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REFLECTING ON NARRATIVES VIA NARRATIVE MEDICINE: EMOTION THEMES DERIVED FROM NARRATIVES OF WOMEN WITH CANCER

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Abstract: *Narrative medicine* provokes physicians' deeper understanding and empathy for both patients and other healthcare providers. Materials that are used to provoke emotions and improve empathy. The aim of this textual close reading and literary analysis work is to discuss examples of life-writings and experiences of cancer patients from the perspective of emotional awareness and their presence during patient-health care professional relationship.

To achieve an understanding of the texts and emphasize difficult emotional themes, text analyses are grouped in a thematically manner.

The results of the narrative document analysis are categorized and interpreted as difficult emotional themes. Sub-themes are created as psychic pain, fear, shame, and anger. These emotional themes are discussed in terms of patient-physician relationship, empathy and the methods of Narrative Medicine.

We may create new alternative roads that can alter and transform patient-physician relations to a more humanistic structure, by close reading and reflective writing. Literary and textual exercises are need to be done regularly to gain narrative competence. Qualitative studies are needed to be done about the reflections of students, health care providers, and patients.

Keywords: narrative medicine, emotional awareness, life writing, illness narrative

Reflexiones sobre relatos desde la Medicina Narrativa: Temas emocionales derivados de las narrativas de mujeres con cáncer

Resumen: La medicina narrativa promueve en los profesionales de la salud una mayor comprensión y empatía, tanto hacia los pacientes como hacia sus colegas. Se utilizan materiales para generar emociones y mejorar la empatía. Este artículo, de análisis literario y lectura reflexive, tiene como propósito analizar ejemplos de relatos de vida y experiencias de pacientes con cáncer desde la perspectiva de la conciencia emocional y su presencia en la relación paciente y profesional de la salud.

Para comprender los textos y enfatizar los temas emocionales complejos, los análisis se agrupan temáticamente.

Los resultados obtenidos del análisis de documentos narrativos son categorizados e interpretados como categorías emocionales complejas, que incluyen subtemas como el dolor psíquico, el miedo, la vergüenza y la ira. Estos aspectos emocionales se discuten en términos de la relación médico-paciente, la empatía y los métodos de la medicina narrativa.

A través de la lectura atenta y la escritura reflexiva surge la posibilidad de crear nuevas vías alternativas que puedan reconfigurar y transformar la relación médico-paciente hacia un modelo más humanista. Es necesario realizar ejercicios literarios y textuales con regularidad para desarrollar la competencia narrativa. Por último, resulta necesario realizar estudios cualitativos que recaben reflexiones tanto de estudiantes, profesionales de la salud y pacientes.

Palabras clave: medicina narrativa, conciencia emocional, escritura de vida, narrativa de la enfermedad

Refletindo sobre narrativas via Medicina Narrativa: Temas de emoção derivados de narrativas de mulheres com câncer

Resumo: *Medicina narrativa* provoca compreensão aprofundada e empatia dos médicos por pacientes e outros prestadores de cuidados à saúde. Materiais que são usados para provocar emoções e melhorar empatia. O objetivo deste trabalho de leitura textual atenta e análise literária é discutir exemplos de escritos de vida e experiências de pacientes com câncer de uma perspectiva de consciência emocional e sua presença durante uma relação paciente-profissional de cuidados à saúde.

Para alcançar uma compreensão dos textos e enfatizar temas emocionais difíceis, análises de texto são agrupadas de maneira temática.

Os resultados da análise documental narrativa são categorizados e interpretados como temas emocionais difíceis. Sub-temas são criados como dor psíquica, medo, vergonha e raiva. Esses temas emocionais são discutidos em temos da relação médico-paciente, empatia e os métodos da Medicina Narrativa.

Nós podemos criar novos caminhos alternativos que podem alterara e transformar relações médico-pacientes para uma estrutura mais humanística, por meio de leitura atenta e escrita reflexiva. Exercícios literários e textuais precisam ser feitos regularmente para ganhar competência narrativa. Estudos qualitativos precisam ser feitos sobre as reflexões de estudantes, prestadores de cuidados à saúde e pacientes.

