

# The Principles and Practice of Narrative Medicine

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## CHAPTER 7

## Close Reading

## THE SIGNATURE METHOD OF NARRATIVE MEDICINE

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Narrative medicine is committed to developing deep and accurate attention to the accounts of self that are told and heard in the contexts of healthcare. Whether in settings of individual clinical care, health promotion, or global health activism, our deepest mission is to improve healthcare by recognizing the persons who seek help with their health. Along with the accuracy of recognition come the powerful consequences for the person—of having been heard, of having achieved an unimpeded and free voicing of the matter at hand.

From such diverse fields outside of healthcare as literary criticism, anthropology, oral history, phenomenology, consciousness studies, and aesthetic theory, narrative medicine has developed methods that strengthen the capacity of the clinician to recognize the patient by attending closely to what he or she conveys. Toward the goal of a full, nonjudgmental, generative reception that is informed by all aspects of what a teller tells—in words, silences, gestures, position, mood, prior utterances—the attentive listener absorbs what is given and can then *return* to the teller a representation of what was heard. As if to say, “This is what I think you told me,” the listener reflects back in affirmation his or her witnessed version of a conversation, giving the teller a view, as a starting point, of what might have been told.

The consequences of attentive and accurate listening in a clinical practice can include deep companionship between teller and listener, mutual investment, reciprocal clarity, and affiliation—ideally hallmarks of healthcare itself. That such listening was perhaps better achieved in the time of Hippocrates and Galen and Chekhov than in contemporary practice alerts us to deep-seated tensions within a contemporary bioscientific ethos that challenges the particular with the universal, the personal with the corporate, and the intimate

with the mechanized.<sup>1</sup> Earnest efforts have been made by health educators over the past several decades to impart listening skills and psychological/affective insight to trainees in many of the health professions.<sup>2</sup> Many disciplines and practices have been recruited to improve the listening performance of clinicians: communication studies, literature and medicine, improvisational theater, health psychology, discourse analysis, and linguistics. Despite the range of sources and skills bent toward the effort to improve clinical listening, patients continue to complain that their doctors, at least, don't listen to them, and so patients find their way to alternative healers, even if they need to pay directly for their services, *because* these practitioners are better able to attend to what they say. Narrative medicine evolved from and has learned from these many teaching projects to strengthen the capacity for accurate, clinically useful listening, bringing to the effort its particular commitment to the acts of reading, the discovery potential of writing, and the intersubjective contact made possible by stories.

## The Origin and Fate of Close Reading

*It is difficult  
to get the news from poems  
yet men die miserably every day  
for lack  
of what is found there.*

—William Carlos Williams  
Asphodel that Greeny Flower

Narrative medicine's recognition of attention as a requirement for empathic and effective care of one person by another—whether or not this occurs in a healthcare setting—accounts for our deepening examination of the acts of reading. Both a model for and an avenue toward attention, close reading fortified with attention to its subjective dimensions has become narrative medicine's laboratory and training ground.

Literary scholar Rita Felski writes in *Uses of Literature* that “[t]he practice of close reading is tacitly viewed by many literary scholars as the mark of their tribe—as what sets them apart, in the last instance, from their like-minded colleagues in sociology or history. . . . A sharply honed attentiveness to nuances of language and form . . . simply is, in Rorty's phrase, what we do around here.”<sup>3</sup> A term with a history of contention, *close reading* is both a brand-name term for a movement within literary criticism that arose in the 1920s and flowered

among the New Critics of the 1940s and 1950s and a generic term for attentive, critical, careful reading. In the following section I will briefly rehearse the history of the appearance of the term and summarize some of the controversies that continue to surround it and will then describe in detail why narrative medicine recognizes close reading as an inspiration and method for respectful and effective healthcare.

Like other transformative ideas, close reading has had many beginnings.<sup>4</sup> In the period between the world wars, this new form of criticism arose when literary scholars sought a fresh examination of the processes of literary acts. The earliest writings about close reading, and the first use of the phrase, were published in the United Kingdom by literary scholar I. A. Richards, starting in the 1920s with the publication of *Practical Criticism* and *Principles of Literary Criticism*.

Richards sought to consider the nature of the thought and experience undergone by the reader. Protean, his work spanned the study of Peircean semiotics, the psychology of interpretation, the philosophy of rhetoric, and the individual consequences of aesthetic experiences.<sup>5</sup> A poet himself, Richards probed not only the meaning of the words of a poem but also the means by which language gives birth to thought and feeling through signs, symbolism, perception, and aesthetic beauty. He proposed radical views on the function of literary criticism, emphasizing attention to individual readers' interpretive process in addition to the attention to the text itself, and asserting therapeutic dividends to the reader who integrates conflicting perceptions into an aesthetic whole. Richards took his conceptual start by contesting Kant's notion that the aesthetic realm exists separate from ordinary life. "Ever since 'the first rational word concerning beauty' was spoken by Kant, the attempt to define the 'judgment of taste' as concerning pleasure which is disinterested, universal, unintellectual, and not to be confused with the pleasures of sense or of ordinary emotions, in short to make it a thing *sui generis*, has continued."<sup>6</sup> Instead, Richards passionately proposed, starting in *The Meaning of Meanings* co-written by C. K. Ogden in 1923 and then in *Principles of Literary Criticism*, that the sense of beauty is available to all humans, that they depend on it to live their ordinary days, and that there are no powers of seeing restricted to the "professional" seers. Richards sought to bring the experience of beauty back to ordinary life:

When we look at a picture, or read a poem, or listen to music, we are not doing something quite unlike what we were doing on our way to the Gallery or when we dressed in the morning. The fashion in which the experience is caused in us is different and as a rule the experience is more complex and, if we are successful, more unified. But our activity is not of a fundamentally different kind.<sup>7</sup>

Richards saw that human consciousness is capable of aesthetic acts even without formal training or artistic gift, and that one uses ordinary experiences as works of art. Accordingly, his interest in literary criticism, his “practical criticism,” was founded on the desire to return to readers the dividends of authentically undergone aesthetic experience. He taught his poetry classes at Harvard by distributing four poems per week. “Extremely good and extremely bad poems were put *unsigned* before a large and able audience.”<sup>8</sup> The matter of the course was furnished by the responses to these poems anonymously submitted, in writing, by the undergraduate students. Their own aesthetic responses to the texts—where they were driven in mind and mood and sense of form—were treated as more authoritative than anything written by experts about the work or the artist. If “What is art *for*?” was close reading’s foundational and eternal and brave question, the answer focused on the interior experiences of the readers themselves.

