The Cure Within: A History of Mind-Body Medicine

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Rarely does a movie plot hinge on a rhetorical phrase, but literacy has its outbreaks. In the recent film *Stranger Than Fiction*, a character has difficulty convincing people he is not crazy after he tells them he hears the voice of an author narrating a story in which he is the central character, and his life is the plot. He finally convinces a literature professor when he reports hearing the author say, “Little did he know . . .” A phrase that does comparably heavy lifting in Anne Harrington’s book, *The Cure Within: A History of Mind-Body Medicine*, is “Were it not for . . .” Harrington uses the phrase only once, on my reading, but the usage expresses Harrington’s working method and the contribution of this book as a model for the cultural study of illness.

Harrington’s “Were it not for . . .” occurs in her book’s penultimate chapter, when she is describing the sixth of six core narratives of mind-body medicine. She calls this narrative “eastward journeys.” A protagonist, who might be a pop star or a physician, makes a journey—often physical but sometimes spiritual—to the East (most often India or China), in order to experience, learn, and bring back some wisdom about healing that is then translated into professional clinical practice or into lay health practices. What gives these stories traction? Why are they immediately recognizable and believable? The answer is that the stories are located within narratives that have already established themselves. Here, finally, is Harrington’s full sentence, referring to an episode in the *Healing and the Mind* public television series narrated by Bill Moyers and aired in 1993. “Were it not for Bruce Lee and Star Wars, it is possible that ‘The Mystery of Chi’ would have met a much more uncomprehending or hostile reception” (224).

Harrington, who is professor and chair of the History of Science program at Harvard, builds her history of mind-body medicine on progressions of “Were it not for . . .” Were it not for earlier stories that establish a recognizable narrative, present stories would not readily find public acceptance. Each *story* is local and specific; *narratives* are generalizable templates that generate multiple stories. As Harrington puts it:

. . . narratives provide us with tropes and plotlines that help us understand the larger import of specific stories we hear, read, or see in action. They also help us construct specific stories of our own—including ones about our own experience—that others can
recognize and affirm. We learn these narrative templates from our culture, not in the way we might formally learn the rules of grammar in school, but in the way we might unconsciously learn the rules of grammar at home—by being exposed to multiple individual examples of living stories that rely on them. (24–5)

Harrington’s distinction between story and narrative—different as it might be from some literary uses of those terms—is crucial to her argument. I read Harrington as practicing a form of social constructionism, somewhere between what Ian Hacking calls historical constructionism—“[t]he least demanding grade of constructionism”—and ironic constructionism. Historical constructionism describes arguments in which, Hacking writes, “ . . . X is the contingent upshot of historical events. A historical constructionist could be quite noncommittal about whether X is good or bad. How does historical ‘social’ constructionism differ from history? Not much, a matter of attitude, perhaps.” Ironic constructionism notches up the stakes. X is not only contingent, as “the product of social history and forces,” but also X’s contingency is troubling because the dependability of X counts in the reliability and security of some group’s world making. As Hacking writes, X is “an inevitable part of the world or of our conceptual architecture,” and it is disorienting to realize that X “could have been quite different.”

The health and illness of bodies are inevitable parts of our world, and so are medical explanations of disease and treatments. Readers of this journal (at least when we ourselves are not sick) may be accustomed to thinking of medical explanations as stories that are compelling because they are situated within familiar narratives, just as scientists are accustomed to the idea that most findings are provisional, pending further research. But such historical irony disturbs those who think that medical explanations are inherently true and prescribed treatments are more than contingencies that depend on when someone gets sick. For readers who seek finality, Harrington will be a disquieting author. Yet her storytelling is so compellingly readable that even those who are disquieted will be carried along by her effortless prose. The book is fun to read.

Harrington carries her constructionism lightly. Having introduced this distinction between narrative and story, she then leaves it in the background. It may be mostly a difference of what Hacking calls attitude that sets Harrington’s narrative version of medical cultural history apart from such scholars as John Hoberman, Roy and Dorothy Porter, or Sheila and David Rothman, yet this difference makes her
work more interesting to readers of this journal. Harrington shows little interest in moving to what Hacking identifies as the next grades of constructionism, the reformist and unmasking attitudes. Harrington’s noncommittal attitude will frustrate some readers, as she reports many of her students are frustrated; they want to know if these treatments actually do what they claim (250). Harrington finally discusses the efficacy of mind-body claims only in the last six pages of her book, and even there she sticks to generalities. Readers seeking a guide to which therapies might benefit them should look elsewhere. Readers wanting to understand what makes therapeutic stories compelling—how those stories build on earlier stories, how they seem to disappear and then reappear in mutated form—will be fascinated. “Were it not for . . . .” is Harrington’s forte.

Harrington employs a mixture of “firsthand observation, participation, and reading” (25) to describe the histories of what she considers the six principal mind-body narratives. First is “the Power of Suggestion,” involving a charismatic healer or convincing treatment that appears able to effect otherwise inexplicable improvement in a sick body. “The Body That Speaks” understands illness as the result of insults to or repressions of bodies that finally express themselves in symptoms. Cure depends on verbal expression or lifestyle change. “The Power of Positive Thinking” combines faith in the power of bodies to heal themselves with cynicism about the arrogance of contemporary medicine. “Broken by Modern Life” centers on stress, understanding disease as a product of what bodies are subjected to in modern times. The “Healing Ties” narrative emphasizes the necessity of personal connections—“social support”—for sustaining health; bowling alone is bad for your health. And finally, “Eastward Journeys” narratives depend on and perpetuate beliefs that there is a secret to health, and it can be found elsewhere, in forgotten and marginalized places and practices.