Palavras-chave: medicina narrativa, consciência emocional, escritos de vida, narrativa de doença

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Introduction

Narrative medicine is defined as ‘medicine practiced with the narrative competence to recognize, interpret, and be moved to action by the predicaments of others*(1)*.’ It provokes physicians’ deeper understanding and empathy to both patients and other health care providers, and evolves their medical practice through the aspect, which does not limit a patient’s illness story merely as medical history. Gaining this narrative competence requires humane and holistic approach to patient stories, effective listening skills, close reading and critical analysis of texts, and reflection on one’s own practices. Founder of the method, Rita Charon, resonates the need for narrative competence as; ‘Despite such impressive technical progress, doctors often lack the human capacities to recognize the plights of their patients, to extend empathy towards those who suffer, and to join honestly and courageously with patients in their struggles toward recovery, with chronic illness, or in facing death’*(2)*.

Mita Banerjee points out some features of life writing, which are agency and authenticity, by paraphrasing Joanna Shapiro’s interpretative approach to illness narratives, such as readers’ perspective and subjectivity, and the problem of telling a ‘true’ story from the accounts of the author/narrator, she also states her own interpretation about how reading first person autobiographical texts, and fictional writings differ in the essence: ‘There’s, of course, a subjective dimension to this experience as “objective truth” a dimension which exposes objectivity as a myth in the first place. Yet, I believe that there is a sense in which life writing accounts differ from fiction in the urgency they convey…’*(3)*. In order to understand the creation of an illness narrative, we need to interrogate, “how people, in the act of their lives, might change the stories they tell, might gain access to other cultural scripts, might come to understand themselves differently”*(4)*, but we, as the addressee, also need to ask how we’re being aimed to attach to a person’s illness narrative.

Autobiographies and patient illness narratives can enable us to witness one’s experiences, in the way that the narrator lets us witness. We can interact with people’s reflective emotions and thoughts about their situation. We can analyze different perspectives of her narration and critically think about ‘how’ these perspectives function for ‘us’ both as readers and health care providers. Charon emphasizes the importance of illness naratives or pathographies as a space for patients to tell their pain experience, to make their voice heard and to escape the dominance of disease on them*(2)*. Literary works and academic papers about pathographies are becoming a field of analysis about patient experiences and reconstructions of these experiences. Conveying an experience is a unique and self-reflective process, which is also highly subjective, and personal. That’s why it’s fundamental to avoid interpreting illness narratives only as a material, which conveys a ‘meaning’ via a constructed text. Additionally, we (as clinician and as readers) need to see these narratives as a journey that we witness and accompany and an experience of emotions that we convey through our own reflective texts. “We are all poets, narrators who symbolically give meaningful form to experiences, and in so doing craft and perform our sense of self and our worlds”*(5)*.

Healthcare providers who are emotionally aware and resilient are less affected by the negative outcomes of these factors. Medical education in all stages should contribute to emotional self-awareness skills. Joanna Shapiro defines emotional self-awareness as ‘emotional honesty’, and claims that ‘little effort is exerted to develop emotional honesty in medical students or residents’*(6)*. To develop emotional honesty, first, we should understand what emotion is and how it evokes. Lynn Worsham offers a definition for emotion, which includes a social and historical judgment and a strong bodily experience. Our embodied responses like emotions, are our connections to ‘social order and its structure of meaning’. So, healthcare providers should first analyze themselves and their relationality in society by means of their identity and its reflection on these bodily experiences. With the help of reflective thinking, textual analysis and writing health care providers can reach the source of their own emotional experiences. Illness narratives, wich are a genre of reflective personal expression, sketch new roads for healthcare providers to improve their empathic reflective skills.

Aim and Method

This narrative study aims to provide a comprehensive example of interpreting and reflecting on the life writings of women with cancer using emotional expressions. It is considered as the introductory study of first author's medical education PhD dissertation on Narrative Medicine and empathy education.

This study is designed as a narrative research. Data has been collected from published literary and reflective texts. To achieve a meaningful discussion from the texts and emphasize emotional themes, texts have been iteratively read and relevant topics groupe thematically.

Scientific, ethical and citation rules were followed in the writing process of this study; No falsification was made on the collected data and this study was not sent to any other academic publication medium for evaluation. Ethics committee approval was not obtained in the study, since data was not collected in a way that required ethics committee approval.

