Migraine, Words and Fiction

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Cambridge
Scholars
Publishing

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This book first published 2022

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-5275-8359-7
ISBN (13): 978-1-5275-8359-7

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FOREWORD

The interdisciplinary field of medicine and literary studies has in the last decades received much attention from both sides. This is – for example – illustrated by the existence of several devoted journals, such as *Literature and Medicine,* the *Journal of Medical Humanities* and *Medical Humanities*. A subspeciality of the "'medicine-literary studies field' is pain, which has also received much scholarly attention. As a result, there are several books that specifically address the association of pain-syndromes and literary studies, such as *The History of Pain* by Roselyne Rey (1993; English translation 1995), *The Culture of Pain* by David B. Morris (1991), *The Language of Pain* by David Biro (2010), *Pain. A Cultural History* by Javier Moscoso (2012), and *The Story of Pain: From Prayers to Painkillers* by Joanna Bourke (2014).

All of these texts, however, deal with chronic pain. In my opinion, a remarkable omission is that there are virtually none in international or local publications in literary studies specifically focusing on one of the most frequent forms of pain, which occurs in attacks: migraine. Chronic pain and pain that comes in attacks are different, not only in a 'medical', but also in a 'literary science' sense. Being a migraine specialist and scholar of literary studies, in this book, I intend to fill the gap of this omission.

I start this book with an answer. Its title is "Migraine, Words and Fiction", and yes, there is an important relation between these entities. In fact, (a diagnosis of) migraine does not exist without words and indeed there is a lot of fiction about migraine. I will prove these points by first exploring the relation between pain and language. Clearly, this issue finds itself on the interstice between medicine (neurology) and literary studies. In line with this, I will explore how people with pain may make their pain 'readable' and how fictional texts about pain 'perform' the pain instead of only describing it. In this book, I will first focus on pain in general, to set the stage for the relation between language and migraine. I will compare medical thoughts on pain and migraine with those provoked by literary works in their being paradigms of expression, and try to bring these together.

There is much literature on pain in medicine and also in literary studies. An analysis from both sides might improve mutual understanding, as there is indeed a need for a dialogue between these disciplines (Morris *Culture* 2). If such a dialogue becomes possible, not only may both disciplines benefit, but also practitioners, patients, readers and dedicated scholars in literary studies. For Gogel and Terry (1987) 'interpretation as a primary activity of clinical medicine [..] sometimes proposes metaphors such as the doctor as a literary critic or the patient as text' (205). After their analysis of possible models for 'the interpretive schools of thoughts', including a critical reading of the work of Brody (vide infra) and several others, they conclude that 'there is something to be found in a merger of medicine with literature or literary methodology, but there is little agreement about what that something is' (210). In fact, this 'something' is what I aim to explore in this book.

I focus on migraine because there is hardly any knowledge from the side of literary studies about this pain-syndrome that comes in attacks and has a double potential in relation to language, both destructive and creative.

Almost everyone knows what pain is. The 'almost' refers to the >99% of living beings who may feel and express pain, including fetuses, babies and demented, intellectually disabled and unconscious people. There are, however, some individuals who (apparently) are incapable of feeling pain at all. This exception is present in a very rare genetic abnormality called congenital or inborn indifference of insensitivity to pain (Van Ness Dearborn 1932; McMurray 1950; Sternbach 1963; Critchley *Divine Banquet*; Danziger et al., 2006; Levy Erez et al., 2010; Nahorski et al., 2015; Staudt et al., 2017).[1] In the general view, not feeling pain seems wonderful, but in practice the condition places a heavy burden on its sufferers. First, those who claim not to feel pain are seen as hysterics, mental defectives or psychotics (Sternbach 252). Second, not feeling pain may be dangerous, as the body does not warn for possible external dangers, which may lead to burns, unrecognized tumors, etc. In this way, not feeling pain may even be

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[1] A spectacular example of this affliction is the so-called 'Human Pincushion', an American who appeared on the vaudeville stage and 'harmed' himself with knifes and needles, apparently without feeling pain. During one of his last appearances on stage he let himself be crucified as Jesus. As more than half of the audience fainted at the sight, he had to stop his performances (Critchley *Divine Banquet* 197-198). Less spectacular are the so-called 'fakirs', who also often suffered from the same condition (Kotsias 2007). The syndrome of congenital or inborn indifference or insensitivity to pain was shown to be caused by mutations in genes coding for sodium channels.

lethal. It seems, therefore, that the ability to feel pain is a necessary condition for any human being.

Thus, except for the ‘congenital insensitivity’, everyone probably knows the feeling of pain. Remember for example the intestinal cramps as an infant, the humiliating pain when hit on the buttocks after a mischief, the pain of the scratch on your knee after falling of your bike, the pain of gout in your great toe, the hangover, or the invalidating pain of arthrosis in the hip. Clearly, pain is ubiquitously present in all life-stages, in numerous forms, disguises and situations. But, in fact, the answer to the question how to express or represent what pain is in reality, still turns out to be extremely difficult to give. Why is this?

First, there is the complex origin of the word ‘pain’. In their article “A Philological Study on Some Words Concerning Pain”, Procacci and Maresca (1985) explain that the Greek words *algos*, *odynia* and *angina* were used for different kinds of pain. The word ‘pain’, however, was derived from *poena*, which meant ‘punishment’. This association pointed at the ascription of pain and suffering to prior transgressions of sin. They also point at the complex significations of the English words ‘ache’ and ‘pain’, and the Italian and French difficulties to separate dolor, douleur and dolore. And what to think about the German word Schmerz? So, what we are talking about is a sort of Babylonian confusion of words.

Secondly, there is the question whether pain has a function. In general, acute pain is considered to initiate evasive behavior, and chronic pain is thought to induce protective inactivity favoring recovery (Pitts 275). It may be argued that the human pain system provides evolutionary advantages, as humans can memorize and thereby avoid pain before bodily harm occurs, and they can also transmit information from generation to generation by word about threats to be avoided (276). For these functions they probably needed words to express their pain.

However, thirdly, there is the difficulty patients experience when attempting to express their pain in words, as well as the difficult interpretation of these words. In this book, I will describe situations where in the compex interaction between words, referents and reality so-called signifiers and signifieds are important. If we use the word ‘pain’ we somehow expect it to mean something, to refer to something. Yet, what is that ‘something’? If we say ‘tree’ pointing at a tree or ‘horse’ pointing at a horse, there is a word that relates to a referent. But what can be the referent of the word ‘pain’? Can we point at pain? Mostly, the only thing left is a verbal expression. The translation of the words of what pain-sufferers feel – and cannot point at – will be at least somewhat unreliable, as there is not only a difficult process of expression, but also one of translation and interpretation. For doctors diagnosing and (attempting to) cure someone, at least this unreliability of the words used for diagnosis and cure have to be overcome. I intend to do this for migraine, but there are many pitfalls on the road.

