

Storytelling, Illness and Carl Jung's Active Imagination: A Conversation with Dr. Rita Charon of the Narrative Medicine Program

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INTRODUCTION

While writing my undergraduate thesis on twentieth-century archetypal psychologist Carl Jung and the role of storytelling in the healing process of illness, I was fascinated to find striking connections between his psychoanalytic theories and the practice of narrative medicine, and I was even more intrigued when I found a lack of academic literature exploring this connection. Dr. Rita Charon, a general internist who coined the term narrative medicine, and I sat down together on a cold Saturday afternoon for tea at the Marlton Hotel near New York University. Graciously, she agreed to meet with me to discuss the similarities between Jung's emphasis on narrative and archetypes to acknowledge psychological distress and narrative medicine's dedication to the patient's story in diagnosis and treatment. Charon's 2006 book *Narrative Medicine: Honoring Stories of Illness* which emphasizes the individual stories of her own patients from her practice as well as the necessity of acknowledging other patient's personal illness narrative, seemed to draw many parallels to Jung's theories of storytelling. While Charon admitted that she did not study Jung in her practice, together we examined the similarities and the differences between narrative medicine and Jung's analytic psychology in regards to the role of the collective illness story of society and what implications this has for the individual's story of illness. We also discussed the drive that human mortality has behind the telling of an illness narrative, one of the main themes of Charon's book, and how Charon may have brought to our attention humanity's ultimate shadow archetype, as Jung would say, of death and our mortal bodies.

Jung, who was mentored by Sigmund Freud, has been called the founder of analytical and archetypal psychology, playing a dominant role in discourse surrounding the human psyche, the unconscious, dream analysis, and how spirituality may be crucial, as well as science, to the practice of psychotherapy (Strubel). Jung coined the term active imagination to describe a process in which the patient interacts with the archetypes, images, and symbols that come forth through the unconscious through a variety of artistic mediums, one possibility being storytelling. Through active imagination, patients use creative processes like storytelling to depict the archetypes they are experiencing and integrate them into their understanding of their experience and sense of self. For Jung this process is crucial for the West, which since the Enlightenment, has lost its connection with the spiritual side of the human psyche and

storytelling (Jung 162-163). In many of his works, including *The Red Book and Memories, Dreams and Reflections*, Jung uses his own storytelling process to recount his experiences in his practice and career along with his personal dreams and visions. Jung suggests to his patients and his readers that active imagination is both beneficial to the patient and the doctor, a concept that Charon certainly echoes.

Charon notes in her book that the concept of the auto-biography, or having one tell his or her individual story, was not taken seriously in Western literary criticism until the mid-1950s (Charon 71). Before this time period, Charon explains that literary criticism attention was placed not on the experience of reading a work or even the experience of writing it, but instead on classifying it, distinguishing between what was poetry and what was fiction. The focus on literary works was very taxonomic, “like biologists classifying things or giving them Dewey decimal numbers” (Charon, Interview). Stories about the self did not have their own literary category in the system, and they were understood simply as letters people wrote to one another or personal diaries. Not until the 1920s during the beginning of the New Criticism movement did the autobiography start to receive close attention. The literary critics of this movement saw the stories of the self as “literary artifacts that merit the fine literary attention we lavish on Don Quixote and Shakespeare” (Charon, Interview). Charon notes a shift in the recognition autobiographies received; she says “even if their writers are not great by definition, there is a greatness to this writing in terms of what it does not only for the reader but also for the writer” (Charon, Interview). The literary critics of New Criticism paid close attention to works, especially poetry, fixating on each word, the tone of the writing, irony, paradox, and the way the “I” operated within the writing and the text. The readers of New Criticism often took the author and her intentions out of the stories they were analyzing, but what they did was shed light on a gap between the author and the “I” which found itself in the story. They focused more on the “I” in the story and the literary techniques and symbols that were present instead of the author’s actual intentions. This gap that can be seen between the author and the “I” that appears in the story is a concept which Charon writes about in her book and a concept that we will return to in our discussion.