A student and then colleague of Richards in the development of close reading, William Empson, delineated the aspects of literary texts that make them literary. First published in 1930, his *Seven Types of Ambiguity* spearheaded the practices of seeking the paradox, tone, irony, and antinomies in poetry, turning the critical tide away from the time’s conventional philological and archival approaches to texts toward a fine and focused examination of the complexities of the text itself.<sup>9</sup>

From the beginning, the continents clashed on the nature of this new form of literary activity. In the United States, starting in the 1940s, notably in the South, close reading was championed by John Crowe Ransom, Cleanth Brooks, T. S. Eliot, Robert Penn Warren, and their associates—an effort tinged for some of them with a nostalgia for the by-then bygone Southern agrarianism.<sup>10</sup> This literary movement of the early 1950s valorized extremely focused readings, mostly of poems, with no attention to the contexts of the poems or to objective correlatives in the life experience of the poet. In an effort to systematize the reading of poetry toward a scientific analysis, the New Critics proposed that seeking the author’s intention in writing or the reader’s emotional response to a text—what they called the *intentional fallacy* and the *affective fallacy*—could misdirect the critic’s effort to understand the poem.<sup>11</sup>

Brooks’ *The Well-Wrought Urn* offered extensive literary commentaries on ten poems, all of them English, from the seventeenth century to the 1940s. The ten included works of Donne, Shakespeare, Milton, Herrick, Pope, Gray, Wordsworth, Keats, Tennyson, and Yeats. Unlike Richards and Empson, the American New Critics were not interested in the reader’s situation. They modeled an ivory-cool cognitive approach to the poem, minimizing the presence of either the poet or the reader in the development of meaning. For example, in discussing Robert Herrick’s poem “Corrina’s going a-Maying,” Brooks writes:

To say that Herrick “communicates” certain matters to the reader tends to falsify the real situation. The old description of the poet was better and less dangerous: the poet is a maker, not a communicator. He explores, consolidates, and “forms” the total experience that is the poem.<sup>12</sup>

Over time, the positions of the American and British close readers influenced one another, not tempering their conflicting positions but enlarging and complicating their own scopes of vision. The 1960 edition of Brook’s and Warren’s *Understanding Poetry*, initially published in 1938, states in the Preface: “Poetry gives us knowledge. It is a knowledge of ourselves in relation to the world of experience, and to that world considered, not statistically, but in terms of human purposes and values. . . . The knowledge that poetry yields is available to us only if we submit ourselves to the massive, and subtle, impact of the poem as a whole.”<sup>13</sup> They highlight for this edition considerations of the contexts of the poem’s creation, its historical moment, and the actions of the individual readers in recognizing the implications of the form. Hence, the history of close reading not only maps profound disagreements on what it means to read a poem but also the literary process of interrelation and influence.

The 1970s and 1980s, cataclysmic theoretical revolutions in literary studies—the influence of the anthropology and linguistics of Claude Lévi-Strauss and Roman Jakobson;<sup>14</sup> the structuralism of Roland Barthes and Jonathan Culler;<sup>15</sup> the deconstructive turn ushered by Jacques Derrida, Jean-François Lyotard, and Julia Kristeva;<sup>16</sup> the influence of Marxist theories of history of Fredric Jameson;<sup>17</sup> the impact of the post-Freudian psychoanalysis of Jacques Lacan;<sup>18</sup> and the vision of Michel Foucault’s macroanalyses of power and system<sup>19</sup>—transformed readers’ understanding of what they do when they read. The response of those schooled in New Criticism was marked at the start more by resistance than excitement, for, as summarized by Andrew DuBois,

[T]he move into theory proper is marked by a move into linguistics and a break from aesthetics. This may be why so many critics considered theory detrimental to the reading of literature, since “reading” and “literature” are intertwined not only with aesthetics but with aesthetic *appreciation*. To remove this as a grounding critical consideration was by some accounts tantamount to the annihilation of reading as we had known it.<sup>20</sup>

Despite such reservations, with the benefit of contemporary theory, literary scholars of the time found new means to closely examine the words on the page, now in view of all that might be hidden in the subtexts or historical/political/psychological shadows of the work. The massive and generative turns that culminated in the postmodern era made possible a raft of probing reading

approaches that took account of social power, individual identity, and political dominance and powerlessness. Such schools of theory as New Historicism, feminist criticism, queer studies, Marxist criticism, autobiographical theory, reader-response and reception studies, and psychoanalytic methods of criticism widened the ground on which the writer and reader were visualized to stand and expanded the range of questions one could ask of a text and its actions.

Close reading has received sustained critique, both at the time of its rise in the 1950s and more recently by cultural studies scholars, autobiographical theorists, and world literature proponents. Some charged that New Criticism, through its careful attention to a small selection of texts, endorsed a narrow and elite canon of works, restricted in general to white males writing in English, as suitable to study. If only the words on the page matter, others alleged, the reader need not contextualize the work by time or space or person. Such matters as race, language, class, or gender are seen to not come in for the attention they require of the reader.

Despite these critiques, close reading has never been abandoned in the classroom and the academy but has sequentially been informed, fortified, challenged, and sharpened by intellectual and creative cultural movements.<sup>21</sup> Seasoned by a postmodern awareness of the indeterminacy of language and the contingency of meaning and reference, close readers continue to examine what they do when they read. In the preface to their 2003 study called *Close Reading*, Frank Lentricchia and Andrew DuBois write that they intend to

represent and undercut what we take to be the major clash in the practice of literary criticism in the past century: that between the so-called formalist and so-called non-formalist [especially “political”] modes of reading . . . The common ground, then, is a commitment to close attention to literary texture and what is embodied there. We emphasize the continuity, not the clash of critical schools . . . We like to imagine an ideal literary critic as one who commands and seamlessly integrates both styles of reading.<sup>22</sup>

Not only has the classroom teaching of close reading survived into the present, but the critical conversation about it has proliferated as well. Lentricchia’s and DuBois’ hope may be, to some extent, fulfilled as current studies of close reading combine formalist concerns and methods with cultural/political ones. Stephen Best and Sharon Marcus introduce a 2009 special issue of *Representations* entitled “The Way We Read Now” with a discussion of the reversal of Paul Ricoeur’s hermeneutics of suspicion, in reign during the rise of theory, that instructed the critic to dig below the surface of the text in a chronic state of seeming paranoia that any meaningful aspect of a text would have been suppressed.<sup>23</sup> Such symptomatic reading—seeking signs of disease

or malice within the text—is being replaced, they suggest, with forms of “surface reading” that might disavow the need to master the text and all its secrets and, rather, to discern its manifest intricacy and pluripotency—in effect, another turn of the spiral toward attention to the words on the page. D.A. Miller notices “too-close reading” as an obsessive distraction for the reader who cannot ignore anything in the text, and yet finds himself in a state of being hailed, almost in friendship, by a work of art so closely known, as if the work of art knows him.<sup>24</sup> Such formulations of contemporary reading, articulating new conceptions of the nature of both “close” and “reading,” join to form a lineage of studies moving away from reading as suspicion toward a recognition of reading as reparation, recognition, and pleasure.<sup>25</sup>

