Narrative Medicine

Trauma and Ethics

Edited by

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Foreword

Rishi Goyal

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With the generous invitation to write a foreword for this volume, I would like to offer a few words on the oscillating nature of trauma as it relates to my dual disciplinary frameworks, Emergency and trauma care and Narrative medicine or medical humanities. The vernacular usage and field of intelligibility for trauma has expanded considerably, but as Rasmussen and Sodemann note in their excellent introduction, it is rooted in a wound or injury. The spectrum of trauma that I encounter in the hospital on a daily basis is wide. On the one hand, I care for patients with serious injuries to their bodies: a man with a bleeding chest wound from a gunshot; an older woman with a scalp laceration and internal hemorrhage after a trip and fall; a youth with a cervical bone fracture following a diving accident. On the other hand, sometimes related to these and other physical insults, trauma also captures the psychological distress and emotional responses associated with life threatening, terrible or emotionally charged events. I have cared for patients with traumatic reactions to car accidents, lightning strikes, stabbings and rape but also to police brutality, racism, transphobia and even slower forms of violence like poverty, neglect, and daily low levels of stress. Trauma is a heuristic that highlights embodied cognition and permits us to perceive the entanglements of psyche and soma.

Trauma's purview and compass are not limited to the individual, the event or the clinical encounter. Trauma echoes and expands to incriminate, diagnose and explain cultural, historical, and institutional forces. In my related work as a medical humanities and narrative medicine scholar, I often read literature, philosophy, medical memoirs, and histories to account for collective, cultural and intergenerational trauma. In *Reading Capital*, Louis Althusser defines a practice of reading he labels as symptomatic reading. This reading is not limited to the surface, superficial meaning of a text, but uncovers and unearths what a text represses as a condition of its possibility. This kind of symptomatic reading is an interpretive act that frames the boundaries of ideology and reveals invisible but present forces that structure our ways of knowing, being and, relating to one another. Like a physician listening for symptoms of trauma in our patients, a symptomatic reading of the many kinds of texts discussed in this volume like Sarah Manguso's poetic memoir *Two Kinds of Decay*, reveals trauma as pervasive and constitutive of contemporary sociopolitical relations. Through a symptomatic reading of cultural documents, we can reconnect individual stories and experiences of physical and mental traumas with historical and collective traumas.

One of the important outstanding questions in the etiology of post-traumatic stress disorder is why some people experience it and others do not. Given similar or comparable circumstances, the common assumption is that some people become "traumatized" and others do not. But as traumatic reactions have gained in visibility and cultural acceptance, we might say that we are all traumatized. Living in the twenty-first century, under the constant threat of war, climate catastrophe, and infectious apocalypse, we exist proximate to traumatic experience. What unites all traumatic experience is a combination of vulnerability, precarity, and exploitation. This risk is unevenly distributed, no doubt. Peoples of the Global South and former Anglo-European colonies, brown and black people all over the world, the impoverished, the incarcerated, the undomiciled, women and trans people, all certainly experience more vulnerability, precarity, and exploitation. Nor do I want to diminish the specificity of a clinical trauma that can cause debilitating nightmares, anxiety, exhaustion, and isolation. I'm only suggesting that the widespread discussion and experience of trauma have given us a valuable framework with which to understand our shared and collective experiences and to guide a symptomatic reading of cultural texts.

If the movements in clinical medicine are the organization of symptoms, diagnosis and diagnostic thinking, and therapeutics, then while I have touched on the first two, I have not mentioned the last. And here again this volume makes an important contribution. Trauma's force seems to be the way in which it blurs boundaries, leaps time and space, and diffuses through experience. While it may sometimes have a clear beginning and signify a discrete event, trauma often outpaces the moment. It ripples and repeats even as repetition is one of its defining symptoms. From Freud's "talking cure" to narrative medicine's insistence on the importance of storytelling, narrativity, narratability and the telling of one's story have been seen as central to a therapeutic practice in medicine, not just a diagnostic one. This volume extends that insight through chapters on trauma-informed practice, narrative-based practice, critical race theory, and expressive and creative writing. While telling one's story of trauma can be a powerful way of mitigating the persisting effects of trauma, it can sometimes also be re-traumatizing. By framing trauma in the context of narrative medicine and ethics, we can develop new research and models to understand and dismantle power relations between tellers and listeners that might adversely the therapeutic power of storytelling. Not everyone is allowed to tell their story and not everyone is heard. We might call the complex of what stories get heard and what can be told, narrative audibility. Ideology, institutional

racism, and histories of sexism prevent many traumatic stories from being told or heard in the medical context. We must learn how to create empathic and safe spaces to allow the telling of stories of trauma to be therapeutic and to not be unwitting perpetrators of new traumatic experiences.

Almost every day I have to tell someone that their loved one has died. This can be a traumatizing experience for the family member, and the emergency room is a particularly difficult place to create a safe space. But it can be done and if we can do it here, we should be able to do it everywhere in medicine. By avoiding assumptions, by staying sensitive to cultural, racial, and social difference, by minimizing hierarchy and approaching the moment with narrative humility, we must prevent the formation of new traumatic experiences and support the healing power of storytelling. But we must also recognize that stories and individuals do not exist in a vacuum. They exist in an expanded cultural, social, economic and historical matrix that is sometimes traumatizing, but that can also be therapeutic.

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