Emotion Themes

Psychic Pain

Every disease brings psychic pain of different levels not only to the patient but also to the people who care for that patient. These people are mostly physicians, nurses, caregivers, and at most the patient's family members. One of the most difficult and painful diseases that we encounter is cancer. Cancer is the insidious enemy of our age. Scientific journals are full of statistics about treatment of the disease and survival chances of patients. Numbers, which actually represent people, whose lives had entirely changed, mostly mean an everyday routine in a clinic, an academic advancement for a title, or a professional development for most of the clinicians. However, the emotions of clinicians are invisible or buried deep down. A person fighting cancer, especially during the active state of disease, is the person who experiences one of the most vulnerable and defenseless periods of life. Considering this life-changing 'chronic' experience is eternal for the survivor, one must develop new, regulatory, imaginative, and creative approaches to the new 'self', like establishing new maps with new roads to reach into the depths of mind and soul. These new ways of perception and thought can change a person's relationship entirely both within and out. Also, it's relevant to the survival mechanisms that a person usually uses before to cancer diagnosis. That's why for a clinician, it's firstly important to understand a person's history and character which are in use to deal with major physical and emotional trauma. Mainly this awareness leads to an ethical, respectful, and informative relationship between patient and clinician, in favor of the patient's autonomy and beneficence.

Here I'll discuss Audre Lorde's painful and traumatic cancer experience both as a self-healing process, and a social responsibility towards other women who share the same traumatic illness experience. Lorde was one of the most influential black, women, lesbian, and feminist, poets of the 20th century. In her bio mythography of how she became a poet, "Zami: A New Spelling of my Name", which she wrote long before her illness, she conveys her self, her otherness, and the different and intersecting components of her identity, within the time and space she's been living by these sentences: "Being women together was not enough. We were different. Being gay-girls together was not enough. We were different. Being Black together was not enough. We were different. Being Black women together was not enough. We were different. Being Black dykes together was not enough. We were different"*(7)*. The very first sentence of her 'The Cancer Journals' reflects the same approach to self-representation, from a different perspective. "Each woman responds to the crisis that breast cancer brings to her life out of a whole pattern, which is the design of who she is and how her life has been lived"*(8)*. She's also expressing her purpose of writing her cancer experience as a voice to be recognised, and respected. Her voice reflects the warrior within that she has been carrying through her lifetime. In addition, Lorde expressed an influential autobiographical agency, with an informative, insubordinate and transformative style of writing, to uncover the inequalities within the healthcare system by telling her experiences out loud. Her ideologic 'I's in her text reflects the clues of her attitudes towards the issues of gender, race, social discrimination, class and policies about community health:

"I do not wish my anger and pain and fear about cancer to fossilize into yet another silence, nor to rob me of whatever strength can lie at the core of this experience, openly acknowledged and examined. For other women of all ages, colors, and sexual identities who recognize that imposed silence about any area of our lives is a tool for separation and powerlessness, and for myself, I have tried to voice some of my feelings and thoughts about the travesty of prosthesis, the pain of amputation, the function of cancer in a profit economy, my confrontation with mortality, the strength of women loving, and the power and rewards of self-conscious living."

In addition, we can see how Lorde chooses to transform her emotions related to cancer, to create and address a community of shared experience. Her healing through writing is extending to a community of suffering women. She is aware of her detachment from her 'familiar identities' that she had known before cancer. She chooses this community that resolves the deep and estranged isolation. By giving voice to this community, she becomes familiar to her new 'self'.

Via her journal, Lorde is speaking in a rebellious voice, against discrimination that she has been subjected to. *"It hurts when even my sisters look at me in the street with cold and silent eyes. I am defined as other in every group I'm a part of. The outsider, both strength and weakness."* Being an outsider enables her to connect with her body from a reasonable distance. However, this causes alienation and consolidates her feeling of otherness. Lorde manages to disentangle the intense and complex feelings by writing and then reflecting on her texts. This awareness of the pain of otherness is the first step of communicating with the women who are also 'other'; sharing her pain and recovery, realize her changing priorities, and finding her stability again:

"Is this pain and despair that surrounds me a result of cancer, or has it just been released by cancer? I feel so unequal to what I always handled before, the abominations outside that echo the pain within…. I must let this pain flow through me and pass on….I need to remind myself of the joy, the lightness, the laughter so vital to my living and my health. Otherwise, the other will always be waiting to eat me up into despair again. And that means destruction."