Since almost everyone knows what pain is, it seems obvious that pain is part of ‘reality’. As hinted at, it may, however, be disputable what ‘reality’ is. Some have even claimed that all humans have their own reality and that our perception of the world is ‘a fantasy that coincides with reality’ (Frith 111). Without a doubt, language is extremely important here, not only to describe this imaged reality, but also – as especially postmodern thinkers have emphasized – to create reality. Stenner and Eccleston state in their article “On the Textuality of Being” (1994), ‘we understand language to be more like a set of tools (for local and contingent use) than as a set of representations of some *really real reality*’ (my emphasis). This raises the question the more: what about the really real reality of the paroxysmal pain of migraine? What is its relation to language? These are the questions I hope to answer in the next chapters, first by taking the text of the migraine patient as starting point and thereafter focusing on literary texts about migraine, in this way bringing medicine and literary studies together, in the hope that both fields will benefit from it.

CHAPTER 1

PAIN AND WORDS

Everyone who doubts the reality of pain should take a hammer and hit one's thumb and then answer the question again: 'Is pain a representation of really real reality?' The answer will probably 'yes' and 'don't ask me to do such a ridiculous thing again'. So, 'many pains [..] are familiar to us all' (Schott *Communicating* 209). Still, in fact, pain has no substance, it is not an object that may be touched, pointed at, objectively measured or made visible. One may argue that pain can sometimes be 'seen'. The facial expression of someone with pain, however, is not specific, as it is indistinguishable from the expression and gestures of sorrow, triumph (a footballer who has scored an important goal), or ecstasy. Besides, it has been shown that language is more important for gestures than the other way around, as even for congenitally blind subjects, hearing a particular language is sufficient to gesture like a native speaker of that language (Özçalişkan et al., 2016).

What is crucial for the understanding of pain is that no one can feel the pain of others and that 'one of its most frightening aspects is its resistance to objectivation' (Scarry *Body* 56). In other words, pain is the 'clearest and most plausible case of an object which no one but the sufferer may experience directly' (Fiser 1). Pain is always an internal sensation and, as such subject to interpretation, speculation, doubt, mythology, gossip and sometimes even to manipulations of power and ideology. In addition to this, it depends on language.

The language of pain

To illustrate the subjectivity of pain and its relation to language the philosopher Ludwig Wittgenstein presented an often-cited metaphor: the beetle in the box (see for a description Cohen's *Wittgenstein's Beetle and Other Classic Thought Experiments*). Wittgenstein proposed to imagine a situation where everyone has a box and knows that it contains a 'beetle'. By looking into their own box, everyone may perceive what a beetle looks like. No one, however, can look into anyone else's box. No one knows what form, color or shape the beetle of the other has. So, the individual designation of ‘beetle’ may point at an object that looks like a ‘real’ beetle, but it may also point at one that resembles a coin or a cigarette. The box may even be empty, causing the owner of that box to use the word ‘beetle’ for ‘void’. Importantly, although the beetle may be represented by a coin or an absence, the word ‘beetle’ makes verbal communication possible. In the end, the content of the box does not matter, as the actual shared language is much more important (Bourke *Story* 7).

When talking about their beetle or about their pain (or e.g. about hunger, love, dizziness or fatigue), people probably talk about different things, feelings or sensations, but what they talk about becomes a common ‘reality’ and something they may communicate about because of the stereotypical way of describing the sensation. Pain has to do with individual experience, but also with intersubjective articulation. Without a doubt, pain is a private object (Fisher 1986). But, for Wittgenstein, a private language, interior and unsharable, would be completely devoid of sense (Moscoso 5). Meaning is only produced by the collective credibility of private sensations. Subjectieve meaning is anchored in homogeneous experiences (201). According to Fiser (1986), ‘patients suffering the same or similar pain syndromes show a remarkable consistency in the use of words’ (9). So, based on this consistency, for the consideration of the ‘objective reality’ of feeling pain, in this text Wittgenstein’s beetle-metaphor will be further worked out, as it is based on a consistency of words.

In her book *The Story of Pain. From Prayers to Painkillers* (2014), Joanna Bourke states that ‘assuming that pain has a definitive, ontological presence is to confuse presentations of sensation with linguistic representation’ (4). She argues that it is a mistake to view pain as an entity, although many pain-sufferers do so. Indeed, patients often talk about pain as an ‘it’; as something that attacks them from the outside. The controversy of whether pain originates on the inside or outside goes back to Hippocrates. Fourth-century BC physiologists believed disease to be the result of an imbalance between the inner and the outer, the ontologists considered disease as an outside object invading the body (Cassell 143). In the latter situation, the noun ‘pain’ came on the same linguistic level as ‘chair’, ‘thumb’, or ‘mouse’. But one could still not point at it.

Bourke calls the idea of an outside event the ‘ontological trap’ of representation (5) and advises to see pain as a ‘type of event’ rather than an object or actual entity, by stating that:

> what do I mean when I say that pain is an *event*? By designating pain as a "type of event" [..], I mean that it is one of those recurring occurrences that we regularly experience and witness that participates in the constitution of our sense of self and other. An event is designated "pain" if it is identified as such by the person claiming that kind of consciousness. Being-in-pain requires an individual to give significance to this particular 'type of' being. (5; emphasis in the original)

Thus, pain is not an object, but an experience, designated as such by an individual and leading to a constitution of our sense of self. Pain is therefore also 'a belief', which brings me back to Wittgenstein's beetle and the subject that believes that also a void can be a beetle.

There is indeed a large body of literature describing the so-called 'pain believe', a concept introduced in 1989 by Williams and Thorn (Williams and Thorn 1989; Strong et al., 1992; Williams et al., 1994). It is defined as patients' own conceptualization of what pain is and what pain means for them (Williams and Thorn 351). To measure it, a 'Pain Beliefs and Perceptions Inventory (PBAPI)' was developed to investigate four dimensions of pain beliefs: mystery, self-blame, permanence and constancy (Williams and Thorn 1989). When using the word 'beetle', everyone believes in one's own beetle. The same probably is true for 'pain'. Important, however, is that by recognizing one's own beetle or pain, one thereby accepts that others may have a beetle or pain as well. This distinguishes pain from sensations such as hunger and love, which are not necessarily experienced by everyone, but, when they are, have an external referent (food, someone to be loved), which is in contrast with pain.