Dr. Charon, who received a PhD in English along with her medical training, put together the connection between the attention paid to stories of the self that emerged in the mid- 1900s with New Criticism and the need for doctors to listen to patient narratives in contemporary medical practices. She came up with the term narrative medicine to describe a practice in which physicians utilize literary analysis techniques such as recognizing the role of the “I” in the auto-biography and the form of the story’s content to more fully understand the patient’s illness and to help the patient through the healing process by recognizing the crucial role that the doctor plays in helping the patient feel that her story has been acknowledged and understood. In 2000, Columbia University’s narrative medicine program opened with Charon as the executive director. To this day, the department functions as a place for health professionals to be trained in narrative competence and to learn how to incorporate narrative medicine into their practices. Charon writes: “As my colleagues and I in the Program in Narrative Medicine are discovering, not only is diagnosis encoded in the narratives patients tell of symptoms, but deep and therapeutically consequential understandings of the persons who bear symptoms are made possible in the course of hearing the narratives told of illness [...] Only in the telling is the suffering made evident. Without the telling, not only treatment but suffering, too, might be fragmented” (Charon, “Narrative and Medicine”, 862). For Charon, it seems that the narrative provides the doctor with a unique insight into the patient’s illness,

better preparing her for fully addressing the patient's symptoms and aiding the healing process. The doctor gives the patient an opportunity to tell her story as she understands it. This process helps the doctor to bring to awareness aspects of the illness that the patient may not have faced emotionally and psychologically.

While reading about the theory of narrative medicine and the way in which Charon describes its application for medical professionals, I drew many parallels with Jung's earlier twentieth-century theories of storytelling regarding Jung's active imagination and the way it promotes psychic healing. Firstly, both Jung and Charon recognize the actual act of telling one's story to another as a necessary component in helping the patient to escape dominion by the illness. Charon argues that when patients are faced with an illness their "life narrative" is thrown off course. Ideas they used to have about what their life would look like and what role they would play in their family, community, and society are drastically altered, and patients are put in the position of having to reconstruct this life narrative through their treatment process (Charon). The doctor, just like the therapist for Jung, plays the important role of the listener and adviser who gives the patient the space to tell her story, have it be acknowledged, and to bring awareness to the components of the story that show the patient's unique relationship with her illness. She writes "That illness and suffering must be told is becoming clear, not only in treating trauma survivors but in ordinary general medicine practice [...] These narratives demonstrate how critical is the telling of pain and suffering, enabling patients to give voice to what they endure and to frame the illness so as to escape dominion by it" (Charon, *Narrative Medicine: Honoring the Stories of Illness*, 65-66). Indeed, much psychological research has focused on how individuals construct meaning through narratives to explain their experiences and put them into context with other life events and their conceptions of their environments and societies.

Dr. Keith Markman, Dr. Travis Proulx, and Dr. Matthew Lindberg write in the introduction of their 2013 edited compilation of research *The Psychology of Meaning* that the psychological study of the meaning through narrative as "a distinct discipline is just now beginning to coalesce. For the first time, psychologists from different disciplines are comprehending themselves as working toward a common understanding of how it is that people come to understand themselves, their environment, and their relationship to their environment" (Markman et al 4). In the book, Markman, Proulx, and Lindberg explore research from psychologists of various disciplines which suggest that finding meaning through narrative is a way to grapple with human mortality, recover from and cope with traumatic experiences such as a serious illness, and to make connections among our feelings, thoughts, and experiences to produce a consistent self narrative.

In a similar way Jung's understanding of active imagination enables the patient to engage with the archetype of illness that she is experiencing in her conscious mind. When the patient becomes aware of unconscious material that surfaces into the conscious mind through archetypes, and then integrates the material, she may change the effects of her complex. In my interview with Charon she noted that for narrative medicine the emphasis is not placed on how the patient can change the role she plays in her story or even the relationship she has with the material but simply acknowledging and becoming aware of the direction in which her narrative goes. She told me, "It's not a matter of the patient saying I'm going to tell the doctor about that dream I had about the black figure, but rather, they both find themselves telling and listening about the black figure, not because the patient decided to do so; I think it's even more

powerful when we talk about writing, because you find yourself having written a sentence that you had never thought you would write” (Charon, interview).

Both Charon and Jung write that the content of patients’ stories often bring up material for patients that they were not previously conscious of. Jung attributes this material as coming from the unconscious mind, either the collective unconscious, the personal unconscious, or a combination of the two. Charon does not speak of the patient’s feelings, thoughts, and opinions which emerge in the illness narrative as necessarily coming from an unconscious mind but rather from a “gap” between the body and the self which she terms as the corporeal gap. She writes that often when the body becomes ill there is a separation between the body and the self, which the patient must then come to terms with and reintegrate through the narrative (Charon, *Narrative Medicine: Honoring the Stories of Illness*, 90-91). In a sense then, Jung’s unconscious and Charon’s body both contain material, which may be “hidden” from the conscious self and needs to explore through the story. Charon writes “Even though the body is material, its communications are always representations, mediated by sensations and the meanings ascribed to them [...] Keeping secrets from one another is only one of the ways that the body and the person who lives in it can work at cross-purposes” (Charon, *Narrative Medicine: Honoring the Stories of Illness* 92). Just as the unconscious and conscious minds can be in conflict or opposition with each other in Jung’s theories, Charon suggests that the body and the self can be disconnected, causing the patient emotional, physical, and psychological stress. Jung writes that patients experience psychological distress when the material of the unconscious is not acknowledged and integrated into the conscious realm (Jung 34), and it seems that Charon argues the same idea in relation to the self and the body with the body containing the unknown and uncertain material that was once attributed to the unconscious.

