On the Education of a Psychiatrist: Notes from the Field

Sheila Harms

A Dissertation submitted to the Faculty of Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

Graduate Program in Education
York University,
Toronto, ON

November 2021

Abstract

The overarching borrowed question that frames the work of this PhD asks, "What does an education in psychiatry do to a psychiatrist?" Early in my practice of child and adolescent psychiatry, the "know how" in the custodianship of care neither readily nor easily translated into "show how," resulting in a pedagogical conundrum that belatedly registered as uncomfortable emotional symptoms about my education. This nidus of professional confusion and uncertainty creates the context for my inquiry into the complexities and dilemmas of contemporary matters of medical education, specifically as it pertains to my identity as a psychiatrist. To probe these queries, three non-traditional, blended methodologies are relied upon. John Forrester's "thinking in cases" is utilized in reading memoirs and critical histories in psychiatry, such that the thesis can be read as a case of many educational cases. I stay close to the reading of Oliver Sacks' memoir whose work in neurology also grapples with questions of the mind; an idea which becomes a leitmotif in my own autoethnographic reflections for re-constructing my education in psychiatry and its potential beginnings as a trainee and educator in both Canada and Uganda. Weaving in and out of historical observations made by Foucault about psychiatry and linking them to Sacks' recall of numerous medical institutional encounters, I tackle the problem of matricide in an educational arena weary of newness and how this deadly curriculum can be generative in its intent. Through attempts at engaging a decolonizing discourse about my experiences as a clinician educator in Uganda, the concept of an educational void and how it was both ruthlessly encountered as a situational dilemma but underwent a thought transformation to understand it as a survival tactic, is described. Psychoanalytic orientations are heavily leaned upon in my interpretations, highlighting the emotional logic inherent in the transference sites constituting the human work of medical practice and education. Broad themes emerge focusing on history, place, gender, and positioning of the body as educational markers speaking to a different kind of experiential pedagogy predicated on somatic revelations to make the mind intelligible in its relevance to the temporality of education. I arrive at the fault lines of education, difficult knowledge, and the uncertainties, including the frailty of my own self as a resource for the mind, that form educational myths needed to tackle obstacles to learning. Through this process, a personal and professional awakening occurs.

Dedication

For my mother, Elsie.

Acknowledgements

For introducing me to Dr. Deborah Britzman and being a source of intellectual heft in my life, a sincere thank you to Dr. Susan Searls Giroux. For the most profound privilege of working alongside the truly brilliant mind of Dr. Deborah Britzman, I am forever changed. With all of the gratitude I can convey – thank you for bringing into clarity an emotional logic that was always present for me but not fully known until the joy of encountering you. To Dr. Alice Pitt for her incisive read on everything, I also want to express my sincere gratitude for the ways in which my scholarship has been deeply affected by you. Thank you also to Dr. Lisa Farley for her generative thinking and generous contributions in this PhD thesis. To Dr. Christine Vanderkooy – thank you for a long-time friendship born out of making music which writes its own melody into the work of this PhD. To my dear friend Dr. Karen Saperson who has somehow managed to be exactly what I need; you are a mentor, guide, inspiration, dearest of friend, and have been an emotional container in seeing me through this project. A sincere thank you for your incredible skills and deep humanity. To Dr. Vic Neufeld and Barbara Neufeld – for the countless dinners on the Chedoke Avenue deck where you spoke in ways that made medicine possible for me, I am sincerely grateful to you both. For the friendships that survive medical school and go on to embody the stuff of too good to be true, thank you becomes an expression of incompleteness tolerated precisely because we have one another. Here, I am referring to Dr. Janine Davies and Dr. Sheryl McClaren – thank you for your constancy and immovability which coalesced in the time of learning medicine together and has sustained me since. To Dr. Godfrey Rukundo, my colleague, trustworthy friend, and co-conspirator in striving to make education better than it is – thank you for believing that we could build a program with origins a world apart. To the students whose brave curiosity has demanded that I find my own learning stance, precisely when I was resistant to it, thank you. To my patients and their families who have taught me what it means to be a physician with a heart, your inspirations born of human pain and grit are daily gifts in medical practice. Thank you. And finally, to Warren Trimble; thank you for chopping wood and carrying water while I laboured to write. I love you with all my heart.

Table of Contents

CHAPTER ONE

Identifying the Educational Problem & Methodologies for Probing it

Something isn't right: Psychiatry and its educational dilemmas

When I entered psychiatry residency and later took on the role of an educator to those more junior to me, I was deeply convinced in the possibility of psychiatry as a somatic aperture for human pain and thought the field privileged potential space that was generative, tolerant, and open to human authenticity for both healer and patient alike. Demands of many kinds were made of me, intellectual as well as emotional, exceeding a degree of certainty I believed to be essential in an expert culture such as medicine. What I discovered through this practice of healing were problems I was working through educationally. Simply put, the "know how" in the custodianship of care neither readily nor easily translated into "show how." I can see an ontological tension residing in this pedagogical conundrum. That is, proof of success was demanded of me by an external authority not directly reliant on observed patient encounters. And passing scores on standardized tests and resulting professional credentials did not penetrate the sticky situations I would encounter with patients, but nonetheless signaled an expertise about the working of the mind that I did not experience. I was frequently left with the question of who would adjudicate the experience of the mind and be the final authority if my own expert authority failed me?

Unsurprisingly then, a challenging clinical practice as a qualified child and adolescent psychiatrist, imbued with patients whose emotional pain was not easily conceptualized in a consultation paradigm nor proficiently remedied in a biomedical model or even a biomedical model committed to psychosocial constructs, often left me with an anxious logic to resolve ineffable conflicts. How could I reassuringly explain to a desperate parent the disorienting trauma of discovering a daughter barely out of childhood having delicately and precisely carved

the words “kill me” into the long of her forearms? The dermal epitaph of deliberate self-harm sabotaged the tools and strategies I was taught to reliably deploy to understand what came before the incisions. How to convince a mother that there is real hope for a future following her teenage daughter’s anxious revelation that the way that she carried her arm in gym was not because of a neurological deficit, but because it intentionally mimicked the posture of a dinosaur claw. Until the moment of the psychiatric interview, she had never been able to say to her mother that she felt much more at home believing her body to be that of a prehistoric reptile. Some patient encounters have led me to experiences of textbook achievements such as pharmacological treatment of the inattentive, hyperactive boy whose impulsive and targeted aggression cleared his classroom. Beyond the success of stimulant medications, the residue of a historical, monstrous identity capable of inciting the catastrophic urgency of a school fire drill never really dissipated for him, leaving behind a social solemnity more problematic than his swinging fists. More often, deep places of confusion about what was really happening to me and around me were subdued by an education primarily predicated on taxonomies of symptoms. My seemingly correct diagnostic interpretations were hardly corrective. No treatment algorithm for the exceptionally bright young man who felt at heart more like a woman could procedurally automate relief from suffering, particularly when handfuls of pills were far more effective in their soothing effects. Displays of professional certainty within these patient engagements often registered for me as premature, sterile, distressing, and at times a forced foreclosure on the complexities inherent in the fragility and unknowability of psychical life.

So, what then does an education in psychiatry do to a psychiatrist[1]? This pressing question has shaped a pedagogical consideration in my own experience in medical education and

[1] This opening question is a version of an inquiry by Willard Waller in his 1932 book “The Sociology of Education,” He posed the question “What does teaching do to teachers?” Later, Britzman (2003) engaged a provocative iteration

the resulting dispositional dilemmas that have been encountered. Education has taken on a number of valences for me: an education in a learning profession, an education made from psychiatric practice working with children and adolescents, and an education of an educator. Each of these learning fragments has mandated evidence of expert knowledge and skills, simultaneously creating conditions where both knowledge and caring are paradoxically insufficient or doubted. And by this, I mean the dependable problem of intersubjective collisions inherent in patient and teaching encounters, bringing to bear histories from patient, student, and healer alike, inevitably resulting in rich layers of human complexity not readily amenable to text-book answers. This is one reason why Freud (1964) referred to medicine as one of the impossible professions in its ultimate promise of dissatisfaction, where the limits of professional practice in relationship to those who engage on its behalf is also experienced by them. Britzman (2009) tells us why the impossible professions affects us precisely "because it proposes a constitutive discontinuity, a lack the profession represses, negates, and projects into others" (p. 129). While contemporary training in psychiatry offered me a paradigm of empirical conviction and a transcendental faith that the mysteries of the mind would eventually render biological certainties, scientifically illuminated through biomarkers and PET scans, I still found myself ill-prepared to explore the conceptions of the mind and at times, became antagonistically oriented towards a failed professional promise of understanding. More so, I increasingly experienced myself as both cause and effect of this failed profession, unsuccessful within a mandate to understand the mind and its proclivity towards brokenness, thereby foreclosing on an interest on the mind's "emotional antics." Furthermore, I would frequently realize a quiet hostility directed at anyone

of this question by looking at what happens to students when teachers learn to teach. In each of these scenarios, what is at stake is an implied educational reality animated by life with its intertwining social entanglements, affecting moments, and mishaps that will come to bear on the teacher and learner alike. These dynamics are very much at play in the opening question that guides my PhD thesis.

who would ask for answers to questions I could not articulate, let alone understand. Carlat (2010) weighs in on this kind of vitriol, describing the psychiatric profession as having reached a crisis point such that a collective professional paralysis has ensued in the wake of psychopharmacology and its capitalistic agendas and allegiances. Over time, I came to understand what Carlat was saying; the practice of psychiatry for me often felt like a one trick pony in its pharmacology-heavy focus. If a pill couldn't fix the problem, it signalled a personals ineffectiveness. Perhaps as a consequence, I had also developed a kind of medical myopia in not seeing psychiatry's emotionality, fostering a kind of automated engagement where I would rely on capsules and metrics, which would later translate into uncomfortable emotional symptoms about my education that I would be forced to contend with. But these observations only emerged after. I discovered later as an educator in medicine the poverty behind the enamor of belonging to a professional group secure in its confidence of a venerative, empirical bio-omniscience.

Madness

It strikes me that I am somehow caught in my own treatment disorder. Education in psychiatry is good for me, and it also makes me sick. This tautological observation has led me into the question of dissatisfaction and how I might find my way into it, resonating as a form of madness described by psychoanalyst Darian Leader (2011). For me, learning is always on the border of a "know-how" but simultaneously fragile in its elusiveness. My problem has more to do with the mottled and silent moments of my affected response to knowledge uncertainty, as compared to the elusiveness itself as a focal point. Indeed, Leader (2011) highlights a quiet psychotic trajectory as one that is qualitatively more attuned to hiding pressing queries camouflaging an underlying paranoia, and conforming behaviourally to expectations as well as demonstrating compliance, with a tacit recognition that suppression of any outward signs of

psychosis is key. He contrasts this to the outward forms of madness that would be readily understood by the majority as "mad" – that is the striking non-sensical symptomatology of what is seen to be bizarre, disorganized, and often violent. The descriptive proximity of quiet psychosis to my educational experience where my affected response proves more problematic than a lack of knowledge is a provocative one for me. Leader (2011) describes madness as being less about the experience of madness itself, but rather about the individuals' responses to it. Madness, he would argue, can be a reasoned response despite the suffering that is associated with it. Specifically, he notes that the reasoning engaged with during a delusional state ultimately makes sense to the one who believes it and therefore has sensical value. He states "a delusion can thus be a way of trying to understand one's experiences, drawing on all the faculties of interference and deduction at one's disposal to find an answer" (p. 18). In other words, Leader describes madness as a place of confusion that works to understand it but attempts at understanding must involve a foray into the meaning of the madness to make attempts at working through. Indeed, this place of working through is a difficult one. This interpretation has obvious links to what I have proposed about my own experience in education and where I find myself at a kind of affecting, professional crossroads. Those around me would not have observed any outward indication that my inward thinking was at odds with the medical world around me, leaving an unsettled uncertainty as my internal guide trying to right a course that frequently felt as though the threat of getting lost was imminent.

Bion (1970) refers to an ability to tolerate the unknown as "negative capability" which resembles the place of working through offered by Leader (2011). Britzman (2009) expands on Bion's idea by describing what uncertainty opens or emotionally permits. She states,

> With the idea of negative capability we are permitted the depth of emotional reality as capable of both registering the world that cannot be known and signifying how it is that we come to be affected. (p. 118)

In this way, the capacity to enter into the unknown, that is to say beyond the answers provided to me by medical texts and positivistic data, points to a constitutive fragility inherent in the work of engaging my education as a potentially feeble, frenetic, or mad place. I must also say that I understand that there is a contemporary intellectualization of madness that may be seen as distastefully flippant or ill-situated when my role as a psychiatrist has exposed me to those whose chronic and persistent experience of psychosis has resulted in devastating outcomes. I am intentionally bringing this symbolic language to my queries and discussion, situating education as a type of personal "madhouse" into my dissertation to indicate that the patient and the physician are more similar in an unconventional education of the illness experience, and simultaneously suggesting that this dilemma is also an idiomatic expression of the ways that the profession of psychiatry has led me to the problems at hand.

While it is uncomfortable to admit, a perceived failure of knowledge as a child and adolescent psychiatrist has frequently animated in me a resisting internal conflict where uncertainty, at times, performed a shameful behavioural response of unsettled confusion directed against my patients. Models of patient engagement attending to standardized interview techniques, effect sizes, and best practice guidelines have often left me at a loss in understanding how to efficiently and cogently disentangle the layers of traumatic loss, painful desires, creative potential, temporality, and idealized longings that penetrate adolescent life and its early beginnings, let alone propose beneficent interventions. That is, an education in psychiatry had broken down for me as a child and adolescent psychiatrist in delivering a psychiatric remedy,

and therefore demanded a type of internal tactical retaliation where my adolescent patients became the target in my mind's eye. This kind of castigation would curiously soothe me, acting as a justifiable mitigation when acknowledging my own perceived professional inadequacies. Curiously, Freud offered a novel lexicon of psychoanalytic terms to help me explore this emotional battle ground in his work with the unconscious and its drives, relying on the unspoken, parapraxis, common forgettings, and slips of the tongue to speak what was not spoken about with respect to my shameful vengeful thoughts. Building on Freud's ascribed saliency when it comes to emotionally oriented language, Winnicott (2014) also appeared to be alive to my situation as an analyst. He recognized that an inevitable emotional storm warning was required when psychiatrists were in the presence of their patients, although it was likely a state of unawares that would catch most of us in the profession. He states, "However much he [the psychiatrist] loves his patients, he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does to his patients" (p. 195).

The lecture entitled "Why I hate my patients" - absent from the psychiatry curriculum I was exposed to, was presumably avoided because any of the Freudian techniques that we did study were generally tolerated as historical and seriously antiquated artifacts. Consideration was hardly given to using his ideas for anything other than quick references to dirty jokes. However, discovering anew the work of Freud whose ideas could be used as deeply generative ways of probing uncertainties and misunderstandings that I was tackling in the work of learning was nothing short of transformative. Freud understood my encounters with patients as a transference problem where "the wandering mind drifts through long ago relations and fixates, obsesses, and forgets them" (Britzman, 2011, p. 2) and then unconsciously re-surfaces to comment on present day troubles. Psychoanalytic ideas had come to bear on my medical education such that patients

and their families were then readily referred to as “difficult” and secondary to failures of my own understanding. I felt justified using this “difficult” title in the wake of my failure, that is, a perceived professional minimization occurred where it felt as though my compromised competency was publicly declared. Through the status of my intense affect, the difficult patient signals for me the intolerable somatic embodiment of difficult knowledge, described by Pitt and Britzman (2003) as “a concept meant to signify both representations of social trauma in curriculum and the individual’s encounter with them in pedagogy” (p. 755). The concept of difficult knowledge articulated the problem I had encountered in the uncertain education of psychiatry. I find myself at a fault line where the divide between the idea of education and what has never been thought of as education is a chasm worth going into. It is precisely through an intentional plunge into this chasm that I enter into an investigation into the status of uncertainty in medical education, the anxiety and emotional logic that come to bear on learning as a practitioner of psychiatry, where the case of difficult knowledge is a signal of the implicit affective reasoning within education, the fault lines in education as a point of entry in a critique of it, and an attempt to engage the obstacles of trying to understand education. I draw upon several fields of thought including postcolonial discussions of psychiatry and its education, critical histories of psychiatry, testimonies from medical practitioners, and psychoanalytic theory to enter into situations of difficult knowledge where helplessness, otherwise thought of as a void, will orient me towards identifying an educational abyss that I encounter and the associated meanings.

Chasms

The kinds of conversations I am interested in require an understanding of psychiatry as a historical practice, or nexus of practice histories which sets the stage for what it means to

undergo an education within it. I draw upon the arc of psychiatry's history to situate my own storied educational within it, as well as pay close attention to the experience of others who have engaged an education in the practice of the mind. In thinking about my medical education and understanding a historical orientation, I am reminded of childhood musical experience where I encountered Bach. Bach's genius was a musical chaos that registered as coherent by way of a social exchange; a musical idea would be antiphonally introduced, expanded, imitated, toyed with, and harmonized to create intersecting eventualities. A great deal happened simultaneously, all pointing to a major idea and its opening departures. I recall being aware of a sophisticated phenomenology which was happening musically and only made accessible to me through playing the instrument. Forrester (2017) put words to this and described this quality as "rhizomic" in its lateral, winding, intertwined application, and performance (p. 1) and used this description to introduce, what he felt was, an under-recognized method of reasoning; that is, thinking in cases. He had long been interested in the history and philosophy of science and its social proclivities. However, it was the historical case, precisely the psychoanalytic case that gave him cause for serious consideration about the scientific place of the individual within the human sciences. Relying on Forrester's orientation offered in his framework "thinking in cases" would have me ask what it is about critical histories in psychiatry that make it an interesting case, or even an exemplar for further educational interrogation? Specifically, I am looking at how psychiatry critiques, testimonies from practitioners, and psychodynamic orientations to these narratives intertwine to illuminate the dilemmas encountered within psychiatry, their meaning, and applications to an education of an educator in a caring profession. I am working with education as an object to be subjectively engaged, a condition - particularly of temporality, a signifier, a site of affect and its historical attachments, and a spatial void that allows me to

come to the educational conclusion that no matter how I work it, things will and have gone wrong. But this is not the end of the story – rather it is the beginning. This conversation and its departure points provides a unique contribution to the field of psychiatry where I have not encountered similar kinds of questions or engagements reflected in the medical education literature.

Methodologies; Studying for Meaning and its Breakdown

The place of lost meaning and the study of where meaning breaks down is not a traditional starting place for scientific rigour in medicine and as such, non-traditional methods are relied upon in this thesis to open a body of knowledge with the hopes of deepening it. Reeder (2008) provides a salient example that highlights this conflict when he remarks on Freud's methodological inclination to listen to his patients instead of working for a cure. Despite it seeming less than scientific, the directive paradoxically registers as more scientifically rigorous in its focus on the understanding of the unknown. Thinking about the mind and its inter-subjective, affecting questions brings me to the limits of my tacit, "expert" understanding where the answers, or cure, are less rooted in the science of positivism, and are more philosophical in nature, requiring a methodology that will do justice to its needed explorations. I engage a blended methodology of three specific types for this dissertation. To create a conceptual banister that will guide my thinking, Forrester's (2017) notion of "thinking in cases" is utilized in reading memoirs and critical histories in psychiatry, with a specific focus on attending to how these narratives construct the confines of learning about and within psychiatry in the time of after, forming "educational cases" that can be drawn upon as interventions to help situate my own education in psychiatry as well as my thinking about obstacles to education. Qualitative methodologies including autoethnography and reliance on principles of phenomenological

interviewing will guide the work of attempting to capture my own observational experience of medical education, in both Canadian and Ugandan contexts, and its affecting consequences such that I am able to arrive at a narrative, probing the question of what my education in psychiatry did to me as a psychiatrist.

Thinking in cases; Enlisting Forrester

The philosopher of science, John Forrester (2017), offers a novel approach to science and pedagogy through his formulation of "Thinking in Cases" setting the stage for coming to understand something as a "case." His conceptualization of knowledge derives from an exemplar, that is, a real-life case example which allows learners to explore its depths to arrive at a generally accepted conclusion. The exemplar, as Forrester describes, has more to do with repeatedly engaging a novel "case" so as to understand it precisely both as common knowledge and common ways of coming to know knowledge. This, he observed, is in stark contrast to a historical practice of science committed to the application of rules and principles, The power of his notion of "thinking in cases" is the acknowledgement of the relationship of the particular with the universal. Otherwise said, Forrester asks what the study of an individual or knowledge about an individual (i.e., the case) can represent for others? More specifically, he argues that "the science of an individual" (p. 10, 2017) or reasoning in cases allows for a recognition of the buried or fixed modalities that are resourced in practice disciplines which rely on its pedagogy as a scientific practice. Forrester's approach to the individual in the sciences offers a generativity precisely in provoking ideas about the individual. He illustrates this in the referencing of Freud's approach to psychoanalysis and its inherent related complexities for the individual by stating, "We know that there is a normative drive in psychoanalytic theory as Freud developed it; the drive to show how each and every erotic life conforms to the model, the exemplar, of the

Oedipus story. Yet what we find most seductive in psychoanalysis is its promise to give an account of the divergences, the detours, the idiosyncrasies of the individual's life" (p. 11). Here, Freud and Forrester provide a handrail to stay close to the problem of attempting to learn from the instabilities, fault lines, and enigmas of psychiatry as a professional practice. I highlight the "divergences, detours, and the idiosyncrasies" as Forrester (p. 11) would refer to them. Perhaps more concretely, using the notion of an exemplar allows me to place education itself precisely on the stage to be viewed as a case for inquiry.

The methodology of autoethnography; In search of an "I"

"You should write in the first person," my PhD supervisor says to me after reading a few of my early essays. "Am I allowed?" I ask in response. At the time, I was unaware of how my naively simple response signaled a historical resistance to my own voice and laboring for identity, constituting an important opening in the discourse of autoethnography and its methodology. For me, training to become a psychiatrist required the development of writing skills in the third person account; expertise predictably reliant on neutrality. Otherwise understood, I had to literally write myself out of my medical education in order to write on its behalf. Prior to my question for permission for a written voice not typically read in hospital documentation, Ellis and colleagues (2011) had already described a postmodern "crisis in confidence" situating a demand for epistemological alternatives to empirically oriented, canonical approaches to social sciences research and its representations of others. The question of my permission had not yet penetrated my thinking as a child and adolescent psychiatrist in the empirically dominated medical field of academic psychiatry. Autoethnography gives me its narrative permissions and potential methodological provocations.

Etymology assists me in registering a basic understanding of autoethnography. Simply deconstructed, it is about the self and a culture understood by the self through writing. Reed-Danahay (1997) defines autoethnography as a form of self-narrative that places the self within a specific social or cultural context. Similarly, Ellis and colleagues (2011) describe autoethnography as a form of narrative inquiry that has the capacity to help social science researchers understand stories as "complex, constitutive, meaningful phenomenon" (p. 274) with openings to issues of ethics, morality, affect, and thinking in an attempt to better understand the self and represented experiences of the other. They note that autoethnography is simultaneously a method and a text, process and product that has the capacity to help social science researchers understand stories as "complex, constitutive, meaningful phenomenon" (p. 274). Through combined works of autobiography and ethnography, a researcher's epiphanal experience assembled as analytical, scholarly hindsight offers a portal to affective and intellectual comparative reflections not previously understood for those inside and outside a culture (Ellis, Adams, & Bochner, 2011). It is interesting to note that my own crisis of certainty in medicine which compels a great deal of thinking also resonates with the social sciences methodological confidence crisis (Ellis et al, 2011). For me, crisis offered the realization that theoretical empiricism is both fallible and porous in its reliability and moved scholarly alignments for me closer to the aesthetics of literature. And so, my resistance to a subjective writing voice likely performs a symptomatic reflexivity familiar to a parochial medical paradigm and simultaneously situates a deeply motivating rationale to employ a methodology more closely aligned with modes of literary aesthetics such as character development, plot expansion, and rich scene descriptions in the creation of a cogent written product intended to live out the tensions inherent in the polarizing gap between art and the medical sciences. Considerations of this methodology within

medical education petition the question of possibility for the written, narrating self in medicine as a legitimated alternative to contemporary discourse and a compelling argument for a place of meaning in its own education.

Needing to find my own voice requires some kind of intellectual coaching and theoretical support. Although Cavarero (2000) does not speak directly to the methodology of autoethnography, her courageous writing about a genre of self-representation, identity, and subjectivity provides a critical foundation for me to approach autoethnographic work. In her storied exploration of narrative, she suggests that the "who" of an individual eludes philosophical knowledge, such that the singularity of the individual demands a place not previously allowed in traditional discourse. According to Cavarero, historical confines of philosophy collapse under the possibility of narrative. Cavarero (2000) also draws heavily on the work of Arendt in offering an alternative to the language of the "universal," supporting Arendt's juxtaposition between "who" and "what," noting that philosophy's main ambition has been to determine "what" a human is relative to other species" (pg. vii). Cavarero (2000) goes one step further and suggests that "who" can be known, although not in an epistemological sense, but rather through a *narration* of the person as protagonist in his or her own storied experience. Despite the richness that is available to the practice of psychiatry in eliciting patient stories, I have observed that the narrative often undergoes a process of re-telling as medical filtering and retrofitting, where the good bits that speak deeply to the uniqueness of the individual risk getting lost, or worse, not registering as germane to the patient's story. In the physician's telling of the patient's story, the patient is often historically pre-determined through a sculpted, listening hypotheses and reliance on symptom pattern recognition in search of the diagnosis. The act of "history taking" then in psychiatry often removes the very parts of the story meaningful to a patient in the act of re-

creating a narrative worthy of documentation in the medical chart, paradoxically enacting the physician's complicity in altering the personal to arrive at a product. This is ultimately understood as a part of therapeutic treatment and we can see that the "who" has morphed into what Cavarero refers to as the "what" signalled and justified by the author's expertise.

Using this example, we can see where the notion of the universal or the generalizable, and not the individual, is rendered desirable and medically useful in considering the patient. There is seemingly little room for an individuals' individuality, unless the patient's constellation and course of symptoms is so unrecognizable, it registers as a "case study" worthy of publication, adding to the physician's success. Both writer and patient are philosophically constituted in this interpellation, both reduced to historical subjects without the potential of entering into a dramatic event afforded by narrative methodology. Despite navigations set at determining a "who," I have arrived at a "what" in Psychiatry and in so doing, have likely not understood what is at stake in this distinction. These observations interpreted through the work of Cavarero (2000) are methodologically relied upon in the autoethnographic explorations of my own stories and history in psychiatric education and its affecting instructions for a child and adolescent psychiatrist.

Before moving on to additional methodological considerations in this thesis, I can see a potential tension or even conflict in my employment of Forrester's case conceptualization as a way to move closer to an understanding of "who-ness" as described by Arendt and Cavarero. There may be some irony in overtly relying on Forrester's use of the case given that he has stated that the particular is also organized by a historical discussion of the scientific universal. And herein lies the potential problem. Does the science of one emerging from a science of many inadvertently constitute an unintended general typology void of the very individuality it is

intended to capture? Otherwise said, does attempting to interrogate a case of "who-ness" make it a case of "what?" I am suggesting that Forrester's case, or rather his description of thinking in cases, commits to the pedagogical encounter of staying close to the deep intimacy of personal narration, precisely to study the "who" at the centre of it.

Phenomenological Questions

Seidman's (2013) stifling experience with a dominant academic culture embroiled in experimental behaviorism led him to a methodological path of expertise in qualitative research in the social sciences. Specifically, he assembled talking tools that constituted phenomenological interviewing, where curiosity is rendered its due power in eliciting stories as a way of understanding the nature of an experience. In using this methodology, the researcher is able to delve deeply into the notion of understanding what something is like, simultaneously mining and relying on language for rich descriptors and ornate metaphors that assist both participant and researcher alike to know and be known. I conceptualize the phenomenological interview as being the antidote to the professional opinion. Seidman's (2013) interpretation of the interview process is directly relevant to the phenomenological in-depth work when he cites Vygotsky's understanding of language: "Every word that people use in telling their stories is a microcosm of their consciousness" (Vygotsky, 1987 in Seidman pg. 7). Asking questions beginning with the word "how" situate the conversation to capture meaning and temporality, which are always elusive in nature in an interview. And meaning and temporality are often temporally situated within rich descriptions of an experience. Seidman (2013) reinforces this kind of temporal confusion which can be read into experiences bound by the elusive quality of time such that "the 'will be' becomes the 'is' and then the 'was' in an instant" (p. 16), reinforcing a kind of epistemology that is being iteratively sought in the work of lived experience. In learning to

understand that deep cultural life that is accessible through posing the question, "what is something like?" the more able I am to adapt and respond to the questions that I am posing. In turning this framework towards writing myself into the field of academic psychiatry, I am attempting to make more obvious what it is that I tell myself about what it means to me to be a psychiatrist educator in a way that makes me who I am. So, rather than interview others, the triptych approach that Seidman uses frames my approach to and readings of how I encounter the histories, narratives, and memoirs of medicine along with interdisciplinary resources. Three of Seidman's questions structure my reading: How is it that you/I came to be in this place and this work? What is it like to be here and do what I am/you are doing? And finally, what does it mean for me/you to do what I am/you are doing? The purpose of the self-interview is to come as close as possible, through the language and attention of an interview, to the nidus of subjective experience. My question is how as psychiatry educators we focus on entering the profession, how expertise is understood, what failures have been endured in professional training, what dreams are encountered in the educational time of psychiatry, and then, how meaning is made.