Prosthesis is mostly offered to remove the visional inequalities. "…pain and all, expresses itself in the highly sexualized hegemony of denial and silence, signified by prosthetics." Lorde refuses to stay silent, and gives voice to her pain, fear and anger. She confronts the new state of her body and self, being aware of the value of staying still alive she manages to focus on and examine her 'real' body after mastectomy, by rejecting prosthesis. What traumatizes her again while she's in a progress of stabilization, is a nurse that she encounters during her first doctor visit after operation:

'When I walked into the doctor's office, I was really rather pleased with myself, all things considered, pleased with the way I felt, with my own flair, with my own style. The doctor's nurse, a charmingly bright and steady woman of about my own age who had always given me a feeling of quiet no-nonsense support on my other visits, called me into the examining room. On the way, she asked me how I was feeling.

"Pretty good," I said, half-expecting her to make some comment about how good I looked.

"You're not wearing a prosthesis," she said, a little anxiously, and not at all like a question.

"No," I said, thrown off my guard for a minute. "It really doesn't feel right," referring to the lambswool puff given to me by the Reach for Recovery volunteer in the hospital.

Usually supportive and understanding, the nurse now looked at me urgently and disapprovingly as she told me that even if it did not look exactly right, it was "better than nothing," and that as soon as my stitches were out I could be fitted for a "real form."

"You will feel so much better with it on," she said. "And besides, we really like you to wear something, at least when you come in. Otherwise it´s bad for the morale of the office."'

What we do, as health care 'professionals', is mostly coding some procedures that should be completed systematically. For this nurse, Lorde is still an 'incomplete job'; the mastectomy procedure has not been completed yet, because the patient is not wearing a prosthesis that will normalize her look. For us, after the procedure, the patient 'must' be very normalized to talk about the successful treatment. What we usually forget is what 'successful treatment' means, by ignoring the feelings and experiences of our patients. The more dramatic expression is that this nurse is aware of her feelings of discomfort, and she reflects them to Lorde via every way of communication; with her ignorant and disrespectful words, and with her disapproving mimics and gestures. Also, for Lorde, the nurse's words are the very symbol of an imposed figure of women in a society where the female body is objectified as a symbol of beauty. To Lorde, these are intensifying her feeling of otherness, her psychic pain. However, determined to stay as a 'survivor' and a 'warrior', Lorde refuses to connect new emotional roads that are established on the pain of otherness and incompleteness. She is familiar with rejecting the rules of patriarchy, and she claims whole control over her body, defending her autonomy:

'I refuse to have my scars hidden or trivialized behind lambswool or silicone gel. I refuse to be reduced in my own eyes or in the eyes of others from warrior to mere victim, simply because it might render me a fraction more acceptable or less dangerous to the still complacent, those who believe if you cover up a problem it ceases to exist. I refuse to hide my body simply because it might make a woman-phobic world more comfortable.'

Professional identity formation is an important topic that medical educators are researching effective methods to teach to health care professionals. In Lorde's experience, the nurse ignores her patient's feelings because she is trying to deal with her own emotions, as a woman at some time in her life, may need a mastectomy, as a woman who would have had a prosthesis if she needed the procedure. She may not even be aware of the source of her fears. She fails to react with her professional identity and respects the autonomy of her patient.

Fear

We should understand that starting from the moment of diagnosis; fear is going to be within for a cancer patient, even though she manages to survive. Death becomes more factual, priorities change, 'self' returns to another being, and another form of life. This alienation from the 'self' does not happen suddenly, and it depends on how a person relates to this new condition. Fear is constant and haunting. It may not disable the survivor, but paranoia and insecurity against the flow of life may traumatize repeatedly. One striking example is from Rita Charon, which she had experienced during her practice:

'I saw a patient in the office a few weeks ago. She had been diagnosed with breast cancer around twenty years ago, had a lumpectomy with five years of tamoxifen and was told she was cured. Recently, she developed a second cancer in the same breast. She treated this recurrence very matter-of-factly, submitting to a mastectomy, declining breast reconstruction, saying she was too old to need that. She recovered from the disfiguring surgery quickly, noncomplainingly.