Additionally, Charon also makes clear that the telling of one’s story of illness not only documents or relays information to the listener but it also plays a role in the development of identity for the patient, a concept which can be compared to Jung’s process of individuation. Both Jung’s and Charon’s theories suggest that through the storytelling the author is able to form her own unique identity on the one hand, distinguishing her from others and others’ experiences, yet also place her within a larger cultural and societal structure. The individual becomes aware of her experiences and the opinions, emotions, and thoughts she holds with these experiences while also finding a satisfying connection with the rest of humanity at large. Charon writes that “telling our story does not merely document who we are; it helps to make us who we are [...] what happens to you, what you remember, and how you tell about it are mutual forces that contribute to your sense of self over time” (Charon, *Narrative Medicine: Honoring the Stories of Illness*, 74).

Charon illustrates this idea that the interpretations we place on our illness narratives create a sense of self and identity with a case example of one of her patients in her book. This patient was a 51-year-old man who came to Charon complaining about a pain in his abdomen and some uncomfortable changes in his bowel movements. This patient’s uncle had died of pancreatic cancer and so he was aware of how fatal this illness could be; he was convinced that he had the same illness as his uncle and that he was going to die. While telling his illness narrative to Charon he realized how willing he was to die and how at ease the idea made him feel. His lab work and examinations came back negative for pancreatic cancer, and in fact, they showed that his symptoms were related to a benign and treatable cause (Charon, *Narrative Medicine: Honoring the Stories of Illness*, 85). Through the process of sharing his story and

perspective of his illness with Charon the patient learned that he was suicidal and that he wanted to die. He was concerned about leaving his wife and his mother, but his overall sense of self was depressed and desired to die. Charon writes, "Illness intensifies the routine drives to recognize self. It is when one is ill that one has to decide how valuable life is, which relationships are most meaningful, and what terrors or comforts the end of life holds" (Charon, *Narrative Medicine: Honoring the Stories of Illness*, 87). Indeed, this patient's physical discomfort in his abdomen and intestines challenged him to think about the value of his own self, his relationships with others, and how he saw his place in the world. This patient's responses to these questions revealed someone who did not value his life, felt guilty about not being there in close relationships, and who was ready to leave the world. Charon's attentiveness to the patient's story and her ability to help bring his suicidal thoughts to awareness helped the patient get the proper psychological treatment he needed as well as to integrate his bodily symptoms with the disconnected thoughts he associated with them.

As well as building an individual identity for the patient, both Jung and Charon comment on how the individual's story connects the patient with humanity and her collective society through shared experiences and collective illness myths that her culture may hold. However, Jung seems to portray this concept in a more psychologically positive framework whereas Charon often emphasized in our meeting the oppressive and limiting elements of the collective illness story which conflicts with the individual story. Interestingly, Charon writes, "As one hears one person in private, one hears behind him or her the rising voices of others, in concert and in conflict, testifying to their own suffering. The murmurings expand, form harmonies and discordances" (Charon, *Narrative Medicine: Honoring the Stories of Illness*, 234). This phrase seems to support Jung's collective unconscious, stating that each individual story can be related back to a collective knowledge of humanity filled with many other stories of human experience (Jung 165). However, Charon notes in her practice that the collective story of illness for her patients often prevents patients from seeking care or creates tension with the individual story, often imposing societal stigmas, stereotypes, and assumptions on to the patient in regard to how she should interpret and feel about her condition. She writes in her book that "all the means of identity have taken on particular forcefulness in situations of globalized and commodified sameness" (Charon, *Narrative Medicine: Honoring the Stories of Illness*, 68). This statement seems to challenge Jung's universal archetypes and perhaps suggests that there is also an oppressive and limiting nature to collective stories and meanings, which connect individuals in the consequence that the individual story gets lost and contaminated with the collective voice. She seems to caution Jungian analysts from imposing collective stories on to individual narratives. Instead, they should let the patient herself tell her story and then support her as she finds meaning through collective stories and her personal life experiences.