Chapter outlines

Chapter two is a close reading of Oliver Sacks' (2015) memoir of his education. He is not a psychiatrist, yet as a neurologist who crosses so many boundaries of genre and fields, he works closely with material that would often be found in psychiatry, including questions of the mind, perceptions of pathological thought and behavior, and its relationship to their learning. Sacks (2015) autobiographical descriptions in his national bestseller, *On the Move: A Life* writes with a kind of raw honesty about how the act of writing, narrating a life with his patients who were symbolic representations of life at the periphery, and whose own experience of being marginalized and misunderstood also bring him back to a place of belonging and safety. For this

reason and more that I explain in the chapter, I read Sacks' reflections as an educational leitmotif for re-constructing my own education in psychiatry and its potential beginnings. In other words, I use Sacks' memoir as a mirror to my educational encounters in training for a practice in child and adolescent psychiatry. In conceptualizing the pedagogical work of reading medical memoirs, I ask when learning really begins based on the first-hand accounts and as a corollary, when language becomes accessible to describe the events surprisingly salient to learning. In reading Sacks (2015), I focus on the place and positioning of the body as an educational marker speaking to a different kind of experiential pedagogy predicated on somatic revelations and its relevance to the temporality of education. Sacks' experience in medical training involves his focus on encounters with drug use and coming out as a gay man.

Through Sacks, the reader comes to understand that his unexpected learning is always in the time of after, or what Freud refers to as *Nachträglichkeit* where distress is attached to the memory of the learning event instead of the event itself. This kind of anxious waiting condition as a framework for "knowing" in medicine is also explored personally when I speak about perceived professional failures encountered through death and dying in medicine. These kinds of affected temporalities and their relationships are closely examined in Sacks' memoir and bring me to my own struggles to contend with uncertainties about the mind in a profession that professes an expertise within. I read Sacks' memoir against my observations and tensions for myths of endurance, evidence in breakdown of meaning, what it means to "grow up" in medicine, and suggestions of an emotional logic at play in obstacles to learning. I pay close attention to places where there is no affect, where a blank slate is rendered most readable, and where mythic structures are created to measure success.

Finally, my exploratory reading focusing on what sex and sexuality has to do with medicine and an education within it tackles the fragilities of belonging in this learning environment. These are some of the limits of understanding that I do not see being engaged in contemporary psychiatry. I will attempt to open the storied structure of the memoir to make sense of the emotional data within my own medical education and to examine its resisting transference dilemmas as a way of coming to medicine as an education in a learning profession.

Chapter three turns to critical histories in psychiatry such as the work of Foucault (2006) in his lectures "Psychiatric Power." He writes capaciously about the subversive and regime-like power dynamics found in institutions such as psychiatry, embedded within a controversial history intended to control madness through a subjectifying, disciplinary apparatus, also simultaneously viewed as a practice of psychiatry. Albeit somewhat adolescent in my need to believe Foucault as a source and site of justification, I endeavor to probe the contemporary historical context of psychiatry using Foucault as a context for my work to take up questions of the body in psychiatry through embodied conflicts rendered palatable by authoritative forces. Specifically, what does the body have to do with a practice of healing the mind? What kind of bodies have constituted the historical work of psychiatry and how might these observations map onto gendered conceptualizations of my own education and contemporary practice in psychiatry? Weaving in and out of historical observations made by Foucault about psychiatry and linking them to Sacks and his numerous medical institutional encounters recalled as memoirs, I explore the problem of matricide in an educational arena weary of newness and how this deadly curriculum can be generative in its intent.

I rely on Sacks' experience with "hospital people" who are viewed as an effect of the challenges associated with the medical establishment and how he navigated these spaces and

often hostile relationships. Sack's relational use of his own body and how it differs from historical accounts is read as an exemplar in probing questions of how bodies are used in caring for another's mind and how this undertaking can be read as physical suffering with a psychic cause. Foucault's "scenes of supervision" create a frame to return to a historical prototype of psychiatry where the absence of the psychiatrist acts as both a judgment and an authority paradoxically at the centre of the practice of psychiatry. This practice lacuna will lead me into questions of what psychiatry is for and what is at stake with a practice reliant on an absent psychiatrist. the body, and how do we understand knowledge about the mind in a practice marked by the absence of the psychiatrist? Here I use both Sacks' encounters and my own to narrate an education made from practice.

Chapter four moves more closely into autoethnography. I have often said about my educational experiences in Uganda that "something comes from nothing" – either in observations about how resources deficits are uniquely overcome by creativity and human tenacity, as well as in thinking about my own state of mind where I attempt to rely on what I thought should be accessible in my mind was conspicuously absent, but survived nonetheless. This phrase indeed acts as an emotional harbinger and an educational marker for what will be explored in this chapter, that is the broader thematic of an educational void and how it was both encountered as a situational dilemma but underwent a thought transformation to understand it as a survival tactic. Chapter four therefore presents an autoethnographic narrative about my experience as a faculty educator in Uganda. However, the perspective shifts where personal narratives are offered from the voice of a clinician educator in a caring profession. Otherwise said, I write myself into the field around the dilemma of trying to educate while simultaneously trying to unlearn my own education. Through this process, an awakening occurs. In this chapter, I have offered both first-

hand accounts of what it was like to be present as an educator with a mandate to see patients and teach while in Uganda. I then do an about face and treat these reflections as transference objects, relying on psychoanalytic theory to organize my thinking around two main questions that I hope will register as common problems to many educators. They are: what is the common problem that I am encountering as an educator in each scenario, and secondly, how can I understand the educational problem using an emotional logic to make sense of what is happening for me as an educator within a temporality that can only be understood as delayed in its ability to bring intelligibility? My reflections then, can be read as a second telling from a place of retroactivity that can be thought of as "after affect" in its directives about me as the educator's education in psychiatry, specifically made from a practice within it.

In doing so, I turn to two main authors, Sally Swartz (2019) and Koichi Togashi (2020) who are both psychoanalysts and deeply engaged in thinking about decolonization in their clinical work. Swartz (2019) practices in South Africa focuses on the notion of ruthlessness as a quality of human survival which is of no use unless it is a point of departure for a disrupted ordinary and renders a new self that has agency and capability. I have borrowed generously from her insights and have used them in the service of trying to make sense of educational scenes where I was rudderless. Togashi (2020), who is Japanese, takes a decolonizing approach to psychoanalysis by critiquing psychoanalytic theory historically interpreted and aligned with the philosophical West and then offers a new set of thought coordinates drawing on Eastern philosophy where he arrives at an ethical turn. It is in this place of human inter-subjectivity that transcends proscribed professional roles, he offers a new way of engagement that underscores and anchors observations I am making in the service of unlearning education as an educator.

The combined work of Swartz (2019) and Togashi (2020) form a framework to help guide a parallel appraisal of my ontological assumptions about what it means to be an educator and how to go about thinking through education as a de-colonizing discourse, steered by psychoanalytic thought. I am working with these authors and their thinking as precisely figures of thought in helping me interpret the various dilemmas encountered as an educator in Uganda which, in turn, pivot towards making some concluding remarks in answer the broad question of what does an education in psychiatry do to a psychiatrist?

Chapter five concludes the dissertation. I do not see evidence of the questions and conflicts that I am raising in the work to of this PhD specifically offered in other educational contributions in medicine, or psychiatry more specifically, although many resources that I rely on allude to the problems under investigation. Emerging from a training largely rooted in empiricism and attempting to find another conceptual model to tackle the notion of an educator's education made from practice, my work proposes to provide an opening into a way out from a kind of thinking that has performed a kind of professional dead-end. And the way out relies on a kind of incision that allows for probing beyond an educational dermis that is deceiving at first glance. All appears to be fine, yet upon closer inspection, I arrive at major thematics including an emotional logic that is both observed in clinical practice with adolescents as well as in the classroom with student physicians as a clinician educator where I weave together much of my experience in medicine. I arrive in the fault lines of education where difficult knowledge and uncertainties form educational myths needed to tackle obstacles to learning. I also find myself embodying and encountering resistance observed in the postcolonial settings of psychiatry and its education, as well as the frailty of my own self as a resource for my mind. In working methodologically through cases critiquing historical voices in psychiatry, voices of colleagues

who have written through the methodology of memoirs and other important histories, and my own narration both as a participant of education and specifically as an educator in Uganda, a triptych emerges emerge to guide me to a work of opening problems that I am working through educationally in a practice of healing.

CHAPTER TWO

A Different Kind of Education: Riding Pillion with Oliver Sacks

I have something in common with Oliver Sacks. We have both undergone a medical education that grapples with questions of the human mind. Sacks trained in neurology whereas I trained to be a psychiatrist specializing in the mental health of children and adolescents. In his memoir "On the Move," Sacks (2015) comes to the conclusion that his irreverent practice of neurology demanded the recognition of psychical life inherent in emotional pain, traditionally tended to by psychiatrists. He saw himself occupying space within both of these medical specialties, despite the crippling stigma often associated with psychiatry. He said, "When I was a resident at UCLA, neurology and psychiatry were presented as almost unrelated disciplines, but when I emerged from residency to encounter the full reality of patients, I often found I had to be as much a psychiatrist as a neurologist" (p. 174). In doing so, Sacks is courageous in declaring his dual identity and as such, signaling a written tenacity in his storied intimacies that shape images of him and his impious genius, leading to a different kind of thinking about medical training and professional practice, precisely as an educational case understood through personal narrative or memoir. But his memoir also signals a different kind of medical education. Sacks' reflections create the affecting conditions where his written recall of an education marked by human desire-- thoughts that will drive his mad creativity, prolific writing, and emotional struggle --make way for what was often troubling in its elusive search. An educational question then emerges from Sacks' account about how he affected his own medical education and his practice. His deeply vulnerable account invites a close reading of his life as an educational narrative informed by psychoanalysis; a tradition that Sacks engaged for over 50 years and admittedly saved him from the brink of no return and perhaps inadvertently fueled his wildly

successful and unconventional writing within a medical establishment often antagonistically oriented towards him. Through his writing, Sacks provides a number of different accounts of his education which I read as an educational exemplar from the vantage point of a psychiatrist attempting to make sense of my own medical education.

I too rely on psychoanalysis, or rather analytic orientations to arrive at some of the narrative themes figuring prominently in my experience of medical education. Sacks really acts as the thematic navigator for me in offering up his generative stories within his memoir, such that described attempts to hide oneself in medicine, or deconstruct or reconstruct oneself to be a palatable medical subject of learning is constantly at play in both our experiences. Similar to the work of Sacks' memoir, I am simultaneously learning my self within the context of medical education. But what becomes clear to the reader is that in the act of learning what it is to be human is always a transference site. That is, the working through and repeated wanderings into my educational situations and their bracketed sceneries brings to the fore associations from moments past commenting on the now. But you will find that I stay close to Sacks' account as a kind of thought bannister, guiding me to a litany of key questions about a professional education oriented towards learning about the mind. For example, in relying on the experiences narrated by Sacks, when it is that medical education really begins? And if I read Sacks as an antiphonal event to make sense of my own experience, when is it that a psychiatric education emerged for me, even as I understand that the muddled, intertwining of moments may not be readily nor easily distinguishable. How then do we understand the registers of time that seem out of place in their before and after-effects? And in the building pyramid of questions that interrogate a different kind of education, what is the pedagogical meaning of telling one's owns account precisely as form of learning? How does my own specificity of self inform the reading of Sacks and what

does this do to my own historical account of learning? What of failure in an expert profession? Additionally, I turn to thinking about what resources were discovered or abandoned in the stifling experience of uncertainty and helplessness? And perhaps most saliently, I consider what happens when learning is traumatic and threatens a demand for unlearning?

In the beginning

What happens before medical school? Sacks tells us he was trapped. Writing about his early school experiences, Sacks laments, "When I was at boarding school, sent away during the war as a little boy, I had sense of imprisonment and powerlessness, and I longed for movement and power, ease of movement and superhuman powers" (p. 3). Confinement and desire are coupled, suggesting an emotional kind of bricks and mortar that will form the story of his early school days within another broader story about education, eloquently written into the work of his memoir. Sacks has a ready antidote to his early academic asylum; it is an affecting logic that he will return to again and again, describing phenomenologically "what something is like" as an educational leitmotif. This psychical wandering begins with an introduction to his body, a portal to understanding the anxiously titillating excitement he experienced while riding horses or motorbikes, and the conflicted desire that surrounded it. He stated, "Images of bikes and planes and horses merged for me, as did images of bikers and cowboys and pilots whom I imagined to be in precarious but jubilant control of their powerful mounts" (p. 3). In his descriptions, Sacks is already alerting the reader to the conditions of his education; that is, peril was a predictable companion of certainty. This trope signaling a kind of fragility lurking around his experience of schooling will re-emerge for both Sack and me in working through our education in a learning profession. And in his opening memoir statements, he also alludes to a somatic orientation to time, having to do with the body. For Sacks, the time before medical school precisely started

with his body; movement before language coupled with a longing for escape. A conflict and a body. If I wanted to read a bit further into it, perhaps the body was the conflict for Sacks. There is more to say about this specific interpretation later in his book and my thesis. For me, the time before medical school was similarly, a conflict about bodies. To be more precise, the time before medical school started with the uncomfortable dismembering of bodies.

Summers would bring to me a welcome reprieve from long bus rides on gravel roads to and from country school. The endless, stretched out moments of the prairie sky animated in me something that I now can understand as a contented loneliness. Our farm was hemmed in by foursquare country miles, big by local standards, boasting large herds of cattle and hogs as a business source whereas chickens, horses, sheep, cats, and dogs were often christened with pet names. To cut costs, my dad would act in lieu of a veterinarian and perform minor surgeries, fill in as a birth attendant to the endless arrivals of mammalian newness, and regularly give needles brimming with pink medicines to alleviate suffering. I followed him around, because it was an opportunity to be with him and do what he did. He was strange to me in that he mostly worked on the land and with the animals, being present outside more than inside. He wasn't a big talker, at least when things in the world seemed just so. The experience of suturing lesions on hog bellies and putting my arm into a cow to help pull out a calf was as exotic as the time was with him. Communication was always difficult with my dad, demanding an exquisite sensitivity to unspoken clues that may or may not register as salient to my pre-teen self. His intense anger was the stuff of excited anticipation and outright fear. I never quite knew if I would get it right, but mostly felt like if things went wrong, it was somehow of my doing.

My dad stitched animals together but he also cut them up. Butchering was a dreaded event that predictably interrupted my holiday reverie and executed all kind of fantastic atrocities

on our farm. Culturally, my parents embraced a value of producing their own food and sharing it with others. Neighbors and extended family would descend on our farm at sunrise, razor-sharp knives in hand, a tangible anticipation in the air, everyone eager to join in on the hanging evisceration of whatever was to be sacrificed for our tables. “Running like a chicken with your head cut off” was not a metaphor on our farm. It was a literal, grotesque event witnessed first-hand that required survival tactics as a child. The men who peeled back the hide of cow with swift, skilled, pointed knife strokes would let me see what was actually skin deep. The butchering never lost its allure for me, gut wrenching as it was. For example, some nerve fibers have, well, a lot of nerve and segmented pieces of butchered meat that lay on the table would twitch now and again. I recall standing and rubbing my eyes to see if I was imaging things and later asking my dad about it. There was no excitement in this surreal event for him. A gruff huff was mustered with no explanation for the spooky strangeness in front of me. And while I too was fascinated, the horror and its somatic experience was never really obviated in the weird wake of observing a live being, registering as something at once familiar and recognizable, then undergoing a careful stripping of itself until a segmented skeleton remained. To this day, the featherless chicken with its knurled, hanging skin and outstretched neck looking for its head, is still deeply uncomfortable. I can see now that the practice of butchering was affecting for me, perhaps because it enacted a kind of emotional dismembering that was my experience with my dad. Things often fell to pieces between us. And perhaps this “too real” flesh and bone experience signalled any potential retaliation against him as too risky. The fear of realizing how good dad was in the act of slaughtering contrasted with the awkward tensions involved in the nurturing care of animals likely animated in me childhood curiosities about the practice of caring and simultaneously situated niggling ideas about “doctoring” and its activities.

First Account of Learning: Before Language

I want to know what it was like for Sacks during his medical training. I desperately attempt to read myself into his experience, and somehow want to have my own obsessive anxiety over attempts at learning assuaged. I started medical school suspicious of the program's claims that student diversity would create a rich atmosphere of resources where fellow learners would both appreciate and utilize the novelty inherent in its constellation. I was grateful for the chance to belong where I suspected I did not. After completing two undergraduate music degrees, education had primarily been a focused foray into musical performance and I had become accustomed to arias, Brahms nocturnes, and tempo rubato. An interiority had been composed over the years of stringent training as a vocalist and pianist that registered more as an opus of "sensing" rather than "knowing." During university, I learned about a medical school accepting students with no formal science training. I wondered if the kind of "sensing" I had come to increasingly rely on in music could be transposed into an inclusive language reflective of a valuable inter-disciplinary currency as an antidote to potential or perceived "hard knowledge" deficiencies. I had always been interested in what I understood medicine to be, and only ever imagined its defining possibilities as it related to gender, age, and capacity, of which I did not meet essential criteria. I was a woman who had grown up in a small prairie farming community with no female physicians to pique a possible career imaginary. I didn't have a science background and at the time of application, I was in my late 20's and was likewise convinced that there would be an abeyance on applications from geriatric learners like me. My acceptance letter however, suggested otherwise.

I read with anticipation how Sacks entered into professional learning as a neurology trainee. My own curriculum of anxiety and anxious logic as a psychiatry resident was palpable – a tender spot that I would iteratively return to and lead to a kind of nervous condition, particularly as it relates to that mysterious moment where knowledge meets the demands of bedside caring. Sacks doesn't seem to be fussed or maybe I misread his silence on the matter. His first account of postgraduate learning in neurology is a memory of journal clubs; a time for doctors in training to analyze research relevant to the care of patients. It inevitably becomes a competition of critique where learners show their knowledge of research methodologies by critiquing the scientific robustness of the study. However, the empiricism that inevitably constitutes the novel scientific discoveries is unconsciously venerated. Although brief in his description, much can be made of the encounter. He suggests to his UCLA learning cohort that in addition to poring over scientific journal articles hot off the press, they should also situate patient observations against 19th century historical readings. An admonishment to curb his enthusiasm ensues. He laments that his proposition is discounted as archaic in its obsolescence and writes with an unusual bite in his otherwise gentle tone saying, "It was as if neurology had no history" (p. 102). To be specific, Sacks writes, "they made little reference to anything more than five years old" (p. 102).

Sacks suggests, even at this early stage of training, that the journal articles will fail them in understanding what medicine is about. On the heels of his truncated comment about the immaturity of information as a point of critique, the imaginary is invited. Or perhaps my unconscious interrupts the reading of his text. In my mind, a kindergarten class has suddenly been symbolically re-created by Sacks where we find ourselves overhearing the animated talk of children. A brief description of the journal club event is offered, yet grown-up language is

temporarily kicked to the curb, and we read that Sacks can't really do anything as this drama unfolds. He too is left tongue-tied. Through free association, my mind wanders to another time where I imagine Sacks as an intrepid child, posture taller than he stands, pretending to be the teacher with a pretend confidence about pretend answers. And yet when we bend our ears to listen to the words that Sacks and his colleagues seek to find, it is as though someone else needs to tell the story of scientific knowledge applied to patient encounters. The language required for this task is nascent for Sacks and his group. In my reading of Sacks in the journal club, the scientific data his group accesses does not tell the full story. They, too, are working to master a language which will not be reliable for some time to come. And in this first recollection of medical learning for Sacks, it is ironically the absence of reliable language insinuated in his journal club turned kindergarten that strikes me as inchoate. The narration by Sacks of this embryonic event leads me to wonder about scenes of his childhood. What happened to Sacks as a boy? As if Sacks can read my mind, he directly leads the reader to the scene of his boyhood, where he says, "As a chemistry-mad boy, I devoured books on the history of chemistry, the evolutions of its ideas, and the lives of my favorite chemists" (p. 102). His recall of childhood offers something far richer and sophisticated; words encountered as emotional alchemy under the supervision of authors whom he could look up to, presumably at a time when language itself was still emerging. And Sacks is onto something here; a scene of natality offered by him lets us know where he came from and what he longed for. But the scene of science is the image that will account for words when language will not do. It is almost as if Sack's education speaks to a time when he is without language, or before language. This is not the only time Sacks will rely on images to speak for him.

Prior to starting his career as a neurologist, Sacks participated in a prestigious neurological exhibit and described himself in this academic encounter by writing, "The exhibit was my way of introducing myself, saying, 'Here I am, look what I can do' to the neurological community in the States…" (p. 130). Through his writing of this encounter, Sacks again renders himself childlike. In imagining this situation animated, I can almost hear his pleading tone, calling out to a parent for undivided attention to be seen and to offer himself as well as his interests as the object of show and tell. Another important moment has been written into Sacks' absence of words. Sacks forgoes the opportunity to lecture in his professional academic debut where numbers, graphs, median values, and other parameters insist on ancillary language to make meaning. Instead, he describes his public foray or "coming out" into academic medicine as an event where he shows himself to his counterparts, without language, relying instead on the aesthetic of images. Sacks gives the reader very little information about this encounter except for a description that he offers. He states that the images of axonal dystrophies represented "special beauties and interests" (p. 130) to him. The feminine qualities he mentions have been aligned, intentionally or unintentionally, with his descriptions of being introduced to academic medicine. The image on Sacks' book cover also introduces us to him and orients the looker before the title is read. Here he sits, young, straddling a motorbike, a body silhouette clad in jeans and leather, cut with delicate, muscular precision. I was visually halted into thinking about why Sacks would begin his memoir with this image. The choice, presumably, was to introduce himself without words despite his prolific abilities with language, highlighting a tension about showing and telling in education.

Being at Odds; Arriving at a Who

An interesting educational marker therefore emerges in Sacks' descriptions; an education that is relied upon to show himself, a showing that is femininely oriented through aesthetic, and without language. This introduction to Sacks' medical education in neurology sets a collision course for the reader, signaling an important educational idea about the very idea of learning. That is, learning about who he is will be at odds with learning demands in medicine. Throughout his time in medicine, he is often in conflict with himself as he discovers educational coordinates set out to position himself antagonistically with the course of recognizing who he is. What then, is he saying with this introduction? Who is he as a neurologist is an emerging question with pressing importance. It is the very question for him, as it is for all of us in medicine, to grapple with as we enter into professional training. However, the "who" of us as physicians often gets confused with "what are we learning?" What can I read then from Sacks' rich, foreshadowing descriptions that hint at early beginnings of an education about who he is, without words?

The work of a memoir can be thought of as an autoethnographic encounter, where the self is the object under cultural investigation through personal narrative. Storytelling, narrative, and selfhood collide in a written effort to understand who someone uniquely is. Philosophy as the study of knowledge should offer something important in the discourse of self-knowledge, and in particular about self-knowledge within an education of philosophy. Cavarero (2000) writes about self-representation as a genre which challenges the historical constitution of the philosophical subject and its analytical assumptions by insisting that the confines of philosophy collapse under the possibility of narrative. "Who" can be known, although not in an epistemological sense, but only through a *narration* of the person as protagonist in his or her own storied experience. Cavarero suggests that the "who" of an individual eludes philosophical knowledge in that the singularity of the individual demands an alternative to the language of the "universal" prevalent

in philosophical discourse, as a way of grappling with the confining phenomenology arriving at "what" something is. In other words, philosophy's main ambition has been to determine "what" a human is relative to other species. A major focus for Hannah Arendt's writing also comments on the philosophical aporia in considering the "who" and the "what." She states, "who someone is, retains a curious intangibility that confounds all efforts toward unequivocal verbal expression. The moment we want to say who somebody is, our very vocabulary leads us astray into saying what he is" (Arendt, 1958, pg. 181).

Cavarero (2000) argues that beyond these distinctions, problematic fault lines emerge when it comes to knowing "who" someone is; fault lines that would find us reverting to discussions deteriorated into notions of "what" a person is. To say more about how these cracks create problematic places for us in education has to do with ontological orientations on the discourse of subject formation. The subject in education, can be understood as play on words, where the self as a unique human being desires intelligibility and at the same time, the subject in education can refer to a topical focus. For Arendt (1958), intelligibility of an individual is made possible through narrative. For Cavarero, intelligibility is problematic because it assumes a kind of subjectification, whereas she contends that the narratable self is in fact, the innate self whose job it is to become familiar with its life narration as a unique and unrepeatable act. An important caveat for Cavarero's (2000) conditions for intelligibility also rely on the need for another. This relational condition for intelligibility is critical in constituting modes of communication, which for Cavarero is one that sidesteps "subjectification" in the ways that philosophy has insisted upon, and instead introduces a sayability that does not start with language but rather, "he/she is a flesh and blood existent whose unique identity is revealed *ex post facto* through the word of his or her life-story" (p. xiii). Here we can see how Cavarero's writing signals to me an opportunity

to make a u-turn and revisit the notion of the body figuring into Sacks' first descriptions of his life-story, albeit a body that, according to Cavarero, is not alone. Cavarero shapes my reading of Sacks in that his early introductions of himself as the subject in his memoir start with images acting as visual descriptions of himself encountered precisely because the reader is there to witness him. The offering of himself through his narrated body, or 'flesh and blood existent' also enacts a beginning for himself, but also as a starting subject in medical education that does not yet have language to offer intelligibility. Yet Sacks is made coherent nonetheless because I, and others, have read it.

The fault lines also become obvious in thinking about applications to Sacks' writing of himself placed in contrast to the demands of training to become a physician where skills in the domain of "history taking" is required. As I have said, history taking is a necessary element of every patient's encounter where a story is told by the patient and interpreted by the medical professional and then entered into a patient chart predictably in third person account. There is an implicit understanding within the profession that the role of the physician's account is to offer expert objectivity within the subjective exchange and to translate the patient experience into a diagnostic possibility. Despite the richness that is available in eliciting patient stories, the narrative undergoes a process of re-telling or medical filtering, where the bits that are not obviously relevant to the diagnosis, are in fact the good bits that risk getting lost as not registering as germane to the patient's story. In the physician's telling of the story of the story, the patient is historically pre-determined through a cultured, listening hypotheses, and reliance on symptom pattern recognition in search of the diagnosis, ultimately leading to therapeutic treatment of the "what." Here, the notion of the universal or the generalizable, and not the "who" of the person, is rendered desirable and useful in considering the patient. There is little room for

a person's lived or elusive specificity, unless the patient's constellation and course of symptoms is so unrecognizable, it registers as a special "case study" worthy of publication. Both writer and patient are philosophically constituted in this interpellation, reduced to historical subjects, without the potential of entering into a dramatic event afforded by narrative methodology.

Both the task of doing medicine and the act of being educated by medicine constitute a kind of surgical undergoing as it relates to narrative. In medicine, efficiency demands that we cut to the quick and arrive at an expert "what." In doing so, excision of the "who" is at stake. In my experience, there is an unspoken rule in medicine that stories don't really matter. In fact, stories are unreliable as a method of knowing. Yet, Sacks' memoir demands a type of methodological rendering not commonly offered nor frequently available within medical education, leaving him metaphorically speechless if he was to rely on the available writing conduits to tackle his personal history in medicine as narrative. According to Cavarero (2000), narration renders a unique fragility because desire is registered. She postulates that between narration and the notion of identity is a determined relation of desire, fundamentally defining the ineffable uniqueness of the person. What of desire in medicine and its education? Sacks' memoir tells us that the discourse of desire was frequently relegated to the resistant space of secretive, hidden, and the feminine. Sacks' writing may in fact, be read as a literary act of resistance in response to an establishment where he repeatedly felt on the outs. Pitt (2003) describes resistance as curious in its consideration of "emancipatory hopes, where critical knowledge can be made from the refusal of official discourse" (pg. 47). This is a beautiful description to better understand how Sacks' memoir is an education of critical self-knowledge and a generative act of resistance to a presumed familiarity rendering him and his desires similar to others acting on the behalf of medicine.