Accompanying these movements within criticism is an explosive attention to the role of emotion and empathy in reading, two central and contested dimensions in the original emergence of close reading.<sup>26</sup> Consciousness studies, theory of mind investigations, neuroscientific investigations of brain activity, and psychological probings into literary actions have attracted interest and funding toward explicating the biological consequences of reading and writing.<sup>27</sup> Banner headlines are made of studies proving that reading fiction, but not nonfiction, triggers empathic activity in the brain of the reader.<sup>28</sup> Neuroscientists try to pinpoint the areas of the brain responsible for these findings, even though the currently available imaging methods are still quite primitive. The existence of such bodies as “The International Society for Empirical Research in Literature” and such fields as “Scientific Study of Literature” alert literary scholars and neuroscientists of a new effort, to some troubling and to others promising, to master the machinery of reading as if its performance was indeed housed only in the brain.

Despite the excesses of the reductionist tendencies to map profound human experiences with brain imaging tests, this upsurge in interest in the emotional and moral consequences of reading heralds promise.<sup>29</sup> It seems to me to be a latter-day recuperation of reader-response studies, a school of critical interest that arose in the 1970s, peaked in the late 1980s, and has been rarely discussed since the turn of this century.<sup>30</sup> Reader-response, during its brief tenure, sought to understand the interior activities of the reader. Formulations of the transactions between reader and text as both aesthetic and moral (Louise Rosenblatt), Proustian descriptions of the trance-like experience of being possessed by a book (Georges Poulet), psychological studies of characterological moves made by the reader (Norman Holland), interest in the workings of interpretive communities of readers (Stanley Fish), phenomenological investigations of readers’ experiences (Wolfgang Iser), gendered studies of reading (Elizabeth Flynn and Patricio Schweickart), probing of the subjective experiences of reading (David Bleich), and locating readers’ personal responses

within the process of rhetoric (Booth) composed a vital and productive realm of criticism. Reader-response was a departure from New Criticism's objective and analytic goals toward an interest in the subjectivity of reading and a commitment to explore and understand it.<sup>31</sup>

Our adoption of close reading as a central method for narrative medicine training and practice blends multiple currents in these decades of study of the ways we read. The fine, disciplined examination of formal features of poetry or prose cannot be overlooked in any serious reading or hearing of texts. In addition, the attention to emotion that arose in reader-response study and now continues in some of the subjective and philosophical studies of literary acts is pivotal to a singular understanding of the transaction between *this* text and *this* reader. The intersubjective contact among members of an interpretive community, whether in a graduate course or on the hospital wards or within a dyad in clinical care, is made possible through this contemporary version of close reading that is fortified with attention to the reader himself or herself. By adopting a critical stance that combines the timeless practice of close reading with attention to the roles of emotion and intersubjectivity in how the reader reads, we hope to be able to maintain deep disciplinary roots in the major movements of literary criticism and reading theory while contributing to clinical work's examination of its complex sites of written and oral textuality. We hope to move toward Lentricchia's and DuBois' state of "command[ing] and seamlessly integrat[ing] both styles of reading," bringing Richards's commitment to the ordinary reader's experience, Brooks's laser concentration on the formal characteristics of a text, a reader-response awareness of the complexity of the reader/text transaction, and the postmodern fluidity among schools of political and cultural criticisms to learn how we experience texts, what happens to us as a result of our reading, and how acts of reading change the world.

## Why Narrative Medicine Is Committed to Close Reading

In an essay in the 2007 Modern Languages Association's *Profession*, feminist scholar Jane Gallop writes that "Close reading . . . learned through practice with literary texts, learned in literature classes, is a widely applicable skill, of value not just to scholars in other disciplines but to a wide range of students with many different futures. Students trained in close reading have been known to apply it to diverse sorts of texts—newspaper articles, textbooks in other disciplines, political speeches—and thus to discover things they would not otherwise have noticed."<sup>32</sup>

If close reading helps persons “to discover things they would not otherwise have noticed,” perhaps it might help clinicians to notice what their patients try to tell them. The close reader, as Tompkins suggests, becomes gradually more receptive to appreciating texts outside of the literature class. She continues: “This enhanced, intensified reading can prove invaluable for many kinds of jobs as well as in their lives.” Transcending the conventional boundaries of close reading, narrative medicine reading practices reach beyond literary texts to examine and try to understand visual and musical arts, personal conversations, the mood in a room, or the silent communication of performance and gesture.<sup>33</sup>

The dividends for narrative medicine in close reading are found in those features that distinguish it from casual, technical, or information-seeking reading. The close reader absorbs a text, squandering nothing. Whether reading a novel, a lyric poem, or a paper in *JAMA*, he or she notes the genre, the diction, the temporal structure, the spaces depicted, and the metaphorical and musical work being done with the words. The close reader registers who is telling the text’s story—whether first-person or third-person narrator, whether or not this narrator is involved in the action of the plot, whether remote, familiar, reliable, inviting, or combative. The close reader appreciates the text’s meter and rhythm; he or she recognizes when the text alludes to some other text outside of itself. As if in conversation with the author, the reader is aware of his or her own place in the text, asking questions about the contract with the author that emerges from the text. What duty, the reader asks in the key of narrative ethics, do I incur by reading this book?<sup>34</sup>

Close reading thickens and complicates the effects of the words on the page. The text is treated as a thing of beauty, an occasion of bliss, a created object of both rare delicacy and raw power. Alternatively, it might be experienced as noxious, revolting, denigrating of values held closely by the reader. Or it may be received with indifference, the reader impervious, despite effort, to the forces of the text. Sometimes a reader encounters a book he or she does *not* want to be inhabited by. Literary critic Wayne Booth, who championed the field of ethical criticism, emphatically reserves the right of any reader to refuse to become the kind of reader being demanded by a particular book. You simply close the book.<sup>35</sup> All of these aspects of the text contribute to its ultimate meaning—for this one reader—and help to expose what this reader undergoes by virtue of reading it.