When I asked Charon about the quotation in her book, she expanded upon her idea saying that behind every patient's story of illness is often a collective story of the illness, which then connects the individuals. For example, she noted to me that in "the early days of AIDs what one person said brought up the whole kind of political, social, cultural, homophobic, judgmental state of affairs, and so sometimes there's a link between the one individual person and not just all those similarly suffering but the whole business that makes for that illness" (Charon, interview). She continued to give examples of patients she has worked with who felt ashamed about their illness because of the way it was viewed in their culture or society. From a Catholic man who wanted his Herpes medication sent to a different pharmacy than the one in

his neighborhood for fear of being stigmatized because of sexual relations to an older man who did not want to get a hearing aid because it would make him seem feeble and weak (Charon, Interview), many of Charon's patients seemed to experience a conflict between the collective story of illness that their society imposed and the realities of their own individual story and the help they needed to treat their bodily symptoms. Charon is warning her readers and doctors of the potentially oppressive and limiting qualities of the collective stories of illness, which reside in the conscious minds of individuals in a culture.

Jung explains that the collective conscious contains the social norms, stigmas, and stereotypes, which are present within a culture. These elements are the ones in which Charon finds tension with the individual stories of her patients. The collective unconscious contains a wealth of material, archetypes, and symbols from throughout human history which can find their way into the conscious mind of a culture depending on the social, political, economic issues the culture is currently facing (Strubel). For example, if a culture contains the stereotype that women are weaker as a gender, the collective unconscious attempt to bring archetypes of female warriors and protective mothers into the conscious mind of the culture to balance and challenge its stereotype. The doctor is put in the difficult situation of mediating between the collective conscious and the individual's story. He or she is required from a moral and social standpoint to listen to the patient's narrative and acknowledge it while also bringing to awareness the potential disconnections between the self, the body, and the collective story of illness for the patient.

Charon recounted experiences with some female patients who came to her practice overweight and at risk for diabetes. She found that some of the women depending on their respective cultures "pride themselves on how large they are and there is a kind of power of the matriarchal body. So, the woman might have heart disease and high cholesterol and developing diabetes, but there's no way she's going to lose weight, because if she were to lose weight she would diminish her power in the family" (Charon, interview). What Charon considered an illness for these patients was actually a sign of power for them, and so Charon was put in the position as a doctor of trying to treat the patient's developing symptoms while also acknowledging the collective cultural narrative of weight that was important in these individual's narratives. Recognizing these collective stories seems important for understanding the context of the individual story, and whether these collective stories empower or limit the patient seems to depend on each person's experience and circumstance. Jung argues that finding one's connection with humanity through these universal archetypes and the collective unconscious is psychologically satisfying along with defining personal identity (Strubel); however, the ways in which the material from the collective unconscious manifests into the collective conscious of the culture can be destructive depending on the complexes formed. Charon is likely to caution that profound conflicts between the body, the self, and the collective conscious of a culture can create much distress for the patient. Through the narrative the individual can integrate all of these factors and become aware of her relationship with the illness to ascribe meaning to it and escape dominion by it. Jung would agree with this concept of integration and the idea that a disconnection between the unconscious and conscious material can create psychological distress, but what Charon seems to be alluding to is the idea that Jung's own language of archetypes could in fact be another constructed myth which could either limit or empower the individual story depending on how the doctor and the patient understand and use his theories.

While both Jung and Charon may have some differences in the way in which they view the collective myth of illness as beneficial or detrimental to the patient's individual story and her healing process, both theorists raise questions and suggestions as to how the sharing of the narrative produces psychological, emotional, and spiritual benefits that when neglected can have distressing effects for the patient in the healing process. While discussing how she pays attention to the form of each patient's narrative – the way in which the story is told – she finds that there is a unique drive and imperative to tell one's story behind the illness narratives. And often, she noted to me that these stories act as cautionary tales or stories which give a reason for an illness, whether that be to accuse the person who gave them the illness, to point out flaws in the society which exacerbated the illness, to charge those who ignored them while they were ill or made it worse, or to reflect within themselves as to what about them brought about the illness. She told me that “there are plenty of books about how I became a national league baseball player or things like an auto-biography on people like Bob Dylan, but they don't have the kind of drive that these illness narratives have” (Charon, Interview).