When accepting the fact that one's own pain, but also that of others, is part of some sort of reality, the issue emerges of *how* pain becomes real. One mode of its becoming real concerns the diagnostic situation of someone with pain who wants to validate his or her pain as 'real' and someone who might be able to interpret these sensationa and can recognize a recognizable pattern. This is the encounter of patient and doctor. Indeed, pain is the most frequent complaint doctors are confronted with.

Patient and doctor

Here, the term 'doctor' will be used for someone who has studied medicine and takes care of patients in a diagnostic and/or therapeutic context. Such a person may also be defined according to the description of Arthur W. Frank (2016) as 'an artificial person who acts not on his or her own personal moral authority, but rather as representative of an authority that has a collective form' (12). In this book, the term 'physician' will be avoided as much as possible, as it refers to something 'physical', and this is not always the case in pain syndromes. At this point it is also useful to note that the term 'patient' comes from the Latin word *patior*, which means 'I suffer' (Gooddy *Disorders* 663).

Many patients with pain and headache do not show perceivable 'physical' abnormalities, so for that they don't need a physician. This does, however, not make their pain less important. Pain as a complaint occurs ubiquitously. An important question is how pain 'shows' itself. Pain (and headache) are most often seen as a 'symptom' (a complaint; a subjective feeling that may be expressed, but not seen from the outside or objectively measured) and not as a 'sign' (accompanied by objective abnormalities).

For Epstein (1992) there are first symptoms or complaints – the patient's own subjective perspective of deviations from normal health, second, signs – the objective manifestations of disease located by the physician during a physical examination and third, (and historically most recent), laboratory findings (32). Of course, pain may co-occur with or be the expression of a visible or measurable lesion, such as a swollen thumb that is hit by a hammer (don't blame me), a scratch, the red toe of the patient with gout, or a brain tumor on a scan of a headache patient. In those cases, however, the diagnosis will not be 'pain', but will be based on the causative factor ('trauma', 'gout', 'tumor'), although the pain itself may be the main, and sometimes only, symptom. When a subject with pain has clearly visible physical abnormalities at examination and/or ancillary investigations (scans, blood tests), that 'sign' becomes in its turn diagnostic 'proof' of the pain and often metaphorically replaces it. In the words of Elaine Scarry, this pain is 'lifted into the visible world' (13). Then it is not said 'he or she has pain', but 'he or she has gout', or 'he or she has a brain tumor'.

A teleological confusion is nearby as illustrated by Friedrich Nietzsche in his 'pain – pin' metaphor (cited by Culler *Deconstruction* 86-87). Nietzsche describes someone who suddenly feels a pain in his foot. When looking down he/she sees a pin lying on the floor and associates the pain with the pin. This situation may cause confusion: the reversal of cause and effect. The person first experienced pain (effect) and then saw the pin as (presumed) cause. The pain was first, the pin came later. So, to make a causal relation between pain and pin, time must be reversed, which leads to the artificial association of two 'things', which 'in reality' may not be associated at all. The pin may have had nothing to do with the pain. Maybe there was another pin causing the pain, maybe the protagonist sprained his or her ankle, maybe the pain was ‘psychosomatic’. For David Biro (2010) this is an example of how we are in such a situation not engaged in science (uncovering truth), but in art and metaphor (creating truth). When experiencing pain we often look for and then find a presumed cause. Often, our metaphorical imagination reorders the temporal sequence and – according to Nietzsche – language blatantly misrepresents the facts (126). A presumed association of cause (lesion) and effect (pain) is probably the right explanation in the abovementioned examples (‘trauma’, ‘gout’, ‘tumor’), although even in those cases this is not 100% sure, but this is much more problematic in many other situations where a structural cause or provocation of the pain is less obvious. Patients often tend to explain their pain by associating it with temporally related occurrences, such as stress, anxiety or the wheather, but these are almost always wrong assumptions which can, unfortunately, also lead to wrong diagnoses and treatment.[2]

Mostly, the one who has to make a diagnosis and install treatment is the doctor. There is a large body of literature describing the possible variants of the encounter of patient and doctor. For example, in his article “A Contribution to the Philosophy of Medicine. The Basic Models of the Doctor-Patient Relationship” (1956), the famous (anti-) psychiatrist Thomas S. Sasz distinguished three options: First, the variant of ‘Activity-Passivity’, in which the doctor ‘does’ something with/to the patient. Second, ‘guidance-cooperation’, in which the patient places the physician in a position of power but is active as well. Third, mutual participation’, both parties have approximately equal power, are mutually interdependent and engage in activity that will be in some way satisfying to both (586-587). The latter seems to describe the current practice of so-called shared decision making.

Next to ‘symptom’ and ‘sign’, another important distinction is that between ‘illness’ and ‘disease’. It appears that the use of these terms in medical and other literature is very confusing and even conflicting. Illness may be described as ‘a sense of dis-ease, a sense of distress, related to a patient’s perceptions and feelings’ (Novack 347), and as such it is disease without objective phenomena. Some define ‘disease’ as something that may be objectively identified as a biological process by a laboratory test (319), but this simple definition has been criticized (Brody *Stories* 45). In his book

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[2] An example of this is the use of antibiotics in patients with headache ascribed to the flu. Symptoms of the flu – by definition, as it is a viral and thus self-limiting disease – always disappear spontaneously. The amelioration is then ascribed to the antibiotics, whereas these have not contributed to the course of the disease whatsoever.

Stories of Sickness, Howard Brody defines disease (= 'sickness') as 'the notion of *being abnormal* or *functioning in an abnormal way'* (45, emphasis in the original). Defined as such, the distinction from illness becomes very difficult. He indeed argues that 'the distinction between *disease* and *illness* has been much discussed, but never resolved, within the philosophy of medicine and the medical social sciences' (61,2; emphasis in the original). S. Kay Toombs refers to Jean Paul Sartre's analysis of pain and illness and his distinction of four levels: (i) pre-reflective sensory experiencing, (ii) suffered illness, (iii) disease, and (iv) the disease state (*Temporality* 230). The first three levels refer to how the patient constitutes the illness, the last to the doctor's conceptualization. When adopting the 'simple' definition or that of Sartre, according to Novack there may be disease without illness (e.g., hypertension), and illness without disease (e.g., hypochondria) (347). The question remains what is 'objective disease'. Is it only objective after demonstrating structural damage, or can it also be objectively based on words only? One must realize that often all we have is the word of the sufferer.