Then she began to worry that the cancer would come back again. She felt new lumps in the mastectomy scar and growths in the soft tissue under her arm. She was terrified that it would come back. She visited either the breast surgeon or me every other week. We did ultrasounds and tested her blood for cancer markers. We both kept telling her she was fine, that after an operation tissues shift as they heal, that her cancer markers were stable. She could not feel reassured, and so she felt we were deceiving her'(9, 10).

Charon becomes aware of the patient's fear of death, and after explaining what death means to herself, she also offers the patient to stand up with her, to accompany her during the lonely journey that she has been going through. She adds while reading her visit records about this patient: "I described what the patient had been going through. I described my assessment of the meaning of her fear of a third cancer, explaining that our role as her doctors was to stand with her in her fear. What they experience is a shared network of strong emotion, and fear. Charon is sensitive to the needs of her patient because she can feel the same fear and decides to share it with her patient instead of burying it down into the depths of her mind. She realizes that she connects with the patient's feelings with the help of the text (the hospital record) that she created. After this experience, she feels a strong need to confirm the connection and calls her patient. Her patient's response of being 'healthier and less afraid' causes her to interrogate different ways of communication through a mystical approach:

"Perhaps by virtue of the narrative work we do, we clinicians can expose the cosmic connections between medicine and all the other human enterprises that give and receive accounts of self, that enter through story-telling into contact, into relation, into world-making."

Audre Lorde also mentions in 'The Cancer Journals' how she managed to live, create and produce with the presence of fear but without being disabled by it:

'…fear and anxiety are not the same at all. One is an appropriate response to a real situation which I can accept and learn to work through just as I work through semi-blindness. But the other, anxiety, is an immobilizing yield to things that go bump in the night, a surrender to namelessness, formlessness, voicelessness, and silence.'

Mostly the main problem is to continue living psychologically healthy after a period of trauma. Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a life-changing, dangerous event. In Lorde's situation, the most prominent source of stress and fear is facing death. It is natural to feel afraid during and after a traumatic situation. Fear triggers many split-second changes in the body to help defend against danger or to avoid it. This "fight-or-flight" response is a typical reaction meant to protect a person from harm. Nearly everyone experiences a range of reactions after trauma, yet most of them manage to recover and survive. However, those who continue to experience problems because of PTSD may feel stressed or frightened even when they are not in danger.

As far as we know, emotions are usually contagious via senses such as vision, touch or sound. However, the transmission may be so subtle that we may not be aware that we are infected unless we feel it. Anxiety is one of those emotions that contaminates us via trembling hands, purple halos under eyes, frequent breaths, trembling voices, sweating, flushing, crying or sometimes a frozen silence. It is sneaky and reminds to us, to both patients and clinicians, when we do not expect it to happen. Therefore, it disables us, and blocks our communication both with ourselves and with others we encounter. It deepens alienation and isolation. Lorde manages to deal with anxiety through techniques of mindfulness. She explores the symptoms of anxiety, and finds other feelings to replace them like relaxation. She constructs new emotional roads, which are connecting her traumatic experiences to her presence more healthily and calmly:

'The visualizations and deep relaxing techniques that I learned from it help make me a less anxious person, which seems strange, because in other ways, I live with the constant fear of recurrence of another cancer.'

Shame

Cancer patients encounter too many uncomfortable and intrusive procedures starting from the diagnosis to the follow-up. Becoming naked, someone touching your body, and asking intimate questions, are some invasive procedures. All of these can make a patient feel invaded by strangers. Even though these invaders can be from a patient's family or relatives, they are mostly doctors, nurses, and caregivers. Susan Gubar who is a literary scholar, and has been dealing with ovarian cancer since 2008, tells her story and so many inspirational stories on her web page column in the New York Times named 'Living With Cancer'. Gubar explains how uncomfortable she feels when someone touches her body, and how her doctors handle this sensitive choice of hers, neither leaving her examination incomplete nor damaging her possession over her own body:

'Throughout 10 years of cancer treatment, I have wondered how the considerate physicians, nurses and technicians I encounter manage not to violate my sense of myself, especially because I have always felt anxious about being touched by strangers — even in benign circumstances'(11).

