senses: As a physician prognosticating her patient's (medical) future and as the embodiment of her mother's remembered history which now transcends time and becomes present. Patient's and physician's roles intermingle as one becomes the other. The physician's work is to foretell the patient's future, but this task is now occurring in a new dimension, time, space and person having united, so that the young physician, not only the inheritor of her mother's past and the teller of the patient's future, now also comes to intuit the foretelling of her own future:

> And even further ahead, when my hearing has dimmed, my hair has softened from brown to grey, and hairs have grown upon my chin, I will await the young doctor's question of permission to examine the signs I have to show. Then I will laugh, and agree, and hold out my hand, and give a knowing glance. And I will be proud and unafraid, for I, too will see my future. (28)

The medical encounter has assumed new possibilities in which the roles, and tasks to be accomplished, the expected outcomes have been transformed from diagnostic only to include a transcendent connectedness as a fundamental aspect of cure. It does highlight a truth about clinical consultations, especially in family medicine, where the presenting problems are often not well-defined. Both patient and physician virtually bring their histories to the encounter; these histories figure prominently in the content and feeling, the affect, of the consultation. The recognition accorded the patient is enhanced, as both physician and patient are transformed in an experience that will resonate therapeutically for both long afterwards.

Anne Michael's *held* graphically portrays the virtual in the inexplicable appearance of people, present in spirit but not corporeally, in John's photographic portraits. This occurrence does not seem to belong to the subject or photographer but arises in the space between them out of both of their needs. A "young man", not named, having survived the first world war, requests a portrait of himself to give to his father. While he was fighting overseas, his mother had died. Now his leaving for distant employment, means his father will be alone again. The initial interchange between John and his subject is significant in what is not said in an encounter but is virtually present:

> 'Will it hurt?' the young man joked.
>
> 'Only if you have something to confess,' John joked in turn.
>
> The young man stopped smiling,
>
> 'A Lewis or a Vickers?' asked Mr. Stanley, who seemed to appear from nowhere.
>
> 'Vickers,' the young man said suddenly restored. (41)

This interchange, (complexified by John's relationship with Mr. Stanley), already points to hidden trauma, unsurprising post World War I, when "men returned from the battlefield grown silent" (Benjamin 84).

The image that emerges from the developer is that of "the young man, beautifully clear and evocatively lit, handsome and whole in body" but also, "beside him, semi-opaque but perfectly distinct, an older woman, well dressed, pearl buttons, her fine head and lustrous hair, and her expression of intolerable longing" (56).

In this photograph John recognizes that the woman's "love for the young man was electrifying, electrocuting" (58). But why should this image appear to the artist now, "no spectre had ever appeared to him in the trenches, no apparition, despite his need. Perhaps we are sent only exactly the kind of proof we can believe" (58)? John, mourning the loss of his own mother, struggles to find an explanation, a scientific explanation, for this phenomenon which has arisen in the relationship between himself and his subject. Yearnings and shame, for which we fail to find words, but long for expression, are invisibly present in our encounters. The reader of *held* experiences this manifestation of the virtual both lyrically and metaphorically, despite Anne Michaels's musings regarding scientific explanations: "Who can deny the reality of starlight? Yet the stars that give us their light do not exist. Who can say for certain that those who no longer exist, our dead, do not also reach us?" (59).

10. “What the Doctor Said”

In “What the Doctor Said”, Raymond Carver’s poem about the actual encounter when he received the diagnosis of terminal lung cancer, the conversation unfolds in an unexpected manner. Similarly to “Fortuneteller”, the office visit is not an interaction between a professional with bad news and a recipient but rather between two people in an unhappy situation. It is only in its unfolding that we understand the difficulty of the discussion not only for Carver but also for the physician, who is at a loss for words while searching for the potential for hope. What actually takes place in any conversation is only realized in looking backwards as the possibility for the new to emerge is not anticipated as the conversation begins to unfold. This retrospective view of reality is similarly expressed in Quentin Compson’s internal monologue in *The Sound and the Fury*, “until time its not even time until it was” (178).

Massumi discusses relationship in terms of *radical empiricism*, a term developed by William James (Massumi 17). Relationships are as fundamentally appropriate for direct study and scientific description as are the observations of discrete data. Massumi, referencing Henry James, argues that: “Relationality is already in the world and … registers materially in the activity of the body before it registers consciously. This is the sense of his famous dictum that we do not run because we are afraid, but that we are afraid because we run. We become conscious of a situation in its midst, already actively engaged in it” (Massumi 251).