Richard J. Baron takes a clear standpoint on this topic in his article "An Introduction to Medical Phenomenology: I Can't Hear You While I'm Listening". He states that most frequently illness is seen as an objective entity that is located somewhere anatomically or that perturbs a defined physiologic process. One may say that such an entity "is" the disease, thereby taking illness from the universe of experience and moving it to a location in the physical world (*Introduction* 606). This strongly resembles Bourkes description of the 'ontological trap' as mentioned above.

However, when a patient has pain ('illness'), not always a 'disease' can be made of it, as there are many situations in which a patient has pain without objective abnormalities. Then, the diagnosis depends completely on the description and behavior of the patient, on his or her words and gestures. The problems that arise in such a situation may be easily seen. The value and accuracy of the diagnosis and subsequent treatment then fully depend on the ability of the sufferers to describe their pain and on the skills of the diagnostician to appreciate and interpret the words correctly. Here, the danger of a 'double trap' lies around the corner. Words are symbolical (or metaphorical), so in the symbolization of pain (translating one's sensation into words) and the transformation of such a symbolization into a diagnosis, which is a process of 'double symbolization', much can go wrong.

Nevertheless, in many pain syndromes nothing better is available than a translation of the words used by the patient into a diagnosis. What a diagnosis is will later be considered in depth (see section 'The diagnostic process'), as it is one of the main themes of this book.

The word diagnosis is derived from the Greek words dia (through, between) and gignoskein (to know) (Parrino and Mitchell). Surely, a correct diagnosis has many advantages. A diagnosis may also have disadvantages, for example, when it is used as a difficult term behind which a doctor can 'hide' and gain or keep a status. In what follows, I will consider some (neurological) examples of such diagnoses. For instance, when a patient tells a doctor that he or she has been blind in one eye during a short period, a diagnosis of 'amaurosis fugax' is made. This diagnosis is a literary translation of the words of the patient (the Greek word 'amaurosis' means 'blindness' and 'fugax' designates the temporality of the occurrence). As another example, 'claudicatio intermittens' is diagnosed when a patient tells the doctor that he or she limps after walking a certain distance because of pain in the legs. The term 'claudicatio' is an eponym, referring to the Roman emperor Claudius, who limped since his youth (Pearce *Claudicatio*). When a patient tells the doctor about experiencing memory loss during a certain time, the diagnosis is 'transient global amnesia', a literal translation of the complaints in other words. That the cause of such an occurrence is largely unknown remains hidden in difficult words. In line with this, Beer has argued that one of the primary functions of technical language is to keep non-professionals out (88). Butler (1997) also refers to this 'specialized language'. For her, it may easily lead to a misconstruction of its own theoretical construction as a valid description of social reality (145).

This diagnostic translation into (difficult) words heavily depends on metaphors. There are numerous articles on the metaphors that describe medical situations and pain. The landmark publication on disease and metaphor is Susan Sontag's *Illness as a Metaphor* (1978), but there are many other elaborations of the use of metaphors in medicine.[3] For Schott (2004) words used in this particular context do not mean what they mean in any other context. As said, the words of a patient expressing pain must be taken seriously and carefully weighted. This raises the question whether patient and doctor speak the same language. Do they have a 'shared' reality

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[3] Examples are: Burnside (1983), Caster and Gatens-Robinson (1983), Hodgkin (1985), Marston (1986), Mabeck and Olesen (1997), Hutchings (1998), Arroliga at al. (2002), Brody (*Stories* 2003), Kirklin (2007), Rosenman (2008), Kirmayer (*Culture* 2008), Periyakoil (2008), Plug et al. (2009), Biro 2010; Casarett et al. (2010), Frank (*Metaphors* 2011), Loftus (2011), Zeilig (2014), Bourke (*Story* 2014) and Neilson (2016).

or use the same metaphors? The 'simple' answer might be 'yes', as doctors are human beings, who also feel pain when they hit their thumbs, but the reality is much more complex.

The different processes of making a diagnosis based on words seem crucial. Many pain scales and inventories are available to 'measure' pain (Noble et al., 2005). The prototype of these pain assessment-scales is the pain inventory of Melzack and Torgerson called the McGill Pain Questionnaire – so named because both researchers worked at McGill University (Melzack and Torgerson). Their questionnaire is purely based on what the person with pain says. In the questionnaire as many dimensions as possible of the 'pain experience' are included. Here, the word 'pain' refers not only to intensity, but also to a variety of qualities (50-51). For these qualities the questionnaire scores around 100 words, dividing them into sensory, affective and subjective qualities. The words included in the list are highly metaphorical, such as 'beating', 'flickering', 'pounding', 'boring', 'drilling', etc. The authors concluded that: 1) there are many words in the English language to describe pain; 2) there is a high level of agreement that the words fall into classes and subclasses that represent particular dimensions or properties of pain; 3) substantial portions of the words have the same or approximately the same relative positions on a common intensity scale for people with widely divergent backgrounds. (53)

The questionnaire was considered useful, not only to specify pain, but also as a diagnostic tool to separate different causes of pain (Melzack *Properties*; Katz and Melzack). For Biro, the McGill Pain Questionnaire not only helps patients to describe their pain but also substantiates the reality of their pain (158).

Due to its length, applying the questionnaire is rather time-consuming and therefore not much used in daily practice, although a shorter version was developed (Melzack *Short Form*). For scientific research, however, the whole questionnaire is still widely used, also expressed by more than 100.000 'hits' on Pubmed.[4]

In daily practice, however, mostly the so called visual analogue scale (VAS) is used, which asks the patient to score the severity of pain on a scale 0 (no pain) to 10 (the worst pain that this individual may imagine) (Huskisson 1974; Hawker et al., 2011). This scale 'translates' the pain of the patient into a number and a visual image, rather than putting it into words. The

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[4] Last accessed 30-1-2022

choice here is between giving pain a number (VAS) or expressing it in verbal metaphors, such as those of Melzack and Torgerson. This choice seems crucial in doctor-patient encounters, and also in the context of this book, in which I, for obvious reasons, choose the verbal (‘metaphorical’) version.