But Sacks' story as a medical trainee is also one of not being comfortable in his own shoes. Sacks admitted to a serious drug addiction throughout much of his formal neurology training in the 1960's that remarkably went largely undetected. The psychotic state induced by amphetamines would create a veil of detachment from himself and the world around him, paradoxically probing generative creativities foundational in his future medical genius. His drug use during neurology training seemed antiphonal in nature, a call to saturate the lonely echoes of love unrequited, countered by formidable sympathomimetic pleasures. Sacks describes the experience as "mindless and all-sufficient – I needed nothing and nobody to 'complete' my pleasure – it was essentially complete, though completely empty. All other motives goals, interests, desires, disappeared in the vacuousness of the ecstasy" (p. 128). His admission of addiction floors me. He was capable of managing specialty training in medicine while loosely tied to reality. He writes, "I would be back at work on Monday mornings – shaken and almost narcoleptic – but no one, I think, realized that I had been in interstellar space, or reduced to an electrified rat, over the weekend" (p. 129).

I am somewhat astonished by this account in thinking that no one presumably noticed. How could this be? If his shaken and narcoleptic self, recovering from a weekend binge was in fact noticed, Sacks does not tell us. Alternatively, if noticed by his teachers, there would likely have been the question about what precisely to do. In my experience with medical education, physicians and their addictions are understood as an inevitable statistic, but nobody wants to be the human data that counts toward its epidemiology. Sacks was lucky. Or maybe I don't know what else to call it. Suspicions of learner substance abuse are deeply suspicious. Of course, the likelihood of abusing substances is not insubstantial nor unfamiliar for many medical trainees or physicians, which often take on the form of a secretive and lonely journey. The question is, how

far will the student go? In my experience as a medical educator, the byzantine and labyrinthian processes positioned to approach this suspicion with the learner under the guise of providing support and acquiring "evidence" through objective behaviorally anchored examples of medical practice affected by substance use, and then engaging ambiguous postgraduate university policies and processes seemingly ambivalent about the problem in the first place, is fatiguing to even write about. It is a hot mess that typically ends up with seriously fractured relationships between learner and teacher. Not because it has to be that way, but because relational skills seem to fall short of this chasm. So, medical education can be something that must be endured, predicated on a belief that at a very basic level, time multiplied by experience – even if this includes an unacknowledged addiction - makes physicians of us all.

This myth of endurance is turned upside down for Sacks. He has seemingly been absent during his time as a neurology resident and yet was sufficiently present in his distracted experience to satisfy the rubric of the day. A kind of fatalistic bravery in defying an academic institution historically made from medical expertise draws me into the moment that Sacks' describes. His supervisors did not or could not or would not engage the chaos that plagued him. Perhaps this deliberate turning away registered as an educational disregard for Sacks, setting up a kind of polarity within his education where he was situated at odds with it. I sense that Sacks too felt deeply out of place, and his resistance to being present speaks to an education non-adherent to classic metrics of success, suspended in time, which simultaneously created a demand to be noticed and a demand for a word-less space for the working out of an emotional logic that would find itself using the educational stage as a personal encounter.

Sacks writes about perceptions of him as an "embarrassment" (p. 122) to the neurology department, but that his publications saved him such that he was also seen as an "ornament" (p.

122). I wonder whose perspective he is taking when he writes this criticism, including the temporality he has in mind when he sees himself as painfully inadequate? Is he writing about the young adult Sacks or a version of himself that is much more childlike? This brief, vulnerable sentence is situated within his medical education and says far more about what is not being said. Threat is readily implied within his education. He is toying with death through his intense drug addiction and learning a profession of caring at the same time. More accurately, in returning to the work of Cavarero, we are encountering a working out of who Sacks is, and for the purpose of this thesis, his "who-ness" is in relationship with his education. We may, albeit inaccurately, come to the premature conclusion that Sack is a drug addict. This is the "what" of philosophy that limits an understanding of the uniqueness and ineffability of what is at play for Sacks as the protagonist of his story. There is something far more generative occurring in his subsequent description of himself during this part of his education that is valiant in its approach. Danger is lurking in that Sacks' account of playing with death as a kind of attempt at learning what he is resistant to and writing his way out of a complete disaster by speaking the unspoken. Recognizing what is at stake, Sacks speaks to himself in a pointed, no-nonsense manner saying, "Oliver, you will not see another New Year's Day unless you get help. There has to be some intervention" (p. 144). Thematics of death now begin to figure concretely into his memoir. This will be the start of a series of mistakes that he writes freely about in publishing a pedagogy of failure on the part of his teachers, that also acts, in part and paradoxically, as "the help" in his medical education.

Early in his training, Sacks describes the case of patient whom he finds endlessly interesting in his enigmatic failure to fit classical diagnoses. Sacks wishes out loud in his own head saying, "What's going on inside there? I wish I could *see* your brain" (p. 105). Sacks'

desire to penetrate the skull was fulfilled. Shortly after leaving his clinic, his patient was struck by a truck in a freak encounter and died instantly leaving Sacks with his patient's postmortem brain in his hands. Sacks reflects, "Could my wish to see his brain have played a part in his fatal accident? I could not help wondering too, whether he had decided to end things and stepped deliberately in front of the truck" (p. 105). His imaginary, including omnipotently murderous whimsies, are offered up like a child in earnest, nescient confession. Or perhaps this is how I imagine Sacks narrating a sentiment where he has lost sense of what is really happening. Scenes of death continue in his memoir, albeit with a black humor that I suspect is at play. As a bench scientist with dreams of success, he is tasked with meticulously dissecting myelin from thousands of earthworms in an attempt to study invertebrate nerve conduction. He also admits incredible fondness for cephalopods, a species without a skeleton that are almost phantom-like in their ability to hang together. And so, his dissection of these species-as-friends is a murderous act he engages for the sake of learning: "I committed a veritable genocide of earthworms in the college garden; thousands of earthworms would be needed to extract a respectable sample of myelin…" (p. 135-136). Sacks systematically articulates his failure in his research efforts gone disastrously wrong, describing how he first loses his written data strapped to his bike, then gets breadcrumbs into one of the centrifuge instruments meant to refine the myelin sample, and finally, loses all his myelin data samples. The discovery of his fantastic successive failures prompts the following directive from his supervisors. "Sacks, you are a menace in the lab. Why don't you go and see patients – you'll do less harm." (pg. 137). In the wake of losing 10 months' worth of meticulously harvested data, he is admonished to the clinical work of patient encounters – as though somehow the work of humanity is less vulnerable and second rate in its non-research focus. And it is this very relegation that acts as an educational pivot in this poignant

scene. Sacks stumbles into the generative effect of loss. Who he is, is narrated by a script where he is protagonist, antagonist, and comic relief. And his story of failure points me to an educational moment that I avoided with all of my heart and soul. That is, my own sense of being a "who" resisting a story of anything less than expert, and perhaps acting as a deadly shroud in understanding the possibility within failure.

Sensing as Knowing

"Self-directed learning" was the pedagogical promise and curse embedded in the model of education adopted by the university I attended for medical school. We were assured that as adults, we could largely determine our own course of medical education vis-à-vis historical experiences and predetermined competencies, in order to meet program requirements. By the time I started medical school, I had also become familiar with a world of employment and professional expectations making it relatively easy for me to speak with patients and to listen for stories, told and untold. Chairs pulled tightly against crammed-in hospital beds, a curtained veil of privacy pretending to seclude, I leaned in to hear past the delirious sounds of the hospital. Dreams and desires were really being spoken about, but it was easier to feign deafness because there were few places for the wishes and the wants of patients to be truly heard unless they serendipitously corresponded to treatment protocols. My leaning towards a kind of "sensing" seemed to be helpful during patient encounters. However, I soon found out, this was not as valuable a skill as I believed it to be.

The "real skills" had to do with human deconstruction, a taxonomized segmenting of the patient into granular symptoms, masticated until they were palatable to the profession, which

translated into a discussion until pathology was located. I recall many bed-side situations, learners like me wearing white coats, trying hard to play the part and yet not knowing our script nor the plot that would take us to the ending, talking about the patient who lay below looking up. The consultant physicians would direct the unfolding drama. Questions were posed to us using terminology vaguely understood but sufficient to register as clear anxiety. Our apportioned answers were unsatisfactory, to my mind, but I found that I couldn't think beyond the encounter. The physicality of our positions around the bed foreclosed on a foreboding architecture that over time would be readily assumed by me - power and authority unquestioned and unchallenged. It registered initially as uncomfortable in its functional inevitability. Over time, I grew accustomed to it as an invisible cloak of confidence, defending against the ineptitude that taunted me.

Pharmakon

Only time would attend to this conflict where language in medicine was like Derrida's (Derrida & Johnson, 1981) *pharmakon* in that it was both my illness and my cure. As training progressed, I sensed a shift in the dynamic of group learning where initial conversations about training backgrounds meant cutting to the chase about who would be legitimate when speaking about "real medicine." In this regard, music was "nice to have" as a resource, but certainly not a "need to have." And so, I had to sound convincing, even if I wasn't. I learned how to leverage language as a way of defending against an identity that I felt I should dislike, yet didn't. I could survive the student competition in the program's pass/fail rubric by creating word aesthetics that sounded plausible in a commonplace vernacular frequently reduced to perfunctory utterances.

It is with this uncertainty that I stumbled into an unspoken, messy business of death that would transform into a kind of moral injury for me. In my senior year of medical training, I was on call on a general internal medicine ward and was paged at around 3am to a patient whose

blood pressure was concerning to the nurse. The fact that the nurse was calling the medical student signalled to me that this was not a critically serious problem. These kinds of calls were given to medical students to think through potential causes prior to the student calling the senior resident to review the case and who could intervene with some level of confidence. While I knew that a falling blood pressure could be a critical event, I reassured myself that an emergency such as this was far more likely to be recognized by the nurses and that the nurse would know what to do. In other words, I tried to convince myself that I would not be needed to respond to a crisis, because if I was called upon, I was convinced I would be unreliable as a resource to myself and others. I spoke briefly to the nurse who indicated that the maximum amount of fluids had already been pumped into the intravenous and now the question remained about what to do next. She added, "It's a bit complicated." I headed in to see the patient and found an enormous, naked, unrecognizable shape on the bed. The patient's kidneys had failed, leaving her incapable of processing body chemistry; the net effect was an exogenous river of fluid finding its way into spaces not usually inhabited by water. Profound swelling engulfed her anatomy leaving her skin literally splitting and weeping. I had seen bloated dead animals on the farm where I grew up and was no stranger to anatomical aberrations, nor to the grotesque. But this caught me off guard in a way that found me grateful for the patient's unconscious state, and therefore unable to register my reaction. Learning the technical term for her condition, "anasarca" offered a sterilized moniker. I called the on-call physician after speaking to the senior resident who had nothing to add, also likely fearful of being chastised as I was. But I was angry at what I perceived to be an injustice to human dignity and wanted to understand the insanity I felt. The on-call physician sounded defeated. "Give her more fluid," he said. I spit out the words, "She's dying." "We haven't been able to reach the family to do anything else," he said. And I hung up the phone to

share the instructions with the nurse. A suffocating sense of futility saturated me. Why couldn't death stitch up her seeping wounds? Better yet, why not spray out her excess in a grand, derisive cascade that rained over the futile wake of fearful confusion? The truth is, I was angry at how thin-skinned the patient was. Her friable dermis made the living barrier between us deeply uncomfortable. The patient's death would have made it much easier for me, creating an end point, instead of insisting on the next step, which was to tolerate a life that had no option other than to weep with iatrogenic tears; tears that were now made from intravenous fluids that I had been a conduit for. This fantasy situated a deep justified anger about an inoculation I had not seen coming but opened to another conflict. I could not authentically wear the sanctimony I had bound myself to because it occurred to me that I had enacted a kind of aggression felt as the limits of another time. I was part of the splitting and the weeping. As a coroner performing an autopsy on myself as a learner, the verdict was unsettling.

Penumbra of Confusion

An anxious logic clearly emerges for me in writing about writing. My thinking was organized not only by anxiety but also by anger toward the patient whose condition, in my mind, had now been conflated with the human who suffered from it. And behind the fear was a deep worry that my presence somehow had an etiological effect in the suffering I saw. These thought processes justified a hostile resentment as a dynamic response to an inert situation that would take captive any meaningful response on my part other than to be in it, not dissimilar to the conditions of the patient lying in front of me. Bion (1970) defines experience as frustration and he thinks of learning as getting to know emotional life. Emotional life has an un-knowable quality to it which must be learned. Bion's term "negative capability" refers an ability to stay with and tolerate the frustrating conditions of uncertainty, a place that has to do with not

reaching for quick solutions but instead getting to know frustration as experience. My desire to escape the learning experience of unknowability was something that I repeatedly attempted in a career oriented towards understanding and answering where this was simply not possible. It is a place of fragility that I would frequently inhabit and return to, and simultaneously want to escape. Helplessness was a costume that was not comfortably worn when the dramatic script called for confidence and expertise. But the reflexivity of the moment, I thought, called for escape from the moment. Bion (1994) sees it otherwise and suggests that experience as a learning construct as about leaning into the challenge of knowing emotional life and remaining present with the penumbra of confusion. Here, quick fixes and easy out's do not mend the learning pain. Instead, learning calls for a steady leaning into the doubtful uncertainty as a way of creating emotional clarity. I sincerely wish I had read Bion before I started medicine.

Turning to Sacks, the subjective observations he offers about his education and the various ways in which he works with the conflicts he encounters very much acts as an exemplar of Bion's (1994) idea of "negative capability." Sacks doesn't really talk about his "education" per se, in that he is not regurgitating knowledge and facts acquired within a clinical or research curricula. Rather he is telling his life story about who he is, in a roundabout manner, often linked to patient cases. His narrative is similar to other medical memoirs that I am reading, in that it is not specifically nor exclusively the classroom encounter that is recalled as education – it is everything that surrounds it making life the classroom he is learning in and worth narrating. Sacks' story is one of changing his mind through forays into attempts at understanding his own emotional life that at first appears to be increasingly inaccessible to him that resonates as a different kind of education. At this point in my reading of Sacks and his postgraduate education, I think I know where Sacks is headed. And then he stops to play.

Refusing to Grow Up (Or Insisting on Play)

In thinking about education, psychoanalyst Deborah Britzman (2009) writes, "It is as if the very thought of education will never let us go beyond what has already happened and so refuses to grow up" (p.1). Although Britzman is speaking to a past that intrudes on the present, she also refers to a period in our lives where intelligibility was made so through play. Seemingly innocuous, childhood play creates historical conditions for our education. But play can also be dangerous, particularly in medicine, where there are many spoken and perhaps more so, unspoken rules. The early days of medical school found me learning about ethics and our responsibility to the public. A lecture hall crammed with young adults, yet-to-be doctors, presumably too naïve or too successful to understand the dangers that would lie within us, listening to material that seemed irrelevant without enough lived history as physicians to situate its seriousness. The topic turned to the issue of personal boundaries. The presenter spoke with a kind of evangelical fervour that made me wonder what had happened in her past to situate such insistence. The lecturer said there was a strong advisement against touching patients outside of the physical exam encounter. This could be considered a violation of trust in a dynamic already marked by inequities of power and position. She continued, that while it may be clear to us what our intent was in touching patients, the risk would manifest in the patient's interpretation. And one more thing, she said, you should not be on a first name basis with your patients. Patients are not your friends. You ought to refer them by their christened or preferred names, however they should not refer to you by your first name without the title of "Dr." to orient everyone to the relationship at hand.

Now looking back, I can put words to the educational dilemma that was unfolding in front of me. I understood the delicate need for awareness, caution, good judgement, and a

commitment to patient safety. However, what was felt at the time of this encounter has become an emotional blueprint guiding a de-facto response within me, rightly or wrongly. The patient, in this teaching encounter, was situated as the wild card, with a not-so-subtle hinting at an unpredictable, dangerous subjectivity at play. While the presenter stopped short of saying this, maybe it didn't need to be said because the emotional register of it had been shouted at us. How then do you help someone who is dangerous to you? I looked to my wickedly clever, wisecracking friend who sat beside me. She was headed into pediatrics. We had both worked with children in our past lives and immediately thought of the countless encounters where kids reach out and touch others and blurt out wildly unpredictable stuff. We had learned through life lessons that they do so instinctively, out of curiosity, out of joy, out of frustration, or out of an unmitigated love and affecting desire that is so powerful to be in the presence of. We started to mutter about the catastrophic situations that we would likely find ourselves in given the professional specialties we were heading into. As medical students, we had held already reached out to hold the quivering hands of fearful children at the very thought of needles. We had leaned into the elderly who gave us grateful hugs, their gestures likely indicating an awareness of our own sense of relief for having survived the encounter. "Harms," she said, "We're fucked. We work with kids who don't follow these kinds of rules. And most of the time, we don't follow these rules either." I retorted something like, "It's like she thinks we'd write the paper 'From first names to fondling in 5 easy steps' until the corrective powers of this lecture could reform us." The intuition that Sacks' teacher had about him "going too far" in his aspirations and desires had now surfaced in my own education, but in a different way. The truth was, I was a bit rattled. How would you know when you and your patient were relationally safe? Did our medical teachers really understand us as responses to unwieldy libidos that would overtake better

judgement? The learning situation I had just encountered spoke to the delusional belief that culture, and particularly medical culture, could be managed such that safety was assured. But how could I know if I had gone too far? I wasn't talking about abuse or egregious aggressions. I was talking about emotional situations present in every relational encounter that were being sterilized for the sake of an academic discussion but did not begin to acknowledge the dangers at play where emotions were present, which incidentally is everywhere.

My pediatrician friend was righter than I could have ever imagined. Kids don't follow the rules that medicine sets out. Early on in my child and adolescent psychiatry career, I had the privilege of working with homeless and street involved youth. I really had no idea what it was like to live on the streets, and so I had to rely on stories told by my patients which would feed my own imaginary. I worked closely with an adolescent youth whose life had been cut to the quick by her mother's fatal drug overdose, poverty, racialization, discrimination, mental illness, and a net effect of feeling as though her very presence was an insult to the space she inhabited. For years, she struggled intensely with dizzying self-harm, repeated suicide attempts, high-risk behaviors, and dangerous drug use to flee from herself. She was typically quiet, soft-spoken, thoughtful, and intensely perceptive. She didn't miss appointments with me, and she also didn't give a shit about what most people had to say. She knew that her life was not like other lives. At the end of one of our last sessions where we had negotiated her "safety" for the next week, she got up to leave and ambled to the door. She turned around and said, "Dr. H, can I tell you something?" "Of course," I said. She hesitated and then said, "You are the closest thing to a mother I have ever had. I love you." I too had come to care deeply about her in a way that I am sure many professionals care about their patients. Did I love her? What I knew of the different kinds of ways that we can love our friends, our community, our earth – the answer was yes. But I

wasn't experienced enough to trust that I was not the only one who had ever held intense emotions for patients without it somehow being wrong; particularly the affective pull for this brittle youth whose life always hung in the balance. And in the vulnerable moment of her confession, the voice of the lecturer screamed in my head, demanding neutrality, an emotional tabula rasa that would respond without reciprocal confessions of love. My position of power and a statement of affect would surely make its intent ugly. I was flattened in this moment and hoped that my pained expression would convey the deep caring I felt for her. However, I think I said something like "You too are deeply loved by many people." Her limp body was found hanging from a park swing set a short time later.

The discursive act of writing about this intensely painful experience provides a kind of retrospective clarity which was not afforded in those conflicted moments. The temporality of coming to this experience is misleading because I am returning to what has already happened and at the time of the event, could not be known by me. In the act of writing, I am attributing emotional experiences to a memory, as opposed to the event itself. The event has passed, but still holds an emotional valence for me that keeps working itself through over time. *Nachträglichkeit* is a term Freud coined to understand temporal, and typically traumatic connections within the psychical workings of the mind, where the recall is imbued with assigned significance and not necessarily preoccupied with the memory itself (Eikhoff, 2006). On the topic of *Nachträglichkeit*, Pitt (2003) says, "Traumatic experience creates a tear in our very capacity to make sense of the event, indeed, to fully experience the event. At the same time, we are drawn to the hole, compelled by some force to worry about it" (p. 96). It is easy to imagine then, my own ripped capacity riddled by dread, fear, emptiness, and hollow despair that followed her death. The enormity of the loss saw my own professional pettiness rear its ugliness, perseverating about

how she should be remembered, who should be present to do so, and what hospital rules applied for those healthcare workers who wanted to attend her funeral. I was spinning ungracefully and it was likely obvious to others that the ends of my professional self were seriously frayed in the wake of her violent departure, relegating me to anemic attempts at understanding what could not be known. In fact, in looking back, it was only ever possible to act before I knew and to experience before I understood. I told myself repeatedly that I had not failed her and that I had done everything humanly possible and that her death would not become a fatal trademark of success (or otherwise) as a child and adolescent psychiatrist. As I lay in my partner's arms, someone who had worked as a teacher in youth corrections for decades and who was no stranger to trauma, he told me, "Not all young people were meant to live." It was a simple statement, which I initially registered as a kind of horrible, raw efficiency about human life that seemed impossible for me to accept. At the same time, his words provided an antidote to the crush of guilt that pressed upon me. The emotional residue following her death acted out a kind of obsessional practice for me that could not tolerate errors. I would rehearse the aspects of her care in my head repeatedly until I had convinced myself that everything had been done. And then I would repeat this very ritual in an attempt to soothe what would not be. I had entered into the tragedy of a tragic profession where the human must die. In my mind, the very thought of errors in situations of care were too literally fatalistic until I could work through and understand the educational forces that refused symbolization of this unthinkable idea.

Implicit in this description of repeating and working through, and perhaps illustrative of it, is this idea that knowledge has its own unconscious life (Felman, 1993) which could only be resisted and negated through a repetitive psychiatric practice of perfection intended to keep pain at bay, and would inevitably re-visit me through break-through, barely tolerable, yet

transformative fragments of before. The well-intentioned rule book offered to me as a medical student relying on a set of ethical commitments intended to create interpersonal boundaries as a practice point of clarity was read as irrelevant in an emotional collision course with another path that would be forged in the time of after. My patient's death was paradoxically an unwelcome beginning where I would find myself encountering a learning constituted by a need for a kind of public evacuation of self under an untenable situation of ethics gone wild. I needed to seek shelter and hide for self-preservation. Sacks too would encounter traumatic collisions in his learning made from the residue of history, simultaneously creating a demand to go underground as a way of tolerating the present and reckoning with the past.

Sex and Medicine

Sacks had playful encounters during his medical training and early career with unlikely friends. His bike, as I said earlier, is symbolically and literally important in his education. It is his earliest companion, his play mate introduced on the very first page of his memoir and featured on the book cover. It is though it has always existed, present in anticipation of his story and ready to take him away from his story as needed. Before there is medicine, there is his motorbike. Sacks describes his bike with an emotional longing so delicate and poignant, the reader wonders what or who he is really writing about. He says, "There is a direct union of oneself with a motorcycle, for it is so geared to one's proprioception, one's movements and postures, that it responds almost like part of one's own body. Bike and rider become a single, indivisible entity." (p. 97). The rider and the ridden are one. Suddenly, play takes on sexual overtones with this deeply intimate description blushing with suggestion, adolescent idealism,

and carnal fascination. But what of this kind of play in his medical education? Or rather, what of these adolescent longings or fantasies in medicine? The reader is caught off guard and feels as though we have stumbled into Sacks' personal diary instead of his memoir about becoming a neurologist. Reading his text closely, I have to wonder what is happening. Is he talking about life or education, sex, and medicine? And can these be thought of as a singular idea?

Later in his book, Sacks refers to a few lines from Thom Gunn's poem 'The Allegory of the Wolf Boy' that plays with the overlap of seeming contradictions:

At tennis and at tea

Upon the gentle lawn, he is not ours

But plays us in a sad duplicity

Sacks writes with an incisive clairvoyance, capturing the heart of the matter by saying "This corresponded to a certain duplicity I felt in myself, which I thought of in part as a need to have different selves for day and night. By day I would be the genial, white-coated Dr. Oliver Sacks, but at nightfall I would exchange my white coat for my motorbike leathers and, anonymous, wolf-life, slip out of the hospital to rove the streets…" (pg. 78). He was 27 at the time and his "coming out" sequestered fractures deep within himself later understood as intense shyness and a sexual orientation not yet comfortable. His admission would have us ask what of the play that is at hand for Sacks? What does his sexuality have to do with medicine? Sacks is working through his own understanding of his sexuality while he is in medicine, and his writing gives us clues into how the limits of medicine also constituted sexual limits for himself. What happens in his writing signals a deep tension between the public and the private which may have been unexpected, but certainly persisted for Sacks. Sacks' writing is courageous in suggesting

that sexual longings are in the medical classroom, perhaps uninvited and awkwardly so, but present, nonetheless. He tells this untold tale, first, by way of another story.

At 40 years of age, Sacks tells us that had an unexpected birthday present. He is groped by a stranger in the water while he is going for a swim. The stranger invites him to have sex and they do. Sacks tells us, "It was just as well that I had no foreknowledge of the future, for after that sweet birthday fling I was to have no sex for the next thirty-five years" (p. 203). Sacks returns to this ingress a second time in his book by recalling a time during an interview for a position at a hospital where he blurts out that he has not had sex for 35 years in response to a question asking for his social insurance number. And he gets more intimate. In another segment of his memoir, Sacks brings us into his bedroom, and permits us to be voyeurs in his intensely detailed description of a particular sexual encounter with a roommate whom he was attracted to. He describes ejaculating while he is giving his roommate a massage, which was responded to with silence and harsh rejection. As Sacks laments about the pain of "going too far," he write how he is reminded that his lover's name are the same as the initials for his mother.

And in this moment, I am almost laughing at the Freudian delight of it all. In what feels like peering over the centerfold of a tabloid publication with Sacks as the model, we get a sneak-peak into Sacks' private life while simultaneously reminding ourselves that we are in medical school and ought not be looking at these images. At least not in medical school. But then he turns the page for us and offers raw images of adolescent homosexual desires come true, replete with titillating details about unrequited sexual love where his mother is symbolically present! The seriousness returns quickly when thinking about the reality for Sacks as a gay, Jewish, British man post World War II. There were reasons to be quietly awkward, particularly in a medical culture venerating a phenotype of males that did not include Sacks. The point is this. There is an

adolescent conflict and ideality that is working itself out through a psychoanalytic narrative of a gay man in a medical closet which is otherwise intended to tell us about his education, his relationship to his education, and his educational contributions as a physician.

What then is the nature of the homosexual closet in medical education? Blechner's (2005) writing about the famous American psychiatrist and psychoanalyst Harry Stack Sullivan gives us some clues. Stack Sullivan primarily practiced psychiatry in the 1920's and 1930's – a time where there were serious personal risks associated with being out, including incarceration. When Blechner reportedly suggested to a senior analyst that Sullivan was gay, assuming that this was an uncontested fact, he was met with defensiveness and challenge. Blechner writes, "It was an example of the fog of distraction, avoidance, and dissociation that has surrounded Sullivan's homosexuality" (p. 1). But what is it about the bedroom antics, now being spoken about in medicine, that can be tolerated only through the fantastical imaginary or a resisting silence on the matter? Why is it that Sullivan and others associated with a gay orientation conjures up anticipatory dread in others when what happens in the bedroom should clearly take a back seat for any physician when the suffering patient is central – even if the suffering has to do with bedroom antics? This very question speaks to the conditions of the closet. It's not like there is an actual closet to look at; that is, a structure that will contain and hide whatever it is that becomes frightening and threatening to other physicians. But there is a body, and the body of the gay physician is what can be located and identified as the unsightly closet contents. Blechner insinuates that the very wondering then about whether or not the physician body participates in homosexual acts is sufficient to render diagnostics such as "schizoid or simply mysterious" (p.2) thereby enacting homophobia now translated within medicine into language of pathology or fantasy. Using this kind of language as a touchstone, medicine is weaponized against the gay

physician whose body now is the site of aberration, inevitably threatening a career viability, or through willful blindness, the gay physician is relegated to a peripheral place. The nature of the medical closet would inadvertently reinforce an intensely oppressive existence for Sullivan as it did for Sacks, leaving him to contend with this deeply problematic conflation of heterosexual fears gone wild.