We have shown at Columbia that rigorous close reading can be taught and learned in clinical settings, where its dividends have been found to enhance patient care.<sup>36</sup> But teaching healthcare professionals how to be close readers does far more than improve their interviewing skills. Here is where we find the transformative potential of our practice of narrative medicine. The close

reader gradually discovers that the world within the text—be it novel, newspaper story, one's own diary, or an account of illness given by a patient in the emergency room—is real. The creative acts of representation—in writing or telling or painting or composing—do not merely reflect something real but create something real. A work of art results in a product, not a copy. Radical, disturbing, a challenge to reductive objectivity, the realization of the createdness of the real by and in language can shock the unprepared newcomer to the acts of reading. Rigorous training in close reading—at least narrative medicine's version of close reading—improves readers' capacity for attention but also revolutionizes the reader's position in life from being an onlooker checking the log of past events to becoming a daring participant in the emergence of reality. The trainee comes to realize that, until told or written or in some way represented, events remain unheard, unconfigured, and therefore imperceptible. Such unformed chaotic experiences will not allow themselves to be known. But once configured by language or image or composition, once form has been conferred onto the unformed, the chaos is discernible both by those who witness it and those who hear accounts of it. Once represented, the chaos is at least potentially comprehensible. It will then have been recognized.

Close reading became one of the narrative medicine's foundational methods for its teaching and practice because it serves all the various uses of the reader's skill. For sure, close reading prepares a student to read complex literary texts with attention and skill and even to read or hear accounts of illness with nuance and sophisticated comprehension. At the same time, it fulfills a far more weighty duty. It not only suggests but demonstrates that one's acts as a person who cares for the sick arise from the same "self" as that person who is transported by a Rothko painting, a Bach partita, a novel by Virginia Woolf, or a graphic novel by Alison Bechdel. The close reader becomes, in the end, more deeply and powerfully attuned to all that may lie in awareness and outside of awareness, in consciousness and out of consciousness, in body, in mind, and whatever is left once those two are accounted for; in relation to the voice and the presence of the other. Close reading may be a threshold to a life fully lived.

## Close Reading and Its Progeny, Attentive Listening

Close reading develops the capacity for attentive listening. Henry James's dictum to novelists, "Try to be one of those people on whom nothing is lost," can be said to readers; it can also be said to listeners.<sup>37</sup> Time and again, in the office getting to know a new patient, I have the remarkable and identifiable experience of "tuning in," of letting what is being said—usually some form of account of illness—wash over me and wash into me. I submit to it, I relax my

vigilance regarding the clinical duties that bristle around any new recitation of illness (the frantic search in the mind for the things to look for in a particular disease, the humiliating ignorance of a medication the patient might name, the anxiety to hear about a thorny symptom) to simply absorb all that is being made manifest. As the shift occurs from “listening like a doctor” to “listening like a reader,” my self shifts within my body and consciousness. I roll my chair away from the computer. I let my hands sit in my lap. Instead of being on an edge of ignorance and challenge, I feel summoned by the patient—is it her account? Is it her words? Is it her presence? Is it her action in having come to me because she thinks maybe something good will come of it?—to what feels like a different self, my readerly self. I think it is the difference between being a judging outsider who is being put to the test to know what to do about a problem and being a welcoming receiver of its mystery, willing to sit within all its doubts.

This sequence in the office is not unlike a sequence of close reading. The same alert, creative presence is needed by the reader or the listener; the same attention to all features of the narrating are awakened; the same intimacy between creator and receiver of the narrative is achieved. But close reading is far easier to talk about than is close listening, and maybe this is why we start there. When the words are on a page, when all heads in the seminar can bend over those words and read them simultaneously, each reader undergoes a parallel experience, or at least a personal experience that begins with a parallel ignition and can be inspected. When one person has a conversation with another person and others listen to or hear about the conversation, the passive listeners are simply not having the same experience as the conversant. A conversation cannot be shared in the way that a text can. Perhaps this is why we start with the reading, even if our ultimate destination is the listening.

Reading is teachable. The reading can be watched as one makes one’s way down an inch of text, once and then again and then again, noticing the verb tenses, putting rectangles around particular words or phrases, drawing lines to connect images that travel together, gleefully getting the pun or the internal rhyme or, mouthing the words, hearing the words spoken aloud, undergoing the meter, relishing the rhythm. When students or colleagues do this in groups, each participant comes to know something about his or her own reader-response while reaping the valuable dividend of witnessing how the minds of his or her colleagues work as well. Reciprocal, these recognitions lead to individual clarity and intersubjective transparency.

As one reads a story—or watches a film, or attends a theatre or dance performance—one takes in countless aspects of knowledge, perception, and emotion. The beholder opens the self to the creator, offering the full use of the

self's equipment as a receiver and decoder of that which is offered. Not that the readers or audience members are radar screens or satellite dishes in space, but rather that there is nothing squandered in the evidence available in the telling or performing being given.

The habits of close reading furnish means of crossing the gap of unknowingness between one individual and another. Literary scholar and writing teacher Peter Parsisi notes that “[t]he real object of literary study is not to bring readers a message, but to bring them into a mode of attention.”<sup>38</sup> The writer writes, and then the reader reads, with the always mysterious inhabitation in the reader of the thoughts and views and sensations and impressions of the writer. That is to say, the thoughts and views and sensations and impressions of the writer are, in the oddest way, absorbed by the reader in order that they be experienced from within. It is as if intense and repeated reading can lead the reader to feel that he or she has somehow ingested the writing—eaten it up, engulfed it with amoeba arms, made it become part of self. Virginia Woolf writes almost mystically about this process in many of her essays, describing the site of reading as a powerful synchrony of personal and historical time, making possible travel beyond the bounds of mortality.<sup>39</sup> Roland Barthes describes the “pleasure of the text” and the bliss of reading in ways that illuminate this process of ingestion, asserting the corporeal components of these literary acts.<sup>40</sup>

These intersubjective processes explain the always startling discovery of students new to close reading who find themselves writing endless sentences replete with parentheses and em-dashes as they encounter Henry James for the first time. Or they are surprised by the slippery stream of naturalistic imagery that unintentionally spools into their term papers after a semester with *To the Lighthouse*. This is not as mysterious as it sounds. Elements of language like temporal structure, diction, imagery, narrative situation, plot, and voice carry messages back and forth from writer to reader. They are either the message's bottles or the messages themselves. Not a little interpretive work has to be done, but in our teaching we have observed that readers new to close reading can become quite adept at careful, slow reading in a relatively short period of training. If the reader is introduced to those elements of text to look for, he or she rather quickly becomes attuned to the temporal, imagistic, generic, spatial, perspectival aspects of a text or image or spectacle.