The migraine sufferer Siri Hustvedt expresses her concerns about the VAS as:

> I have always found it comic when a doctor asks me to rate my pain on a scale of 1 to 10. Here numbers take the place of words. Rate my pain in relation to what? The worst pain I’ve ever had? Do I remember the worst pain? I can’t retrieve it as pain, only as an articulated memory or an empathetic relation to my past self: childbirth hurt, migraines hurt, the pain in my cracked elbow hurt. Which one was a 6, a 7? Is your 4 my 5? [..] Does a 10 actually exist, or is it a sort of ideal representation of the unbearable? (*Shaking* 181)

Indeed, such scores may have a disorienting effect on those who find themselves translated into it. So, when making a ‘diagnosis’ – although only based on symbols such as words – one must keep in mind the reference to a commonly perceived reality, such as in Wittgenstein’s beetle in the box. A right diagnosis of pain is important but must take into account issues such as unjustified ‘objectivation’ or ‘metaphorization’ of pain and too easy interpreting its causes (pin – pain). There is, in my opinion, a necessity to see the constructs of words about pain as more than just a representation, a measurement or interpretation. Crucial is ‘diagnosis’. Every diagnosis by definition is retrospective (it ‘looks back’ as it bases on passed events).

The diagnosis of pain with words

As said, it is difficult to define ‘pain’, especially so because it often has no (presumed or detectable) objective signs in ‘reality’. Patients with pain syndromes lacking objective ‘proof’ or ‘representation’ of the existence of their pain (when scans, blood tests and physical examination are normal), however, might experience a pain that is just as ‘real’ as the pain of the patients whose pain may be ‘proven’ and named after the lesion causing it.

The structuralist Ferdinand De Saussure (1857-1913) specified the meaning of words in terms of ‘signifiers’ (words) and ‘signifieds’ (objects). The signifiers depend on their difference with the meaning of other words (eg. ‘mouse’, ‘spouse’ or ‘house’). They may be attached to ‘real’ objects in reality, but occur first as images or ideas in our head when we think about a ‘mouse’, ‘spouse’ or ‘house’. These images or ideas and by implication their existence in reality De Saussure called ‘signifieds’ (De Saussure 2011). Although the images in people’s heads may be very diverse, they can still fall under one signifier. For example, our mental image of a photograph of a mouse, a real mouse or a drawing of Mickey Mouse, all can fall under the signifier ‘mouse’. De Saussure reconceived the problem of reference as one of signification rather than as mimesis (xvi).

But what about the signifier ‘pain’? Of this word, almost everyone has one’s own ‘image’, idea or sensation (beetle in the box, hit with the hammer on one’s thumb), but one can call it a ‘signifier without signified’ in the sense that it has no ‘material’ place in reality. Pain is not there like a cat on the mat. It is in one’s head (even when it is in one’s toe or thumb – or head).

That signifieds and signifiers are distinct is easily seen: the sound ‘mouse’ is distinct from what that sound means or indicates in ‘reality’. Yet the distinction of the signifier ‘pain’ with the sensory phenomena that this signifier indicates is much more difficult. The main cause of this seems to be the fact that there is no object in reality (signified) that embodies (the image of) pain.

For Scarry the only state that is as anomalous as pain is the imagination (162). For her, pain is a state remarkable for being wholly without objects and its imagination is remarkable for being the only state that is wholly its objects (162). Pragmatically, ‘pain’ has been defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (International Association for the Study of Pain, cited by Quintner et al, 2003). The emphasis on structural damage may indeed be called ‘pragmatic’, but it is not the whole truth, as there is also pain without (visible) structural damage. The pin, scratch or red toe are closely attached to the sensation (and sometimes erroneously to the cause) of pain, but in fact they are not more than metonymies (tropes of contiguity in place or time) or examples of synecdoche (a part stands for the whole/ pars pro toto).

Foucault states that ‘the signified is revealed only in the visible, heavy world of a signifier’ (*Birth* xvi-xvii). Seen as such pain may be seen as a signifier without a signified. Nevertheless, there must be ‘something’ in reality that represents pain. Is this the word ‘pain’? Indeed, this ‘something’ often mainly consists of its translation in language.

Mark D. Sullivan (1995) discusses this translation in his article "Pain in Language. From Sentience to Sapience", predominantly basing his arguments on Ludwig Wittgenstein's standpoints:

> Wittgenstein believes the pain sensation alone is not sufficient to account for our experience of pain. He argues that a language based entirely on private pain sensations could not distinguish between correct and incorrect use of pain words and would therefore be meaningless. (5)

So, pain expression must be mediated by the conceptual structure of public language, or by the use of analogy. Pain is not only constructed by language in the Saussurean sense of an idea in our head, but also by a language that communicates ideas that were already formed in our head as part of a common experience and not in need of interpretation or classification (6). The common experience may be called 'reality', or at least 'part of reality'. We all have a box and in all our boxes sits a beetle waiting for existential explanation.

The patient as text

As said, for the expression, representation and finally the diagnosis of pain often only words are available (which may be seen as a Saussurean signifier without signified). Thus, what the patient says counts and in the transference of this reality of experience, he or she must be unconditionally believed.

In a sense, a patient may be read as a text. Such readings of patients are in line with the meaning of the word 'text' as it is used in literary theory: A text is anything that may be 'read'.[5]

When a patient experiences pain there may be no structurally visible abnormalities. Nevertheless, a diagnosis must be made for the benefit of the patient. As the words become or replace the signified (the image in one's head), it may indeed be argued that, in a sense, patients with pain can be 'read' as a (fictional) text, as they are only represented by the words they utter. This has been called 'the readability metaphor'.

It has indeed been suggested that people with symptoms such as pain may be 'read as a text' (Daniel *Patient as Text* 195). The patient's words must be transcribed into a diagnosis. In translating the patient's experience into a

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[5] Sutrop (1994) even claims that ' "Text" has by now so many different meanings that its use seems altogether meaningless. All is text. Text is all'. She blames Roland Barthes to be one of the roots of 'this terrible mess' (39).

clinical text, a differential diagnosis is made. A critical moment, however, appears when one tries to detach the told to the telling. Nietzsche's pin – pain metaphor lays around the corner here.