As Harrington tells stories that take their tropes and plotlines from these narratives, she moves seamlessly between popular culture and medical science. Each narrative has pop stars, whether the Beatles or Norman Vincent Peale, who popularize that narrative, and each has scientist-clinicians, some of whom become popularizers. Harrington does not doubt that mind-body medicine expresses some truths or that it can be effective, but she is reserved about what those truths may be, and how treatment effects can be achieved. Her interest is neither veracity nor efficacy (both of which require their own narratives in order to make sense as criteria). Rather, Harrington wants to know what makes narratives of mind-body healing so durable: why do they
stay around, with new stories emerging every decade or so, displacing previous stories, while preserving the core narrative?

First, the narratives “offer people a diverse set of cultural resources to make sense of their experiences” (245), a value that carries an implicit criticism of scientific medicine’s failure to help people make sense, even when that medicine is effective. Second, many mind-body narratives have origins in religions and resonate with religious practices or desires. Third, and speaking to why matters of health are such pervasive metaphors for multiple issues today, “large parts of mind-body medicine have functioned as amplifiers of a range of very distinctive moral and social concerns about the costs of modernity” (246). Fourth and finally, mind-body narratives hang around because, like stories, they are open to multiple interpretations, and this interpretive openness allows diverse people to meet quite different needs from the same stories. “[A]ll of the stories of mind-body medicine have been fluid and elastic things,” Harrington writes, “constantly on the move between one social context and another, and always available for appropriation and reapprropriation by different social groups” (247).

But most of us still want to know, do the treatments work, and for what? Harrington’s ending features four examples of what she ironically calls “bodies behaving badly” (251 ff). That phrase underscores the counter-cultural, against-the-empire quality of mind-body medicine. What Harrington means by “bad behavior” is the inexplicable non-conformity of some bodies to the expectations of mainstream medicine. One example is children in institutionalized care who suffer physical and developmental delays despite having their physical needs met. The explanation is that they lack emotional bonding to caregivers. A second example is statistical: the mortality rate dips before “major cultural and religious holidays” (252). Harrington’s third example is historical: Cambodian women went blind after being forced by the Khmer Rouge to witness the torture and execution of loved ones. And finally, the single, anomalous case of Mr. Wright, whose untreatable tumors “melted like snowballs on a hot stove” (quoted in Harrington, 252) when he believed (incorrectly) that he was receiving an experimental, life-saving drug, and who died quickly after reading a report that said the drug did not work. Harrington links only one of those cases, Mr. Wright, to one of her narratives, the power of suggestion. But using her framework, the cared-for but unloved children fit the “healing ties” narrative; the statistical shift in the death rate might fit either the “power of positive thinking” or the “body that speaks” narrative, depending on the individual and circumstances; and the Cambodian women exemplify the “body that speaks” narrative.
Writers like Rachel Naomi Remen (not cited by Harrington) present many “bodies behaving badly” stories, and Harrington can be read as showing how Remen gains such broad appeal by drawing on familiar narratives. Remen’s own autobiographical story—from mainstream academic pediatrician to storytelling healer—is a variant of the “eastward journeys” narrative. Like Remen, Harrington argues there is more going on in her examples than medicine can explain. Unlike Remen, Harrington is an historical constructionist who seeks a framework that places even “limits-of-understanding” stories into narrative templates, giving them a cultural location. The bodies may be behaving badly, but the stories about this bad behavior are told according to readily recognizable narrative templates.

In naming and exploring these narratives, Harrington remains anchored as a social scientist, seeking to understand the “modernist malaise” in which people are “drawn to ‘health’ and ‘healing’ as an arena for working out cultural and spiritual dislocations” (230). To remedy dislocation, people want to believe there is some wisdom out there beyond scientific horizons, and that wisdom can provide both spiritual and physical healing. But as good modernists, these same people want this wisdom “validated by science and updated to appeal to quick-fix consumerist sensibilities” (230). Harrington will make the quick-fix sensibility uncomfortably self-conscious. But if her constructionism offers any promise, it is that the stories will go on, whether or not they will fix anybody’s body.

To push Harrington’s narrative framework further than she might like, her book reaffirmed my belief that what counts as an effective treatment depends on what story the evaluator of efficacy is caught up in. The last word should go to a participant in one of David Spiegel and Irvin Yalom’s groups for women with metastatic breast cancer. Spiegel’s initial data from the group seemed to show that members had better survival outcomes than control cases, but subsequent replication studies did not confirm this effect. Harrington interviewed a woman who helped her sort out the group’s feelings about how participation affected them. “If you eliminate the concept of time,’ she told me, ‘I guess then that you could say that we live longer’” (204). Stories are all about time; by some accounts, narrative constructs time. What counts as longer depends on what your story does with time.

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NOTES

2. Ibid.
3. Ibid., 20.
4. Ibid., 19.

BIBLIOGRAPHY