These skills of the attentive reader are then transferrable to the skills of the attentive listener. I learned this from a patient who had been under my care for around ten years, a woman with hypertension, back pain, and a history of breast cancer.<sup>41</sup> She had faced her breast cancer squarely, almost matter-of-factly, underwent a lumpectomy in her left breast, and completed a course of hormonal therapy. We celebrated her achievement of her five-year cancer-free period. Some years passed, and she developed a second cancer in her left breast.

Although she soldiered through a mastectomy and additional chemotherapy and recovered physically from the surgery, she developed anguishing fear that the cancer would again recur. She visited her breast surgeon or me almost weekly, anxious about small changes in her breast tissue and certain that a third cancer was underway.

I remember so clearly the day she described powerfully her sense that something was waiting in the wings, as if about to pounce. I remember leaning against the sink in the examining room, listening to her words, taking in her panic at this invisible pursuant. Knowing her quite well by then, I took the chance to wonder aloud if it was dying that she feared. We talked about dying, about the certainty of it, about the fear that surrounds it. I remember realizing how much I myself was deriving from this frank and unafraid opening-up of the subject of death. We found a way to be together in the forecast of death, even though hers felt much closer to her than, at that moment, mine felt to me. She realized that the recurrence of her breast cancer had tormented her with the unspoken—until now—certainty that she will at some point die. This conversation, oddly, brought peace to her, for she felt she understood more clearly what it was that had brought her such anguish. I wrote a description of this situation, trying to better understand it myself. When I showed her what I had written, when she read the story and when she helped me to make it even more accurate, she learned even more herself about what she had undergone. Her repeated visits to her doctors for reassurance became no longer necessary, and to the day on which I write this she is healthy and remains at peace.

I see, in retrospect, that my listening to her that day included the close reader's attention to metaphor and figural language, to tone, to mood. I am grateful that I did not surrender to the instrumental means of reassurance, "But look, your cancer markers are not elevated. Your repeat mammogram is fine." Instead, her words and her mood and her actions revealed to me the presence of another truth, a lurking fear that had yet to be perceived. Like the kind of listening I might do in a narrative inquiry interview on a qualitative research project, I was trying to treat her utterance as a unit, with an underlying unity despite the ruptures of paradox. Our conversation that day added to the good we have done to one another since then, for it strengthened the ground of relation between us that a more conventional medical approach would not have been able to achieve.

## The Interior Processes of Close Reading

If close reading crosses the gap of unknowingness between two people, it also is a means of crossing the gap between what one consciously knows and the

“unthought known,” that which is known outside of awareness.<sup>42</sup> There are many avenues toward knowing one’s unthought known—interpreting one’s dreams, psychoanalysis, and aesthetic creation are perhaps the most powerful ones. Close reading too can reveal aspects of knowledge and self otherwise out of awareness. Like the writer or artist who embarks on a creative process without knowing where it will lead, the close and creative reader embarks, with every book, on an uncharted process toward discovery.

The opportunities afforded by close reading bring the reader to look attentively at his or her own ways of making meaning. How does my mind work? What are its practiced or chosen or fated moves? Readers come to know, if they *watch themselves read*, how their own cognitive and affective and characterological methods converge to create meaning. Whether reading or listening or acting, the person is using his or her singular means of recognizing stimuli, experiencing them, ordering them in some characteristic way, and feeling his or her way toward coming to conceive what, perhaps, this phenomenon is about. When the analysand talks while the analyst listens and silently participates, he or she has recourse in the second person’s frame of mind. When the reader reads, he or she has recourse to other readers who have read the text, to other texts the author wrote, to other times the reader himself or herself has read the text. And so the close reader is accompanied on the readerly journey, not necessarily by another person who will actually say things back, but by a similarly attentive presence—the self increasingly known.

Many mysterious processes occur through close reading. How does it happen that a reader, reading a novel or poem written centuries ago in a foreign language, can recognize herself in a character or a situation in this fiction?<sup>43</sup> Why is it the case that a reader might feel a powerful bond of intimacy with an author long dead? It may seem unusual to propose that absorbing the words of another—perhaps dead for centuries, perhaps writing in a language unknown to the reader, perhaps living in one’s exact time and place—can expose something powerful about the reader to the reader himself or herself. How can it be that when I read Henry James, I see with such otherwise unavailable clarity aspects of my own peril? It is not exactly recognition. There is little similarity between this master of nineteenth- and twentieth-century American fiction and me. Yet, his sentences open up some view of myself to myself. In their cadences, their never-endingness, their ever-receding conclusions, their always-qualifying second and third and fourth thoughts, I find some familiarity, some belonging, some kinship not in belief or way of life but, instead, in turn of mind. My close reading of James entitles me to appreciate some of the ways in which my own mind works. Roland Barthes describes this phenomenon in *The Pleasure of the Text*, a description that reassured me about that which I underwent at the hands of my author: “The text chooses me, by a whole disposition of invisible screens,

selective baffles: vocabulary, references, readability, etc.; and lost in the midst of a text (not *behind* it, like a *deus ex machina*) there is always the other, the author.”<sup>44</sup>

I am visited now, in my mind, by one of my Master of Science in Narrative Medicine students. He is a successful corporate man-of-the-world, manager of a large unit in the public relations office of a prominent healthcare company. He was smitten by Felicité in Flaubert’s “A Simple Heart.” This businessman was exquisitely drawn to the frail yet hardy self-contained peasant woman who loved, in the end, her stuffed parrot. The enigmatic resonance between reader and character can be a spring of deep meaning and self-recognition for the attentive reader. Another student is a physical therapist who created and directs an integrative healthcare practice providing physical therapy, acupuncture, massage, and other modalities of care. He had never read modernist British fiction and felt, early in his narrative medicine training, that he didn’t know how and couldn’t really learn how to read Virginia Woolf. But he found himself transported into *To the Lighthouse*, quite against his expectations. He could not get enough of the novel, of other writings by Woolf, and when he wrote about her works in his papers for me, he discovered, in Woolf’s characters and forms, critical aspects of himself:

Woolf places her novel in the interior lives of her characters, the place that is unheard, unspoken. She allows us to be inside the mind and soul, inside the anxieties and emotions, the place in each of us that is invisible to the world, the place in an individual that is separate from the other. This is the only space in which this novel could exist. Time and space are connected as one, a chronotope, as Bakhtin says in *The Dialogic Imagination*, “The intrinsic connectedness of temporal and spatial relationships are artistically expressed in literature . . . It expresses the inseparability of space and time (time as the fourth dimension of space)” (84). In *To the Lighthouse*, the space and time exist in the interior lives of the characters.