For Stephen L. Daniel (1986) a patient is analogous to a literary text which may be interpreted on four levels: (1) the literal facts of the patient's body and the literal story told by the patient, (2) the diagnostic meaning of the literal data, (3) the praxis (prognosis and therapeutic decisions) emanating from the diagnosis, and (4) the change effected by the clinical encounter in both the patient's and clinician's life-worlds. (*Patient as Text* 195)

Thus, there is the important distinction between what the patient says and what is objectively visible/measurable. In general, doctors tend to react to the objective signs and less so to the words of the patients. Daniel, however, goes as far as to argue that any reader's experience of a poem, short story, or novel is similar to the physician's encounter with a patient. In his article he emphasizes that medicine is an interpretive art and the body has become a grammar of signs in a language any observant physician could read clearly and completely (198). Important is the effort to find meaning for the clusters of literal signs and symbols (204). This is the process of differential diagnosis which favors one possible diagnosis and neglects or rules out another leading to 'the physician's imaginative preconception of what the truth about the patient might be' (205). The clinical 'truth' becomes a judgement based on words, interpretation, emotions, empathy, criteria, poetics and politics.

The idea of 'reading' (the pain of) patients as a text has been adopted by many scholars. The reader of the text (often the doctor) is interpreting, rather than studying some kind of empirically existing reality in its own right. Everything depends on interpretation, but there is a distinction between the 'knowable' and the 'interpretable'. The first 'is already there', the second is 'produced'. The 'patient as text' is not a way of revealing the truth, but one of constructing, based on a part 'truth' and a part 'interpretation'.

Nancy M. P. King and Ann Folwell Stanford (1992) comment on what they call 'a close reading of the patient' (186) and warn for 'the temptation of labeling the narrator unreliable' (1987). This seems obvious, as – in my opinion – what a patient says must always be believed. Even if the utterances seem improbable or impossible, the reasons of the patient saying those words must be taken seriously. When patients describe their symptoms, sometimes 'strange' metaphors are used. One of my patients, for example, described her headache as the feeling of a birds' nest on her head.

'Is this possible, doctor?', she asked. 'Of course,' I replied, 'You have made it possible'. Another patient described shooting pain from the right side to the left side of her head, thereby neglecting all neurological anatomical borders. For me, the descriptions of her pain were more important than my anatomical knowledge. Indeed, these pain paroxysms were later described as 'epicrania fugax' (Cuadrado et al., 2016) and we have to take them seriously because there are patients who describe them as such (Haan *Bestaat het?* 2017).

In "The Interpretive Maze: Reading Doctors Reading Patients", King and Stanford describe the so-called communication triangle of author, subject and reader (191). In their view patients can be positioned as authors, the story they tell as the subject, and the physician as reader.

Dekkers accepts the suggested metaphor of 'the patient as text', but only under the condition that it should also include the body as a text (280). He argues that the body also has a story to tell. In the encounter with a patient, the doctor must not only 'read' the words, but also the 'bodily signs'. This seems obvious and raises the issue: What text is to be interpreted? On the other hand, George S. Rousseau (1986) finds 'the patient as text' a cliché. For him it is an option as long as one realizes that there are senses in which the patient clearly is *not* the text (177). As examples of such senses, he mentions empathy and compassion. For him, doctors not only are readers, but also artists (160), and thus the patient not only is a text, but also an 'inspiration' that goes beyond reading. Unavoidably, inspiration also implicates interpretation.

In her article "Doctor-Patient/Reader-Writer: Learning to Find the Text" (1989), Rita Charon defines several possibilities for the patient as text: The the illness itself in which the patient is one character, the pathography in which patients record and interpret their own illness and the texts with 'joint authorship' in which doctor and patient co-author the story (138). The latter seems to resemble the current practice of shared decision making.

There are also scholars who warn against the tendency of too easily accepting the metaphor of reading patients as text. Rimmon-Kenan (2006) argues that patients often try to adopt the language of medicine, perhaps because it gives them the feeling of control and the illusion of being able to discuss their condition as peers (246). Here, the 'text' of the patient (verbal utterances, but also non-verbal signs such as grimaces, gestures, etc) is influenced by the situation (the 'reading') and therefore less reliable. The words do not represent the 'embodied self' of the patient anymore, but also reflect the intention and the context.

The terms 'embodied' and 'embodiment' are used in different definitions by cognitive scientists, psychologists, workers in robotics, researchers in artificial intelligence, linguists and philosophers. The concept of 'embodiment' is called 'tricky'. In linguistics, a common definition of 'embodied' is that mind and body are inextricably linked and on equal planes (Biro 44). So, a Cartesian split between mind and body is rejected. One can see embodiment as 'being in the world' in the sense that 'I am my body', rather than 'I possess a body' (Toombs *Illness* 202). Another term is 'body without organs', introduced by Deleuze and Guatarri. Here, the lived physical body and the self which 'experiences' itself as being 'inside' the body are both consequences of reflexive, normative ways. The 'self-inside-the-body' is the body without organs (Nick J. Fox *Refracting* 352)

As possible safeguards against paternalistic misreading the patient, Hudson Jones (1994) mentions the importance of 'the patient's interpretive role' and that therefore the doctor-patient relationship reaches beyond the scope of the reader-subject-author analogy (194). It is important to seek a dialogical reading and see the patient as a person rather than as a text (197). King and Stanford also caution against 'paternalism in a modern dress' (186) 'one-sided reading' (189). They stress that a dialogic encounter between doctor and patient should avoid 'the physician's tendency to create monologic interpretations' (196). This criticism was also adopted by Gogel and Terry (1987), who see patients not as 'passive texts' (214), and stress the importance of a model that allows the patient's personal reading of his own body and condition (214). Baron in his short article "Medical Hermeneutics: Where is the "Text" we are Interpreting?" (*Hermeneutics* 1990) also emphasizes that the texts of patients are not fixed things (27). He warns for making the patient a 'source document' (28). This idea is also expressed by Shapiro (2011), who emphasizes that patients' stories can change from one telling to the next (68). The texts of patients must not be seen as 'objective truth'. Kirmayer (1992) warns against accepting language as too 'objective' and advices to realize that language itself creates meaning. Besides, he points at the possible 'destroying' effects of pain on language, a notion that lies close to the opinion expressed by Scarry in her book *The Body in Pain* (1985), and which will be discussed extensively later in this book in the context of migraine.

After 'the patient as text' a new 'textual' layer of the patient-doctor encounter emerges, that of the medical record. In their article "The Voices of the

Medical Record”, Poirier and Brauner describe how a patient is not only turned into a ‘text’, but also into a medical record, a ‘managerial, historic, and legal document’, which they also describe as ‘somewhat schizophrenic’ (29). The content of the medical record must reflect its writers’ medical interpretation and should be understandable for the reader. The record may contain the discourse of one doctor ‘talking’ to himself, or the contributions of several different doctors. Poirier and Brauner compare this with the ‘heteroglossia’ of Mikhail Bakhtin, mentioned earlier, which are fragments of texts that ‘circulate’ around the principal one and relate to various other texts, forming a ‘social phenomenon’. Thus, the medical record creates a complex world, as novels do.