In the clinic, relationship between patient and doctor is on-going. It is “the felt reality of relation” (Massumi 17). The goals and outcomes of any specific visit come into focus only looking backwards. Massumi says, “Participation precedes recognition: *being precedes* cognition” (252). The becoming of subject and object are actually defined by the relationship. The nature of this becoming is determined by the newness, by the intensity, of the happening: “As long as the event is

ongoing, its outcome even slightly uncertain, their contextual identity is open to amendment. In other words, they are embedded in the relation as the real potential to be exactly what they will have effectively become when the event will have run its course" (Massumi 252). At the conclusion of the specific encounter subject and object, in their coming together, will in some way, by virtue of the encounter, be changed. "The being that precedes cognition" (Massumi 252) is always trying to realize its potential. To the extent that there is uncertainty, or *vagueness* in a situation, to that extent does the encounter have the potential to redefine the participants.

"What the Doctor Said", a poem describing Carver's receiving his diagnosis of metastatic lung cancer, was published in 1989. It is an example of how affect envelops relationships with intensity, questions established paradigms, and is captured as emotion in specific settings. As a conversation between Raymond Carver and his physician, it focuses on the immediacy of the moment, the difficulty in finding any words, for both participants, to deal with the grief of the situation. Just as the meaning of "Fern Hill" is absolutely embedded in the vitality of its grammatical structures, so too does the "What the Doctor Said" use enjambment, lack of capitals and punctuation, a breathlessness and ironic humour, to convey the feeling of the encounter for both participants. The poem challenges the usual structure of a medical encounter, physicians' understanding of their roles, the expected energies physicians and patients bring to the consultation, the role of religion in medicine, and how the time of the encounter is experienced. The structure of the poem as an intense, pathos-filled conversation, the intimate relationship of the participants, the entwined nature of their speech, the physician's turning to religion and nature as solutions outside of the medical model, describe a medical encounter the affect of which is unexpected.

The poem begins with a capital H, promising with this standard punctuation that this will be an encounter that fits a conventional mode, but immediately belies this supposition when the

doctor's blunt opening statement, deviating from the standard SPIKES protocol of breaking bad news, a mnemonic that emphasizes first asking the patient his perspective and how much about his condition he wishes to know, is followed by highly unusual suggestions for palliation. The poem begins:

He said it doesn't look good
he said it looks bad in fact real bad
he said I counted thirty-two of them on one lung before
I quit counting them
I said I'm glad I wouldn't want to know
about any more being there than that

Note that the physician, all too aware of what this diagnosis means to his patient, is emotionally unable to follow the SPIKES protocol, which suggests giving a gentle warning to prepare his patient for the reception of the terrible news. In fact, the physician seems as upset as his patient. The speaker, somewhat unexpectedly, responds with irony and humour.

The physician, cognizant of the inability of medicine to offer its paradigmatic solution to this dilemma, turns to a religious solution, a possibility that is unthinkable in our modern medical model which believes that every problem has a solution, even if it is not yet known:

he said are you a religious man do you kneel down
in forest groves and let yourself ask for help
when you come to a waterfall
mist blowing against your face and arms
do you stop and ask for understanding at those moments

Asking for understanding contains a complex ambiguity which binds the physician and his patient. Is Carver to ask for sympathy for his irrevocable suffering, for the sins of his life, for an explanation of why this is happening to him, or is he to ask for forgiveness for the responsibility for his illness he might feel? Or is the physician asking for forgiveness, projecting his own need for his patient's understanding of his perceived failure to be able to provide a cure?

The enjambment of the poem, the lack of capitalization at the beginning of lines, reproduces the intimacy of the physical space, the emotional entwinement of physician and patient, the simultaneous arrest and rapidity of time that must shape this encounter for both:

> he said I'm real sorry he said
> I wish I had some other kind of news to give you
> I said Amen and he said something else I
> didn't catch…

In Arthur Frank's terms, this encounter is a chaos narrative, a speaking of irrevocable pain, which requires some literary device to find expression in words. "…chaos is the ultimate muteness that forces speech to go faster and faster, trying to catch the suffering in words" (Frank 102). Just as discussed in *The Member of the Wedding,* the problem of the chaos narrative can be understood structurally: It is a problem that often has no obvious genesis and always no clear future; as such narrative cannot provide a completed story. Frank points out that certain types of suffering can only be understood when the hearer understands that the sufferer is living in an ongoing world in which there can never be closure, a life from which all purpose seems to have disappeared:

> The interviewers [of concentration camp survivors] described by Langer seek to impose liberation [from the concentration camp] as, if not a goal, then at least a definite end to the stories they hear and the horrors these stories tell. The Holocaust witness who resists this

> narrative imposition inverts the narrative order by showing the interviewer the inapplicability of finding any ending in liberation. (Frank 107-8)

As such, there is no resolution in Carver's poem; both doctor and patient are affected, like two metal spheres colliding and rebounding. Physicians are trained to "impose" narrative, to offer a satisfactory ending, a solution, to their patient's problem. On the contrary, affect acknowledges that emotions can remain unresolved. The physician, recognizing his patient's bind, and the impossibility of his own paradigm to offer a solution, resorts to a system of explanation from religion.