Such sightings of the self occur when readers allow themselves to be taken into a text, not as acts of will but as aesthetic surrender. Not without effort and skill, this committed and close reading gradually opens the reader to self-expression and self-examination. In Wayne Booth’s terms, we come to know ourselves through “the company we keep.”

## Close Reading Enacts the Principles of Narrative Medicine

Several overarching principles that govern narrative medicine as a whole have been pivotal in our development of a commitment to close reading as a

signature method for the field: (1) action toward social justice; (2) disciplinary rigor; (3) inclusivity; (4) tolerance of ambiguity; (5) participatory and nonhierarchical methods; and (6) relational and intersubjective processes. In a reflexive arc, these principles warrant our adherence to close reading as a practice, while our close reading deepens our commitment to the principles. Our fidelity to these principles appears in the design and execution of our graduate program, the design and execution of our curriculum in the College of Physicians and Surgeons of Columbia University, the performance of our externally sponsored research projects, and in our many collaborations with national and international partners. By articulating the contribution that each one of these governing principles makes to our work in close reading, I hope to exemplify the contributions close reading makes to the field as a whole.

*Action Toward Social Justice:* I start with the most overarching goals of our work: narrative medicine is committed first to just and effective healthcare. I need not rehearse here the evidence that ill health is tied to inequality, racism, sexism, and other injustices. I need not detail the forms of trauma, violence toward persons, state violence, corporate or personal greed, and deprivation that are the root causes of much of the world's suffering and disease. Our creation of narrative medicine was from its start an effort to bring equality to healthcare—across class, gender, ethnicity, sexual preference, and health status lines. We see close reading as a critical tool in seeking healthcare justice. The capacity to imagine the situations of others is prelude to acting on their behalf and to developing the receptive stance of the respectful and humble witness. At its best, this is what close reading does.

*Disciplinary Rigor:* In conceptualizing narrative medicine's commitment to close reading, Maura Spiegel and I relied on some of the foundational critical approaches that inspect, analyze, or theorize the acts of reading. The more rigorously our work is located within the disciplines of literary criticism and narratology—and their ever-expanding neighboring disciplines like relational psychoanalysis and cognitive neurosciences—and the more fluent we and our students become in both contemporary critical discourses and the lineage of ideas from which they arise, the more engaged our work becomes in the currents of the day and the more likely it is that our own efforts in narrative medicine will be responsive, responsible, heard, and consequential. Accordingly, one goal in teaching and practicing close reading in narrative medicine is to welcome students and colleagues into the critical community of ideas, controversies, and discourses regarding textuality and narrative acts and to learn how such ideas influence the world of healthcare. Without limiting ourselves to one narrow school or approach to literary criticism and narrative theory, we try to open doors to complex formulations of what happens when a reader reads a text or a listener hears a tale.

A rigorous foundation in theory and its articulation obviates a tendency to only “read for the plot,” to overlook issues of power, or to develop anemic or puny readings for lack of robust conceptual models. Not theory for theory’s sake, our practice calls upon tested and emerging perspectives on the texts or aspects of literary action we study so as to attain full benefit of the interpretive community of which we are part.

*Inclusivity:* Our principles include inclusivity of theoretical approaches, genres, artists, and perspectives, exposing students and colleagues to the geography of critical approaches, texts, and textual practices. As individual scholars, each of the faculty has developed loyalties and preferences—mine for a Jamesian narratology and a psychoanalytically inflected practice of reading, for example—but our teaching attempts an inclusivity that will extend beyond the particular chosen specialties of the individual faculty members. We and our students try for an intellectual and personal flexibility, not restrictive and not judgmental. The inclusivity extends beyond intellectual frameworks to include aesthetic tastes, areas of interest, forms of intellectual and creative activity, and specific goals sought.

*Tolerating Ambiguity:* Ambiguity is a constant in our work and a required aspect of our teaching and practice of close reading. A position of non-totalizing elemental contingency undergirds our reading of literary texts, our responding to one another’s creative writing, and our witnessing of events in healthcare. Colleague Sayantani DasGupta has written extensively about narrative humility, the awareness of the impossibility of knowing accurately what another’s account fully encompasses. “We cannot ever claim to comprehend the totality of another’s story, which is only ever an approximation for the totality of another’s self. . . . Narrative humility acknowledges that our patients’ stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction, and engaging in constant self-evaluation and self-critique.”<sup>45</sup> Whether a story is heard in a clinic office or a novel by James, the receiver of the account of the other can only approximate, near, guess, wonder about what the source of the story might have had in mind. That receiver is also attuned to the impact of that story on himself or herself—challenging beliefs, supporting assumptions, raising worries about the self, awakening memories, giving pleasure, giving pain. In *The Ethics of Ambiguity*, Simone de Beauvoir observes that “to attain his truth, man must not attempt to dispel the ambiguity of his being but, on the contrary, accept the task of realizing it. . . . To say that [existence] is ambiguous is to assert that its meaning is never fixed, that it must be constantly won. . . . It is because man’s condition is ambiguous that he seeks, through failure and outrageousness, to save his existence.”<sup>46</sup> Attuning oneself to ambiguity, then, is a movement within the

development of the human self that narrative medicine in all its facets tries to support.

Central to the clinical as well as the critical enterprise, tolerating ambiguity encourages a generosity toward discord in which opposing readings or interpretations can coexist and be contained by a community of practice, whether a graduate seminar or an ambulatory clinic staff. Such collective “containing” confers on the group itself the power to tolerate difference, to open each individual to obscure dimensions of the matter at hand, and to see one’s position more clearly. The following two principles—participatory methods and relational processes—follow from the recognition of ambiguity and doubt at the heart of the enterprise.

*Participatory and Nonhierarchical Methods:* Narrative medicine undertakings do their best to embrace participatory egalitarianism. In teaching and learning close reading, the doors must be open at all times for singular interpretations, opposing readings, vigorous shifts in one’s own understanding of a stretch of text. It has seemed to me that close reading *in particular* brings out the absolute requirement that all take part, that no voice stays unheard, and that all in the group have equal time. These standards lead to some rather heated sessions that can be lived through without rupture because the group has created the collective means to tolerate the disagreement.

When we teach close reading—whether in the required “Methods of Narrative Medicine” graduate seminar or in medical center seminars or workshops at Columbia and elsewhere—the premium is on each participant’s undergoing and registering his or her own reading experience. I find myself often asking of participants, “What did you undergo by virtue of reading this text?” We typically read texts aloud a great deal, examining the words in fine detail for whatever narrative features might seem to be key. We then write in the shadow of the text we are reading as a powerful means to discover what we are learning or feeling through our close contact with it. When one person reads aloud what he or she has written, the others in the group respond to the writing, taking the opportunity to share individual reactions and to add to what the writer might learn in the process of the work. By these means, the focus of our teaching of close reading remains participatory, developing the agenda to include the tendencies of us all.