From the ideas of the abovementioned scholars it may at least be concluded that illness has acquired ‘an unprecedented textuality’ (Morris *How to Read* 140), and that this is especially true for patients with pain, as they often have only words to make their suffering part of reality. As a ‘text’, they need the best ‘reader’ they can get. A doctor must fulfill this task, being a ‘professional reader of pain’ (139).

But, considering the fact that the ‘reality’ of describing and reading pain is a problem by itself, as there is always a distance between author and narrator, the important question that now emerges is how to measure pain, as its expression mainly depends on words. How to detect the presence of pain? How to make sure that the pain can be read in the right way? The sufferer translates his or her sensation of pain – or other sensations, such as ‘hunger’ or ‘love’ (if he or she knows them) – into words and the listener firstly must believe the utterances and secondly interpret them. There is, however, an important difference between the sensation of pain and that of love and hunger, as explained by Scarry (*Body* 5). Whereas love (someone or something to be loved) and hunger (food) refer to objects in the external world, pain is not ‘*of* or *for* anything’ (5; emphasis in the original). Pain has no referential content (no signified), and therefore ‘resists objectification (in language)’ (5; my addition between parentheses). Morris quotes the novelist (and doctor) Richard Selzer, who once argued that the language of medicine cannot quite pin down the object it seeks, no doubt because it is not an object (*Culture* 218). So, a process of interpretation (and exclusion) is necessary to make a diagnosis of pain.

The diagnostic process

Let me now look at forms of texts connected to the diagnostic process, which in most cases start with an encounter between patient and doctor. This encounter is often called ‘asymmetrical’, as knowledge and emotions of both parties are not on the same level (Meeuwesen et al., 1991). The doctor who takes a clinical history may be compared with a historian (Riese 437). The encounter may lead, as Rimoldi states in his article “Diagnosing the Diagnostic Process”, to the conclusion that the diagnostic process is a problem-solving situation with doctors as active searchers and selectors of information in the hope this will enunciate a diagnosis, a diagnostic impression or no diagnosis whatsoever (271).

The medical curriculum trains students to perform the ‘life’ encounter with a patient in a systematic way, depending on the circumstances in which the patient is seen. Obviously, a patient with an acute illness in the emergency room has to be handled differently (more quickly and pragmatically) than a patient with an ‘elective’ complaint, such as chronic pain, who is visiting the out-patient clinic. As headache-patients are mostly seen in the latter situation, I will focus on that type of encounter. In medicine (and neurology), a disease is generally called ‘chronic’ when it lasts for more than 3 months, but for pain, even lasting more than 6 months (Lavie-Ajayi et al., 193) has been mentioned. Both periods are arbitrary and the origins of these are hard to trace.

The established approach to a patient with chronic pain consists of first taking a ‘history’, by asking about the current complaint, previous illnesses, medication and intoxications (alcohol, smoking, caffeine, drugs). This task is not easy in the case op pain. This ‘history’ may be considered unreliable, as the patients have to describe (their complaints) from memory, but nevertheless they must be believed unconditionally. It can be easily understood that this method will not lead to very reliable descriptions in patients who are mute, severely demented, aphasic, oligophrenic, unwilling, foreign or comatose (Schott *Communicating* 211). However, also in ‘normal’ patients (a contradictio in terminis), history taking often is difficult.

After questioning the patient, a physical and neurological examination is performed by the doctor, which may be rather threatening. For Leder (1984), in the physical examination the patient experiences her/his body as a scientific object beneath the dispassionate gaze and the palpating fingers of the doctor (*Medicine* 33). Toombs (1987) says of this situation that the patient perceives himself to be an object of investigation, rather than a suffering subject (232).

Taking these descriptions together, it becomes clear that a neurological examination (often necessary when the patient has pain and of crucial importance when the patient suffers from headache), contains elements that emphasize this 'objectification of the body', including fundoscopy (literally looking into the patient by looking at the retina with a special lens) and the investigation of reflexes (the patient is not only objectified, but also turned into a mechanical puppet).

As the neurologist William Gooddy describes,

> a patient must conform with a large number of test patterns, whether it be in his eye movements, his response to having the soles of his feet stroked, his explanations of the certain sounds spoken to him, his ability to recall the names of kings and queens, his attitude to politics, newspapers, radio and television, and his judgement of the safety or desirability of remaining alive. If he falters in responding to a bright light flashed in his eyes, if he cannot distinguish a penny from a shilling, if he does not quite know the similarity between a house-fly and a tree, if he no longer wishes to drive lorry-loads of waste paper five days a week for the next forty years, he may be subjected to the most rigorous correctives, which include powerful persuasion, the strongest available and sometimes dangerous drugs, a collection of tests which require the penetration of his deepest interior, and the direct attack upon his most vital and valuable organs, some parts of which may actually be removed and studied elsewhere. (*Disorders* 664)

The 'gaze' of a doctor on the patient during the physical examination may be compared with that described by Michel Foucault in *The Birth of the Clinic. An Archeology of Medical Perception* (1994) as 'the eye that knows and decides, the eye that governs' (89). He describes the clinic as the first attempt to order a science on the exercise and decisions of the gaze (89). The gaze is used to regroup and to classify patients by species or families (89).

In the chapter "Seeing and Knowing", Foucault further reflects on the importance of the 'clinical' gaze. In his opinion, the gaze refrains from intervening, is silent and gestureless and has 'the paradoxical ability to *hear a language* as soon as it *perceives a spectacle*' (108; emphasis in the original). So, the gaze seems part of reading the patient as a text, as described above. Foucault distinguishes a hearing gaze and a speaking gaze, between which a balance must be sought. He points at the distanciating effects of the gaze and at the artificiality of the diagnoses thus made. The gaze classifies, includes and excludes. When dealing with patients with pain, the 'gaze' is predominantly used to exclude pathological signs, as the diagnosis of pain-syndromes mainly depends on symptoms that are invisible. Of course, the gaze still is important by looking at and interpreting non-verbal signs such as grimaces, gestures, clothing, etc.