The hope that affect offers, as opposed to the experienced emotions, is inherent in its nature: Affect is conceived of as a process, emotion as the capture of that process in a specific situation. While the emotion of the participants in "What the Doctor Said" is clear, affect implies a broader perspective: "Reserve the term 'emotion' for the personalized content, and *affect* for the continuation. Emotion is contextual. Affect is situational: eventfully ingressive to context. Serially so: affect is *trans-situational*" (Massumi 236). Affect is the vitality of being, it is "an excess of continuity invested only in the ongoing: its own" (Massumi 236). That is, it is the potential, the virtual, the unsaid but present, the force that resides in every situation. It makes it possible for the physician and patient to reach for potential beyond the context, throughout their ongoing relationship:

> The true duality is not the metaphysical opposition between the subject and object. Subject and object always come together in context. They tightly embrace each other in their reciprocal definition in discourse, as the owner and ownable of conventional content. The true duality is between continuity and discontinuity (trans-situation and context). (Massumi 237)

In “What the Doctor Said” the physician and narrator resist the conventional context of the medical relationship, physician and patient, bearer and recipient of bad news. Rather, the potential offered by affect is that of continuity beyond expected meaning, the creation of perspectives and connections and reciprocities that unite physician and patient in a new possibility.

Massumi provides a material perspective on the concept of affect in relationship by turning to a discussion of the presence of affect even in relationships of non-living matter in the case of the Bénard instability, the behaviour of molecules of water dissipating heat that enters a liquid at a constant rate. At a certain moment, when the molecules suddenly “sense” gravity, their motion changes from random to ordered. “They have acquired the collective ability to be *affected* by gravity” (Massumi 244). The molecules, not initially open to acting collectively, because of the influence of gravity, through their interacting suddenly become open to qualitative change. “Call the openness of an interaction to being affected by something new in a way that changes its dynamic nature *relationality*. Relationality is a global excess of belonging-together enabled by but not reducible to the bare fact of having objectively come together” (Massumi 244). The elements of this phenomenon, water and heat, are not new; nor of course is gravity. It is the way that the water and gravity, under the influence of heat, have come together to produce an unpredicted phenomenon, entirely new and unexpected. It is thus that chaos theory can only express a probability, not a certainty, that an event will occur. Analogously, it is the openness of relationship in the medical setting, conceived as a sort of chaos theory, that allows for the creation of the unexpected, beyond the usual paradigm. The reading of *“*What the Doctor Said” encourages the clinician to look for unexpected potential, even in situations that appear grim. Furthermore, it requires that the physician understand the emotions that he brings to a fraught encounter. Describing the participants in a clinical discussion, Stern writes: “The two find their way in a

rapidly changing field. The person listening has their own shifting vitality experiences, which are a crucial part of the field. In other words, there was never an exactly specified goal" (Stern 125).

This physician, confronted by his own inability to offer a cure, rather than turning to another diagnostic or therapeutic maneuver with little hope of benefit, instead opts for a novel conception of the dilemma: "Relationality is the potential for singular effects of qualitative change to occur in excess over or as a supplement to objective interactions. Relationality pertains to the *openness* of the interaction rather than to the interaction per se or to its discrete ingredients" (Massumi 245).

In reality, the physician's approach in "What the Doctor Said" would be unusual in an acute setting; perhaps in an established palliative situation it would be more likely. It does introduce, however, the idea of thinking outside of the box in a setting where what, at present, would likely be the enumeration of what medicine possibly has to offer in the way of conventional treatments. "What the Doctor Said" allows students and clinicians to engage with their patients with the understanding that there is a dialogic, moral relationship that calls for empathy and imagination. Poetry provides the lyrical insights that promote the *openness* referred to by Massumi.