Blechner (2005) also noted that Sullivan's homosexuality was absolutely essential and integral to innovations in both his clinical and theoretical work. Blechner states, "Because there has been so much anxiety and mystification about his [i.e., Stack Sullivan] homosexuality, the importance of his sexuality to his history has also been obscured" (p. 3-4). The same argument can be made for Sacks but oriented towards reading his life as an educational narrative informed by psychoanalysis. It can be presumed that there is a dizzying confusion at hand for Sacks when playing hide and seek in medicine. He comes out of the closet and then retreats into hidden, unspoken places. But there is no actual game at play. Homosexuality, from the nuanced written accounts of Sacks had no place in medicine forcing a decision algorithm for him in lieu of a risk assessment. What was at stake? What to do? Stack Sullivan reportedly opened a ward exclusively for gay young men diagnosed with Schizophrenia in the 1920's with an astonishing recovery rate that makes it even more unthinkable, recognizing that the timing of his intervention predated the advent of antipsychotic medications (Blechner, 2005). Biological recovery was clearly linked to cultural and interpersonal interventions. An atmosphere was created in Sullivan's ward where descriptions of sexual encounters by staff members were encouraged to reduce any closeted anxiety or stigma. This permission to verbally normalize homosexuality and simultaneously depersonalize the self from the pathological, may have been what Blechner referred to when he described Sullivan as having an uncanny ability to connect with "cut off"

patients, saying, "…when he spoke with schizophrenics, they no longer sounded schizophrenic" (p. 4). Stack Sullivan's brilliance in understanding the poignant and deeply relational interface between health, mental life, and sexuality exceeded his time. Sacks too is talking about sexual exploration and sexual intimacy in his memoir, but something about it feels out of place – like he is telling us awkward secrets about his sexual life that are relegated to the status of "too much information." My gut reaction, otherwise understood as a transference response, signals an opportunity to stop and pause. What is it about Sacks' telling that feels like he has gone too far? It is not the sexual details nor the image of sweaty bodies. Rather, it is the precarious vulnerability of making the gay bedroom a viable classroom in the recall of his medical education. I wonder if Sacks' felt as though the medical closet was a deep professional vice, keeping the hinges on the door of "coming out" as resistant as the voice of medicine in recognizing the systemic oppression inherent in historical attitudinal polarizations insisting on conceptions of sexual orientation as "normal" and "abnormal." My hesitation is read as a sense of dread for Sacks, but not dread about the commonplace experience of sexual encounters turned into the stuff of comedy, pain, or satisfaction. Rather, I dread the inevitable uncertain, paralyzing isolation inherent in attempting to break through the cemented stoicism pervasive in medical discourse that does not lean far from the axis of heteronormative. An education about the healing of a body and mind did not offer this for the homosexual Sacks, just as his own suffering was not noticed, as far as we can tell. This kind of educational experience as an effect of his education is a prescription for the practice of caring he was to encounter. No wonder he gets stuck.

Still, Sacks' writing suggests that he is thinking in Sullivan's protesting footsteps, albeit something is different for Sacks. Sullivan takes charge and builds a ward where he is in control of evoking a normalizing discourse for oppressed patients about being gay. In Sacks'

recollections, he symbolically becomes the patient described in Sullivan's account, in need of a normalizing discourse but where the silent opposition about his sexuality translates as the psychopathologizing homophobia that would form the bricks and mortar propping up the meaning of his medical school education. Sacks' mother who is also a respected physician in his community, says to him after finding out that he is gay, "You are an abomination. I wish you had never been born" (p. 9-10). Blechner's (2005) description of the plight of gay male patients is at the heart of the matter for Sullivan and Sacks. Blechner writes,

> In fact, one important source of his [Sullivan's] understanding of the embeddedness of psychopathology in interpersonal relations was his own experience of his homosexuality. Many a gay man has tried to understand his experience of homosexuality intrapsychically, without reference to how it affects his relations with other people, and how his relations with other people affect his experience of his sexuality. You can scour your oedipal complex and preoedipal relations all you want, but if you don't take account of the fact that other people, shaped by social convention, are condemning you for an essential aspect of your being, you will never get anywhere. Sullivan recognized this. It was the insight behind his ward for gay schizophrenic men (p. 7)

The residue of this impossible situation constituted a relational positioning for Sacks where longing for inclusivity was iteratively returned to in his writing, a perspective that was on the outs. His sexual exclusion would seep into his academic encounters, challenging the idea that sex or sexuality is only for the bedroom. And for Sacks, an important orientation to belonging and being accepted in an academic environment where he was ostracized and unlike most of his colleagues was to identify a space that would allow for deep interrogations into himself as a gay man, writer, and artist working in the field of medicine. Sacks says, " I did have a position. At

the heart of medicine. That's where I am" (p. 222). Recalling Cavarero, he might well have said, "This is *who* I am."

The heart of medicine, as Sacks refers to it, would take him to a community, similar to the one built by Sullivan – a life built upon co-habitation with hospital patients. This educational scenario described by Sacks in his memoir and its resulting questions will be taken up in Chapter 3 entitled "What is Psychiatry for?" Questions about the problem of authority, love, and the body as understood through Sacks' encounters will be taken up as educational dilemmas in the hospital, working through what a hospital education does to the clinician educator.

CHAPTER THREE

What is Psychiatry for?

This chapter starts with the question "What is psychiatry for?" by considering three problems as key to understanding the breakdowns of body of thought and practice in the education of psychiatry: judgment, authority, and relationality. Throughout the chapter, we will iteratively find that judgement is conflated with authority and vice versa pointing to type of rigid confusion when somatically encountering bodies in attempts to know the mind. Set in contrast to this are the relational ways in which confusion is tolerated and worked through. To assess these problems in psychiatry's education, I return to Sacks the neuropsychologist, this time to couple him with Foucault the historian and Arendt the philosopher. Odd bedfellows indeed. Together they bring an ethical turn in psychiatric education that can engage the emotional situation of matricide, which paradoxically offers a way through the messy conceptual collisions and perceived polarities associated with the body in education. It is this lethal imaginary space of maternal elimination which ironically sets the stage for the natality of a psychiatrist educator like me, reliant as I am upon my own female body to question the discourse of a masculine authority. These affecting conditions will serve as the ambit for my interrogation of a "life and death" educational space in my experience of psychiatry.

Masculine Authority and the Psychiatry Phenotype

Where did psychiatric education find its origins? I didn't bother probing this question until the work of this PhD, mostly because I didn't think I would like what I was certain to find. I had gone far enough in my own education to convince myself that I didn't want to know. And perhaps my premature foreclosure on these kinds of curiosities grew out of my childhood in bible belt southern Manitoba where I was iteratively reminded that my own gendered origins

were a sacred act of charity. God apparently did miraculous things in the performance of creation, a beginning marked by constructing my very sex from the ribs of a man. I came from Adam. What came before Adam, as I was taught, was God. Who can argue with that chain of signification? In the Olympics of human life, females are awarded the bronze medal. Shouldn't I just be appreciative that we medaled at all? Somehow this description has always struck me as mildly insulting and didn't quite convey the kind of supernatural, awe-inspiring drama to convince me of a prized provenience. The narrative that positioned me as an afterthought made right by a carcass inspired dreams for me about a different encounter in shaping the body of my genesis.

Moving into a world of academic psychiatry, this nascent desire to become somebody situated an unspoken question deeply relevant to the problems animating psychiatry's education. More specifically, I decided to look into how the human body figured prominently into its narrative. How is the body implicated as the site of a learning encounter in the work of knowing? That is, how is it that we come to think about ways of knowing that will, at times, look like either judgement, or authority, or being dependent on relationship for intelligibility? And what might these valences have to do with the body? I knew that in my case, the unpalatable experience of starting as someone else's ribs, or perhaps more accurately stated, the experience of being judged as such and legitimated through a canonical authority, primed me to probe the historical origins of psychiatry and its relationship to the bodies that would literally embody its practice. From my vantage point, I see medicine acting as its own authority over its physicians and patients alike, but also being acted out by physicians, in part, through their judgements. It should come as no surprise then that this form of institutional introjection where bodies acting as an authority and bodies being acted upon by acts of authority will do so with an assurance of conflict. I begin here

with the question of authority as a problem, particularly as it relates to the practice of psychiatry which registers at first glance, as a navigation of concerns of the mind and less so of the body. My curiosity is therefore directed at the body's emergence as an important site of authority in psychiatry and its import in the practice of the mind.

Foucault is undoubtedly one of the ultimate authorities on the problem of authority, particularly in relationship to the history of psychiatry and its education. In his lecture series, "Psychiatric Power," Foucault (2006) describes the beginning of psychiatric education, or rather an education of the mind, which started as a fantasy about bodily order. This fantasy was articulated by 19th century French psychiatrist François-Emmanuel Fodéré's description of an ideal asylum, which was interestingly romantic in aesthetic but was simultaneously constituted by a set of commitments to the regimented maintenance of psychiatric patients. Foucault writes of this dramatic stage as follows:

> What will take place in this setting? Well, of course, order reigns, the law, and power reigns……an order reigns in the simple sense of a never ending, permanent regulation of time, activities, and actions; an order which surrounds, penetrates, and works on bodies, applies itself to their surfaces, but which equally imprints itself on the nerves… (p. 2).

Foucault suggests that the fabric of the fantasy is "an order, therefore, for which bodies are only surfaces to be penetrated and volumes to be worked on" (p. 2). This type of bodily invasion, not to be mistaken with the healing intent of a surgical incision, is purposed with the installation of calm and order. The paradox at hand is seemingly obvious. Where is repose for the mind when the body is being attacked? This somatic irony is where Foucault begins his overview about the necessary place and penetration of the body in the history of psychiatry and by extension,

provides an incision that opens up a new vantage point to conceptualize the meaning of the body in its education.

What does the body of a psychiatrist look like? As a point of clarification, I am using the term "psychiatrist" but I am really interested in physicians who are relegated to the work of the mind. This could mean physicians in specialties such as psychiatry, neurology, etc. In reading Foucault's (2006) account of the earliest descriptions by Fodéré, there is little question about what type of a body belongs to a psychiatrist. Fodéré, in Foucault, states the following,

> Generally speaking, perhaps one of the first conditions of success in our profession is a fine, that is to say, noble and manly physique; it is especially indispensable for impressing the mad. Dark hair, or hair whitened by age, lively eyes, a proud bearing, limbs and chest announcing strength and health, prominent features, and a strong and expressive voice are the forms that generally have a great effect on individuals who think they are superior to everyone else. The mind undoubtedly regulates the body, but this is not apparent to begin with and external forms are needed to lead the multitude (Fodéré in Foucault, 2006, p. 4).

The description is striking in definitively linking authority to the masculine body, opening to many possible turns and interpretations. At first glance, I have registered that the subject being spoke about is clearly not me. Almost immediately, it feels as though I have opened a can of worms by noting the obvious and in doing so, being unintentionally provocative. I can hear the eye-rolling anti-feminist, conservative, rhetorical, whispering backlash from the medical community as I capture these reflections on paper. It is like a schizophrenic moment that splits my reality, forcing me to defensively write my way out of a confrontational education that has already erased me. In this moment, Freud's id-ego-superego paradigm helps me to

understand, at least in part, what is happening. The anxiety of being erased as a female psychiatrist registers a bit like being buried alive. In this conflict, the ego must negotiate between the id and the superego where the id demands an object of satisfaction – that is, my body as the keeper of my mind. Yet the superego tells me that an idealized self-image must have a mustache and beard (i.e., not me). Education becomes the superego in this scene, enacting a prohibition against the female body.

In registering this awareness, I also recognize that an observation such as this may likely offend those in a medical culture whose requirement to engage a discourse of gender includes an exquisite sensitivity to power threatened and rejected. Coming back to history then, I may generously assume that Fodéré was the product of his time in his proclivity for males to represent psychiatrists and that time has indeed moved us into another space, more forgiving of stereotyping myopias, open to all genders as well as the creativity implicit in diverse perspectives. But relatively recent publications by Hirshbein (2004) and Vinogradav (2017) on the history of women in psychiatry come to the same conclusion that I am arriving at: in principle, female psychiatrists did not exist until they did in the mid to late 20th century. And when women were allowed as psychiatrists, the authors' data points to a psychiatric narrative relegating women to the custodial work of seeing patients and teaching, with limited experience or representation in places of academic advancement, scholarly publications, and leadership which were otherwise normative for males. Education, more broadly speaking, has a penchant for custodial work symptomatic of a troubling cliche. Britzman's (2003) *Practice Makes Practice* highlights the problem of persisting stereotypes in education that foreclose on the important possibilities inherent in discussions of gender and identity. She states, "In the case of women teachers, who are merely seen to carry their 'natural' abilities into the marketplace, they

are apt to be characterized as either martyrs or idiots" (p. 29). Britzman offers a related problematic which situates my experience and says it better than I could or have. She notes, "Stereotypes engender a static and hence repressed notion of identity as something already out there, a stability that can be assumed. Here, identity is expressed as a final destination rather than a place of departure" (p. 29). It is oddly exasperating that in 2021 the question of navigating space for women in medicine has not been rendered an artifact of time past. As with education, the question of gender identity and the premature stereotypes in medicine have mostly silenced a more critical and inclusive discourse that lies in wait. This absence symbolically aligns with Fodéré's description of bodies that represent psychiatry, resonating as a contemporary belonging, suggesting that gender is indeed a burgeoning idea within the profession. In returning to where we started this discussion, that is with Fodéré and an ideal of the male psychiatrist, we are introduced to a figure that will have a permanent arc in psychiatry, first as a hero who will emancipate the psychiatrically unwell from the shackles of the asylum and then later fulfilling the role as the overseer of the asylum, understood in its contemporary form as the hospital administrator. I will return to the hospital administrator as a masculine dynamic and authority that comes to bear on the question of the gendered problem of authoritative bodies in the work and education of psychiatry later on. In the meantime, permit me a quick memory that is triggered as I write about my female body being relegated to spaces that are both permissible and not permissible, suggesting that Fodéré's thinking is in the DNA of academic psychiatry and my education.

As a psychiatry trainee, I knew that I wanted to pursue child and adolescent psychiatry. I didn't veer from this goal from the start of postgraduate training. Throughout my education, I got to know the clinical and academic leaders within child psychiatry (i.e., all men) where I

frequently received positive feedback about my ability to engage with patients and was praised for a mind capable of thinking beyond rigid taxonomies characteristic of Diagnostic and Statistical Manual (DSM) knowledge. I was venerated both as a clinician and as a potential researcher. In my hesitancy to pursue research at the time of training, I indicated to the Academic Head that I was hoping to pursue a masters or PhD after I had completed my residency. His response to me was that I would "never" complete a master's, let alone a PhD after residency. The lure of money and the "demands" on female time would not permit this. He did not outright come out and talk about how my children would need me at home – he didn't need to. Further education was simply not in the cards for me, which by extension, would also silently exclude future academic leadership opportunities. I was later told by the clinical lead that the Academic Head had taken him aside and shared with him an impression about me, describing me as very, very capable. Capable enough, in fact, that if I worked hard enough and did not lose sight of what I was in pursuit of, I may even be successful enough to be a program director for postgraduate training in psychiatry. I can assure you that this suggestion was made by him with neither malice nor sarcasm – that was not his way. While I have no misgivings about the importance of medical education and education leadership, it was the unequivocal foreclosure on the idea that I could only strive to be the "what" of being a woman relegated to the custodial work of medicine and its education that is deeply troubling. "My body" would not be "the body" capable of higher education, therefore excluding me from a competition of bodies that may someday oversee or direct his work[2].

[2] My academic advisor was partially correct in his expectations that I could enter into a career path focusing on medical education leadership. I was the inaugural program director for postgraduate subspecialty training in child and adolescent psychiatry within our academic institution and then went on to be the program director for a large postgraduate training program in psychiatry. It was during this time, that I was offered an opportunity to do PhD work. I also went on to become the second female Associate Chair, Education in our academic department. While the predictions from the academic leader about my potential were true, the limits of capacity suggested for me were intentionally not attended to.

Psychiatric Education and Matricide

Fodéré's text does not leave room for creative imagination about how a woman could fit the bill of what the aggregate body of a psychiatrist is. The masculine imaginary has been announced as the phenotypic prototype of a psychiatrist, necessarily creating a practice of exclusion for women. Where then can I find myself in the question of the problem of authority as it relates to bodies? At least in the creation story of Adam and Eve, my body registered as a skeletal segment that was in fact, an important story line. According to Fodéré, I was extinct before making it to the psychiatry starting block. The irony of this omission is not lost on me, particularly when there was plenty of room to bring the likes of me and my body as a patient to be worked on by men who dominated psychiatry's profession. A woman's gender mattered significantly when an object was required to engage and cohere a psychiatric practice, precisely for men. In attempting to name the larger phenomenology at play, it is a strange realization to stumble into a historical scenario as an academic psychiatrist where my body acted as its own exclusion criteria, without my consent or knowledge. In this scene, something nefarious has surely been attached to my body and by extension, my mind, to make it a somatic space uninhabitable for me to do what I am currently doing in academic psychiatry.

In saying this, I am not sure that a climactic, dramatic, and reparative moment hast ever occurred, declaring Fodéré's rendition of the psychiatrist's body obsolete, ushering in a new world of psychiatrists where all bodies and genders are welcomed. Yet somehow a temporality of before signifies another arc of psychiatric practice where men constituted practice until women were there. It is difficult to really understand the collision course that would see women emerge in this arena and presumably, the imagination is left to fill in the blanks. Perhaps in this

tortuous eventuality, women are conceded to as an eventual artifact of progress, or accepted, or put up with, or relegated to other identities in their appearance as professional counterparts to the original psychiatrists. However, an intensely provocative problem has emerged having to do with my own beginning as a psychiatrist. Where did I come from? Was I an educational child without an educational mother? How was it that my own psychiatric natality was allowed in a history predicated on exclusion? I am struck with the veracities of gestation and birth and motherhood captured within this question, leading to many ways of thinking about the educational question at hand. Was there ever a figure of an educational mother and if so, what happened to her? The question of my psychiatric natality (i.e., coming into the world of psychiatrists as a female) is shaped by a narrative of what was not permitted. A severed umbilical cord emerges in this prenatal discourse, pointing to an excision of a symbolic educational mother. I begin to think about my current body as an effect of psychiatry being dependent on a symbolic reckoning of the past and wonder what a "re-birth" might signal. Arendt's *The Crisis in Education* (1993) stages a conflict between the newly arrived and those already there, describing the problem of natality as an unwelcome newness in a human world wary of it. Arendt writes,

> Basically, we are always educating for a world that is or is becoming out of joint, for this is the basic human situation, in which the world is created by mortal hands to serve mortals for a limited time as home. Because the world is made by mortals, it wears out; and because it continually changes its inhabitants it runs the risk of becoming as mortal as they. To preserve the world against the mortality of its creators and inhabitants, it must be constantly set right anew. (p. 192)

In my experience, philosophers are typically thin on the use of emotive or affecting language. But in the above passage, demonstrative descriptors invite the reader into a shared groaning,

weary from forces denuding an anticipated newness in education. It is unusual language for an unusual perspective that catches me off guard. While Arendt is supporting the notion that we as humans come into the world first to begin and not to die, the problem of education turns this on its head. The human condition, according to Arendt, knows only weariness as an effect of education that is resistant to renewal. And I wonder here if Arendt is saying, we are born into the world to begin but education kills us to protect what is already here. And then perhaps we can get back to the work of beginning. The phenomenon described by her is perhaps why she chose provocative language for the title of her article: a rejection of newness is anathema to the work of education, signifying a crisis indeed. But I want to look past the obvious and take a moment to stay with the following Arendtian quote,

> It is in the very nature of the human condition that each new generation grows into an old world, so that to prepare a new generation for a new world can only mean that one wishes to strike from newcomers hands their own chance at the new. (p. 177)

Arendt is clear about what is at stake. In using the term "strike," a danger is exerted and a kind of potential lethality introduced. Another way of animating the text is to ventriloquize what I think I am hearing, which is: "we will kill your newness to prepare you for a world that only has animus for anything other than what already is." I am reminded of a conversation that I had with a colleague whom I was talking to about the burden of being junior faculty and how its reality was palpable in different parts of the university experience. She shared with me, in hushed tones, a statement made to her by a senior male faculty member which she had never forgotten. "We eat our young in this department" he had said to her. This notion of academic cannibalism reverberates in my thinking about gendered bodies being determined structures of historicity in the discourse of psychiatric education. The mother of all women who would arrive on the scene

of Psychiatry as a psychiatrist, according to Arendt, has been fatally eliminated. Her elimination is a form of educational matricide.

Pitt (2006) tackles the thorny issue of matricide in her essay "Mother Love's Education" by understanding it first as an act, albeit mythical, of the mind which then can be explored through different orientations. Pitt suggests that the idea of matricide can be understood as both cultural commentary and story incorporating Winnicott's notion of object relating as a central theme. In my work with Pitt's ideas, I too offer observations of matricide understood primarily as a cultural object under threat but also touch upon object relating and object usage where the infant's traumatic loss of an object (i.e., the breast) creates relational scenes worth paying attention to in surviving it so as to start again. Here Seidman's trope of "what something is like" re-emerges in my encounters of matricide where I ask, what can the nature of the relationship with the maternal, even when she is absent, show me about my body and my encounter with an education of exclusion?

My first reactions to the idea of matricide can best be described as a petulant state of childlike regression in my somatic registering of rejection and exclusion. The history of losses I have stumbled into – the realization that my body never belonged, specifically as a consequence of matricide, translates into a psychical scene where I find myself shrieking at a host of nameless, faceless male psychiatrists with the accusation, "You killed me!" But this emotional eruption finds its way into a more productive encounter with matricide when returning to Pitt's articulated importance of considering the stark and unsettling concept of matricide, that is the murder of one's mother, as a symbolic act, often interpreted psychoanalytically, where fantasies about her death are no less threatening or dangerous. As a footnote, Pitt suggests that the discussion on matricide is less about settling the score of matricide as a point of feminist debate,

but rather poses the pressing question of why and what remains in the aftermath of this symbolic event. Regarding the importance of symbolism, Pitt writes,

> Symbolization, a process that traverses cycle and external reality as well as thought and fantasy, takes the act of naming the world to a deeper level where one is able to reflect upon one's representations. To put it another way, we use language to represent to ourselves and to others, objects, concepts, and affects. (p. 88)

Pitt's (2003) understanding of the importance of symbolism in its portrayal of matricide as an educational idea is paradoxically generative in its deadly intent. In offering a way to "name the world to a deeper level," she writes past Arendt's conundrum and beautifully builds another set of handrails for me to hang onto, built for and from the stuff of symbolic representation, as I navigate further into the educational depths of Fodéré's bodily exclusion of female psychiatrists. While Pitt's focus is on what it means to bring the mother into different forms of representation, she offers an orientation to matricide which is helpful in thinking about Fodéré's description. Pitt speaks to an exclusion of women from culture and history where "matricide is represented as a trauma of history that inaugurates women's social status as inferior and subject to laws and knowledge made for and by men" (p. 89). In the earliest accounts of psychiatry, Pitt's language could not ring truer. She goes on to state, "The problem of representation of the mother is her absence from representation, and matricide is a means by which her absence is assured" (p. 89).

Pitt later uses the word "erasure" as a fitting metaphor describing the grand matricide that cheated not only a beginning but also a sense of natality for female psychiatrists. The discourse of masculine normalization that has relied on a historical erasure of females has also acted to strengthen the effects of the masculine fantasy which constituted the erasure. This kind of invisibility relegates me to a part of psychiatry which continues to be without recognizable

morphology. Something about the historical account provided by Foucault (2006) threatens me, and my reaction tells me that there is more at stake than the practice of reading a historical text. But a crisis is perhaps the educational point that is trying to make its way to me, reminiscent of Arendt's essay title as I stumble through what is mostly felt, almost inaccessible to language in making meaning. There is no existential crisis at hand. I clearly exist as a female psychiatrist in the here and now, but somehow I have not yet made it to the starting line. My entrance or beginning into the scene is belated and continues to be belated in a practice of academic exclusions. But the idea of beginning as a consequence of ending is precisely what I think Arendt is getting at when it comes to education. It is somehow fitting that the idea of "matricide" is responded to with the language of "natality" – a kind of antiphonal call from the grave of the mother to her innate, generative ability. Educational theorist Natasha Levinson (1997) builds on Arendt's idea of natality by stating,

> The world does not simply precede us but effectively constitutes us as particular kinds of people. The resulting social identities position us in relation to one another, to the past and to the future in particular ways, putting us in a difficult position of being simultaneously heirs to a specific history and new to it. As a result, we experience ourselves as "belated" even though we are newcomers. (p. 437)

Otherwise put, those who are new are already old and those who receive newcomers already hate them and wish for their end. Similarly, the newcomers must hate those that get in their way. This problem registers as a weight that the medical profession carries from having grown out of a practice of exclusion. Here, an opening occurs to both understand an antagonistically inherited non-space signified by a body that is not mine, but also finds a way around the messiness of trying to get into a game where I am not invited to play. Symbolically, Arendt suggests an

antidote to the hostility directed at another's newness, which boils down to being in relationship with one's own newness. Levinson suggests that one can engage acts of "self-creation in relation to the world that preceded us and to which we respond" (p. 439). In other words, I can't change the past by changing a past where I didn't exist. But I, identifying as a woman, can creatively constitute a new kind of relational space for and with myself as a psychiatrist educator. I think Arendt and Levinson are suggesting education as a kind of relational engagement to address the body barrier, which to me means a deep commitment to recognizing and exploring our deep intra and inter subjectivities that would lead us into and beyond contemporary conversations predicated on and paralyzed by gender. Here I return to Pitt's (2006) orientation to matricide relying on object relating and object usage as it become more apparent in its applications. It is through the survival of the destroyed object (i.e., the mother) where the infant (or psychiatrist) can emerge from the rubble of destruction to encounter herself anew, no longer fearing retaliation, but as an independent, autonomous being who is free to create relationships, even with what has been destroyed. In doing so, a new economy of educational relationship is being created which will also figure into a number of Sacks' accounts of his own body in education and its associations with the concept of matricide.

Brains versus Brawn versus Heart

One of the three main problems mentioned in the introduction had to do with authority and judgment in the adjudicating the breakdowns of a body in the work of education. Here I engage the problem of judgement as a form of authority and look at authority as an act of judgement. In a sense, I am using these terms interchangeably although they are quite different in their opening of the problem of the body in psychiatry and in their provocations as it relates to education in psychiatry. In fact, the framing of authority and judgement as a potential

interchangeable concept animates a kind of problematic relationality which is another vicissitude orienting my thinking about the body, which I will speak to in the remainder of this chapter. In any event, I will return to Foucault (2006) here and rely on his observations about physician authority as a gendered idea.

Implied in Fodéré's description of masculine physician authority and his purpose is a relationship of power harkening back to a more primitive time where might was right, and human survival depended on it. Foucault (2006) made note of this kind of militarization of language through images of powerful conflicts between the psychiatrist and the patient. However, in Foucault's scenes of the beginning of psychiatry, or "proto-psychiatry" as he will refer to it, it is not only the body of patient, however big or small, masculine or feminine, that registered as a threat. Rather, a mind presumed to be unwell should be feared, particularly if the owner's mind did not concede to the goliath of supervision that surrounded it. But in Foucault's account of scenes of supervision within the asylum, it is the supervisor's body whose physique paradoxically mattered in corralling the psychiatric patient's wandering mind. This physique again constitutes both inclusion and exclusion criteria for physician bodies that matter. The description of masculinity offered by Fodéré introduces a practice of masculinity that has taken up the matter of brains versus brawn versus heart and has settled its own score. The body of the physician is not intended for therapeutics directed at thought and feeling. Rather, the physician's power is called upon as a necessary act of force to do battle with the dangerous minds of patients whose sickness will relegate them to the status of an unwieldy subordinate. In this scenario, the patient has been set up to "talk back" to the doctor's power with an unwelcome voice however it is the patient's body that will be managed in a silencing act. A psychiatrist's body in this historical account is subjected to and becomes the subject of a physical conflict with the unwell

mind, presenting itself as a warning sign. This morphological signal is also educational in nature. What does the body need to do in the bodily work and relationality of being a mind doctor? Presumably, get bigger.