The ‘gaze’ on pain was eponymously worked out by Sontag in her short essay *Regarding the Pain of Others* (2003). In this text, she focuses on photographs depicting and/or representing pain. The advantage of a photograph is that it combines objectivity with ‘a point of view’ (23), which is total subjectivity. But, she admits, for the identification or misidentification of the photograph words are necessary. No picture can gain ‘meaning’ without words. For her, sentiment is more likely to crystallize around a photograph than around a verbal slogan (76). The description of a photo in words resembles the so-called ‘ekphrasis’, the ‘verbal representation of visual representation (Mitchell 152). For him, on the one hand ‘words can “cite”, but never “sight”’ (152), on the other hand writers can make us see (152). He states that language can stand in for depiction and depiction can stand in for language (160).

Maybe Sontag is right in her conclusion that sentiments are more likely to crystallize around a photograph than around a verbal slogan, but I would argue that the words of pain also are ‘ekphrastic’: they produce an image and (should be) sufficient to ‘mobilize’ the sentiments of the listener and ‘viewer’, although – in a sense – the doctor will also ‘read’ the patient as a kind of painting. The main shift, however, is from one sense to another, from hearing and saying to seeing and saying. Deborah Padfield elaborates this in her article “Representing the Pain of Others” (2011). She starts with emphasizing the danger of using words without checking the picture they generate in the minds of others (242). One of the dangers of language – she argues – is that often people assume they understand each other when at times they are speaking of very different experiences (241). This danger is particularly immanent in the health setting.

Brody (1994) describes the encounter of patient and doctor as the ‘deeply rooted ‘need to know’ versus an equally deep ‘need to be known’ (*Broken* 81). The power disparity between the parties (82) is difficult to overcome as no patient would favor ‘the help of relatively powerless physicians’ (82). According to Mintz (1992), medical language frequently creates a distance between doctors and patients, enhanced by special forms and metaphors. For him, by means of the words the patient is dehumanized. Dekkers (1998) adds to this discussion that doctor’s and patient’s narratives are often seen in opposition to each other (288). In his opinion, the clinical encounter may even be seen as a meeting of two worlds. Patients and doctors are in two quite different ‘realities’ (289). Here, the obvious task of both parties is to search for a shared reality. Charon (2006) does not have much confidence in the doctor – patient encounter either. For her, doctors use to talk in technical jargon, usurp authority, withhold critical information, deceive patients about their medical conditions, ignore what patients brought to the conversations and control what would be talked about and how (*Self-Telling* 193).

Maybe the disadvantages of ‘the patient as text’ and the hierarchy in the patient-doctor encounter disappear when techniques from literary studies are used and the patient is seen as a ‘literary text’. In this way, some more distance might arise, but on the other hand, the positions of both ‘parties’ may become more equal, more as ‘author’ and ‘reader’, as I shall argue hereafter.

The patient as literary text

The thought of reading a patient as ‘literary’ text might seem strange at first sight. Illness and disease are serious matters, which differ considerably from fiction. Nevertheless, imagine a patient telling a doctor about his or her complaints. The patient searches for words to describe something that is real to him or her, and sometimes even ‘looks in the sky’ for the words. The challenge for the patient is to describe an internal perceived ‘reality’, for which words and images are the only available symbols. In fact, patients hereby ‘create’ an extension of their reality, thereby creating a new world on a new ontological level. Without any doubt this resembles the creation of a fictional text. This ‘fiction-like text’ must be appreciated and interpreted by doctors. For Rousseau (1986), ‘doctors *must* imagine a fictive world, in addition to a real one, if they are to perform their work’ (160; emphasis in the original). He further asks ‘in what *precise* sense [..] is medical diagnosis based on imagination?’ (160; emphasis in the original). For him, a possible answer is that literature helps the doctor to read, explicate and interpret, as well as to control language (161). This explanation, however, seems not to go far enough. Literature is not only an aid for a doctor, but also a substantial and intrinsic part of the encounter with the patient. Analyzing texts produced by patients is the daily work of doctors. So, they must be sure to be good at it.

Texts may be analyzed in many different ways. The formalists, for example, saw a literary work as an assemblage of ‘devices’, which they interpreted as interrelated elements or ‘functions’ within a total textual system (Eagleton 3). For them, literary language deformed ordinary language, often leading to an ‘estranging’ and ‘defamiliarizing’ effect. They saw literary language as a set of deviations from a norm, a kind of linguistic violence (4). Formalists focused on the study of texts without taking into account any outside influence. Consequently, as Eagleton argues, their standpoint leaves the definition of literature up to how somebody decides to read, not of the nature of what is written (7). This makes the formalists' way of interpreting text less suitable for the patient – doctor encounter, in my opinion. The structuralists, on the other hand, emphasized the relation between 'signified' and 'signifier', as described above in the paragraph about Ferdinand De Saussure. The resulting 'pain as a signifier without signified', seems not the ideal starting point for the patient – doctor communication either, especially so in the search for a common 'reality'. Important for the post-structuralists (e.g. Michel Foucault) was the notion of 'discourse', defined as a group of statements which provide a language about a particular topic at a particular historical moment' (Hall, 29). Although of great importance to the present book (and further worked out in chapter 3), discourse analysis seems more suitable for more general, historical and cultural issues than for the analysis of two persons talking to one another (although at the background of the language of both the speaker and the listener certain discourses certainly are active). The 'reception theory' emphasizes the role of the reader in determining the meaning of a text. Eagleton even states that without a reader there would be no literary text at all (64). Within reception theory, reading is more important than writing. There is an 'implied reader'; a certain kind of reader is already included within the very act of writing itself (73). The latter situation, with the writer taking the possible reception of the reader into account, resembles that of patient and doctor, as there is the effort of the patient ('writer') to try to 'persuade' the doctor ('reader'), by means of his or her 'rhetoric', or call it 'performance'.

In her article "Illness as Argumentation: A Prolegomenon to the Rhetorical Study of Contestable Complaints", Judy Z. Segal describes the rhetoric of the doctor-patient interview by referring to Aristoteles:

> The second rhetorical concept is *pisteis*, Aristotle's catalogue of persuasive appeals, including the following: *ethos*, the appeal from the character of the speaker; *pathos*, the appeal to the audience's emotions; and *logos*, as Aristotle says, 'the arguments themselves' – both are inductive (largely, arguments from example) and deductive (arguments by reasoning from general principles). (231; emphasis in the original)

She emphasizes that one should be cautious with illness theories that are based on 'types of patients', and advises to direct attention to what patients say, thereby especially taken *pisteis* into account and to see illness as a conclusion drawn from a series of arguments that may be judged on their