Charon's observations regarding the form of these stories and their underlying draw to others and to be told reminded her of a seminar she had attended for writers with a history of serious genetic diseases in their families. These writers had all written essays about the risk they lived with in their lives, whether it was breast cancer, early onset dementia, alcoholism, or cystic fibrosis. Charon noted that everyone at the seminar, even though they were just meeting for the first time, seemed to feel an incredible “primal identification” with one another as they shared this common feeling of being at risk for a serious illness and not being able to control the outcome (Charon, Interview). She writes in her book that “with narrative emplotment we attempt to make causal sense of random events or humbly acknowledge the contingent nature of events that have no cause, enabling us both to diagnose disease and to tolerate the uncertainty that saturates illness” (Charon, *Narrative Medicine: Honoring the Stories of Illness*, 236). In our meeting she connected this quotation with the writers in her seminar group remarking that these individuals seemed to feel isolated in their at-risk conditions and that the writing of their stories was a way to cope with the unknown of their genetic history and to connect them with others who were experiencing the same stress, anxiety, and perhaps loneliness. While the writers in the group felt that no one else could possibly understand their stories without having their conditions, Charon felt that their narratives of coping with the risk of a fatal illness could be beneficial to all as they remind each individual, regardless of her current medical or psychiatric status that she too will have to face the inevitability of death.

In the seminar, Charon expressed to the others that it is important for everyone to read their work, even if they do not have an identified illness. She told me that the at-risk individual's stories “felt like a model for the public at large to not overlook the shadow of death, to not understand at a very personal ordinary level that I too will die; I don't know of what, but that's my future” (Charon). Charon's observations about the lurking fate of death in the illness narratives of the writers in this seminar as well as with her patients and other illness narratives reminded me of Jung's fascinating shadow archetype. The shadow archetype, in Jung's psychoanalytic theory, represents an aspect of ourselves as individuals or of the collective society that we do not like, do not want to associate with, and often have difficulty integrating into our consciousness and identity (Jung 34). For example, if one of Jung's patients was experiencing reoccurring anxiety dreams about an annoying or threatening figure which persisted to follow and aggravate the patient, Jung would most likely identify this figure as the person's shadow. He would ask the patient to describe the figure, which often results in

negative associations and descriptors, and then ask the patient how he or she would feel if someone used that same language to describe them. Often the patient is upset and startled at the idea that the very thing or figure she despises or fears represents an aspect of herself that she would rather ignore. Jung writes that the unconscious will keep bringing up this figure for the patient and its associated anxieties and stress until the patient finally acknowledges the shadow (Jung 34).

Charon seems to be making a parallel argument that the narrative is a way for the patient to confront the uncertainties, fears, anxieties, and stress associated with her own mortality. In a way, it seems that Charon has brought to light what Jung might call humanity's greatest shadow archetype, death, a topic which is laden with uncertainty and the unknown. In order to cope with an inevitable fate and the lack of control one can feel when faced with an illness, both Jung and Charon encourage the patient to use the narrative as a way to acknowledge and face her mortality. The awareness, integration, and meaning-making that occur through the story help to reduce the patient's anxieties and stress, allowing her to better manage her illness and to create a more beneficial relationship with her doctor through treatment.

Narrative Medicine and Jung's archetypal psychology also emphasize the role that the doctor, or therapist, plays for the patient in the storytelling process in replacement of past spiritual advisers. Both of these theorists write that past spiritual advisers aided patients in facing uncertainty, death, their identity questions, and their illness by listening to patients' narratives and providing acknowledgement and support in recognizing the story's themes, symbols, images, and perhaps unconscious content that needed to be integrated. However, Jung and Charon, despite writing almost one hundred years apart, seem to both realize that the role of the spiritual advisor in society has diminished, putting pressure and responsibility on the doctor or the psychologist to fulfill the necessary role of listener to the narrative. Jung often points to the Enlightenment as a marker in history where the spiritual advisor lost her role (Jung 67) while Charon points to the rise in technology use along with the priority of money and documentation for billing in the medical industry as at fault. Doctors are unable to provide patients with the human acknowledgement of their story along with the support needed to bring awareness to what elements the story brings up and how it relates to the patient's healing process. Patients are left searching for another person or outlet to share their stories with as a way to calm their anxieties and fears about the uncontrollable changes in their body and their mortality. With this realization, Charon, and Jung, brought up with me the ultimate question for our generation to answer, a question which requires further investigation and research for present scholars and doctors: If doctors are no longer in the role of past spiritual advisers, "who's doing it now? Who do people turn to? It's a very serious question," Charon noted to me.

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