Sacks (2015) too was aware of this signal, either consciously or unconsciously. In his memoir, Sacks goes to great lengths to tell us about his preoccupation with weightlifting and how it oriented him towards his own mind. Olympic level weights became a point of welcome distraction for him, and his body responded in kind to a heroic call in the need to get larger. He writes with admiration about an Olympic weightlifter whom he is training with. Sacks says, "He had enormous thighs and was a world-class squatter. I admired his squatting ability, and I too wanted to develop such thighs" (p. 99). Later, it will become clear to Saks that there is a link in his mind between succeeding physically and succeeding as an academic physician. Sacks writes about the reasons behind his frenzied, maniacal efforts in weightlifting, almost as a footnoted afterthought. In what reads as a guilty admission, Sacks states,

> I sometimes wonder why I pushed myself so relentlessly in weightlifting. My motive, I think, was not an uncommon one; I was not the ninety-eight-pound weakling of bodybuilding advertisements, but I was timid, diffident, insecure, submissive. I became strong – very strong – with all my weightlifting but found that this did nothing for my character, which remained exactly the same. (p. 122)

Prior to this, he acknowledges that to set a record in powerlifting, which he did, was the equivalent "to publishing a scientific paper or a book in academia" (p. 101). Something prized is associated with a herculean strength that Sacks was alive to. His reflections point to a kind of internal chastising where I could imagine him saying to himself, "Sacks, man up and brace yourself." In other words, the real work of a physician at the start of psychiatry is to literally,

man up. An educational curriculum in psychiatry is therefore made of testosterone and dumbbells.

But for Sacks, this strategy failed. Sort of. Sacks laments his degenerating body while in hospital recovering from extensive weight-lifting injuries. He is visited by a powerlifting hero and friend who hobbles into Sacks' hospital room. Sacks says, "We looked at each other, our bodies half-destroyed by lifting" (p. 122). And yet prior to this depiction, Sacks talks about using his body and his strength in acts of healing; a description that would otherwise be assumed in Fodéré's account, although falls short as a therapeutic function in the zeitgeist of psychiatric historicity. In between his internship and residency at UCLA, at the height of his weightlifting efforts, Sacks goes back to England and visits his parents whom he had not seen for 2 years. He writes of the delicate precariousness of carrying his mother up and down the steep, rickety stairs in their England home after she fractures her hip:

> Our winding staircase, with worn carpet and sometimes loose stair rods, was not safe for someone on crutches, so I carried her up and down as she needed – she had been against my heavy lifting, but now she was glad of my strength…. (p. 101-102).

The image of his behemoth of a body in the reverse role of mother, converges on another idea of what the physician's body can do and is for. It is this moment that is cause for pause as I return to the idea of authority and matricide here. Sacks' account acts as a hinge for my thinking. He is obviously using the strength and size of his body, similar to the descriptions by Fodere. But Sacks' use of his body is more than his brute physicality. The aesthetic in his description points to a beautiful and tender emotional logic at play, taking us out of his body and into his mind, while not leaving his heart behind. Sacks' use of his body here can be read as a physical enactment of natality, affectively engaged such that there is a newness in the letting go or a

moving beyond the confines of a masculine male whose body is used only as an act of strength to enforce authoritative judgements. At the same time natality is acting as a kind of embodiment for Sacks, he also somatically embodies negative capability in his ability to hold the uncertainty symbolically represented in the frailty that is his mother. He is using his body as a placeholder for uncertainty and the pain associated with clutching at what cannot be grasped and in doing so, Sacks brings us to the idea of embodied uncertainty as a generative place of possibility. The act of carrying simultaneously acts as a conceptual hinge for us in thinking about the embodied intersectionality of natality and negative capability, particularly in relationship to matricide as an authority, but also alerting us to the kind of personal dance that Sacks is showing us.

There are two orientations that are notable for me; first matricide as it applies to Sacks' mother and second, matricide as an experience for Sacks. On the one hand, there is a clear symbolic vulnerability for Sacks' mother whose body is being portrayed as frail and dangerously lifeless in this text where only his body is animated. Whether he is carrying her to life or death as he traverses the rickety steps is unknown to him at the time. However, his writing here, on the one hand, feels like a harbinger for her death where he is carrying the one who gave him life symbolically to this place beyond life. Perhaps a more generative orientation in this scene is thinking about matricide as an orientation to understand Sacks body. Here he discovers the use of his large, muscular body as not only male but also as not male. It is interesting to read how his description of himself in physical relationship with his mother brings him to a body or a feminine embodiment that is more of a home for him. He is cradling his mother in this tender scene, like a mother would cradle a child, in an act of giving life. The scene can be thought of as Sacks carrying her to give her life, bringing to the fore the notion that what the mother's body is for is anathema to what is going on in the hospital. In other words, physicality is used as a container

for caring as opposed to corralling. We see this in the following additional examples where he uses his strength as another kind of body, quite literally, within his role as physician. One scenario is a neurological crisis due to intracerebral pressure, where a patient's brain stem is pushed into the opening at the base of the skull; an opening never intended to be a conduit for the passage of backwards flow of brain matter into the spinal column. Sacks says, "…with the speed of reflex I grabbed our patient and held him upside down; his cerebellar tonsils and brain stem went back into the skull, and I felt I had snatched him from the very jaws of death" (p. 121). His physical strength also appears in another scenario where he is working with a young woman on the ward who was both blind and paralyzed. She was in a palliative state, waiting to die. She finds out that Sacks has a motorbike and tells him that her dying wish is to go on a ride with him. Sacks writes,

> I came to the hospital one Sunday with three weightlifting buddies, and we managed to abduct the patient and lash her securely to me on the back of the bike. I set out slowly and gave her the ride … she desired. There was outrage when I got back, and I thought I would be fired on the spot. But my colleagues – and the patient – spoke up for me, and I was strongly cautioned but not dismissed. (p. 122)

Here, the body acting as an authority again suggests a symbolic feminine relationality that is both maternal and mythical in her strength to carry not only herself but others. The work of carrying and being carried signals a different positioning of bodies bringing to the fore the image of the mother and child holding tight, one to another. It is interesting too, to note the dynamic movement in each of these scenarios shared by Sacks, movement that is both emancipating and medicinal. In free associating with these images, there is clearly a sense that he carries a kind of vulnerability that will not be sustained. But in the act of carrying, one gets the

sense that he is cradling the potential that is life itself – an homage to natality that is also simultaneously introduced. These images are in stark contrast to the one-dimensional, static images offered by Fodéré.

I too have used my female body as a psychiatrist, albeit not in dramatic ways described by Sacks, but in maternal ways rendered in Sacks' images. I was recently on-call and was phoned by the nurse-in-charge about a homeless adolescent who was wanting to leave the emergency department. The patient had been to the hospital many times before and it had repeatedly been a traumatizing experience for her. She wanted to leave and at the same time had nowhere to go. It was close to midnight when I got the call from the nurse, keen to demonstrate his knowledge about the mental health act. He wanted me to know that the patient stated an intention to leave and that he had an ethical obligation to tell her what her various options were, including going to a shelter, being discharged to the street, calling family members who had dropped her off at the emergency department stating that she was not welcome in their home, or calling in the on-call doctor to place her on a form insisting on a short hospital stay because of safety concerns, etc. To me, all of the options presented did not sound like options at all.

I found myself frustrated with the ineptitude or willful obstruction on the part of the nurse in managing a common problem in this setting with a relatively common solution. Of course, teens wanted to leave the hospital. This was to be expected. They need to be listened to and engaged to understand the resistance. A conversation is what it boiled down to. I got out of my pajamas and dressed myself with an angry invigoration wanting to believe that this was a human situation with a humane solution as opposed to a mental health crisis requiring psychiatric legislation. When I arrived at the hospital, it was well past 1am. I asked the patient permission to enter into her room. She told me that she wanted to leave but sounded deflated and lackluster in

her sense of urgency. I relayed an appreciation of her desire to be elsewhere and asked her what the hospital surroundings felt like for her. She told me of being in the hospital before, being bored, being locked in her room, being afraid that she would never see her pet lizard who was the only living being that gave her comfort at bedtime. I clued in. Tell me about your lizard. How does your lizard help you at bedtime? What does it feel like to have your lizard with you at bedtime? He tucks me in, she said. He cuddles in beside my head. He tells me I am ok.

Although I find the thought of a reptile beside my own head entirely repulsive, the youth had brilliantly conveyed to me what she needed, and I thanked her for having a lizard who was clever enough to instruct the doctor in finding good enough options for her. I offered to get her some warm blankets, a snack, a flashlight, and possibly an object that reminded her of her lizard. She agreed and told me that she was willing to stay for the night, and then added a half-hearted proviso saying that her conditions were contingent on going home the next day. When I came back with my doctor's bag full of every-day items, she looked at me with fearful eyes, dull, yet with a penetrating longing that I couldn't quite explain. I returned to conversations about her lizard and asked if she would like to be tucked in, like her lizard would do for her. A slow reassurance registered on her face and she said yes. I was instantly uncomfortable in that moment, realizing that I had potentially offered a response beyond an acceptable boundary, not quite sure how she would want to be tucked in. What if the need was too great? How would I be asked to use my body? She knew better than I did and told me it was only her feet that needed the blankets tucked around them. This is what her lizard would do.

This act of bedtime ritual therapeutics never anticipated as a relational point of adolescent clinical care, and never spoken about in medical training, I do with my body. I am not like Sacks but simultaneously acting similarly on behalf of medicine. No acts of neurological greatness, no

heroic granting of last wishes; rather, a simple attending to what a lizard would have done. In this scene, I wonder if the authority attached to my physician status moved closer to the effects of newness where my judgement in consultation with a youth instructed by her lizard, was subjected to a gestational period, deeply informed precisely by the intersubjectivity that was taking place, delivering a new kind of relational authority which proved to be educationally and clinically generative. This will also be a recurring theme as I move through my education.

Hospital People

For many physicians, bringing our own bodies and minds to a patient encounter where a shared reality of suffering is engaged and its repose is collectively undertaken evokes a kind of aesthetic that is both dynamic and redolent. This speaks to the notion that I introduced at the beginning of the chapter having to do with using relationality to understand the body and its authoritative applications in psychiatry. In direct contrast, is the image offered by Fodéré where the issue is one of a bodily mechanistic; a static presence that signals a kind of placeholder until something else happens in a series of foregone conclusions. Patients are to be affected upon and led away from themselves. In this space around Fodéré's psychiatrist, a type of relational deficiency is suggested, leaving an industrial taste in the reader's mouth. In contrast, Sacks' writing highlights a kind of deep relationality that he experiences with patients and as well as discovering an embedded reciprocity with them. He begins these descriptions by writing,

> As soon as I started clinical work in October 1966, I felt better. I found my patients fascinating, and I cared for them. I started to taste my own clinical and therapeutic powers and, above all, the sense of autonomy and responsibility which I had been denied when I was still a resident in training. (p. 146)

His act of caring and engagement would repeatedly render ire from the hospital administrators to whom he reported. The scene where Sacks responds to a patient's dying wish for a motorcycle ride and almost loses his job imprints a kind of map that will unconsciously steer him away from the constraints imposed by his experience of administrative tensions which can be translated into contemporary realities in medicine consisting of best practices, quality control, and accountability measures. There is a clear sense of duality that emerges for Sacks throughout his memoir as it relates to the medical arena: there are hospital people, many of whom are also physicians, and then there is everyone else. In highlighting this binary, I am trying to lay bare the challenge at hand. Specifically, what is it about the historical positioning of bodies within the hospital (i.e., asylum) that renders an intelligibility in contemporary education for my own body as a female physician interested in working with questions of the mind?

I keep Sacks close to me as I delve into this question of meaning. I read his story as my own to open the idea of how past renderings of the psychiatrist as a function of the asylum may not be as rarified as I thought. Sacks provides many examples about his encounters with hospital administration that position him in particular ways, opening to new dynamics that speak to an oblique educational valence shaping Sacks' practice. In his first outpatient clinical experience as a consulting neurologist for a migraine clinic, he describes deep clinical engagement with patients, which capture both his intellect and his imagination. He is singled out by the clinical head of the migraine clinic, who likely saw Sacks' potential and wanted to be in a mentoring role for him. But the mentee outsmarted the mentor, literally and symbolically, when Sacks wrote a book on migraines which was subsequently plagiarized by his boss. Sacks was threatened to stay away from any more academic writing pursuits and was eventually fired for his success. For Sacks, his caring was simultaneously an academic pursuit, but over time became an act of

profound resistance to the administrative structure around him, which ironically had academic ties. He continues to set up scenes that he will encounter with various hospital people where we find him at odds with an infrastructure that is intended to promote his caring.

In late 1960's, Sacks begins independent clinical practice at Beth Abraham, a 500-bed chronic care facility where he rehearses the role of a patient, living amongst those he was responsible for. It is important to be cognizant of the fact that this hospital would most likely have looked like an asylum setting for many of these patients, prior to de-institutionalization which occurred in the early 1970's. Sacks famously becomes interested in a group of individuals with post-encephalopathic symptoms rendering them chronically locked into frozen, parkinsonian states. He attends to the patients with a kind of careful consideration and intellectual granularity that was and is, uncommon in chronic care settings where longstanding clinical problems are frequently managed with the passing of time. These patients would be the inspiration for Sacks' investigative research, leading to the dramatic events of recovery and "awakening" – eventually making its way into the Hollywood movie "Awakenings" featuring the late actor, Robin Williams. In this setting, he curates his own medical exclusion and finds a home where he negotiates living accommodations on the hospital grounds and welcomes the nurses, therapists, custodians, and patients, many of whom were his friends. I am sure that most, if not all of the staff at Beth Abraham liked the idea of having access to the physician scientist amidst them, particularly because his choice to live alongside their work would have signaled a different kind of physician investment and would have marked a practice of non-conformity. It must have been strange, and almost dangerous for Sacks, on some level, to arrive at the place where he could deeply engage with patients, having been castigated for his caring in the past. On the other hand, it may have been the only place where he felt as though he was protected from

hospital administrators: those that had both criticized and threatened his practice. While Sacks camouflaged himself in patient care on patient grounds, he may have relied upon a prediction that hospital administrators would leave him alone as they had done so historically with patients, instead relying on supervision at a distance

Sacks had conflicted relationships with many hospital administrators, primarily over his clinical engagement with patients. But his philosophy about education would prime us to understand the impending skirmishes that would iteratively occur with hospital people. He writes,

> At one point, the neurology department asked me to test and grade my students. I submitted the requisite form, giving all of them A's. My chairman was indignant. "How can they all be A's?" he asked. "Is this some kind of joke?" I said , no, it wasn't a joke, but the more I got to know each student, the more he seemed to me distinctive. My A was not some attempt to affirm a spurious equality but rather an acknowledgement of the uniqueness of each student. I felt that a student could not be reduced to a number or a test, any more than a patient could. (p. 181)

Sacks' retort to his administrator would have us know that the disagreements he experienced went well beyond differences of clinical opinion, offering an expanded argument inciting a compromised fantasy of physician bodies that most were likely not prepared to acknowledge. Recall Fodéré's attributes of a physician – a big scary body, described with almost militaristic qualities in his ability to block the exit door when patients would be unruly. Sacks' positioning of his body in very maternal ways defied this call to arms. He provides numerous examples of encounters with hospital people where a litany of his "aggressions" have been directed at him. On one occasion during a strike at Beth Abraham where patients were left without routine care,

Sacks would call on his medical students and organize a round-the-clock response for immobilized patients who required turning, toileting, or physiotherapy. He willingly moved past the picket line to act as nurse, therapist, janitor, and physician. At the end of the 10-day strike, he finds his car window smashed, with a note stating that he is both loved and that he was a strike-breaker.

During his time at Beth Abraham, Sacks is also chastised for his academic publications, findings which were met with castigation and hostility from physicians affronted at the suggestion of success solely observed by Sacks but not otherwise witnessed by them. Sacks writes, "I had cast doubt on predictability itself" (p. 178) as one explanation for the academic aggression and animosity that he chronically experienced. After 3 years of intense service at Beth Abraham, he returns from a trip to England to find that an administrator has evicted him from his hospital grounds apartment because the administrator's mother was unwell and required housing. When attempting to defend the arrangement made with him to remain in the apartment, particularly to maintain close contact with his patients, Sacks writes, "My answer irked the director, who said that because I was questioning his authority, I could leave the apartment *and* the hospital" (p. 191-192). In the wake of his dismissal from Beth Abraham, he is offered a job at Bronx State hospital on Ward 23, caring for adolescents with Autism, Schizophrenia, and Intellectual Delays. When he is given permission to take out a young, non-verbal, autistic, chronically institutionalized young man, and returns with reports that the outing had been successful despite staff predictions of disastrous outcomes, Sacks described staff as resentful. He writes, staff "seemed furious at our description of Steve's good behavior and obvious happiness in the garden and his uttering his first word. We were greeted with black looks" (p. 212). Sacks is then accused of undermining a successful behavioral modification program by

offering opportunities for play as a distraction from the conditioned framework that would otherwise guide therapeutics. Sacks notes, “I replied, defending the importance of play and criticizing the reward-punishment model. I said I thought this constituted a monstrous abuse of the patients in the name of science and sometimes smacked of sadism” (p. 212-213). On the heels of this encounter, he is accused of sexually abusing young patients. This profoundly destructive encounter with his colleagues demanded an affecting price for Sacks that most cannot appreciate. On the heels Sacks’ poignant descriptions of being antagonistically oriented – ironically not towards invasive illness species - but rather with people who represent places of healing, I turn to my own personal interpretations of what it is like to be in relationship with representations of authority.

The Suffering Physician

I too had dark moments within the confines of the hospital and with hospital people. Many of them continue to be painful memories that are best tucked away, for now. Some experiences had to do with my clinical errors being discovered and finding no gentle place to heed them, despite the rhetoric of quality improvement proselytizing blame avoidance in hospital settings. Others had to do with challenging calcified pedagogies or advocating for medical learners who, in my mind, were at the behest of a big, indifferent machine relying on their service and simultaneously paying little attention to the meaning of an education of service. Other examples had to do with speaking up for patients in the psychiatric system that would commonly aggress against them. While I use the term “hospital people,” perhaps too loosely, I am not speaking of particular or specific people, per se, but rather representatives of the effects of a failed system that can’t reliably be counted on or is often anaphylactic to the suggestion of transformative correction. The examples described above are far more normative than they are

outliers in my experience. It tires me to think about narrating the all-too-common conflicts which primarily center about the task of trying to bridge the deeply human with the residue of the asylum. Neither of these partners, that is, the human and the asylum, are particularly well suited for each other. Sacks seems to have the stomach for it, likely because he course corrected early on and did not orient his clinical compass to that of being an institutional or historical body. He had patients and writing as a distracting aesthetic, a life-preserving reprieve. It is the "hospital people" moments that instantly drain any reserve of creativity or life for me, and so I have learned that they are best avoided, as Sacks also did, despite a blundering insistence on being reckoned with.

I am quite sure the hospital people did not know what to make of Sacks, and perhaps in fairness, Sacks was also confused about what was really happening in his altercations with them. What has become clearer to me in studying these encounters described by Sacks is the utility of drawing upon a psychoanalytic interpretation of how the hospital and its people function. Otherwise said, the hospital (and its representatives) is often a defense against the suffering that is apparent, suffering that ranges in its own expressions and articulations. It can act as a giant place for denial and does so with an admirable efficiency such that repudiation is kept far at bay. Coming back to the notion of matricide, we can also see that the efficiency of the hospital as a mechanism of male supervision and authority which also offers an efficient defense against thinking about women. It enacts the very historical conditions that create a cultural space of forgetfulness about the symbolic mother.

In turning again to the idea of hospital culture, the physician, conceptualized as a casualty of this paragon, is only recently beginning to be recognized, albeit through the lens or discourse of physician burnout, stress, and inducements for individual resilience. I am talking about

something related to burnout but different; something more penetrating and riskier in its affecting depths of self-other relationality prone to residing in the wild places of the unconscious or the concealed. I am reminded of a recent physician suicide widely reported in the COVID-19 context. Dr. Lorna Breen was the head of an emergency department in New York during the pandemic. She was the posterchild for perennial success and achievement in medicine. She was also heralded as a physician who was compassionate and deeply committed to her patients. The predictability and control that would render her leadership successful was all but obliterated in the pandemic. After a brief hospitalization for depression, she killed herself. In a New York Times article (Knoll, Watkins, & Rothfeld; 2020), the following quote is offered,

> If Dr. Breen is lionized along with the legions of other health care workers who gave so much – may be too much - of themselves, then her shattered family also wants her to be saluted for exposing something more difficult to acknowledge: the culture within the medical community that makes suffering easy to overlook or hide; the trauma that doctors comfortably diagnose, but are reluctant to personally reveal, for fear of ruining their careers. (Knoll, Watkins, & Rothfeld, 2020, para. 92)

The devastation in this testimony forms a kind emotional rubble from a prohibition to speak past the message that physicians are not to speak about themselves. I hear the advice of my PhD supervisor in my mind. She often says to me, "Write in first-person narrative. Stay close to the texts you encounter when you write back." Yet, my instinct is to distance myself from my own mind, my own body, my own education, and to write around these experiences with the option to meander into an obscurity where my own subjectivity has the option of getting lost and never returning. This wasn't always the case for me. Medicine cemented a kind of self-sterilization, where intimate subjectivity would not be permitted in writing and would also be intuitively

difficult to negotiate in the adjunctive discourse of myself in clinical encounters, in the work of the hospital, or even in medical education. It is clear that something about writing in first person is an irritation, or even ominous for me although it has been difficult to diagnose. Or perhaps this is less of a diagnostic dilemma, and more denial. What is clear is that I don't want to see my own suffering as a physician. I don't want the mirror of Dr. Breen's story held up in front of me to reflect a disease chronicity with an insidious lethality that could be my own, even if it is only relegated to the metaphorical. Why my resistance to the mirror? Ironically, as a psychiatrist who is trained in the working and healing of the mind, I have a fragile uncertainty about my own mind being broken or lost. I don't have the knowledge or the skills to do advanced resuscitation for my psyche if it shatters. This dilemma registers as the tragic impossibility of Humpty Dumpty; once he falls apart, the putting back together again is a fantasy. And this fantasy brings us back to the beginning of Foucault's lectures about psychiatry, where we find the resisting conflicts in the form of bodies denied and also relied upon. Perhaps the question of the psychiatrist's body and its relationship to the body of the patient is the true stronghold of psychiatry, palpable in the beginning, distracting us from our minds and the work of minding our patients' psychical realities. Here the fantasy forecloses on the capacity to imagine, or more specifically engage an imagination of an embodied mind having the fortitude to go beyond its somatic confines, instead leading us in a direction having to do with militant beliefs about controlling bodies through patient supervision. And this very space is where the authority of the body constitutes a culture equally susceptible to its own illness.

Scenes of Supervision: Relationality or Reason?

Foucault's (2006) lectures on psychiatric power help me understand byzantine world of contemporary psychiatric practice and the ways its practice denies its order. He architecturally

locates the space of the psychiatric ward, its people, and its hospital function with compelling descriptions. I recall being a new graduate when my clinical boss approached me. He had plans to open the biggest child and adolescent inpatient ward in the country in our very own academic hospital. At the time, I was really quite naïve about the politics at play, and the subsequent resources involved with the development and delivery of hospital services. My preoccupation at the time had to do with a clinical understanding informed by training, which interestingly had not included an inpatient experience in child and adolescent psychiatry. I suppose I thought that the training experience I had undergone intentionally omitted inpatient services as a philosophical and moral imperative. Why create a place, such as a locked hospital unit, where young people could enter and be adversely affected by the act of entering? Any door opening to this psychiatric service constituted an agenda about child and youth mental health counter to what was empirically preferred – at least so I thought. I couldn't have been more wrong. Use of language with phrases such as early intervention, avoiding stigmatization, patient-centered care, eschewing institutionalization, community-based engagements, became a "blah, blah, blah" type of rhetoric that I understood was at play. I recall saying to my boss, alive with indignation at the event at hand, "How can we do this? How can we open a psychiatric ward for children and youth? This is iatrogenics at work!" I had learned the word "iatrogenics[3]" in training and found its relevance to be more widespread than I could have imagined. If we build it, they will come, and if they're not sick when they arrive, they will be sick when they leave. And what do we

[3] As I understand the term, iatrogenics refers to an illness that is acquired within the hospital through common hospital processes, such as providing medical treatment. A frequently cited example is a hospital acquired infection. But there are other ways in which undergoing hospital care makes people unwell. For example, it is common for older adults to develop functional decline or experience deconditioning due to the limited opportunities for movement while on hospital wards. In the situation that I refer to above, I am speaking about the natural sick roles the hospital constitutes in its power to suggest illness when illness may not have existed prior to the role ascription.

know about the kind of cure needed for a sickness that we, as hospital people, are responsible for?

I was dumbstruck with the undoing at hand. I was perhaps more stunned to find this written segment by Foucault, describing my observations, but 200 years earlier:

> Psychiatry says, more of less: "let your mad little children come to me," or, "you're never too young to be mad," or, "don't wait for the age of majority or adulthood to be mad." And all of this is translated into the institutions of supervision, detection, training, and child therapy that you see developing at the end of the nineteenth century. (p.125)

The ward did get built and was subsequently opened with fanfare and photo opportunities for politicians and hospital administrators alike. I needed a job and this was the only one being offered at the time. I therefore became one of the inaugural child and adolescent psychiatrists working on the largest inpatient child and adolescent psychiatry ward in Canada. The opening and subsequent occupying of space was fascinating, mostly because the common discourse by most was discursively anchored to questions of surveillance. Where would the "care desk" be positioned to have optimal vision? Where would the cameras be? How could we use the space to ensure that children and youth were always monitored and never out of sight? What kind of observation levels would allow for the closest proximity to close proximity at all times? And while I am not critical of the need for observation, I am noting a kind of perseveration about it as a clinical idea that has philosophical and educational implications.

One of the more recent forms of supervision I have noticed on the ward is a kind of absence. That is, isolation. It is a technique used when youth who are observed to have "secondary gain" from the hospital social milieu and presumably lose sight of their own therapeutic work. Otherwise said, they are having too good of a time and are thought to

demonstrate too little improvement as a result of too many communal distractions on the ward. These youth who are therapeutically assigned to "independent work" frequently struggle with deliberate self-harm in the form of cutting themselves and experience intense chronic suicidal ideation, often in response to the disorienting emotional distress associated with rejection or perceived abandonment. Although one would be hard-pressed to find what I am about to say written into a policy or treatment protocol, what happens in practice would suggest that this symptom constellation (i.e., fear of abandonment, impulsive acts of deliberate self-harm, etc.) becomes the clinical "pertinent positive" sign signaling the "isolation as treatment" I speak of. Ironically, the hospital acts in accordance or in lieu of their super-ego. These youth also often feel like they are the family blemish not worthy of treatment and so the isolation, in some ways, is a fitting, unconscious manifestation of their own self-loathing.

But the institutional reach of isolation goes beyond the confines of the youth. The intentional act of inciting of pain through countless cuts to the body as a way of paradoxically diverting emotional distress into what is felt to be a deserving physical punishment is understandably difficult for any parent to accept or manage. The down-stream effects create a self-esteem graveyard for parents who, in their angry helplessness, watch a kind of novel, juvenile self-destruction that is mind boggling to be in the presence of. They too are in a kind of isolation where by virtue of having their child or youth taken away from them and placed into a hospital precisely because of the self-harm, it is either explicitly or implicitly understood as the job of the ward to fix this wild display of developmental senselessness, before a successful return to the family system. But the teens have minds that are often far more resistant to being convinced of their cure than the hospital people or the hospital systems can handle. It is nearly impossible to cajole youth into saying that they are no longer suicidal and no longer cutting – a

sign of safety that would allow the hospital to discharge them into the care of anxious parents already convinced of impending failure in keeping their child safe. In other words, it is nearly impossible to achieve a cure. But recently while on call, I overheard a Child and Youth Worker talking about putting a patient I had just admitted on to the ward on "Phase 1." I was unfamiliar with this term and asked about it. It meant that any youth who presented with the symptoms I have described above were kept in their rooms, given paper handouts to inspire emotional skill development with the intention of getting the youth to commit to life and also committing to therapy. It this situation, the supervision scheme of isolation is very compelling in its cure. No big forbidding body is needed to stand over the youth to scare them into curative behaviors. The youth will be tactically situated to orchestrate their own escape through admissions of cure or betterment. The isolation is more intolerable than the sickness.