The ultimate goal of a participatory and nonhierarchical principle is power symmetry. There are limits on the symmetry—teachers grade students’ papers, attending physicians evaluate medical trainees. And yet, those granted the conventional power position in such dyads can choose to alter routines toward equality. Since clinical or university routines favor conventional power asymmetry, if only implicitly, those who seek nonhierarchical participation have to break step and challenge convention. We hope that our practices and those of like-minded colleagues can effectively challenge the inbuilt hierarchical

systems within the academy and healthcare systems, or at least channel a growing awareness of the high costs of fragmented groups in silos with little to bridge their divides.

*Relational and Intersubjective Processes:* Learners learn together. Selves become selves in relation to others. The isolated, deracinated, up-by-the-bootstraps individual is a fantasy concocted by those fearful of human contact. Narrative acts of telling and listening or writing and reading affirm that there is no work of art without a spectator; as James writes in an essay on the novels of George Eliot, “the reader does quite half the labor.”<sup>47</sup> We even more boldly claim the presence of narrative co-construction in professional, pedagogic, personal, and societal transactions: the listener or reader or spectator is an active shaper to that which is told or written.

Close reading is a specific illustration of relationality and intersubjectivity. The mysterious processes described above whereby a reader is chosen by an author, whereby a reader “ingests” the thinking and feeling of an author and makes it part of self, or whereby a reader recognizes himself or herself in the fictional characters imagined by a stranger are instances of the inevitable and irreversible human contact occasioned by close reading. Medical students at Columbia University are, at the beginning of their medical studies, often unused to narrative medicine methods. When they participate in the required curriculum in narrative medicine, joining in small, rigorous, participatory seminars on literary arts, visual art, or philosophical topics, they are surprised by the intimacy and transparency developed with their classmates. A qualitative research study of medical students’ responses to their narrative medicine seminars documented the importance of the intersubjective processes by which these seminars were taught:

I . . . feel like the most important thing is getting us to realize how to work with our classmates and talk with them and work outside of the normal classroom mentality, and realize that there are these people we can go to when . . . we do struggle with death and dying, it’s not us doing it alone.<sup>48</sup>

The clinical routines of narrative medicine as both practiced and taught are influenced by practices of narrative therapy and relational psychotherapies. In facing the complexities of Virginia Woolf’s *To the Lighthouse*, our close reading graduate seminar relies on concepts and practices of narrative psychologists and relational analysts including Michael White and Stephen Mitchell.<sup>49</sup> The boundaries are permeable between a narrative approach to close reading and a narrative approach to close listening in a therapeutic setting. This is not to suggest that readers diagnose their characters or their authors or texts. Rather,

it suggests that the processes that obtain between reader and writer are as singular, as formative, and as transformative as are those between a person and his or her therapist. Training in close reading is indeed a powerful prelude or preparation for the clinical work of coming to know, care about, and develop affiliation with a patient, a student, or a psychotherapeutic client.

These six overarching principles illuminate both the processes of reflection on and growth of our field. As narrative medicine matures, the field encompasses more and more explicitly questions of trauma, state violence, global health inequities, and health disparities. Our partnerships with the Columbia University Oral History Project and with the storytelling project *Narativ* have led to participation in international work to hear silenced voices and to amplify evidence necessary for a just world. One example is an educational and advocacy project addressing healthcare for marginalized populations, including Europe's Roma population. Our growing engagement with the Veterans' Administration in the United States emerges from the commitment to respond to trauma, especially trauma suffered in our name as Americans. The focus on intersubjectivity and bearing witness to others' suffering poise narrative medicine to respond skillfully to accounts of trauma and injustice, equipping the listener with the resource of nonjudgmental attention.

We realize that the polarization of the world politically, culturally, economically, religiously, and nationalistically increasingly fractures any kind of underlying human unity—it is Sunni versus Shia, Ukraine versus Russia, 99% versus 1%. (Oxfam reports, in 178 Oxfam Briefing Paper, that “those richest 85 people across the globe share £1 trillion, as much as the poorest 3.5 billion of the world's population.”)<sup>50</sup> We have gradually come to recognize that the *having* of a human body gives us a rare ground of unity—we share the same body, we have the same organs, we are prey to the same diseases, and we all will die. In a world where grounds for diplomacy seem to be disappearing, matters of physical and mental health may be now the most promising portfolios within which to develop commonalities of values, meanings, and goals. Our bodies may be the only thing left that we truly, globally share. It is no accident that much of global justice work today is related to physical or mental suffering, whether inflicted by the state or by natural disasters. Our bodies are becoming both the instance of care and the tools of care, and eventually perhaps an egalitarian healthcare will be seen as an avenue not just toward healthy bodies and minds but toward healthy worlds.

The idea that one person can understand what another person says or means is the deepest part of science and the deepest part of art. This idea is the groundspring of language, of beauty, of knowledge, of government, of culture, and of love. In the shadow of that meta-perspective of human experience, we place our work in narrative medicine at a series of boundaries, realizing that

the effort is always to bridge the divides, to seek the permeability, to unlock the channels that might provide unexpected benefit to both sides. Whether the two sides of the divide are psychopharmacology and psychoanalysis, a doctor and a patient, a war veteran and a nurse, or two readers reading one poem, the effort is to transcend the partisan or defensive, toward contact with one's partner not in argument or agreement but in paradox, a contact that will not nail answers but will craft vessels for thought. In the process of the craft comes relation.

What we do when we do clinical work as nurses, physical therapists, or doctors includes what we do when we read. Hand in hand with the gait training and diabetes management comes Felski's "sharply honed attentiveness to nuances of language and form," comes the aesthetic sensations of beholding an original creation, comes the affective and emotional processes that, if nothing else can, can open the pores between the subject and the object, the seer and the seen, the person seeking care and the person offering it.

## Coda

Fiction-writer Aleksander Hemon visited Columbia to present our Narrative Medicine Rounds in the spring of 2014. He read almost in its entirety his personal essay "The Aquarium" that details the events of the illness and death of his infant daughter Isabel from brain cancer.<sup>51</sup> The aquarium of the title is the green-glass tank in which he and his wife and daughter felt trapped:

One early morning, driving to the hospital, I saw a number of able-bodied, energetic runners progressing along Fullerton Avenue toward the sunny lakefront, and I had an intensely physical sensation of being inside an aquarium: I could see outside, the people outside could see me inside (if they somehow chose to pay attention), but we lived and breathed in entirely different environments. Isabel's illness and our experience had little connection to, and even less impact on, the world outside. (pp. 201–202)

In the discussion after his reading, a novelist asked him a daunting question: "What is writing *for*?" Hemon answered, "To make contact, to bring about engagement." I couldn't help but ask, a few questions later, "What is healthcare *for*?" Without a beat, Hemon replied, "To make contact, to bring about engagement."