The "connexional experience" (Matthews et al.) describes the clinical encounter in which "the needs of both the patient and the clinician for connection and meaning in their lives…are met through a transpersonal or spiritual dimension of medical care that is most readily recognized in occasional moments of particular closeness during medical encounters" (Mathews 973). These are embodied experiences, marked by "gooseflesh or a chill". The clinician has a sudden sense of profound connection with the patient's world, a feeling of unity and "a lingering feeling of joy, peacefulness, or awe" (Mathews 973). Providing an explanation for such a spiritual state, a combination of body and mental configurations, Damasio writes, in terms very similar to

Massumi's concept of the virtual, and Frank's dialogic orientation, "Sustaining such [spiritual] states depends on a wealth of thoughts about the condition of the self and the condition of other selves, about past and future, about both concrete and abstract conceptions of our nature" (Damasio 286).

11. Conclusion. "Tintern Abby" and Healing

We have come to expect that there are biological/technical solutions to every medical problem. However, many of patients' concerns require solutions that reconceptualize their presenting problem. As such, a first step is the recognition that the relationship between physician and patient is an important element in care. A therapeutic relationship involves appreciating, as Damasio has shown, that feeling, while a mental process, involves input from the whole body. In *The Death of Ivan Ilych,* it is Gerasim's embodied intervention, his genuine empathy, that provides relief.

The conversation between physician and patient is not a neutral, fact-based relationship but is rather, subject to the principle of indeterminacy, a virtual space in which the participants transform and become who they might be. Where the encounter will lead is unknown. In both "Fortuneteller" and *held* the occurrence of the virtual is anticipated by neither participant but binds them in unexpected ways. In "What the Doctor Said", the heart of the conversation, although masked in a frantic humour, reveals the sense of hopelessness felt by both participants.

Language is emotion-laden; failure to recognize the importance of how the story is communicated, its vitality, as well as the "what" of it, leads to diagnostic errors and the physician's failure to appreciate their patient's actual concerns. The lyrical and metaphorical use of language in "Fern Hill" has the potential to more fully sensitize physicians to how their patients discuss aging.

"Dimensions" illustrates how emotionally competent stimuli, registered as impulses in the deep recesses of the body, become slowly incorporated into consciousness. As they move from the field of emergence into the emerged, these impulses become increasingly transparent, take shape, are transformed and provoke change. This is a model for how the virtual is incorporated into a clinical relationship.

The medical paradigm depends on the narrative mode to cure—a story with beginning, middle and an end. *The Sound and the Fury* and *The Member of the Wedding* recount *experiences* best understood as lyrical; we appreciate that these experiences, though not usual, are possible and that sometimes our best response is simply to listen and acknowledge. To attempt to provide a solution is to reduce the affective enormity of the testimony.

What I have argued is that literature has an essential role to play in the face-to-face relationship of physicians and patients, not as a "communication skill" but as an affordance far beyond the notion of communication of facts. In fact, the recognition of the emotion in certain testimony might be curative in itself.

Brittany Pladek's doctoral thesis, *The Poetics of Palliation*, argues that Wordsworth's poetry was an actual source of healing, especially at a time when biological cures were extremely limited. Just as "Monet Refuses the Cure" was actually healing for my artist-patient with macular degeneration as it allowed her, in its lyricism, to conceptualize her problem as perhaps more than a deficit, so too does "Tintern Abbey", in its technique, in its switch of affect in its portrayal of youth and aging, similar to "Fern Hill", imagine a way of conceptualizing our growing older that undermines our twenty-first century notion that aging is nothing but loss of beauty. The sound of the words-cataract like a "crack" of sound, the hard rock, the dark woods--all speak of youth, of energy; and we long for it:

I cannot paint
What then I was. The sounding cataract
Haunted me like a passion: the tall rock,
The mountain, and the deep and gloomy wood,

But there is also a joy in the revelation that comes with aging. Not only does “Tintern Abbey” point to the possibility of reconceptualizing aging but we actually feel a sense of enlightenment, of peacefulness and inspiration in the world around us.

> And I have felt
> A presence that disturbs me with the joy
> Of elevated thoughts; a sense sublime
> Of something far more deeply interfused,
> Whose dwelling is the light of setting suns,
> And the round ocean and the living air,
> And the blue sky, […]

At a time when there is increasing interest in interdisciplinary studies, the English Department has a great role to play in the study of how imagination shapes our desires. It can address the sense of loss that might permeate the physician-patient relationship. Wordsworth wrote, in 1800, in “The Preface to the Lyrical Ballads”: “If the time should ever come when what is now called Science, thus familiarized to men, shall be ready to put on, as it were, a form of flesh and blood, the Poet will lend his divine spirit to aid the transfiguration, and will welcome the Being thus produced, as a dear and genuine inmate of the household of man” (607). That time is now ripe.

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