On a side note, for many youths, we were right for the wrong reasons to build the inpatient ward. From their perspective, at least as it has been relayed to me in post-discharge interviews, the hospital stay has been an opportunity to see others like them in an otherwise lonely experience. They echoed Barbara Taylor's (2015) experience of a psychiatric asylum in her memoir, "The Last Asylum" – a place she found deeply containing and orienting in an otherwise chaotic world what would predictably incite a chronic unravelling for her. The closing of the institution was distressing to her and led to an intellectual protest in the form of her memoirs. In the same way, many of these youth rely on hospital walls and locked ward doors to insulate against an exteriority that is experienced as exclusionary and hostile. My patients have repeatedly told me that their memoirs from the inpatient unit have been etched into the undersides of their hospital beds and into the wall paint of the hospital unit. Somehow an

unanticipated and unconventional womb had emerged for the youth to heal each other, good enough in its structural nurturing conditions, but not recognized as such.

These contemporary observations have an eeriness about them when returning to Foucault and his lectures on psychiatric power. In his first five lectures, Foucault (2006) dedicates efforts to describe a kind of psychiatric historicity contextualizing his later work which will define the formation of a psychiatric subject. In his retrospective, he begins with a penetrating analysis of the origins of the psychiatric asylum and the practices that were effects of the asylum, simultaneously serving as a prototype of psychiatry, or "proto-psychiatry." In this progenitor to the practice of psychiatry as we know it today, the asylum (or psychiatric ward) is a central space. Foucault draws heavily on the writings of 19th century psychiatrist Esquirol and re-asks the question that he believes Esquirol is posing, which is, "what is it in the hospital that cures?" (p. 101). Foucault answers,

> In the hospital, it is the hospital itself that cures. That is to say, the architectural arrangement itself, the organization of space, the way individuals are distributed in this space, the way they move around it, they way one looks or is look at within it, all has the therapeutic value in itself. In the psychiatry of this period, the hospital is the curing machine. (p. 101)

How is it that the hospital manages to cure? Foucault (2006) offers an interesting interpretation that acts as the photographic negative to my own description of the hospital. In Foucault's proto-psychiatry, he narrates scenes of supervision where psychiatric patients can be observed at all times, and where the psychiatrist is almost paradoxically absent. In the asylum, it is the psychiatrist who will supervise the wardens (i.e., managers), who supervises the nurses, who instruct the janitors, who all have a role in supervising the patient. It is a tidy, hierarchical

system that no longer directly relies on the psychiatrist; the supervision itself has replaced the psychiatrist and signifies his presence and authority. Foucault says that the hospital can cure because it can function as a "panoptic apparatus" (p. 102). It intuitively sees everything at all times through permanent visibility, central supervision, and the principle of isolation.

There are many educational dilemmas within this scene, but the one that is compelling to me has to do with the clear mismatch or conflation of foci. What can observations about the body tell us about the mind? Without intending to get stuck in rhetorical queries, the very basis of psychiatric knowledge is put into question in these scenes of supervision. A problematic of relationality between subject and cure is at hand when the psychiatrist believes he is directing treatment and yet is paradoxically absent. Psychiatry is doing or enacting because a body is there to be worked on, and at the same time is reliant on other bodies to do its work. But in this organizational schema, we are still left with pressing questions of how the mind works, how it veers off course, and how it is cured from confusions that leave patients unwell. In other words, we are no closer to a science of the mind in this historical and contemporary framework of psychiatry, leaving a kinetic chain of uncertainties in its wake.

Foucault describes an educational ground zero for me, subsequently creating an accessible bandwidth for understanding what is happening. He suggests that reaching into the human body with regimes of control, order, and regularity are critically essential in the practice of psychiatry and form "the very constitution of medical knowledge, since exact observation is not possible without this discipline" (p. 2), bringing into question the idea of psychiatric knowledge. In their reading of Foucault's historical rendering of the asylum and its relations to psychiatric knowledge, Britzman and colleagues (in press) state, "In this arrangement, there was power before it functioned as knowledge and the knowledge, on the part of doctors, supervisors,

wardens, and even patients, was mainly intuitive and rested on the authority of bodies." Foucault (2006) therefore is not subtle in his descriptions of a crisis of knowledge. Medical knowledge has reached a tipping point more broadly understood as a crisis of truth. This brittle moment simultaneously formed the foundation of psychiatric practice from the 18th century up until the early 19th century and, according to Foucault, was mechanized as a tool in its practice. It is no small irony that this crisis has stimulated the work of a PhD for me.

The Entrance is Too Near

Increasingly microscopic in his interrogation of what makes psychiatry intelligible, Foucault (2006) notes that knowledge tests for medical practitioners in the early 19th century are legitimated by the appearance of anatomical pathology. Here, other medical specialties were permitted to ascribe illness in the form of a "localized lesion within the organism and identifiable in the body" (p. 265). This "made it possible to constitute clusters of signs from which the differential diagnoses of diseases could be established" (p. 265). In other words, a pathological focal point could be located and excised or targeted. Psychiatry sees a very different path where the question of differential diagnosis or even diagnosis itself is rendered feckless when the body is absent in its diagnostic utility but is essential in maintaining the case for the psychiatric asylum. For example, once the site of illness could be observed, the illness reality could be substantiated and thus qualify as a diagnostic possibility. In psychiatry, it is easy to see here how Foucault relies on the use of the body which, through its ability to use the senses, can fulfill the criteria to be understood as a diagnosable reality. Once the body is obtained as the site for diagnostics that can tautologically speak to the questions of diagnostic inquiry, psychiatry is seen to be working with observable illness. Foucault then reduces the practice of psychiatric inquiry into a clinical binary such that the pressing question is simply whether or not the patient is mad,

notwithstanding the superfluous nature of the body. These skeletal elements, Foucault argues, constitute a historical interruption where "in psychiatry, the essential moment that punctuates, organizes, and at the same time distributes this field of disciplinary power I have been speaking about, is this test of reality, which has a double meaning" (p. 268).

Foucault circles back to his original crisis dramatized by the search for truth in psychiatry now recalibrated to make subjects through requests for psychiatric intervention on the question of madness and reality. The request and the subsequent adjudication by the psychiatrist constitute the power of the psychiatrist, according to Foucault (2006). This test of reality, broadly taken up as the ongoing subjectivity that saturates the practice of psychiatry, acts to simultaneously confirm the diagnosis of madness and constitute disciplinary authority. Psychiatric sickness follows a path. Foucault gets to the heart of the matter by stating,

> Consequently, we can say that the psychiatric test is an endless test of admittance into hospital. Why is it that one cannot leave the asylum? One cannot leave the asylum not because the exit is far away, but because the entrance is too near. (p. 269)

My encounter with iatrogenics resonates again in a story that underscores the notion of an entrance being too near and the endless psychiatric questioning that constitutes judgement as authority. I recall being on call and was asked to see a 9-year-old girl admitted to the inpatient unit on a mental health form, rendering her unable to leave even if she demanded it, because she was determined to be a physical risk to herself and others. She had waited for days in another hospital to be transferred to our centre of excellence. How was knowledge about this 9-year-old generated and interpreted in a way that turned so very sour? We are left with only our imagination to know what was said, and more importantly, words that were resisted in thinking about the kinds of risk a 9-year-old can pose. It was unclear other than to read that this was not

the first time that she had been dissatisfied to the point of physicality. I met with her and we spoke for a long time about her recent troubles. She had supposedly become violent in her classroom, causing the kind of uproar that was immediately relegated to the status of a crisis, which signalled more broadly to her educators, the possibility of a mental health breakdown. When I asked her about what had transpired, she calmly articulated with a convincing sense of clarity that she had wanted to do her classroom project on the history of Black people and how they had been enslaved. As a Black person in a predominantly white world, she felt that this was an important topic for her. However, this "topic" was not for the pickings and she was told that she could not do the project. She said to me in simple terms, "I was mad and I let them know." Indeed. I asked her if anyone had understood that the anger that she had was rightfully experienced in being told 'no' to her curiosity about her own history and her own identity. Our conversation moved from this point and progressed with no sign of abnormality. However, the emergency had already taken place. The possibility of an interpretive play on her words "I was mad and I let them know" is almost ominous is its proximity to Foucault's historical observations about madness rendered contemporary. I realized that when speaking to her, there was no test to declare her "well" as much as there was evidence easily available to the contrary. The interview mattered less than the bodily outburst which easily found its way to the opening of the hospital, in its possibility of abnormality as described by Foucault (2006),

> Abnormality is the individual condition of possibility of madness; it is what must be established in order to show that what one is treating, that what one is dealing with, and what precisely one wants to show are symptoms of madness, if really of a pathological order. For the different elements constituting the object or motive for the demand for

> confinement to be transformed into pathological symptoms, these elements must be set within this general web of abnormality. (pg. 272)

It was clear to me that the entrance was too near for this 9-year-old, where the question posed about her behaviour provided sufficient conditions to convert observations of them into a pathological symptom. I am not suggesting that aggression is a typical or effective response in her situation, although I am bringing into focus the conflation of the notion of the atypical with abnormality, and how the discourse of abnormality in the psychiatric setting constitutes the "web of abnormality" that Foucault speaks of. How was it that a state of abnormality had been considered, both at school and at the local emergency department, such that she would calmly wait for days to be transferred to a tertiary care setting? Perhaps this is a fitting case to use as an exemplar in thinking about what it signals as an educational problem and how this moves us towards questions of meaning in education. It was presumably the acting out behavior for her that precisely enacted a problem having to do with meaning. However, the acting out became the crisis which really only allowed individuals a glimpse at the real crisis of exclusion that was at hand for the 9-year-old.

Before I speak to the educational meaning in the example of the 9-year-old, I want to take Foucault's example of the "entrance being too near" one step further in its metaphoric relevance. While it was not difficult to think about scenarios where the institutional entrance was gratuitously accessible, the opposite has also been my experience. In other words, the entrance is too near, but it is closed. Youth whom I have been providing care for on an outpatient basis will, at times become aware of therapeutic services that are being offered by our mental health program and indicate a desire to be admitted to the inpatient ward. They have learned through various means about what the mental health ward has to offer. Typically, their rationale is well

thought out and bears a kind of maturity, suggesting that they understand the hospital encounter (i.e., inpatient or outpatient) as part of the way forward in relieving their suffering. Many of them have spent time on psychiatric inpatient wards or with mental health clinicians, and so come to this conclusion with experiential knowledge prioritizing the perceived opportunity for progress over emotional discomfort. And yet when I have attempted to arrange admissions or transfers to various services within the hospital or the community, the door will not open. The youth is deemed either too sick, or not sick enough, or does not have the "right kind" of illness, or the youth appears "too eager" to be a part of treatment, inciting a kind of paranoia about the kinds of nefarious intent that could be fuelling the youth's motivation. This practice of exclusion predicated on a history where the entrance is too near sets up a diabolically ambivalent dilemma nothing short of an impossible crisis.

Educationally, there is a parallel and a paradox to be found here for me. How should we involve education when education itself is frequently oriented towards emergency and its own crisis of natality and matricide. In the case descriptions above, how can we think about education without the thought of education itself becoming a crisis? Here, the work of understanding as an educational mandate runs the risk of being swept up in the urgency of a crisis that simultaneously signals a space for the language of abnormality as a defense against it or forecloses on it, rendering the learner at dead ends in trying to make sense of it all. In revisiting these interpretations, we also are returning to the original idea of authority in psychiatry that itself acts as a form of judgement, coming to authoritative conclusions. Educational iatrogenics are also at play in that there is a "dead end" as a metaphor that we are left with, suggesting a new educational problem that has been created as a side effect of the original crisis. The dead end is the problem of the entrance to the asylum being too near suggesting that illness is waiting to be

constituted. However, over time I have observed a kind of cultural animosity that has grown at the possibility of the entrance, reinforcing the real confusion that is at the heart of the matter. That is, the mind and knowledge of its working still remains elusive to psychiatry, no matter if the door is wide open or closed tightly. This very conflict also speaks to the emotional situation of psychiatric education where those learning within it, like me, are also affected by it. I am also intimately aware of how much of this conflicted drama depends on the exchange of language; perceptions of what is being said, misunderstandings about what is not said, critical omissions, awkward silences, words stumbled over, and moments felt. In recognizing these vulnerable vicissitudes constituting the psychiatric interview, I will now turn to the act of interviewing in psychiatry as a conduit for knowledge and its breakdowns.

The Psychiatric Interview: Foucault's Heredity and Melville's 'Bartleby the Scrivner'

Foucault (2006) preoccupied himself with specific modes of psychiatric testing, including psychiatric questioning, otherwise known as the psychiatric interview. Here the physical body is paradoxically absent in its diagnostic utility. As far as Foucault is concerned, a grand ploy is set up in the act of taking a medical history, where a search for family pathology is liberated and ultimately successful in determining a historical chain of significations that would sanction the notion of madness as a medical origin:

> Heredity is a way of giving body to the illness at the very moment that this illness cannot be situated at the level of the individual body; so, one invents, once cuts out a sort of huge fantastical body of the family affected by a mass of illnesses…. Trying to trace heredity therefore means substituting a different body and correlative material for the body of pathological anatomy; it constitutes a meta-individual *analogon* of the doctor's organism. (p. 271)

Within this heredity, the body acts to condemn itself in that its presence will be sufficient as a substitute for any lack of symptoms and absence of pathological anatomy that can be excised and held up to account for disease. In this scene, psychiatric questioning constitutes the progenitor to abnormality. It is as if the psychiatric interview says, "The patient's body, present for the interview, will likely be sufficient in my search for disease. If I can't find pathology in the patient, I will find it in the family." There is a density of forces at play leaving the patient unaware of the vectors acting upon them. Or not. How the mind and its working can be understood as pathological or abnormal is a tactical function of the psychiatric interview, but the question really has to do with who has the upper hand in this encounter.

In my training of psychiatry, the review of the "family history" is often looked to as a litmus test, of sorts, referred to during an encounter with a patient who does not, or cannot, or refuses to provide symptoms that are compelling enough to warrant diagnostic certainty. But the problem, as Foucault has pointed out, is that the psychiatric door is too near. Many of my adolescent patients disengage but stay put in the interview when it would otherwise be obvious that an ending had occurred. In the adolescent failure to depart and failure to speak, he or she has inadvertently made clear a tacit infrastructure that is the psychiatric interview. In other words, the patient must speak. However, many of my patients have responded (or not) in the way that Bartleby, the Scrivner made famous (Melville, 1995). That is, Bartleby refused to speak by answering any question with the utterance, "I prefer not to." Melville's short story invites us to consider the meaning of silence ***as*** an interview and what happens when we can't get to the question. He cannot or will not speak, except to compulsively repeat a preference "not to" coupled with a refusal to depart. A world therefore is created where the primary object of a seemingly vapid Bartleby (or patient) demands an emotional subject in the life of the physician.

And to make the point further using Seidman's approach to understanding what something is like as a mode of interviewing, in the case of Bartleby, we are left to understand what it is like to converse with the non-conversant. This engagement with a seeming silent absence through Bartleby's refusal to engage, forces the spotlight onto the one who interviews. Bartleby's narrator (or me in the role of the interviewing psychiatrist) then must embark on a transference journey where the affective vectors of blinding rage, frustration, defeat, madness, compassion, tolerance, identification, admiration, and perhaps the notion of love emerges around the irresolute hesitation of Bartleby.

I too have experienced the compulsion to repeat in endless attempts at questioning the mutism of adolescent patients, believing with an evangelical fervor that if the right question is posed in just the right way at the right moment, a magical opening will be discovered and truth revealed. Or rather, illness as a form of truth will be revealed. What Foucault (2006) refers to as "heredity" is what I am referring to as a confident account of what I did not have confidence in. But according to Foucault's historical interpretation, the silence is less of a problem as compared to the possibility of madness that lurks. A major fault line now appears. The ontological crack that introduces a faultiness to the story is, in fact, the silence that is Bartleby (visa vi my adolescent patients). His character is presumed to have no navel to point to any sign of illness heredity, leaving the psychiatrist's work unintelligible. This exemplar finds its way into Foucault's observations where heredity links the patient to madness in a way that defends against boundaries of a meaningless situation for the psychiatrist. The physician in this scenario, is made as lifeless as a silent Bartleby or as fantastical as the possibility of patient abnormality and seemingly becomes the limits that will tether them to illness. Herein lies the scandal in psychiatry; the doctor is as sick as the sickness.

Why have Psychiatry?

In offering the story of Bartleby, I am not suggesting that psychiatrists are sick and therefore they should not practice psychiatry, nor I am suggesting that we should do away with the psychiatric interview. Rather, I am returning to the iterative ways in which a profession that is seemingly predicated on the healing of the mind discursively finds itself at odds with its institutional mandate, thereby facilitating its own confusion. My observations also are placed in contrast to modes of medical practice taken up by Sacks attempting to connect and cohere in a kind of generative relationality that would bring clarity for him. I can see a number of different reasons for the institutional disorientation described by Foucault, which comes to bear on the question, "Why have psychiatry?" In posing this question, it stands to reason that psychiatry itself is not an inanimate force that can act upon patients, thereby demanding a body to take on the role of a psychiatrist. However, Foucault (2006) argued that the architecture of the asylum and its aspirations took on a kind of authoritative power, as actions upon actions that functioned as if it were doing the work of psychiatry. Foucault states, "Psychiatric power is above all a certain way of managing, of administering, before being a cure of therapeutic intervention: it is a regime" (p. 173. What then does the psychiatrist do? Here is Foucault's view, "The Psychiatrist is someone who directs the operations of the hospital and who directs individuals. Just to indicate not only its existence, but also the clear awareness of this practice on the part of psychiatrists themselves…" (p. 174). In the absence of the psychiatrist's presence and without a patient's body to orient the discourse, knowledge about illness then acts a substitute for reality, leaving one with only the mind as a problem with unsatisfactory solutions. And if the psychiatrist is removed, the scenes of supervision remain to provide an account of the patient that exists as its own form of knowledge about mental illness. And in doing so, Foucault suggests that

psychiatrist renders himself as mad as the patients. At this point, it is reasonable to step back and ask why then have psychiatrists when the scenes of supervising in hospitals will do? And if your patients don't speak to you but you can rely on heredity as a form of diagnostic confirmation, why have psychiatry?

Unfinished Business

After what feels like an unexpected meandering through disjointed histories and contemporary observations, it seems appropriate to summarize these curiosities in the affecting spirit where they have landed for me – that is, in the form of unfinished business. In returning to the start of this chapter, I am aware that a convoluted yet ambitious path has been traversed in tackling problems of judgement, authority, and relationality in psychiatric education where I have yet to settle the score of matricide, natality, and the gendered body. How might I come to a kind of reckoning with a history plagued by an education predicated on gendered exclusions as a not-so-secretive past? Psychiatric signs and symptom may have changed, but the biological framework of psychiatry continues to signal an education that relies on bodies to act and to be acted upon in the absence of making sense of the mind, reinforcing a tautology at play. Because the psychiatrist says you are ill, so it is, thereby removing the psychiatrist from his or her knowledge but rather positioning the knowledge of psychiatry as a knowledge which cannot affect the knower. And herein lies another psychiatric lacuna as a symptom of matricide. The idea of matricide says that even if murdered, the symbolic mother is affected in this equation of knowing and knower. And yet, a feminine orientation to this equation would suggest that knowledge is always relational in its situation with the knower. However, in severing the relation between the knowledge and the knower as a gendered effect of matricide, we are left with another educational problem having to do with natality, where natality itself is also

compromised. It is as metaphorical interpretation where the birth of the baby has been aborted or where conditions give way to habitual stillbirth. We arrive to end, as per Arendt's position in *The Crisis of Education* (1993) in an attempt to know. Newness will not be tolerated, even if it signals an attempt to bind together the thought to the thinker who inhabits a body, ironically essential in its role as placeholder for knowledge in psychiatry.

It is here that the idea of the psychiatrist's body looms large as the conduit for this unfolding drama characterized by a conflicted inter-subjective space with little affective reprieve offered by the Eurocentric, western leaning histories in psychiatry. Overtly naming the historical orientation which feels like a map to no-where allows my compass to be redirected to other traditions that might posit an epistemological opening to the gendered problem of bodies, natality, and matricide I have been struggling with. I find the psychoanalytic work of Togashi (2020) offering a generative way into my problem, and perhaps in doing so, transforming it. Togashi (2020) suggests that Cartesian dichotomies impetuously infiltrate and anchor western modes of psychoanalytic thinking, inadvertently conceptualizing the dynamic of dualities and their boundaries as a cultural artifact of colonization. It is easy to see how in my discussion so far, dualities marked by mind versus body, male versus female, physician versus patient, and knowledge versus knower are prominent themes that have helped me articulate educational tensions but have limited staying power in moving beyond the many uncertainties that I am left grappling with in this chapter. He writes, "Surrendering ourselves to the moment without division, between certainty and uncertainty, puts us in a vulnerable position" (p. 109). As a decolonizing antidote to this situation, he suggests that there is a "zero moment" prior to the existence of forms, roles, and objectifications where two human beings come together before they know each other as therapist and patient (or any other duality for that matter) which requires

a kind of transcendence into a very uncertain space that is deeply intersubjective in its humanity. This space is referred to as "the ethical turn" (p. 71) where "therapists and patients are required to surrender themselves to emptiness, in which both participants efface the preoccupation with themselves in the presence of each other, leaving a field of thought beyond right and wrong, good and bad" (p. 20). In this space is a call to *being* as humans without the organizing awareness of the many dichotomies I have spoken to.

Here Togashi articulates an awakening to the possibility of suspending interpretation, diagnostics, pathology, or unmet needs in favor of an intersubjective and relational framework that can, in its capacity, tolerate the not knowing and perhaps offer something previously unimagined. As I enter into the imaginary of this phenomenon described by Togashi, it is clear that it is a holding space; a maternal place that is tolerant and nurturing of uncertainty. This maternal space is, in fact, the birthplace of uncertainty. It is the womb, both expectant and simultaneously giving up and giving away. In this function, it is deeply feminine. And here is where I can understand a matricidal act and a gendered body in education as well as a space for natality. The place of the feminine is both a proposed philosophy of education, but also represents an ethical turn. It is an uncertainty that will permit destruction and simultaneously begin again in an endless moment of deep humanity necessary in the transformation of the learning, and also necessary for me. It strikes me that the ethical turn is made from the wake of matricide, which is the expectant and fledgling natality so necessary for transformation. In other words, matricide and natality are two sides of the same coin. If we rely on Foucault and Arendt to see natality, we are relegated to spaces of weariness and power respectively. But Sacks upends these forces, bringing to the crisis of matricide a yearning for life through a deep relationality unconsciously animated in his memoirs. Here the power lies not in the authority or authoritative

judgement through bodies, but rather we encounter a reprieve in the form of the ethical turn which amounts to a call to put down the armour of expertise relied upon in the nakedness of the intersubjectivity that can create anew. Isn't this a beautiful start to a description of a kind of creative wonder that can help us understand what education is and what education is for?

In closing this chapter, I return to the question of what psychiatry is for and pivot on the ethical turn where the problem of bodies and their genders is the crisis of education. Whose body counts, what bodies signal about the kinds of authoritative judgements and relationalities that work towards and fail in the healing of the mind, and how bodies are relationally overseen as a form of constituting knowledge in psychiatry are questions that have challenged and changed my understanding of an education within psychiatry. And so, in considering the body as judgement, authority, and relationality and the links between the conditions for expert entrapment are constituted, but so are the conditions for a creative reprieve in the practice of psychiatry and its education. How so? Matricide can give way to an ethical turn where we find ourselves vulnerable in our educational uncertainty and also new to it such that it can act as an orientation towards a profoundly relational inter-subjectivity possessing its own educational expertise but requires additional discovery as well.

While these questions and ideas remain critical, I am trying to convey a sense of being pressed upon by the imperative of moving towards a truly inter-subjective educational field that can not only tolerate the very human uncertainties inherent in the epistemological exploration of a theory of mind but can thrive as an effect of accepting the uncertainty. In the next chapter, this dynamically creative potential and its transformational effects on me as a psychiatrist will be explored through personal reflections as a psychiatry educator working in Uganda. I would like to remain close to Sacks and his account of awakenings as I narrate my own story of as a

psychiatry educator coming to my own “educational awakening” where working with questions of the mind somatically inhabited in a setting that is mostly strange to me is connected to an affecting experience of coming alive. Stories from my experience as psychiatry educator will be used as transference objects where the details, the conflicts, the tone, and the affecting vectors within the narratives represent possibilities for probing an educational intelligibility made through uncertain relational spaces. I will continue to rely on Togashi (2020) and Swartz (2018), both psychoanalysts who are interested in decolonial challenges inherent in moving towards an inter-subjectivity that can help me to articulate the educational spaces as an educator of psychiatry and what it means to survive it.

CHAPTER FOUR

On Waking Up

In previous chapters, I have described my formation as one who has undergone an education in psychiatry. As I shift positions in this chapter to reflect the position of educator in psychiatry while in Uganda, I speak dialectically about how I came to understand what it means to be estranged from knowledge previously relied upon in psychiatry and in doing so, how I formed a relationship with incomplete learning as a very particular resource, so as to think deeply about it as an educator. But to tell this kind of story, I have to resort to the method of collage in that my learning came in fits and starts, and from engaging with the histories of the human sciences, discussion of pedagogy, and psychoanalysis. Coming back to the collage metaphor where the act of mentally sifting through educator encounters, seemingly at random, identifying "stand out" experiences, and attempting to intelligibly piece them together using has performed a kind of personal glue that coheres a practice of education in psychiatry for me. It will become clear how this teacher aporia becomes the interlocutor which orients me towards my educational affect within it.

At first glance, my experiences as an educator in Uganda may seem outside the norm or somewhat unusual for many, perhaps because of a global geography that may be less familiar. But it is the affecting geography where I am attempting to create familiarity, in the way that Winnicott does, where he writes "in a way which he constantly assumes familiarity" (Swartz, 2019, p.1), depending on who his reading audience is. Swartz (2019) describes this kind of Winnicottian writing with familiarity as a style where he provides descriptors about common scenarios between an infant and a mother that are instantly recognizable to those interested and where the reader can fill in the blanks or provide anecdotes of their own before sentences are

completed. I too want to bring readers into this kind of space, albeit an educational one as an educator where highlighting the conditions, the challenges, the ways in which conflicts are encountered, and coming to an understanding of resource within it may indeed be a place of familiarity for other educators.

And in attempting to create educator familiarity, I re-visit common questions about learning to be an educator; questions that can really be read first as a litany of guilt, anxieties, and fears, but also questions that give way to the joy that is encountered when undertaking problems about what it means to be an educator and to survive its tutelage within a rubric of doctor confusion. Specific questions that I take up include ones about needing to reassure myself that I have a place as an educator, then naming the common resource problems and limits that educators face once committed to the task, and what it is about the ways in which the stories of conflict can precisely be used as a resource in understanding the problems encountered. I tell my own stories as a psychiatrist educator in Uganda focusing on what happened, what didn't happen, and what I thought was needed, and how this led to thinking about emptiness or the void as an educational ethical turn described by Japanese psychoanalyst Togashi which fundamentally speaks to the ways in which something can come from nothing. In doing so, the educator is transformed. Specifically, I focus on using narrated vignettes in Uganda to highlight how it is that the doctor approaches patients or patient encounters that she does not understand despite being relied upon as a psychiatrist educator to do so. I intentionally use psychoanalytic interpretations to illuminate the vicissitudes of affect that occur in learning encounters. These include: ruthlessness, forgetting, emptiness, deferral of time, dreams as resources, and what it means to understand uncertainty as a gendered form of transcendent survival which can stand in for the psychical shackles described in previous chapters from the perspective of a learner.

In order to explain this educational claustrum, I continue to employ the methodology of autoethnography to explore these reflections. I have conceptualized my experience in Uganda as an educational case where autoethnographic narrative is the organizing principle in engaging observations about the problems of psychiatric education for me as the teacher, and then I treat each story as a transference object where interpretations are informed by the employing the affecting unconscious. In doing so, I have come to appreciate how laborious it is to both author the stories of an educator in Uganda and then to simultaneously comment on them. In fact, the narratives which have been offered up are treated symptomatically and as a problem that I am trying to take space from in order to meaningfully get back into it without enacting the problem itself. In other words, how do I think about an educational problem without becoming the problem. I reflect on these narratives as educational indicators animating my struggle of trying to know apart from what I think I know as well as trying to be recognized by myself as a knower thinking about the mind.