Close reading brings us to a brink—of identity, of knowledge of self, of knowledge of other. It transports us, it summons us, it liberates us from narrow precincts. Once equipped with the not insubstantial skill it takes to do well, close reading provides a chance for permeable contact with other persons,

other times, other viewpoints, other selves. There is no wonder in our minds that it is a signature method for the work we want to be able to accomplish in the care of the sick and in the effort, more widely conceived, of making contact, of bringing about engagement.

## Notes

1. See Hurwitz, “Form and Representation,” for a summary of case history genres through the ages, which reflect the styles of listening deemed critical to the clinical enterprise along the way. See also Starr, *Social Transformation of Medicine*; Relman, *When More Is Less*; Gawande, *Being Mortal*.
2. Such textbooks as Newell, *Interviewing Skills for Nurses*; Lipkin, Putnam, and Lazare, *The Medical Interview*; Cassell, *Talking with Patients*; Fortin et al., *Smith’s Patient-Centered Interviewing*; and Coulehan and Block, *The Medical Interview*, are among many such guides to eliciting clinical histories and achieving interpersonal rapport needed to understand the patient.
3. Felski, *Uses of Literature*, 52.
4. North, “What’s New?”
5. Ogden and Richards, *Meaning of Meaning*; Richards, *Richards on Rhetoric*.
6. Richards, *Principles of Literary Criticism*, 11. The internal quotations in this excerpt from Richards are quotations from Hegel’s *History of Philosophy*.
7. Richards, *Principles*, 16–17.
8. Richards, *Principles*, 4.
9. Empson, *Seven Types of Ambiguity*.
10. Ransom, *New Criticism*; Eliot, “Tradition and the Individual Talent”; Brooks, *Well Wrought Urn*; Brooks and Warren, *Understanding Poetry*.
11. The two influential essays by Wimsatt and Beardsley, “The Affective Fallacy” and “The Intentional Fallacy,” are collected in *The Verbal Icon*.
12. Brooks, *Well Wrought Urn*, 74–75.
13. Brooks and Warren, *Understanding Poetry*, xiii.
14. Jakobson and Halle, *Fundamentals*; Levi-Strauss, *Structural Anthropology*, Vol. 2.
15. Barthes, *S/Z*; Culler, *Structuralist Poetics*.
16. Derrida, *Of Grammatology*; Lyotard, *Postmodern Condition*; Kristeva, *Desire in Language*.
17. Jameson, *Political Unconscious*.
18. Lacan, *Écrits*.
19. Foucault, *Order of Things*.
20. Lentricchia and DuBois, *Close Reading*, 34.
21. See Parisi, “Close Reading, Creative Writing”; Bialostoksy, “Should College English.”
22. Lentricchia and DuBois, *Close Reading*, ix.
23. Ricoeur, “Freud and Philosophy”; Best and Marcus, “Surface Reading.”
24. D. A. Miller, “Hitchcock’s Understyle.” See Ferguson, “Now It’s Personal,” for a study of too-close reading as a means of being hailed by a work, in a simulacrum of friendship.
25. Sedgwick, *Touching, Feeling*; Jurecic, *Illness as Narrative*; Davis, *Reading and the Reader*.
26. See Reddy, *Navigation of Feeling*, for a history of the emotions, and Leys, “Turn to Affect,” a critique of the adoption of neuroscientific means of characterizing emotion or locating its production in the brain. See also Keen, *Empathy and the Novel*, and the growing body of work on theory of mind in Zunshine, *Why We Read Fiction*.
27. See Kandel, *Age of Anxiety*; Chalmers, *Conscious Mind*; Dehaene, *Reading in the Brain*; Oatley, *Such Stuff as Dreams*.
28. Kidd and Castano, “Reading Literary Fiction.”

29. Felski, *Uses of Literature*; Rudnytsky and Charon, *Psychoanalysis and Narrative Medicine*; Brockmeier and Carbaugh, *Narrative and Identity*; J. Hillis Miller, *Reading for Our Time*; Royle, *Veering*.
30. Harkin, "Reception of Reader-Response."
31. For milestones of the work in this complex field, see Rosenblatt, *Literature as Exploration*; Poulet, "Criticism and Experience"; Holland, *5 Readers Reading and Dynamic of Literary Response*; Fish, *Is There a Text?*; Iser, *Act of Reading*; Flynn and Schweickart, *Gender and Reading*; Bleich, *Subjective Criticism*; Booth, *Rhetoric of Fiction*. Tompkins's *Reader-Response Criticism* is an authoritative anthology and introduction to the field.
32. Gallop, "Historicization of Literary Studies," 183.
33. Tompkins, *Reader-Response Criticism*.
34. J. Hillis Miller, *Ethics of Reading*; Booth, *Company We Keep*.
35. Booth, *Rhetoric of Fiction*, 138.
36. See Charon, Hermann, and Devlin, "Close Reading and Creative Writing"; Devlin et al., "Where Does the Circle End?"; Chambers et al., "Making a Case."
37. James, "Art of Fiction," 390.
38. Parisi, "Close Reading, Creative Writing," 65.
39. See Woolf's "Reading," "How Should One Read a Book?" and "On Re-Reading Novels."
40. See his *Pleasures of the Text*, and the essay "Reading" in *The Rustle of Language*.
41. I have written elsewhere, with the patient's supervision and her permission to publish, about what she and I learned together. She has given me permission to share her story for the benefit of other patients. Charon, "Membranes of Care."
42. Bollas, *Shadow of the Subject*.
43. Felski, *Uses of Literature*. See also the scholarship on enchantment and disenchantment in literature including Bennett, *Enchantment of Modern Life*.
44. Barthes, *Pleasure of the Text*, 27.
45. DasGupta, "Narrative Humility," *Lancet*, 980, 981.
46. de Beauvoir, *Ethics of Ambiguity*, 13, 129.
47. Stein, *Appreciation*; James, "Novels of George Eliot," 485.
48. Eliza Miller et al., "Sounding Narrative Medicine," 339.
49. White and Epston, *Narrative Therapy*; Mitchell, *Relationality*.
50. Wearden, "178 Oxfam Briefing Paper."
51. Hemon, "Aquarium."