Procedures are more complicated, mostly when they are also physically painful. Parts of bodies are sacred and exposing them to strangers for one's own sake is a kind of revelation. However, for patients, it is hard to perform these types of rituals as a routine, daily happening, especially when conditions are more difficult than we assume. For patients, especially with cancer, every follow-up visit, and every diagnostic or treatment procedure is some kind of exam or trial where doctors are examiners or judges. Their bodies will be assessed and evaluated for a decision to pass or fail, and what if they fail? This is the haunting question that determines how she'll be living the rest of her life.

'On numerous occasions, we have to be prodded and pierced. Our skin is shaved and painted, our bodies sliced open, various growths excised, sundry organs lopped off, and then we get stapled or stitched back together. At subsequent office visits, fingers press into our flesh, pushing into mouths, necks, armpits, breasts or bellies. Without any preparation, we must devise tactics for dealing with the physical intimacy of treatment'.

I guess that every woman remembers her first gynecologic examination. The invader transvaginal ultrasound device passes the barrier of perineal muscles and reaches the warm entrance of the cervix, conqueror! As Gubar emphasizes, during this kind of intimate relationship between a doctor and a patient, the patient's body becomes the agent of a way of communication. However, only the doctor would understand the monologue, even if sometimes it's an inner monologue. Gubar refuses the one-way feature of this interaction and changes it into a dialogue, a more proper and fair sharing. As an 'experienced' patient she finds ways to build bridges, to share the momentary microclimate, to create new roads of emotional maps. We as physicians, have a lot to learn from our patients:

'While waiting for radiologists to insert tubes into my body or for nurses to instruct me on wound management in the past, I tried to keep up a continual pattern of questions. The humiliation of bending over for a rectal exam, the discomfort of a gastrografin enema; before the creepy corporal proximity of exams, I queried those in charge — not to take my mind off my body, but instead to somehow embody them. How long have they worked here? Where did they come from? I wanted to remind us that their touching me meant that some part of me was touching them'.

Gubar also mentions shame from a different perspective. While she is writing about mourning for a 10-year-old boy named Seven Bridges who had a colostomy, and hanged himself because of being bullied, and subjected to racist insults by his classmates, she shared her experiences about having an ileostomy, and dealing with the leaks and smells. Humiliation and stigmatization are the signature of intolerance. It is an intolerance against being out of defined and imposed social norms, which defines the integrated and aestheticized bodies. She also mentions that because of her memoir 'Memoir of a Debulked Woman', she has been criticized by a reader, for causing harm to people who had the ostomy procedure. She defends herself by pointing out the potential damage that patients would be subjected to if they become silent about their emotions, like shame:

'Is shame so toxic an emotion that articulating it promotes it? Yes, I concede, shame may be contagious. In an effort to grapple with my shame, I express it and you, recognizing our commonality, catch it. Ought I therefore be ashamed of my shame and stifle its expressions? But silence can intensify shame, just as shame can intensify silence'(12).

Anger

What we should consider about anger, also with rejection, is that it can be the first reaction to an actual and sudden life event. As far as we understand from her journals, Audre Lorde experienced this sudden fierce anger against her breasts, her body. What she claims that she had felt, the betrayal, personalized her body and creates a dualism between her mind and her body:

'The year before, as I waited almost four weeks for my first biopsy, I had grown angry at my right breast because I felt as if it had in some unexpected way betrayed me, as if it had become already separate from me and had turned against me by creating this tumor which might be malignant. My beloved breast had suddenly departed from the rules we had agreed upon to function by all these years'.