Before I continue, I want to highlight the idea of decolonization and how I might employ it methodologically to thought and written word within the reflections of this chapter. While I do briefly turn to the work of Memmi (1992) whose work has taken up questions that speak to the devastating consequences of colonization, I use his insights and observations applied to the educator scenario that I am trying to negotiate. Perhaps more appropriately said, Memmi (1992) helps me identify and situate an initial discourse about what it means for me to take a place as an educator in Uganda and why I can arrive to this space at all. However, I did repeatedly arrive in Uganda over the past 20 years, and I have frequently participated as an educator, aware that I wanted or needed to find a different way to interrogate my own thoughts. Moving then to understanding the place of mental departure in education can also be thought of as form of

decolonizing or a sense of decolonizing, although it is not the same as decolonization. Treating written text within a decolonizing frame, loosely defined, involves a necessary element of resolve, suggesting faith in an unbending psychical waiting stance until a thought opening can appear. This chapter is about the being at the loose ends of learning, or even embodying the loose ends of learning. One might even see this as a decolonizing sense applied to education, where the grip on preconceptions, diagnostics, and labeling of taxonomies is intentionally loosened.

In this chapter, I turn to important writers such Sally Schwartz (2019) and Koichi Togashi (2020), both psychoanalysts who have an interest in decolonization in their clinical practices, in coming to a conceptualization of thinking and writing in decolonizing ways about my experience as an educator in Uganda. Togashi (2020) also openly articulates his work as being mindful of western thinking but is oriented in Eastern modalities of thought and contemplation. The departure from western thinking to embracing an eastern orientation, according to Togashi, is conceptualized as decolonizing in nature, and he specifically highlights a loosening of grip on the reflexive need to know, to name, and to interpret to one of being deeply present with his patients in a very particular space. Togashi (2020) describes this position as a place where "patient and analyst can recognize each other as having a shared subject yet experience each other as individual minds" (p. 4). This position presupposes a moment which surpasses description or taxonomy and surrenders to a shared inter-subjectivity where sameness and difference can be held. In my mind, this is much like the qualities of the womb, where two separate existences are related and dependent on one another. It is Togashi's sense of containing distance that I am trying to aesthetically employ in holding onto the different remnants,

curiosities, and fragments of thought in sharing my experiences in Uganda, while simultaneously making them intelligible for medical educators beyond me.

Swartz is a South African analyst (2019) who speaks of decolonizing psychoanalysis by leaning heavily on Winnicott and the role of ruthlessness in both practice and political protest. She suggests that a quarrel is needed with intel gate keepers who have legitimated psychoanalytic knowledge and that survival of this altercation is essential. She notes that in order for psychoanalytic theory to be decolonized, "it needs to replace the coercions of apparent 'universals' with the infinite choice of the particular, the variable, the multiple routes to spontaneity and freedom" (p. 143). Here, Swartz, perhaps unknowingly, aligns her comments to the legitimacy advocated for by Forrester (2017) in his admonition for "thinking in cases" to be a viable method of inquiry to arrive at a "who." I am not sure that Forrester went as far as to consider "thinking in cases" as a decolonizing thought process, but it is interesting nonetheless to consider this. Swartz (2019) goes on to say about her version of thinking in cases, "This entails giving up on deferral of authority to others, and the responsibility of finding new and appropriate forms of agency" (p. 144). For Swartz, decolonizing thought is about establishing independence through an internal rebellion against authority, where one distinguishes themselves as an independent as well as "being authoritative in that independence" (p. 144). This sentiment will be used in speaking to my experience as an educator in Uganda, recognizing that in order for me to understand myself as an independent rebel against the authority of western thought, I am also rebelling against the origins of psychoanalysis. While I cannot speak for others, and it is not my intent to provide a narrative from another' perspective, my purpose is to find a unique way into unique stories "beyond defensive isolation, beyond compliance and beyond mimicry" (Swartz, 2019, pg. 144).

Coming to the Work of Psychiatry Education in Uganda; Guilty Arrivals

I share the following journal entry as a way of introducing you to my experience of Uganda.

When I first encountered Uganda as a medical student in the early 2000's, I was struck by a resource setting comparatively very different to the one where I studied, which registered initially as guilty inequities. These early experiences in Uganda have demanded a kind of interrogation into my own assumptions necessary to make sense of what I didn't want to admit I was unsettled by. At times, egregious resource disparities in medicine translated literally into life and death matters. In Uganda, I have witnessed, first-hand that belonging to the have-not's, was sometimes a death sentence when it came to healthcare. Nothing in any of my educational experiences had pressed upon me so intensely. While I refer to learning as an unsettling experience, it was also a time of feeling alive to learning and in doing so, feeling alive to myself as a learner. And so, I returned to Uganda as a postgraduate trainee for half a year in 2006 as part of my formal training in psychiatry. Among many things, this experience offered an opportunity to meet many individuals who became both friends and colleagues, even until now. One of those individuals is Godfrey.

In 2013, I responded to an invitation from Godfrey who had taken on the position of Chair in the Department of Psychiatry at a university in the west of Uganda. He asked if an educational partnership in psychiatry postgraduate training was of interest to me. I was now on faculty at McMaster University in the role of Associate Professor and Training Director in psychiatry and had openly declared an interest in education scholarship. Godfrey asked if we could we bring our learners and faculty together to share expert psychiatry knowledge and skills in his postgraduate training program. I could only articulate the moment as too good to be true because it allowed me an opportunity to return to meaningful relationships in Uganda, both

professional and personal, but it also offered a kind of opportunity to return to a context that I had experienced as possessing an uncanny educational heft, and at the same time I could not really articulate why or how or what this signified.

The truth is, his invitation to me also arrived at a time when I also wanted an escape from my Canadian clinical context. The incessant demands for practice governance in Canada often resonated for me as management rhetoric and had become an unwelcome companion in my clinic where I was also an educator. Losing its shadow was nearly impossible in a milieu obsessed with quality improvement. Contextual constraints like these had begun to wear at me. Did Godfrey's offer legitimate my desire to escape? Was I happy to have more than tourism as a motive for travelling to Uganda? Could I wonder, out loud, if my clinical load might be reduced giving me a clandestine reprieve from the relentlessness of clinical care and education through the work of the educational partnership?

Memmi (1992) suggests that the colonizer is one who is on a "voyage towards an easier life" (p. 3) that eventually results in an understanding where a new status is benefitted from. He asks,

> For how long could he fail to see the misery of the colonized and the relation of that misery to his own comfort? He realizes that this easy profit is so great only because it is wrested from others. In short, he finds two things in own: he discovers the existence of the colonizer as he discovers his own privilege. (p. 7)

I knew that it wasn't an easier life that I wanted however I knew that a meaningful life was desired, and perhaps Memmi was onto something as it related to my motive and my wishes. I found it increasingly difficult to think whether it be creatively, critically, generatively, or at all in my clinical educator work at home. I knew that I could not make sense of what I only felt as

lacking. And lack as a resource seemed to me to be deeply problematic as a motivation to go to Uganda. What I most anticipated is that Godfrey's invitation could open for me a novel mode of thinking about education that was increasingly aloof for me in the Canadian Psychiatry context. I was not entirely strange to what psychiatry entailed in Uganda, but I was aware that each encounter I did have in Uganda forced a welcome reconsideration of what I thought I knew. I present the following case where I am a clinical supervisor to Canadian trainees whom I have accompanied to Uganda to participate in the educational exchange with Godfrey and his trainees, as an example of coming to these observations.

Arriving at Questions of Understanding: The Case of the Blue Chairs

We arrive in Mbarara in early September 2018. I am accompanying and supervising two Canadian senior psychiatry trainees in Uganda. We have spent months with a preparation that I have little faith in. We start our experience in Uganda by participating in hospital department rounds; a time dedicated to reviewing all patients, their problems, and their progress. Patients stand and form protracted lines well in advance of the workday start. Despite the numbers, seats are few and enact a disparaging inequity registering as a familiar condition articulated in the psychiatric interviews that will continue long into the workday's end. Patients are in differing states of mind in this line-up to see the doctor. There are some that are very unwell and whose caregivers work in desperation to manage the nakedness, the intrusiveness, the screaming, and the non-compliance while at the same time trying to secure a position in the que. No seating space is unaccounted for and therefore, standing takes a back seat for patients. In this simple status, a hierarchy exists – those who have a seat to wait in and those whose seat never existed. In the sitting arrangements for major ward rounds, another hierarchy is declared in accessing any sliver of space that can be found. It is a cast of thousands that come together to hear deeply

private stories of the psychiatric patient and the illness encounter. The numbers of professional learners and trainees easily exceed 30: students, staff, patients, and the occasional curious passerby who wanders into this scene. The consulting psychiatrist sits behind a large, roughly made table, historically created to segregate patients from staff and to architecturally signal the various positions suggested by the setting. But the table doesn't offer enough edges to insist on separation. People spill around the table such that a halo of humanity forms, oblivious to the structural demand for a separation. The lines of human proximity cannot be avoided and touch is inevitable.

Buttocks are used as insistent maneuvering agents to create an opening in already over-crowded benches. This is a pressing issue indeed. I look to my students who are accustomed to their own closed offices and privacy unquestioned. I suspect that the negotiation for a seat is at the bottom of their list of expectations for this trip. Now, as we all sit squeezed against each other, imitating the patient queues that await us, intimacy opens to a different kind of learning. No one appears uncomfortable with the close quarters, except perhaps for the Canadians. They lean in and whisper to me about the observed lack of privacy and confidentiality. Shocking! "This would never happen in a Canadian setting," they say. And while Godfrey has lamented the physical space and its problematic effects on patient confidentiality, I wonder if this constellation somatically and affectively staves off threats of profound isolation that inevitably penetrate when mental illness hijacks the mind and the social collections of those involved. I have been deeply touched as I suspect the learners have as well, with the ensuing experience of humanity in the bodily architecture of patients and professionals enacting a culture of caring. It is a beautiful and poignant affront to my Canadian sensibilities, notwithstanding the effects on confidentiality.

In the midst of the rounds, one of the senior Ugandan faculty wishes out loud for 50 individual plastic chairs as a solution to this problem. He remarks that this would certainly set their department apart from others in its opulence. If only. But the department budget with no budget lines cannot support this request. In private, I casually ask about the price of a plastic chair and the next day Godfrey and I are stuffing 50 new, neatly stacked, cobalt blue chairs into his vehicle. He has already arranged for a service man to come and etch the place of belonging into the backs of the chairs, lest anyone consider walking off with department goods. Pulling into the department parking lot leads to an awareness that our arrival was somehow anticipated. A small but diverse group awaits the work of ushering the stacks of novelty into the department. The hands that help include the cleaner's 4-year-old daughter, a patient's 80-year-old grandfather, and a 45-year-old husband and father recovering from Bipolar Affective Disorder, who shuffles and drools from the side effects of his medications as he walks. There is almost no verbal exchange in explaining the task at hand. The chairs are carried with perceived purpose and perhaps, respect for the task. Soon more patients are engaged in the line-up carrying chairs; it is striking to me that these contributions were neither requested nor formally acknowledged. No one complains. No one asks what we are doing. In fact, all are smiling as they go about carrying on. As I watch, I suspect that no one knows what the chairs are intended for or how the newness will benefit any of the bodies that participate in the labour of bringing them to a place where ownership evades many. And while I feel deeply satisfied about being included in this collective effort, at the same time I wonder if the event signifies something educational for me.

As I reflect on this story, I notice that we all carry these material objects intended to make subjective space where it has not existed: that is, a space for being, for belonging, for thinking. The work of carrying these chairs has signified for me a kind of symbolic educational need; I

don't quite know how to think about education, particularly in my role as faculty in this Ugandan university, other than to see my own experience leading to this moment as being insufficient to prepare me as an educator. But holding onto the edges of the blue chairs somatically registered a type of newness, a thinking bannister that has oriented me to essential questions of what it means to be a psychiatry educator and how learning to be one is shaped by disorientation to it. These questions have been absent for me until now.

It's All Out on the Table: Empty Resources

Questioning what resources are available to do the job as a physician educator is not particularly uncommon nor all that interesting. A mundane mental list of necessary objects is easily generated: stethoscope, reflex hammer, some sort of compact electronic device that will let me access the internet so that if a website citing empirical treatment algorithms is not easily available, Dr. Google will be. Perhaps for some, the need for pen and paper comes to mind (this depends, of course, on how old-school the educator is). But for the psychiatrist, the list of tools is relatively sparse, so to speak. The list really comes down to one important resource for me; my mind and its ability to recognize the working of others' minds, particularly when my own is not especially cooperative. But grappling with the question of my mind as a resource is an awareness recalled as an afterthought in relationship to my job as a psychiatry educator in Uganda. I share the following scene from one of my trips to Uganda as a clinician educator.

In the dining room of the Ugandan guesthouse where I have stayed over the years, the open-air windows surround an alcove where a few roughly made wooden tables and chairs are positioned and where a tropical breeze and the sounds of fluttering banana leaves accompany the guests. One morning, I enter the dining room to see that there is only one large table set in the dining alcove. The smaller tables where I have predictably settled are no longer there. I then

realize that a large tablecloth covers all of the tables which have been pushed together, uneven in its collective surface in a configuration where they would otherwise be separate. The place settings suggest that a crowd is anticipated. I make an assumption about belonging in this morning's seating arrangement and conclude that I don't. This suits me just fine and so I look for another place to sit. Successful in my pursuit, I sit down at a small table in another room with no place setting. I get up to ask the server about cutlery and dishes, volunteering to get my own, recognizing that the one waitress is tending to a large crowd. Her stress is palpable and I am happy to lend a hand. The server is flustered and says, "They are all on the table, madam" nodding towards the collection of dishes at the pushed together tables. "The dishes are finished." It's all on the table, literally and figuratively. There is no more dinnerware, no storage, no hidden stash, and no special serving dishes for when the guests come.

The educational problem as I see it, and have experienced many times before, mimic the encounter of limited resources. As an initiation to my day of teaching psychiatry in Uganda where I feel that there are many expectations to fill human resource gaps that are no fault of anyone's in particular, I find myself wondering what happens if my limits too, are reached? Limits to knowledge, insight, compassion, judgement, creativity, stamina, etc. all come to mind as the resources that I rely on to do my work as a psychiatry educator. But what if my stores are empty? More specifically, what if I have found a dead-end in the form of my mind as a resource? The possibility of interpreting this scene psychodynamically where the problem of resources can be read as an anxious introjection mimicking the inanimate properties within the dining room surroundings, but somehow present from the time of before. To be clear, the expectations placed upon me as an educator are not introjected. I have been told explicitly by Godfrey that my role is to teach, share expertise, and see patients as a way of filling the educational gaps while visiting

the university hospital setting as a guest faculty member. But the unconscious adaptation of my mind attentive to an empty table is perhaps less to do with the concrete educational issue of specific curricular resources, but rather a working through to arrive at an understanding of myself as a learning resource in relationship to the questions that I have about being an educator. And this requires memory where my interpretation of the work that I do passes through the history of my own education.

My awareness of emptiness and the question of its meaning enacts a kind of doubt tuned into days gone by where deficiencies that I didn't know about myself were made clear and coalesced in the name of education. I recall being in my last year of medical school and things turning really sour for me. I had always struggled with multiple choice questions, having relied primarily on my ability to perform music for most of my post-secondary testing. At least this is what I told myself or wanted to believe. In any event, I got three consecutive "red flags" on tests that were given to our medical school class to ensure we were all on track. I was in trouble. Or more appropriately put, I was trouble. I got a letter indicating that I would be asked to see someone to guide my progress and to provide support through the program in order to help me be a successful student. This support person turned out to be a middle-aged euphemism seemingly unimpressed with the perceived ineptitude that sat in front of him. In short order, he told me I did not have what it took to be a physician and that I should strongly consider leaving medicine. End of story. Not once did he ask if there was anything going on in my life that might leave me not at my best. I did not tell him that my marriage, like many other partnerships struggling with the demands of medicine, was unravelling. I did not tell him that I was trying to put together a life as a physician, which I loved so far, while another part of my life was falling apart. Instead, I told him that I was capable of being a physician and that I would do the work

needed to be done in a way that I knew I could and would be successful. His sneer would exculpate any possible interpretation other than a skepticism, confident of the desperate and naïve incompetence he was trying to cleanse the profession of.

To me, a tragedy occurred in his empty utterance. I was a danger to medicine, in the same way that Sacks' research supervisors described him, resulting in his banishment to the backwoods of patient care. Similar to Sacks' experience, those representing institutional leadership had a mandate to invite students and their situations that would inevitably fall "outside the norm" precisely as an example of educational success and not liability. My outsider status came, in part, from a former education in music. Sacks, as I have surmised, was an outsider because he did not have success as a bench scientist, but also because of his sexual orientation and his insistence on thinking in a manner that could go beyond empiricism. The faculty member, if he was aware of my "outsider status" could not or would not engage the work of "setting the table" for me, for others like me, and for others who were yet to arrive on the educational scene at medical school who shared similar life experiences. Yet, the work was unfortunately not seen as educational work. The ill-informed judgement by a non-physician male who was a literal stranger to me and only knew me as an effect of testing metrics would act on behalf of the institution and deliver an empty pronouncement about me. The road to arrive at the empty table in a Ugandan guesthouse, where facing my fears of having nothing to offer as an educator can be read psychodynamically as an introjection where I became the doubt apparent in his pronouncement.

I see now that the problem has less to do with me personally and my assumed emptiness in medicine, and more so to do with a void and how we both experienced it – educator and student, and in its wake, how it helps us to think about resources in medical education. While the

gentleman who made the empty pronouncement may have also been an effect of the weariness that Arendt (1993) describes where newness is anathema to the practice of education and therefore received me with a beleaguered hostility, I needed to survive it, nonetheless. His hostility, as Arendt predicted, enacted a sense that my newness to education was like a form of invasion. But it strikes me that there was an opportunity for this gentleman to either step aside or work to overcome communicating more than his hostility. It is not difficult to imagine how it is that I have emotional antennae attuned to empty spaces. However, beyond this awareness, the emptiness that occurred in the transaction enacts an opening to think deeply about it. How then to think about emptiness as a resource problem or as a potential resource?

Emptiness

I turn now to the idea of how emptiness can help me as an educator withstand this situation. In short, extricating myself as the problem to identify what else might be happening realigns my orientation to it and to myself as an educator. I have, in so many words, spoken about his words as an introjected illness that amputated any idea of my educational potential, which I too readily embodied until the work of coming to the table and working to set it right. In naming the etiology of this illness introjection which behaves like an annihilating emptiness, I now have a pinpoint location to guide a kind of psychical excision made possible through leaning on the work of Togashi. If illness or pain has been psychodynamically introjected, then psychical excision is surgically required, with the proviso that viable tissue remains intact. And paradoxically, the viability that remained, constituted the idea of a generative void as a way to help me to think as an educator. Togashi (2020) speaks about the use of emptiness as therapeutic tool in his psychoanalytic work, which he aligns with Ghent's idea of emptiness or surrender (Ghent, 1990 in Togashi). Ghent's idea of surrender embraces Eastern philosophy where, in

contrast to a western interpretation of submission or defeat, emptiness possesses a "quality of liberation and letting go" (p. 118, Ghent, 1990 in Togashi, 2020). In making observations about my story, what is it that needs letting go of and how is this interpreted or capable of being an act of resourcefulness? In departing from stunting educational ideas or practices, a void is indeed left. And while the western instincts are to fill the void, a commitment to the void emerges as an educational idea where the qualities of "freedom from any interest to control or dominate, as well as devotion to human relationships, and allows for creativity and development to unfold in the intersubjective field" (p. 4). This notion of another space described as a different kind of empty would see a dismantling of medical education paradigms where aggressive projections rendering the problematic student an empty transference decoy, must be dismantled with the hopes of something different, something less loaded, the heft of emptiness more apparent.

The emptiness of the table in the Ugandan inn and how it located a signal attuning me to past pain enacted on behalf of education, led me to the very resource that I had initially equated with a threatening attack. Here I discovered that a different conceptualization - that is, departing from a personal enactment of being a problematic emptiness (i.e., identifying as a nothing or a nobody in educational medicine) to thinking generatively about emptiness and its educational potential (i.e., the educational conundrum at hand) offered surprising joyful and creative emancipation not otherwise imagined.

Phantasmagoria and a Goat: Decolonizing Dreams

I return to a trope that Sacks (2015) repeatedly animates, particularly in his memoir chapter on Awakenings, but never says outright; that is speaking about the joy of not being taught but learning to teach, nonetheless. Sacks (2015) is fascinated by the uniqueness that constituted each postencephalitic patient he encountered, rendering a way of thinking that

paradoxically helped create symptomatic intelligibility out of patient observations he called "fossil behaviours" (p. 170) - behaviours that represented unconscious reactions, undeveloped in their signification of clinical differences. He notes, "it was a syndrome that included an enormous range of disturbances occurring at every level of the nervous system, a disorder that could show far better than any how the nervous system was organized, how brain and behaviour worked at their more primitive levels." (p. 170). He describes this phenomenon as a "phantasmagoria" (p. 170) which infers a kind of sequential orientation of images that may be imagined or real or dreamlike in its quality. And it is in this dreamy state of mind that a question is raised: how might the dream or the dreamlike state help the teacher in its strange approximation of reality? I return to a phantasmagoric scene I actually encountered in Uganda and narrate it precisely as a dream, not because it wasn't real, but because its enigmatic qualities render it strikingly similar to a presumed non-sensical series of events reminiscent of the qualities attributed to madness.

On my way to the hospital where I will have a full day of teaching ahead, I must go past the inn's small parking lot. I clutch nervously at my bag, demanding insistence of its presence, with nothing in it of significance. Today a goat stands where cars would typically be. A small group of people are gathered around it, talking, gesturing with animation. More people emerge from nowhere. A woman whom I recognize as one of the cleaners at the inn is brandishing a large, mean-looking rudimentary knife. She has dark eyeliner on. She turns to me and speaks. I am somewhat caught off guard by her acknowledgement of me. I find myself wanting to hide yet feel compelled to continue watching. She tells me she will slaughter the goat - she knows how. There is a pride in her voice that commands respect. It takes 6 adults who emerge from nowhere to help pull the goat up a set of stairs; one takes a back leg, 3 at the front of the goat pull on the

lead rope, another 2 try to push the goat's behind hoping that force will propel it where it needs to go. The silent goat will not budge. I wonder if he wonders about being pulled apart. Is the goat the bad guy or the hero? Or is the goat a bystander? I can't tell. The goat looks forward with a stoicism that does not betray thoughts or emotions. I can't read the goat. I find myself confused about this anticipated bloody mess happening in a parking lot. And what is she doing here? Why is she here? Is this what really happens when something is cleaned up? I wonder if yellow tape will be included in what feels like a crime scene not yet declared with a goat at the centre of it all.

So, what are the mad or psychotic properties in reading this scene as a dream that can act as a topographical map in orienting the educator? In other words, how can madness or wild thinking help us think as educators? In my scenario, there is a weapon being brandished, someone who claims an expertise with it, and a seeming victim or potential victims. And then a lot of anxious fluttering on my part, irrespective of how I imagine myself embodied within the scene. But the rest is up for speculation. In order to read this story as psychotic or as a dream-like fragment, the fantastical elements in this scene can be identified and which dominate the common vernacular renderings of psychosis. But in returning to Darian Leader's (2011) comments in chapter 1 about quiet psychosis, madness – as a phenomenon - is not easily nor readily appreciated. Something else is needed to make sense of a psychotic story. A suspension is required: a suspension of intelligibility over time that would otherwise foreclose on knowing what cannot be known, allowing the uniqueness of the situation to be exactly what it is. And only over endless random encounters and benign conversations, does the madness render itself obvious at the very moment when it constitutes its own intelligibility. Leader (2011) says in a world increasingly oriented and even coerced to "think in uniform ways, from the nursery to the

corridors of professional life" (p. 2), attending to psychical realities that are deeply individual, such as a psychotic belief or a dream, can be a welcome surprise in the creativity that it directs us to as a form of thought, precisely as educators. He goes one step further in reminding us how madness as a quality engages the world through a quote by a patient of a famous schizophrenia researcher, "In my world, I am omnipotent, in yours I practice diplomacy" (p. 14). In other words, psychical life in psychosis assumes a correctness that seeks its own cure. These suspensions are similarly counter-intuitive to educators; the nightmare situation of being in the front of the class as a teacher but not knowing how to teach the lesson nor when it will end highlights this. And this orientation to thought; at once suspended, tolerating unintelligibility and the suffering that it imposes on the educator primed for the expertise of delivering a learning cure at every turn acts now as a new form of education for the educator. Otherwise put, the problem may be aptly understood as being mad without going mad as an educator. It is the very primitive dimensions of the dream which presents its own reality in brute form; that is, we cannot argue with it because it veils its own procedures. The manifest meaning of the dream is less important as opposed to the latency of understanding that is being missed, highlighting the idea of a "missed experience" which signals an atonement to it. It is this precariousness of intelligibility that Sacks also knew how to lightly hold, so to speak, in his discovery of awakening amongst his patients which was never a phenomenon with "immediacy." I am seeing dreams, broadly applied here, as one of the decolonizing antidotes to learning where the grip on certainty loosens and offers temporal possibilities anew through stall tactics employed against the reflexive, immediate need to arrive at conclusive certainties, without getting lost in the dream. I found it through my story of a goat in Uganda.

Hospital Gates

Arriving at the hospital grounds in Uganda, the smell of fear, acrid and anticipatory surrounds me. I don't need to bend my ear far to find explanations. I overhear two young people working at an open-air hospital kiosk selling soap and biscuits talking in English loudly enough that I can eaves drop. The one insists that her colleague is not taking seriously enough the nefarious possibilities of the hospital. "Gwe (i.e., casual use of the word "you") – you should be fearing. They can inject you and you don't even know if they have given you poison."

Doubt about western medicine hems the road to it. I smile with the recognition that I too am one of the doubters, acknowledging that while the source of our leeriness may be very different, the shared distrust in medicine is not groundless, to be sure. I find myself asking the same question these two kiosk dwellers are asking about the psychiatric hospital, which is, "What is actually going on in there? What happens?" Good questions with no clear or obvious answers.

Passing through the gates to the Psychiatry Department that never get locked, one response to the question, "What happens in there?" is offered. I see a colleague who works as a physician's assistant and we greet each other, speaking briefly of the day's work ahead, recognizing that he will see upwards of 80 patients. There is much to do, but I don't have the same kind of dread that, at times, finds me at home when there are large clinical loads and teaching duties. As we talk, a young woman comes to the sloped driveway where we stand. She is tiny and dusty with Ugandan soil clinging to her. Perhaps she has come from the farm or the village. She kneels on her mud-soaked skirt and asks my colleague for support. I have come to understand that support typically refers to money but can really mean any number of things that in the end will result in some kind of unpossessed resource. He gently declines her request. She

is so pregnant I wonder if she will deliver on the driveway. She then genuflects in front of me, her nose stretched so far over her taut belly I am certain gravity will topple her over.

A few days later, I accompany the Ugandan residents where we are asked to see this very woman, now postpartum on the obstetrics ward with her limp, HIV+ newborn. She handed the sleeping infant to me, again in a kneeling position while the residents looked on with a collective affect I found difficult to read. The mother is so very unwell and her newborn is eventually apprehended from her. It is her fourth child she has been unable to take home.

Stepping back to think about this devastating scene as an educator who is trying to locate it psychodynamically and then comment on its potential as an educational resource, I wonder about the notion of deferral and its application. While there is undoubtedly much to say about the depth and complexity of this situation in that somebody wants something, somebody needs something, and that someone has to suffer their fate, what I will directly comment on is the temporality of learning which presses upon me as an educator. The moment can be recalled as a story in its complex devastation; but it is also as a story that comes from behind. Possibilities of intelligibility or defense against the painful losses in this scenario collapse into a singular demand to stay with it over time. In other words, I could not tell this story before now, being frustrated in an attempt at doing so because I could only encounter the story while experiencing it through estrangement or as a fragmentation best described as an educational deferral. *Nachträglichkeit*, a notion introduced by Freud and later expanded upon by psychodynamic experts (Eikhoff, 2006) to orient us to that which occurs in the time of after, speaks also to the work of education in this scenario which was simultaneously never there but is present only in the time of now as a deferred experience. The resource of temporality is perhaps too simplistic in its description; it is more likely the associated affect that accompanies time which can be thought

of as a resource. Specific to this scenario, the learning experience can be equated with frustration and where learning becomes a state of frustrating uncertainty which takes a temporal toll on the educator. Frustrating indeed, as the role for the educator becomes obtuse when what was needed was not only the moment, but the iterative moments of the story that had no context. Herein lies the educational problem. I watched, and in doing so, joined the learners in reverting to a kind of countertransference directed towards the woman where we acted out a historical interview that emerges earlier in this PhD dissertation; we took her history and asked, is she mad or not? In pointing this out, I am not making a criticism so much as an observation about a response to the impossibility of knowing in medicine, the perceived mandate to demonstrate and to embody expert knowledge and be the leader of it. So how would deferral help me think in this scenario? This question does not have an easy answer in that the stall tactics of learning would seemingly require time, or rather insist that I bear the burden of the story to register and coalesce, but only once the deferral has occurred. Perhaps, this encounter leads me to understand that learning for the educator (and the student alike) is enduring a period of gestational uncertainty where the delivery of knowledge worth having registers after the moment is gone.

Maggots and a Sleeping Educator

I enter the hospital building and turn the corner towards the small nursing station that contains all of the drugs for the entire psychiatry ward in 2 small carboard boxes, gingerly placed upon one rusty shelf. I can smell the clinical encounter before my eyes register the event that would never otherwise be encountered in a Canadian setting. With the Ugandan residents at my side, we come upon a girl seated on the bench in an open space where patients will settle during rounds. Urine is steadily running out of her and there is a small pool underneath her, the sun glinting on its surface, unaware of what it was bringing to light. She looks down and does

not speak. The head nurse tells me that the young woman has been escorted by the Obstetrics and Gynecology team and "dumped" at the psychiatry ward. Funny – in Canada, being given someone else's work is also called a dump. But it is striking here in this context how the language of inconvenience and waste is too close to home. She was not wanted on the other ward, signaling a need for a place where the outcasts go. Psychiatry is the obvious place.

The Ugandan residents immediately get to work, doing what they think needs to be done. I am not really sure what they think it is that is required but the sense of ownership and responsibility for this patient that is not theirs is remarkable and deeply moving. They quietly get gloves, shoo away the peering eyes of other patients and caregivers, politely asking for the privacy they too would desire, and kneel close enough so they can speak quietly to the mutism that is in front of them. The young woman tenses around the male residents and they are aware of her resistance. She is small, unkempt, has terrified eyes, and the smell is almost dizzying as the urine continues to leak. The female resident beside me registers an absent affect, almost shellshocked. Maybe I am projecting but I can only read an atmospheric blank that hangs in front of all of us. I am the only faculty around at the residents look to me. I proceed to kneel in front of her and greet quietly. She looks frozen but utters her greeting in barely-there whispers. Speculations happen around us. How did she get to hospital? What happened? Has she attempted an abortion and in doing so, punctured the bladder? Is she mentally unwell? I ask if she will come with me and a female resident. Can we help her? Can we examine her? She is crying. I offer her a tissue. No one else has one because tissues are a luxury item. She accepts and we go to another room. A space actually. I use the term "room" too loosely. It is the alcove at the entrance of the department where the nurses stand to give out free medications to patients who wait the length of a day for government hospital prescriptions. There is a large window

opening to the public and a door that does not completely close. We have a sheepish, uncommanding divider that almost doesn't do the job of interrupting lines of vision. I am gagging from the smell. The patient says little, mostly grunts and looks away. She allows us to examine her but there is nothing much to see except the steady leak of urine. Everywhere is wet despite the sun that warms the air. We call for another nurse who speaks the patient's local language. She is tough on the girl. I read this as a response to perceived victimhood but the truth is, I am lost in arriving at any understanding. All I have is the grasp of speculation. The nurse interrogates the silent girl and I am reminded of Bartleby in her preference not to respond.

Later the nurse who speaks the patient's language comes to me and tells me that after the resident and I left the bedside, she was able to get some answers from the silent patient. I asked about the verbal encounter, curious to hear about the cadence of affecting communication, anticipating a dull agogic exchange leading to an otherwise silent exchange. The nurse is flat in her expression but reports with the slightest tinge of pride in her voice that she said to the girl, "You will die and your insides will rot so that maggots are coming out of you and yet we don't know what has happened to you." According to the nurse's report, the fear of uncertainty easily convoluted into a threatening, pressing, lethal etiology staring down the girl's preference not to speak, and animated in her the ability to respond. She does eventually speak: she is pregnant, with syphilis, and has made an unsuccessful attempt at an abortion.

I recall what it was like to be actively in this scene as an educator, its disorienting and elusive qualities were felt in the silence of the patient, in the blank stares of the learners, in the rigid one-dimensional qualities of the scene, with only a series of somatic clues pointing to investigative work as a way into a problem that was yet to be determined. I too felt that my line of vision was compromised in seeing clearly what was happening. But the problem was and is,

always a scene that works in a currency of incomplete fragments. An image of a juggler throwing up balls in the air, each with an important, apportioned bit pertinent to the case; symptoms, pathology, diagnosis, etiology, patient care, hospital culture, gender, healthcare systems, education, trauma, alienation, etc. go up and down and my instinct as an educator is to grab one to stop the dizzying pendular complexity that is in front of me, if only to steady myself. The narrative, however, is told as a coherent educational case which is precisely cohered as a deferral, similar to the case of the woman on the driveway. I wonder if the situation would have me name my own educational framework revealing itself to me in Uganda as "Thinking as forgetting."

But if I step back from this scene and make an attempt at treating it like a transference object, opening up new way of thinking about educational problems instead of personalizing them, this case highlights a trope of being strange in this event, somewhat like a static position with unknown coordinates on a map. Even moving from one point to another in the story was confusing and also reads this way as it is told. Nothing made sense. Nothing seemed right. I have attempted to highlight a position where all characters "made strange," resorting to a state of self-alienation with a purpose. But this is not the first time I have educationally experienced nor observed this affecting state in others and its repetition signals something important for me; by this, I am referring to an affective educational marker that psychodynamically points to the transference. Uncertainty here may be read as a kind of denial or regression to an earlier state of not knowing where all are tongue-tied. An easy association can be made here with the scene in chapter 2 where Sacks participates in one of his earliest accounts of journal club, a time dedicated to expert medical knowledge, but finds that he along with his fellow learners are also unable to locate language, manifesting a kind of developmental regression that is specific to

education. What is there to do when there is nothing in the moment to do? Can forgetting then be a resource? Did the girl threatened with death by maggots really not recall until she did? Why is it that she or anyone remembers anything painful at all? Did the learners really go blank or is this a projection on my part as a clinician educator? How can the educator who is lost be helpful in a psychical about face where expertise tied tightly to recall has unravelled? This paradox emerging within the story is only understood as an afterthought, not intelligible in the moment, but is provocative for educational introspection, nonetheless.

Despite the knowledge and skills that surrounded this youth in the form of the team, a kind of ruthless forgetting can be read as the transference, where forgetting or silent denial is the affecting defense called upon to stay the course as an articulation of difficult knowledge in a deeply traumatized learning encounter. It can also simultaneously be understood as a resource for the educator.

Britzman (2015) alludes to this very situation by stating,

> …how are we to advance theories of pedagogy with a capacious understanding of learning that recommends emotional life as our significant resource for thinking anew? May we write psychoanalytically and use the psychodynamics of pedagogical exchange as our best specimen? (p. viii)

Britzman's (2015) *A psychoanalyst in the classroom: On the human condition in education* speaks of forgetting by describing it as an "idea that what we do not know; as well as what we do not want to know anything about, instructs the knowledge we thought we already had" (p. viii). The quality of this forgetful space is what I am interested in here. The story reads on the one hand, as a kind of educational vacancy in that no one really knew what was going on and had the fearful effect of a "hot potato" where no one really wanted to touch it. On the other

hand, the scenario is alive in its painful suffering and the need for its cause to remain uncertain in order for intelligibility to have an effect as an act of deferral. If the quest to understand had been foreclosed on and premature assumptions or pronouncements made, least of all by the educator in this scene, the story would have been altered dramatically and perhaps, for the worse. But no one did this, or perhaps could do this, instead those involved in the scene mostly assumed a questioning stance which demanded specificity enough to move beyond an initial ineffability and landing at an articulation of "what is going on in there?" Although the embodiment of this question may not have provided an immediate answer, our bodies, and specifically my body enacted the query through a shared encounter with the learners, the staff, and the patient where I as the clinician educator in this scene, had to rely on a space of psychodynamic forgetfulness to draw me into a closer kind of examination of this story. I will do so by turning Swartz and Togashi to help me bring a new meaning to the use of affective denial or forgetting.

Swartz (2019) says of the scene of the infant and the mother, "The infant cannot use an emotionally absent or overwhelmed or terrified mother ruthlessly. Total presence is essential to survival…" (p. 8). She goes on to say, "Tolerance is too passive a word to describe the quality of survival to be summoned while being used ruthlessly. It requires putting much else aside" (p. 7). In other words, to survive means to simultaneously forget in the moment that one is engaged in a struggle to do so. The quality of the space that is holding or tolerating the ruthlessness of uncertainty in the story needing to be transformed but not yet ready to undergo such change, otherwise described as forgetful denial, is like a generative "ground zero" in this educational scenario. Something is happening in the nothingness, but not yet declared as a point of clarity. And this holding of a slumbering educational moment may be something to think of as generative placeholder, in wait of a rupture, but not yet ready to benefit from the painful opening that is to

come. The educational situation riddled with the threat of maggots is also similar to the one described by Togashi (2020) who writes about a patient repeatedly falling asleep during their sessions and then wakes to leave. Togashi gets anxious about the slumbering state of his client and must reckon with this unanticipated problem, relying first on the many different explanatory interpretations he generates to help him understand. These efforts turn out to be of no use to him. He concludes that surrendering to her sleep was all he could do. And in doing so, he fell into a shared, deeply human space unheeding of judgement and authority, where an unnarrated slumbering uncertainty that embodied the empty moment, even if is it a sleepy one, was essential for transformation of those in it. This, Togashi (2020) says, is also the place of an ethical turn; a place where both analyst and analysand are left empty handed by surrendering to an emptiness that is beyond themselves, a space that is exceeds the morality of right and wrong and relies on a purity inherent in human intersubjectivity. He also refers to this moment as "the psychoanalytic zero" which he uses interchangeably with the idea of an ethical turn. And to be clear, it may be reasonable to ask what is ethical about this turn, in particular for the analyst who we are using as an exemplar in thinking about the interactions of an educator with learners in education. Togashi (2020) suggested that as analysts, there is an awareness and an expectation as a professional that constitutes the job of addressing suffering for the analysand. However, he is suggesting that there is a moment that predates the awareness and "asks analysts to pay attention to the ways in which they and their patients encounter each other as human beings" (p. 29).

Coming back to the case of the girl whose death by maggots is imminently feared, but whose offering was one of silent suffering, enacted the very conditions for the educator to enter into and remain in, as much as humanly possible, and paradoxically, was the only possibility in that encounter. Education as embodied by me as the educator, is sleeping. And the sleep that I

speak of is not purposelessly futile but, the sleep that Togashi (2020) speaks of and can be thought of as a state of present engagement for an affecting forgetfulness that fails in the moment to respond but is as necessary as the surgical cure that will come for the young woman in need of repair. I will end with a comment that takes my own thoughts and translates them into a far more elegant statement by Swartz (2019) who suggest that quality of ruthless forgetting that I am speaking about is "common to both preservation of the original failure and subsequent thinness of concern, but also, in the right context, a reach for a new beginning" (p.9).

Taking Tea and Survival

Here, the common act of "taking tea" during the medical workday borders on sacred, I suspect, because it marks time away from unrelenting demands that are essential to survival. For me, it serves as a sort of placeholder in the day, a pause from the backbreaking clinical load and associated teaching, simultaneously recognizing the impossibility of the task and the good-enough efforts that are made nonetheless by all. I find that the tea break evokes in me a deep familiarity in a place that is miles away from home. I am reminded of my prairie Mennonite upbringing, a life that promotes simplicity, disavows the ostentatious, and where the everyday acts, particularly around work and eating customs, are infused with their own religious significance in an attempt to create meaning, precisely because meaning making has always silently been in question. Nonetheless, home comes to mind and I am left wondering about this thought association while I am here as an educator halfway across the globe.

During one of our afternoon teaching sessions, we talk about the importance of children. I have suggested that we "take tea" while we learn, wondering out loud about capacity for this act to "make concentration come." Concentration too has a will, as it turns out which can be stubborn when it is hungry. The reality that I have stumbled into is the dilemma that faces many

of the Ugandan psychiatry residents; that is, they also live at the edges of poverty and access to food often takes a backseat to rent demands or "airtime" for mobile phones.

We are learning about side effects of anticonvulsants which are commonly prescribed by this group to the many patients who suffer with the devastating effects of epilepsy. It is well known that these medications can reduce fertility as a potential side effect. I ask, "Who cares about sperm counts?" "I do" says one of the Ugandan male residents, without missing a beat. Everyone bursts into laughter. But it is no laughing matter. To be childless in this setting is a devastation that none can really imagine unless understood as a personal reality. A story is told by Godfrey about one of his patients; a male who has a severe intellectual disability. But he can get an erection and can be coached by relatives and neighbors about what to do with it. So, he is introduced to a woman in the community who is childless. And they are married and "produce" two children together. According to Godfrey, the wife willingly takes on the task of changing the diapers of her infants and her husband, because this maternal role, irrespective of the incapacities of the husband, brings a respect that clearly trumps the stigma of being an unmarried, childless female. Godfrey offers this story as a clinical example of a successful psychiatric outcome.

In my narration of this educational session and leaning on psychoanalytic metonymies rendered apparent from the narrative, the thematic of survival can be read into each of the characters and the necessary inter-subjectivities in the storied aliquots. Of course, I cannot speak for anyone other than myself in knowing what it was like to be there, as part of the scene. In an attempt to make psychodynamic observations about the educational scene and what it might tell me about common conflicts and resources, I stop short of making ontological or epistemological interpretations on behalf on another. But in returning to this narrative, I notice the thematic of

survival and how aesthetically idealized edges contain its storied contents. A sense of home pacifies the wandering mind, hunger is satisfied, barrenness is cured, education is successful, and the psychiatrist heals. These idealities are my own and provide a sense of what is at stake in the task of surviving education and the underlying pain of encountering loss and disappointment as an educational reality. This story also thematically returns and aligns with the four main educational elements which have already been captured thus far in my Ugandan reflections. These elements include: time and its delayed work, forgetting as a necessary form of affect, the void as a form of knowledge, and relying on madness as a creative antidote against cognitive ossification. While I highlight these ideas as corollaries in relationship to educational survival and what it may entail, I also am trying to make the case that there is a relationship at the heart of education that speaks to the difficulty I am trying to get at, raising the question of why survival in education matters at all and how its gendered qualities bring us back to a discourse from previous chapters.

If the idea of survival is to be any use at all to an educator, the question must be asked, when does survival become an issue for us humans? I am drawn again to the work of Swartz (2019) in considering the idea of ruthlessness in education as well as how we might think about it as a stratagem by surviving it. The concept of ruthlessness as it is understood psychoanalytically by Winnicott and described by Swartz (2019) introduces a kind of therapeutic non-compliance which occurs between infants and their mother, where infants use their mothers in the fight for their lives. Winnicott was an expert observer in interpreting these interpersonally poignant scenes between infants or children and their mothers. This dynamic struggle takes place at the breast where hunger demands satiation from the mother at all costs in order to survive. Swartz says that ruthlessness has particular qualities. “To be ruthless is also not simply to be

pitiless; in its full-throated demand, and in its expression, it embodies a vigorous act of trust. It is shamelessly naked, exposing the rawness of need as it is felt" (p. 7). However, Winnicott's observations ventriloquized through Swartz can be retrofitted to the educational stage and the observations I am making as an educator in Uganda, but also simultaneously surviving my own situation precisely as an educator, in order to think about it.

How does the educator survive and what is it that threatens existence? In returning to the four elements suggested above including time and its delayed work, forgetting as a necessary form of affect, the void as a form of knowledge, and relying on madness as a creative antidote against cognitive ossification, it strikes me that the demand for the educator is, in part, to be the site of embodiment of these demands so that education can be made intelligible to those wanting to learn, including the educator herself. For example, being present in the above scenarios is different than being "in the moment," recognizing that time and the educational moment do not always work hand in hand, leaving the educator in wait. And while in wait, forgetting to remember and inexpertly welcoming a void as a form of logic to employ as a temporary measure for the learners, which could prove as generative as entertaining what otherwise might be considered mad. In other words, the educator is of use while being used alive. And here I will embrace the analogy of the mother and infant unit but render a slightly different educational interpretation, which is the inter-subjective reality of the educator and the student. It is not only the educator that is surviving in this dependent arrangement, but it is the educational collective where the educator can be used, or even consumed in service of education itself.

Working with Winnicott's view, Swartz (2019) also depicts the situation between analyst and analysand as one of ruthlessness:

> We want to be eaten. Patients who are able to use us ruthlessly come to therapy to feed and be fed, all in the service of reaching beyond withdrawal from or persecution by an internal world made too present by a failure to survive. Winnicott suggests that to offer ourselves for eating in this way demands that we put aside our own preoccupations and ways of experiencing time. We are being asked to dream our patients, even when their capacity to dream might be damaged. (p. 8)

I consider this dilemma as interchangeable with education, and specifically with medical education. As an educator, I exist, or at least my desire is that I am used in the service of change for learners, not certainty. And this change, presumably takes something from me, first by making my bodily self available as a temporary site where students can find a shared location in the scene of education and then wander with imagination and authentic curiosity in attempting their own educational work. Implicit in this shared survival, is an educational desire. That is, I return to the question, "what's really going on in there [i.e., teaching hospital]?" And I can answer that by returning to my own affected state, which is to register the educational claustrum as not only problems of education, but life's problems as well. In recognizing this shift, I attempt new ways of intelligibility for learners through conflicts imaginatively transformed. Perhaps more simply put, to arrive at the same educational problem but to see it anew, albeit in a more interesting way is perhaps the essence of education. And for what purpose? Why bother surviving education?

It strikes me that I am writing or attempting to write with persuasion or compelling rhetoric that education can be organized categorically into a complex relationship with ethos, ethnos, logos, and pathos, all elements as case and cause for surviving life. So, can it be argued

then that life's problems are also educational problems, in the way that my observations bring me to the fore of an educational discourse? Surely, humanity is subtly at stake because, as Arendt has argued, something new comes into the world (Arendt 1993). The survival of the educational situation imbued with the dynamics of life is not much different than the analysand and analyst doing the shared work of ruthless survival reminiscent of the infantile vulnerabilities at play in starting life.

And I can add here that in my experience of "being used" or "being worn down" as an educator, there were obvious conflicts and emerging questions leading to the work of this PhD. But there was and also is an intense beatitude that accompanies my experience as an educator underscoring for me what it means to be alive. Swartz (2019) comments that the pain of being present and used ruthlessly as a mother for the sake of a collective survival with both mother and infant intact "is possible because there is joy just as deep and wide and engulfing as the state of being worn thin" (p. 8). Indeed. The wearing down may have left me weary, at times, but not worse for wear. Quite the opposite. It has led me to what Swartz (2019) describes as the aftereffects of surviving ruthlessness and the ruthless qualities of education. She notes that surviving ruthlessness as an inter-subjective encounter allows for the capacity to see, with compassion, the other as uniquely and distinctly different from oneself and also, necessarily, out of our control. This freedom from omnipotence, internally or externally imposed, otherwise interpreted educationally as surrendering the fantasy of being in control or being controlled, including the subjugation of learners and learning itself, is precisely what I am suggesting allows for the quality of ruth. Swartz (2019) concludes, "…ruth is compassion specifically for the other used ruthlessly in the service of survival." (p. 8).

CHAPTER 5

Afterwords

As I begin to conclude, I would be remiss without returning to Sacks (2015), my memoir guide, to draw upon his survival tactics documented in his chapter 'Awakenings' in coming to some of my own conclusions. I rely on this chapter not only because its title can be read as a pithy harbinger for the title of chapter 4, but also because I read Sacks' chapter on awakening as a psychoanalytic description of his personal coming alive in the same way that his postencephalitic patients did. In his awakening, he also emerged as a medical educator who has something important to say through both the prolific, storytelling brilliance of his scientific writing and his narration of being in relationship with writing. Sacks unequivocally situates his mother as central in coming to his case stories that would form "Awakenings," but also recognizes that her own skill as a storyteller, her deep interest in his narration of the authenticity of the individuality of the cases, and her faith in the importance of his scientific inquiry constituted the conditions of his storytelling as a form of negotiation in the pursuit of his own psychical survival and natality. His "use" of her in the writing of "Awakenings" was also temporally correlated with her death, a loss which he described as "the most devastating loss of my life – the loss of the deepest and perhaps, in some sense, the realest relation of my life" (p. 193). And here we get a glimpse into what Sacks was in pursuit of – and by this I am referring to an ongoing dynamic negotiation for an authentic, free self. The experience of losing his own mother shapes an understanding of waking up to the work of surviving education, both formal medical education where he was largely an outsider, as well as surviving the conditions of life's education through increasingly tender and intimate relationalities that could tolerate the necessary pain associated with it, including a deep connection with writing in cases.

In writing myself back into the field through autoethnographic encounters interpreted psychodynamically, I now understand more clearly how this act of taking apart and putting back together again is like having been strange and having made strange within a medical milieu symptomatic of the educational madness etched into its history. This self-alienation undertaken with an educational purpose can otherwise be understood as the early, albeit dormant efforts of in search of an "I." I could not see who I or where I was until the suffering discomfort brought to light by an entrance that was too near in its approximation, illuminated my positioning as a hospital person in relationship to myself. Through the process of writing into and around the narratives that have shaped educational questions predicated on the possibility of understanding, even if suspended or paradoxically made from fragments of unintelligibility, life, has snuck up on me, from behind, and tapped me on the shoulder pointing to a generative detour revealing alternatives to the authoritative practices made from masculine residue. Otherwise said, educational survival for me is really about an awakening made possible through thinking and writing in cases, delving deep into the psychiatric history that situated my extinction only to find decolonizing possibilities where authentic engagement can occur. Similar to Sacks, I too have written about the many ways in which education broadly speaking, represents the status of uncertainty demanding a ruthless survival of its opacities and resistance to voice through an orientation towards relationships enabled by my body, registered not only as an academic exclusion, but paradoxically as a gendered embodiment of the maternal potential for natality, capable of enduring a beleaguered or hostile welcome. I have settled into the fault lines where the divide between the idea of education and what has never been thought of as education has been worth the labour of interrogation because I have materialized in its wake. This ethical turn, a chasm of lost meaning precisely relying on these presumed spaces of uncertainty shared as a

deeply human condition along with those patients and colleagues I learn alongside, has transcended the exclusions that now seems antiquated, and offers a point of departure to create my own understanding of education. Coming to terms with the idea that I have been the subject of time, perhaps even unwillingly, I have come to relationally experience this forgetful void as a friend whose maddening yet creative qualities have become a new authoritative antidote to submitting to and enacting the fragile ossifications that I have come to understand as education. In this act of educational resistance, I have survived myself. This kind of object relating turned into object usage with my self as the object in questions has affectively illuminated a personal resource not understood until the time of now. I am useful to myself. And this brings me back to Swartz (2019) and her understanding of ruthlessness according Winnicott. She says that to be used ruthlessly, it "opens the way for a new form of relatedness" (p.7). Is this not the very definition of education? How is it that we can come to know ourselves and one another anew through the changing of our minds? While this may require maddening resources, it is, nonetheless, essential for the enlivenment at stake.

Bibliography

Arendt, H. (1958). *The human condition,* (2nd ed.). Chicago: The University of Chicago Press.

Arendt, H. (1993). *What is freedom? In between past and future: Eight exercises in political thought* (pp. 143-171). New York: Penguin Books.

Boler, M. (1997). The risks of empathy: Interrogating multiculturalism's gaze. *Cultural Studies, 11*(2), 253-273. https://doi.org/10.1080/09502389700490141

Bion, W. R. (1970). *Attention and interpretation.* London: Tavistock Publications.

Blechner, M. J. (2005). The gay Harry Stack Sullivan: Interactions between his life, clinical work, and theory. *Contemporary Psychoanalysis, 41*(1), 1–19. https://doi.org/10.1080/00107530.2005.10745845

Britzman, D. P. (2003). *Practice makes practice: A critical study of learning to teach*. Albany, NY: State University of New York Press.

Britzman, D. P. (2009). *The very thought of education: Psychoanalysis and the impossible professions*. Albany, NY: State University of New York Press.

Britzman, D. P. (2015). *A psychoanalyst in the classroom: On the human condition in education.* Albany, NY: State University of New York Press.

SUNY Press.

Britzman, D. P. (2011). *Freud and education*. New York, NY: Routledge.

Britzman, D., Guzel A., & Harms, S. (Forthcoming). Reading Foucault's lectures on Psychiatric Power. In D. L. Carson (Ed.), *Foucauldian philosophy and implications for educational research.* Routledge.

Carlat, D. (2010). *Unhinged: The trouble with psychiatry - a doctor's revelations about a profession in crisis.* New York, NY: Simon & Schuster.

Cavarero, A. (2000). *Relating narratives: Storytelling and selfhood.* New York, NY: Routledge.

Derrida, J., & Johnson, B. (1981). *Dissemination.* Chicago: University Press.

Eickhoff, F. W. (2006). In Nachträglichkeit: The modernity of an old concept. *The International Journal of Psychoanalysis*, *87*(6), 1453-1469. https://doi.org/10.1516/ekah-8uh6-85c4-gm22

Ellis, C., Adams, T. E., & Bochner, A. P. (2011). Autoethnography: an overview. *Historical Social Research / Historische Sozialforschung*, *36*(4), 273-290. https://doi.org/10.12759/hsr.36.2011.4.273-290

Felman, S. (1993). *What does a woman want?: Reading and sexual difference*. Chicago: John Hopkins University Press.

Forrester, J. (2017). *Thinking in cases*. Cambridge: Polity Press

Foucault, M. (2006). *Psychiatric power: Lectures at the college de France, 1973-1974*. New York, NY: Palgrave Macmillan.

Freud, S. (1964). Analysis terminable and interminable. In *The standard edition of the complete psychological works of Sigmund Freud, volume XXIII (1937-1939): Moses and monotheism, an outline of psycho-analysis and other works* (pp. 209-254). London: Hogarth Press.

Freud, S. (2006). *The Penguin Freud Reader.* London: Penguin UK.

Hirshbein, L. D. (2004). History of women in psychiatry. *Academic Psychiatry*, *28*(4), 337-343. https://doi.org/10.1176/appi.ap.28.4.337

Knoll, C., Watkins, A., & Rothfeld, M. (2020, July 11). *'I couldn't do anything': The virus and an E.R. doctor's suicide.* The New York Times. https://www.nytimes.com/2020/07/11/nyregion/lorna-breen-suicide-coronavirus.html.

Leader, D. (2011). *What is madness?* London: Penguin Books.

Levinson, N. (1997). Teaching in the midst of belatedness: The paradox of natality in Hannah Arendt's educational thought. *Educational Theory*, *47*(4), 435-451. https://doi.org/10.1111/j.1741-5446.1997.00435.x

Melville, H. (1995). *Bartleby, the scrivener: A story of wall-street, 1853*. Minneapolis: Indulgence Press.

Memmi, A. (1992). *The colonizer and the colonized* (expanded ed.). Boston: Beacon Press.

Pitt, A. J. (2003). *The play of the personal: Psychoanalytic narratives of feminist education.* New York, NY: Peter Lang Inc.

Pitt, A. (2006). *Love's return: Psychoanalytic essays on childhood, teaching, and learning*. New York, NY: Routledge.

Pitt, A., & Britzman, D. (2003). Speculations on qualities of difficult knowledge in teaching and learning: An experiment in psychoanalytic research. *Qualitative Studies in Education*, *16*(6), 755-776. https://doi.org/10.1080/0951839031000163213 5

Reed-Danahay, D. (1997). *Auto/ethnography: Rewriting the Self and the Socoial*. New York, NY: Berg.

Reeder, J. (2008). The enigmatic "nature of the subject" with philosophy at the interface of psychoanalysis and society. *The Scandinavian Psychoanalytic Review*, *31*(2), 114-121. https://doi.org/10.1080/01062301.2008.10592839

Sacks, O. (2015). *On the move: A life.* New York: Knop/Random House.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York, NY: Teachers College Press.

Swartz, S. (2018). *Ruthless Winnicott: The role of ruthlessness in psychoanalysis and political*

protest. New York, NY: Routledge.

Taylor, B. (2015). *The last asylum: A memoir of madness in our times*. Chicago, IL: University of Chicago Press.

Togashi, K. (2020). *The psychoanalytic zero: A decolonizing study of therapeutic dialogues*. New York: Routledge.

Vinogradov, S. (2017). Book Forum. Women in academic psychiatry: A mind to succeed. *American Journal of Psychiatry, 174,* 488 – 489. https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2017.17030317

Waller, W. (1932). *The sociology of teaching*. New York: John Wiley & Sons Inc.

Winnicott, D. W. (2014). *Through pediatrics to psychoanalysis: Collected papers*. New York: Routledge.