The aggressiveness, and metastasis ability of cancer cells are affected by the microclimate of the cells. Lately, it is a major research field about immunotherapy-based cancer treatments, and one may find multiple articles about how to control the spread of malignant cells in a several

cancer journals: 'Cancer cells possess a unique ability to adapt to different environmental conditions, assuming different morphologies and migration characteristics to stay motile'. Alternatively 'The microenvironment influences the mode and dynamics of cancer cell migration'*(13).* What if the anger of a cancer patient can also spread? It is affected by the microclimate of the patient, and it can be controlled by the intense relations between these two. Who is a cancer patient's microclimate? For Lorde, it is the love of women that surrounds her, the community that she creates. Therefore, William Major in his article about Lorde's autopathography, precisely identifies the source of Lorde's anger, and discriminative approaches to cancer patients as I formerly mentioned:

"I believe that socially sanctioned prosthesis is merely another way of keeping women with breast cancer silent and separate from each other" Lorde unmasks the normative ideology of health by promoting her body's colour, deformity, and materiality… Shirley Neuman notes, "is that western cultures assume an analogy between mind, masculinity and culture, and body, femininity, and nature." Mastectomy, prosthesis and bra, are feminine norms about body and culture…"(14).

She strictly criticizes and refuses these "natural norms" that are imposed on women. One can consider these imposed roles on men, as rule-maker, and women, as rule-breaker. By patriarchy, a woman's anger is considered as a natural, feminine response of a rule-breaker, and should be rooted out. As a feminist scholar, Lorde expresses her anger, using violence against women:

"As women we have been taught to respond with a guilty twitch at any mention of the particulars of our own oppression, as if we are ultimately guilty of whatever has been done to us. The rape victim is accused of enticing the rapist. The battered wife is accused of having angered her husband. A mastectomy is not a guilty act that must be hidden in order for me to regain acceptance or protect the sensibilities of others."

Catherine Guthrie is another inspirational woman who refuses breast reconstruction aftera bilateral mastectomy. Her story also has subthemes about men's judgements about the female body, and the surgeon, with whom she discussed breast reconstruction, is the prototype of the indifferent and distant stranger, who is concerned about doing his job to correct the incorrect body.

"He sketched out how he would carve apart the largest muscle in my back. With one end of the muscle connected to its blood supply, the harvested flesh would be pulled through the empty socket on my chest and placed over a silicone implant. I saw a steak laid over a tennis ball.

"But isn't that muscle doing something?" I asked.

To which he answered, "You'll look normal in clothes; that's all most women want"(15).

As I see in both texts, anger is not easily identified and expressed, like fear or pain. However, I believe one can see one's own anger by reflective writing.

Conclusion

Healthcare providers could support each other to realize their emotional responses and gain appropriate control over them. We can remind ourselves that emotions are connected to our behaviors by mental roads that we are accustomed to acting on. We may always create new roads by close and attentive reading and reflective writing for the benefit of people who suffer.

On the other hand, life writing is a way of understanding, analyzing, and legitimating the emotions of both patients, and the people in the healthcare system that somehow intersect, and interact with patients, by creating a safe space for expression. When the author has the ability and courage to reflect on and communicate the experience with considerable narrative competence, this also stimulates a similar emotional response and understanding in the reader that can be related to aesthetic projection, and called empathy. Shared experience from different perspectives also contributes to the process of healing, engaging and connecting with oneself and the outer world again. In the texts I analyzed I have seen that all the authors create a new life that has a space for all the emotions accepted together, self-critically reorganized and reflectively expressed. I will finish with a concrete example of this from Audre Lorde's The Cancer Journals:

'I am 46 years living today and very pleased to be alive, very glad and very happy. Fear and pain and despair do not disappear. They only become slowly less and less important. Although sometimes I still long for a simple orderly life with a hunger sharp as that sudden vegetarian hunger for meat'(8).

While conducting the healthcare service, not only healthcare professionals' but also patients' perspectives should be included and acknowledged throughout the whole illness experience with all dimensions. Especially difficult and entangled situations that cancer patients face and represent via the illness narratives constructed as texts both provoke affective empathic understanding and meaning-making in the readers. This phenomenon, wich can either be named as artistic empathy or mutual creative and shared experience, is a new two-direction road established between a narrator/subject and an addressee -a patient and a physician, a patient and another patient- which seems to help the narrator/subject to reposition her identity as a cancer patient, and deal with traumas and difficult emotions, also provokes the addressee to give meaning to the experience of a stranger. Narrative medicine practices that create space, which patients and physicians encounter via texts, can open the doors, and prevent them from ignorance towards others' emotional status and different perspectives.

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